This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 09-30-2025

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0001	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/31/2024 1:57 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/31/2024 Time: 1:57 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR Of PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by JOHNSON MEMORIAL HOSPITAL (15-0001) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	Adam Putvin		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Adam Putvin			2
3	Signatory Title	CFO			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	84,503	-7,539	0	-256,309	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	1		0	9.00
200.00	TOTAL	0	84,503	-7,538	0	-256,309	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 1:57 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1125 WEST JEFFERSON STREET	PO Box:			1.00
2.00	City: FRANKLIN	State: IN	Zip Code: 46131-	County: JOHNSON	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	JOHNSON MEMORIAL HOSPITAL	150001	26900	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	JOHNSON MEMORIAL HOME HEALTH	157510	26900		07/01/1997	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2023	12/31/2023	20.00
21.00	Type of Control (see instructions)	9		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N		22.00
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y		22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2024 1:57 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	162	26	0	0	1,308	24	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.				57.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 1:57 pm

		V	XVIII	XIX	
		1.00	2.00	3.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N	63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 1:57 pm

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

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				1.00	
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)				
68.00	For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?				68.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00

			1.00	
	Long Term Care Hospital PPS			
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N	81.00
	TEFRA Providers			
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87.00

		Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
		1.00	2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.	N	0	88.00

		Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge	
		1.00	2.00	3.00	
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.	0.00		0	89.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	Y	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 1:57 pm

		V	XIX	
		1.00	2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
107.01	If this facility is a REH (line 3, column 4, is "12"), is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no. (see instructions)			107.01
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2024 1:57 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	720,614	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	Y	N	123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 1:57 pm

						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					N	149.00
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)						
155.00	Hospital	N	N	N	N		155.00
156.00	Subprovider - IPF	N	N	N	N		156.00
157.00	Subprovider - IRF	N	N	N	N		157.00
158.00	SUBPROVIDER						158.00
159.00	SNF	N	N	N	N		159.00
160.00	HOME HEALTH AGENCY	N	N	N	N		160.00
161.00	CMHC		N	N	N		161.00
						1.00	
	Multicampus						
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

				1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act				
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)				168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)				168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			9.99	169.00
			Beginning	Ending	
			1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)				170.00
			1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 5/31/2024 1:57 pm

		Y/N	Date	
		1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE			
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	07/01/2024	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	05/22/2024	Y	05/22/2024	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II Date/Time Prepared: 5/31/2024 1:57 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
	Provider-Based Physicians		
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?			36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TINA	SEVERS	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7946	TSEVERS@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 5/31/2024 1:57 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I Date/Time Prepared: 5/31/2024 1:57 pm

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	44	16,060	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		44	16,060	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	14	5,110	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		58	21,170	0.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		58				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2024 1:57 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,407	126	4,756			1.00
2.00	HMO and other (see instructions)	1,019	1,334				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,407	126	4,756			7.00
8.00	INTENSIVE CARE UNIT	379	11	1,515			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		25	480			13.00
14.00	Total (see instructions)	1,786	162	6,751	0.00	641.95	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits	0	0	0			15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	3	0	6	0.00	0.03	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	641.98	27.00
28.00	Observation Bed Days		0	3,030			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	24	67			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2024 1:57 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	505	45	1,860	1.00
2.00	HMO and other (see instructions)			231	413		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	505	45	1,860	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part II Date/Time Prepared: 5/31/2024 1:57 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	38,634,364	-76,277	38,558,087	1,335,317.33	28.88	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		1,926,155	0	1,926,155	21,078.44	91.38	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		731,672	-25,500	706,172	19,900.00	35.49	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		5,920,762	0	5,920,762	55,111.21	107.43	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		24,250	0	24,250	97.00	250.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		12,160,119	0	12,160,119			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		210,298	0	210,298			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		318,173	0	318,173			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part II | Date/Time Prepared: 5/31/2024 1:57 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	3,948,248	-5,389	3,942,859	162,990.34	24.19	26.00
27.00	Administrative & General	5.00	2,654,819	-8,046	2,646,773	60,721.23	43.59	27.00
28.00	Administrative & General under contract (see inst.)		766,479	0	766,479	8,844.24	86.66	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,032,829	0	1,032,829	34,759.28	29.71	30.00
31.00	Laundry & Linen Service	8.00	144,552	0	144,552	2,838.43	50.93	31.00
32.00	Housekeeping	9.00	889,733	0	889,733	34,073.28	26.11	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	723,417	-390,698	332,719	13,158.28	25.29	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	381,819	381,819	14,708.00	25.96	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,184,696	-10,463	1,174,233	24,711.70	47.52	38.00
39.00	Central Services and Supply	14.00	93,767	0	93,767	2,093.40	44.79	39.00
40.00	Pharmacy	15.00	1,144,226	0	1,144,226	23,133.53	49.46	40.00
41.00	Medical Records & Medical Records Library	16.00	712,495	0	712,495	26,077.67	27.32	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part III Date/Time Prepared: 5/31/2024 1:57 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		37,474,688	-76,277	37,398,411	1,323,083.13	28.27	1.00
2.00	Excluded area salaries (see instructions)		731,672	-25,500	706,172	19,900.00	35.49	2.00
3.00	Subtotal salaries (line 1 minus line 2)		36,743,016	-50,777	36,692,239	1,303,183.13	28.16	3.00
4.00	Subtotal other wages & related costs (see inst.)		5,945,012	0	5,945,012	55,208.21	107.68	4.00
5.00	Subtotal wage-related costs (see inst.)		12,160,119	0	12,160,119	0.00	33.14	5.00
6.00	Total (sum of lines 3 thru 5)		54,848,147	-50,777	54,797,370	1,358,391.34	40.34	6.00
7.00	Total overhead cost (see instructions)		13,295,261	-32,777	13,262,484	408,109.38	32.50	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part IV | Date/Time Prepared: 5/31/2024 1:57 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	911,916	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	7,451,330	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	71,535	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	94,882	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	261,087	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	3,875,294	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	22,546	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	12,688,590	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part V | Date/Time Prepared: 5/31/2024 1:57 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	5,920,762	12,688,590	1.00
2.00	Hospital	5,920,762	12,688,590	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 15-0001 | Component CCN: 15-7510 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-4 | Date/Time Prepared: 5/31/2024 1:57 pm

Home Health Agency I | PPS

						1.00	
0.00	County				JOHNSON		0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	0.00	0.00	0.00	0.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		0.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			0.00	0.00	0.00	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
						CBSA Data	
						1.00	
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.					1	19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).					18020	20.00
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	2	0	0	0	2	21.00
22.00	Skilled Nursing Visit Charges	0	0	0	0	0	22.00
23.00	Physical Therapy Visits	1	0	0	0	1	23.00
24.00	Physical Therapy Visit Charges	0	0	0	0	0	24.00
25.00	Occupational Therapy Visits	0	0	0	0	0	25.00
26.00	Occupational Therapy Visit Charges	0	0	0	0	0	26.00
27.00	Speech Pathology Visits	0	0	0	0	0	27.00
28.00	Speech Pathology Visit Charges	0	0	0	0	0	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	0	0	0	0	0	31.00
32.00	Home Health Aide Visit Charges	0	0	0	0	0	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3	0	0	0	3	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	0	0	0	0	0	35.00
36.00	Total Number of Episodes (standard/non outlier)	0		0	0	0	36.00
37.00	Total Number of Outlier Episodes		0		0	0	37.00
38.00	Total Non-Routine Medical Supply Charges	0	0	0	0	0	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 5/31/2024 1:57 pm

		1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.231115	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	10,826,060	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	83,098,288	6.00
7.00	Medicaid cost (line 1 times line 6)	19,205,261	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	8,379,201	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	8,379,201	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	2,807,921	136,664	2,944,585	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	648,953	136,165	785,118	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (see instructions)	648,953	136,165	785,118	23.00

		1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
25.01	Charges for insured patients' liability (see instructions)	649	25.01
26.00	Bad debt amount (see instructions)	5,862,866	26.00
27.00	Medicare reimbursable bad debts (see instructions)	50,257	27.00
27.01	Medicare allowable bad debts (see instructions)	77,318	27.01
28.00	Non-Medicare bad debt amount (see instructions)	5,785,548	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	1,364,188	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	2,149,306	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	10,528,507	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 5/31/2024 1:57 pm

		1.00	
	PART II - HOSPITAL DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.230634	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		5.00
6.00	Medicaid charges		6.00
7.00	Medicaid cost (line 1 times line 6)		7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)		8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP		9.00
10.00	Stand-alone CHIP charges		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)		12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)		16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	2,807,921	136,664	2,944,585	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	647,602	136,165	783,767	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (see instructions)	647,602	136,165	783,767	23.00

		1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
25.01	Charges for insured patients' liability (see instructions)	649	25.01
26.00	Bad debt amount (see instructions)	5,862,866	26.00
27.00	Medicare reimbursable bad debts (see instructions)	50,257	27.00
27.01	Medicare allowable bad debts (see instructions)	77,318	27.01
28.00	Non-Medicare bad debt amount (see instructions)	5,785,548	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	1,361,405	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	2,145,172	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,145,172	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/31/2024 1:57 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		3,328,085	3,328,085	0	3,328,085	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,779,614	3,779,614	0	3,779,614	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	479,609	10,908,930	11,388,539	5,640	11,394,179	4.00
4.01	00401	COMMUNICATIONS	210,012	246,400	456,412	0	456,412	4.01
4.02	00402	DATA PROCESSING	647,298	3,519,591	4,166,889	-141	4,166,748	4.02
4.03	00403	MATERIALS MANAGEMENT	439,979	35,158	475,137	-316	474,821	4.03
4.04	00404	ADMITTING	1,102,364	19,346	1,121,710	-1,043	1,120,667	4.04
4.05	00405	PATIENT ACCOUNTING	1,068,986	1,119,095	2,188,081	-89	2,187,992	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	2,654,819	11,618,079	14,272,898	-6,495	14,266,403	5.00
7.00	00700	OPERATION OF PLANT	1,032,829	3,601,381	4,634,210	-251	4,633,959	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	144,552	78,372	222,924	-521	222,403	8.00
9.00	00900	HOUSEKEEPING	889,733	126,237	1,015,970	-9,360	1,006,610	9.00
10.00	01000	DIETARY	723,417	361,453	1,084,870	-572,911	511,959	10.00
11.00	01100	CAFETERIA	0	0	0	572,594	572,594	11.00
13.00	01300	NURSING ADMINISTRATION	1,184,696	220,686	1,405,382	-96	1,405,286	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	93,767	58,139	151,906	-51,594	100,312	14.00
15.00	01500	PHARMACY	1,144,226	9,507,551	10,651,777	-7,833,924	2,817,853	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	712,495	307,752	1,020,247	-24	1,020,223	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,146,212	1,479,931	7,626,143	-499,381	7,126,762	30.00
31.00	03100	INTENSIVE CARE UNIT	1,680,414	1,473,458	3,153,872	-48,024	3,105,848	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	262,567	262,567	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,308,020	683,929	2,991,949	-307,484	2,684,465	50.00
53.00	05300	ANESTHESIOLOGY	2,122,910	603,546	2,726,456	5,376	2,731,832	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,537,615	1,058,251	3,595,866	-115,089	3,480,777	54.00
60.00	06000	LABORATORY	2,270,747	3,402,512	5,673,259	-227,591	5,445,668	60.00
65.00	06500	RESPIRATORY THERAPY	1,370,098	823,922	2,194,020	-70,041	2,123,979	65.00
66.00	06600	PHYSICAL THERAPY	1,043,432	23,680	1,067,112	-9,515	1,057,597	66.00
67.00	06700	OCCUPATIONAL THERAPY	326,377	250	326,627	0	326,627	67.00
68.00	06800	SPEECH PATHOLOGY	192,311	292	192,603	0	192,603	68.00
69.00	06900	ELECTROCARDIOLOGY	431,972	197,128	629,100	-14,670	614,430	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	49,439	101,464	150,903	-1,464	149,439	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,689,262	4,689,262	-1,246,030	3,443,232	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,773,369	2,773,369	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,454,450	8,454,450	73.00
76.00	03020	ONCOLOGY	611,907	110,542	722,449	-12,177	710,272	76.00
76.97	07697	CARDIAC REHABILITATION	170,197	147,095	317,292	-4,709	312,583	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	853,771	1,812,423	2,666,194	-293,134	2,373,060	90.00
91.00	09100	EMERGENCY	3,258,488	2,158,405	5,416,893	-153,255	5,263,638	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	24,744	58,658	83,402	0	83,402	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	37,927,436	67,660,617	105,588,053	594,667	106,182,720	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	205,389	32,727	238,116	-1,913	236,203	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	335,475	577,617	913,092	-7,091	906,001	192.00
192.01	19201	SOUTH CLINIC	83,261	597,925	681,186	-579,589	101,597	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	82,803	5,962	88,765	-5,500	83,265	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	0	0	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	894,247	894,247	-57	894,190	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	0	6,726	6,726	0	6,726	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	517	517	-517	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	38,634,364	69,776,338	108,410,702	0	108,410,702	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/31/2024 1:57 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-204,050	3,124,035		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	3,779,614		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-7,716	11,386,463		4.00
4.01	00401	COMMUNICATIONS	-32,308	424,104		4.01
4.02	00402	DATA PROCESSING	-239,831	3,926,917		4.02
4.03	00403	MATERIALS MANAGEMENT	0	474,821		4.03
4.04	00404	ADMITTING	0	1,120,667		4.04
4.05	00405	PATIENT ACCOUNTING	0	2,187,992		4.05
5.00	00500	ADMINISTRATIVE & GENERAL	-7,797,469	6,468,934		5.00
7.00	00700	OPERATION OF PLANT	-65,172	4,568,787		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	222,403		8.00
9.00	00900	HOUSEKEEPING	0	1,006,610		9.00
10.00	01000	DIETARY	0	511,959		10.00
11.00	01100	CAFETERIA	-217,098	355,496		11.00
13.00	01300	NURSING ADMINISTRATION	5,290	1,410,576		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	100,312		14.00
15.00	01500	PHARMACY	0	2,817,853		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-69,722	950,501		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-2,386,331	4,740,431		30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,105,848		31.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
43.00	04300	NURSERY	0	262,567		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,684,465		50.00
53.00	05300	ANESTHESIOLOGY	-402,650	2,329,182		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,480,777		54.00
60.00	06000	LABORATORY	-31	5,445,637		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,123,979		65.00
66.00	06600	PHYSICAL THERAPY	0	1,057,597		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	326,627		67.00
68.00	06800	SPEECH PATHOLOGY	0	192,603		68.00
69.00	06900	ELECTROCARDIOLOGY	0	614,430		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-100,000	49,439		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-4,843	3,438,389		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,773,369		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,454,450		73.00
76.00	03020	ONCOLOGY	-14,387	695,885		76.00
76.97	07697	CARDIAC REHABILITATION	-101,450	211,133		76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-134,491	2,238,569		90.00
91.00	09100	EMERGENCY	-1,775,050	3,488,588		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	83,402		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-13,547,309	92,635,411		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	236,203		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	906,001		192.00
192.01	19201	SOUTH CLINIC	0	101,597		192.01
192.02	19202	WEST CLINIC	0	0		192.02
192.03	19203	DIABETES CENTER	0	83,265		192.03
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	ADULT/CHILD CARE	0	0		193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	894,190		193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0		193.03
194.00	07950	PARTNERSHIP HFC	0	6,726		194.00
194.01	07951	TRAFALGAR CLINIC	0	0		194.01
194.02	07952	EDINBURGH	0	0		194.02
194.03	07953	JAIL	0	0		194.03
194.04	07954	ATHLETIC TRAINERS	0	0		194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-13,547,309	94,863,393		200.00

RECLASSIFICATIONS | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/31/2024 1:57 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - NURSERY RECLASS					
1.00	NURSERY	43.00	215,999	46,568		1.00
	TOTALS		215,999	46,568		
	B - IMPLANTABLE DEVICE RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	2,773,369		1.00
	TOTALS		0	2,773,369		
	C - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	381,819	190,775		1.00
	TOTALS		381,819	190,775		
	D - SHORT TERM DISABILITY RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	8,612		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	4,823		2.00
3.00	DIETARY	10.00	0	8,879		3.00
4.00	NURSING ADMINISTRATION	13.00	0	10,463		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	12,000		5.00
6.00	ANESTHESIOLOGY	53.00	0	6,000		6.00
7.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	25,500		7.00
	TOTALS		0	76,277		
	E - EMPLOYEE WELLNESS RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	3,223	2,417		1.00
	TOTALS		3,223	2,417		
	F - PART A RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	0	5,500		1.00
2.00	ANESTHESIOLOGY	53.00	0	7,500		2.00
	TOTALS		0	13,000		
	G - MEDICAL SUPPLIES RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,527,266		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
	TOTALS		0	1,527,266		
	H - DRUGS CHARGEABLE RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	8,454,450		1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	73		2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	409		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00

RECLASSIFICATIONS | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/31/2024 1:57 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
	TOTALS		0	8,454,932		
500.00	Grand Total: Increases		601,041	13,084,604		500.00

RECLASSIFICATIONS | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/31/2024 1:57 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	215,999	46,568	0		1.00
	TOTALS		215,999	46,568			
	B - IMPLANTABLE DEVICE RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,773,369	0		1.00
	TOTALS		0	2,773,369			
	C - CAFETERIA RECLASS						
1.00	DIETARY	10.00	381,819	190,775	0		1.00
	TOTALS		381,819	190,775			
	D - SHORT TERM DISABILITY RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	8,612	0	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	4,823	0	0		2.00
3.00	DIETARY	10.00	8,879	0	0		3.00
4.00	NURSING ADMINISTRATION	13.00	10,463	0	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	12,000	0	0		5.00
6.00	ANESTHESIOLOGY	53.00	6,000	0	0		6.00
7.00	PHYSICIANS' PRIVATE OFFICES	192.00	25,500	0	0		7.00
	TOTALS		76,277	0			
	E - EMPLOYEE WELLNESS RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	3,223	2,417	0		1.00
	TOTALS		3,223	2,417			
	F - PART A RECLASS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	7,500	0		1.00
2.00	DIABETES CENTER	192.03	0	5,500	0		2.00
	TOTALS		0	13,000			
	G - MEDICAL SUPPLIES RECLASS						
1.00	DATA PROCESSING	4.02	0	141	0		1.00
2.00	MATERIALS MANAGEMENT	4.03	0	316	0		2.00
3.00	ADMITTING	4.04	0	1,043	0		3.00
4.00	PATIENT ACCOUNTING	4.05	0	89	0		4.00
5.00	ADMINISTRATIVE & GENERAL	5.00	0	393	0		5.00
6.00	OPERATION OF PLANT	7.00	0	251	0		6.00
7.00	LAUNDRY & LINEN SERVICE	8.00	0	521	0		7.00
8.00	HOUSEKEEPING	9.00	0	9,360	0		8.00
9.00	DIETARY	10.00	0	317	0		9.00
10.00	NURSING ADMINISTRATION	13.00	0	96	0		10.00
11.00	CENTRAL SERVICES & SUPPLY	14.00	0	51,594	0		11.00
12.00	PHARMACY	15.00	0	20,922	0		12.00
13.00	MEDICAL RECORDS & LIBRARY	16.00	0	24	0		13.00
14.00	ADULTS & PEDIATRICS	30.00	0	239,055	0		14.00
15.00	INTENSIVE CARE UNIT	31.00	0	47,808	0		15.00
16.00	OPERATING ROOM	50.00	0	306,285	0		16.00
17.00	ANESTHESIOLOGY	53.00	0	2,124	0		17.00
18.00	RADIOLOGY-DIAGNOSTIC	54.00	0	107,561	0		18.00
19.00	LABORATORY	60.00	0	227,585	0		19.00
20.00	RESPIRATORY THERAPY	65.00	0	60,574	0		20.00
21.00	PHYSICAL THERAPY	66.00	0	9,512	0		21.00
22.00	ELECTROCARDIOLOGY	69.00	0	14,670	0		22.00
23.00	ELECTROENCEPHALOGRAPHY	70.00	0	1,464	0		23.00
24.00	ONCOLOGY	76.00	0	11,932	0		24.00
25.00	CARDIAC REHABILITATION	76.97	0	4,709	0		25.00
26.00	CLINIC	90.00	0	254,481	0		26.00
27.00	EMERGENCY	91.00	0	152,468	0		27.00
28.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	1,913	0		28.00
29.00	SOUTH CLINIC	192.01	0	21	0		29.00
30.00	PHYSICIAN OFFICE BUILDING	193.02	0	37	0		30.00
	TOTALS		0	1,527,266			
	H - DRUGS CHARGEABLE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	462	0		1.00
2.00	PHARMACY	15.00	0	7,813,002	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	3,259	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	216	0		4.00
5.00	OPERATING ROOM	50.00	0	1,199	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	7,528	0		6.00
7.00	LABORATORY	60.00	0	6	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	9,467	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	3	0		9.00
10.00	ONCOLOGY	76.00	0	245	0		10.00
11.00	CLINIC	90.00	0	38,653	0		11.00
12.00	EMERGENCY	91.00	0	787	0		12.00
13.00	SOUTH CLINIC	192.01	0	579,568	0		13.00
14.00	PHYSICIAN OFFICE BUILDING	193.02	0	20	0		14.00

RECLASSIFICATIONS | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/31/2024 1:57 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
15.00	JAIL	194.03	0	517	0		15.00
	TOTALS		0	8,454,932			
500.00	Grand Total: Decreases		677,318	13,008,327			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 5/31/2024 1:57 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	4,926,609	0	0	0	0	1.00
2.00	Land Improvements	3,096,219	36,561	0	36,561	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	105,541,099	693,424	0	693,424	0	4.00
5.00	Fixed Equipment	15,086,526	0	0	0	58,355	5.00
6.00	Movable Equipment	41,776,089	716,166	0	716,166	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	170,426,542	1,446,151	0	1,446,151	58,355	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	170,426,542	1,446,151	0	1,446,151	58,355	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	4,926,609	0	1.00
2.00	Land Improvements	3,132,780	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	106,234,523	0	4.00
5.00	Fixed Equipment	15,028,171	0	5.00
6.00	Movable Equipment	42,492,255	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	171,814,338	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	171,814,338	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part II Date/Time Prepared: 5/31/2024 1:57 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	3,328,085	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,779,614	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	7,107,699	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	3,328,085		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,779,614		2.00
3.00	Total (sum of lines 1-2)	0	7,107,699		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part III Date/Time Prepared: 5/31/2024 1:57 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	171,814,338	0	171,814,338	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	171,814,338	0	171,814,338	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	3,411,471	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,779,614	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	7,191,085	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	-287,436	0	0	0	3,124,035	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	3,779,614	2.00
3.00	Total (sum of lines 1-2)	-287,436	0	0	0	6,903,649	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/31/2024 1:57 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,914,359			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/31/2024 1:57 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	CAFETERIA CANTEEN VENDING REVENUE	B	-217,098	CAFETERIA	11.00	0	33.00
33.01	MISC OTHER REVENUE	B	-84,913	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	MISC OTHER REVENUE	B	0	DIETARY	10.00	0	33.02
33.03	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.03
33.04	MISC OTHER REVENUE	B	-69,722	MEDICAL RECORDS & LIBRARY	16.00	0	33.04
33.05	MISC OTHER REVENUE	B	-31	LABORATORY	60.00	0	33.05
33.06	MISC OTHER REVENUE	B	-4,843	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.06
33.07	MISC OTHER REVENUE	B	0	ONCOLOGY	76.00	0	33.07
33.08	MISC OTHER REVENUE	B	-239,831	DATA PROCESSING	4.02	0	33.08
33.09	MISC OTHER REVENUE	B	5,290	NURSING ADMINISTRATION	13.00	0	33.09
33.10	CABLE SERVICES	A	-41,765	OPERATION OF PLANT	7.00	0	33.10
33.11	TELEPHONE SERVICES	A	-1,177	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	33.11
33.12	TELEPHONE SERVICES	A	-13,552	COMMUNICATIONS	4.01	0	33.12
33.13	COMMUNICATIONS	A	-18,756	COMMUNICATIONS	4.01	0	33.13
33.14	ADVERTISING EXP - A&G	A	-456,889	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	ADVERTISING EXP - PHYSICAL THERAPY	A	0	PHYSICAL THERAPY	66.00	0	33.15
33.16	LOBBYING EXPENSE - AHA	A	-6,880	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	LOBBYING EXPENSE - IHA	A	-3,344	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	PROF - BUILDING-PLANT WORK ORDERS	A	-23,407	OPERATION OF PLANT	7.00	0	33.18
33.19	PROF - BUILDING-PLANT WORK ORDERS	A	-7,716	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.19
33.20	1993 AHA LIFE	A	84,563	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	33.20
33.21	HAF EXPENSE	A	-7,245,443	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22	INTEREST EXPENSE	A	-287,436	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.22
33.23	ELECTROENCEPHALOGRAPHY OFFSET	A	0	ELECTROENCEPHALOGRAPHY	70.00	0	33.23
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-13,547,309				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 5/31/2024 1:57 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	2,386,331	2,386,331	0	211,500	0	1.00
2.00	53.00	ANESTHESIOLOGY	402,650	402,650	0	211,500	0	2.00
3.00	70.00	ELECTROENCEPHALOGRAPHY	100,000	100,000	0	211,500	0	3.00
4.00	76.00	ONCOLOGY	24,250	0	24,250	211,500	97	4.00
5.00	76.97	CARDIAC REHABILITATION	101,450	101,450	0	211,500	0	5.00
6.00	90.00	CLINIC	134,491	134,491	0	211,500	0	6.00
7.00	91.00	EMERGENCY	1,775,050	1,775,050	0	211,500	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			4,924,222	4,899,972	24,250		97	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	2.00
3.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	3.00
4.00	76.00	ONCOLOGY	9,863	493	0	0	0	4.00
5.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	5.00
6.00	90.00	CLINIC	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			9,863	493	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	2,386,331		1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	402,650		2.00
3.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	100,000		3.00
4.00	76.00	ONCOLOGY	0	9,863	14,387	14,387		4.00
5.00	76.97	CARDIAC REHABILITATION	0	0	0	101,450		5.00
6.00	90.00	CLINIC	0	0	0	134,491		6.00
7.00	91.00	EMERGENCY	0	0	0	1,775,050		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	9,863	14,387	4,914,359		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/31/2024 1:57 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
				NEW BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	3,124,035	3,124,035				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,779,614		3,779,614			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	11,386,463	37,950	1,683	11,426,096		4.00
4.01	00401	COMMUNICATIONS	424,104	4,998	0	63,009	492,111	4.01
4.02	00402	DATA PROCESSING	3,926,917	79,613	1,771,925	194,206	48,957	4.02
4.03	00403	MATERIALS MANAGEMENT	474,821	48,658	8,394	132,005	10,517	4.03
4.04	00404	ADMITTING	1,120,667	28,475	0	330,737	12,330	4.04
4.05	00405	PATIENT ACCOUNTING	2,187,992	84,573	14,816	320,723	31,913	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	6,468,934	121,149	37,189	794,098	27,924	5.00
7.00	00700	OPERATION OF PLANT	4,568,787	429,056	57,042	309,875	17,770	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	222,403	30,573	6,281	43,369	1,813	8.00
9.00	00900	HOUSEKEEPING	1,006,610	23,744	5,652	266,942	5,077	9.00
10.00	01000	DIETARY	511,959	49,815	26,306	99,824	9,429	10.00
11.00	01100	CAFETERIA	355,496	53,045	0	114,555	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,410,576	125,485	41,464	352,299	16,682	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	100,312	21,607	41,822	28,132	0	14.00
15.00	01500	PHARMACY	2,817,853	26,020	7,069	343,296	8,341	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	950,501	49,332	10,214	213,766	13,418	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,740,431	350,716	189,987	1,775,596	44,605	30.00
31.00	03100	INTENSIVE CARE UNIT	3,105,848	100,292	45,114	504,166	10,154	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	262,567	7,949	0	64,805	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,684,465	581,971	564,920	692,464	31,913	50.00
53.00	05300	ANESTHESIOLOGY	2,329,182	5,011	17,988	635,126	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,480,777	210,249	435,323	761,348	18,858	54.00
60.00	06000	LABORATORY	5,445,637	102,365	178,980	681,281	24,660	60.00
65.00	06500	RESPIRATORY THERAPY	2,123,979	4,756	19,624	411,064	6,528	65.00
66.00	06600	PHYSICAL THERAPY	1,057,597	80,605	12,800	313,056	9,066	66.00
67.00	06700	OCCUPATIONAL THERAPY	326,627	16,978	3,025	97,921	2,176	67.00
68.00	06800	SPEECH PATHOLOGY	192,603	1,056	474	57,698	2,176	68.00
69.00	06900	ELECTROCARDIOLOGY	614,430	13,735	43,018	129,602	15,594	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	49,439	2,315	2,344	14,833	725	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,438,389	0	17,782	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,773,369	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,454,450	0	0	0	0	73.00
76.00	03020	ONCOLOGY	695,885	89,011	2,741	183,587	13,418	76.00
76.97	07697	CARDIAC REHABILITATION	211,133	31,934	13,091	51,063	0	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,238,569	146,457	20,935	256,153	7,616	90.00
91.00	09100	EMERGENCY	3,488,588	126,337	39,411	977,628	21,396	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	83,402	16,597	82	7,424	8,341	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	92,635,411	3,102,427	3,637,496	11,221,651	421,397	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	236,203	16,495	5,656	61,622	5,440	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	906,001	0	135,774	93,000	59,472	192.00
192.01	19201	SOUTH CLINIC	101,597	0	0	24,980	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	83,265	5,113	688	24,843	1,088	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	0	0	0	1,813	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	894,190	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	6,726	0	0	0	2,901	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/31/2024 1:57 pm

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
			NEW BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	4.01	
202.00	TOTAL (sum lines 118 through 201)	94,863,393	3,124,035	3,779,614	11,426,096	492,111	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/31/2024 1:57 pm

		Cost Center Description	DATA PROCESSING	MATERIALS MANAGEMENT	ADMITTING	PATIENT ACCOUNTING	Subtotal	
			4.02	4.03	4.04	4.05	4A.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING	6,021,618					4.02
4.03	00403	MATERIALS MANAGEMENT	59,148	733,543				4.03
4.04	00404	ADMITTING	244,223	352	1,736,784			4.04
4.05	00405	PATIENT ACCOUNTING	408,310	276	0	3,048,603		4.05
5.00	00500	ADMINISTRATIVE & GENERAL	461,734	2,444	0	0	7,913,472	5.00
7.00	00700	OPERATION OF PLANT	73,458	41	0	0	5,456,029	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,770	40	0	0	309,249	8.00
9.00	00900	HOUSEKEEPING	47,700	597	0	0	1,356,322	9.00
10.00	01000	DIETARY	64,872	10,427	0	0	772,632	10.00
11.00	01100	CAFETERIA	0	0	0	0	523,096	11.00
13.00	01300	NURSING ADMINISTRATION	171,719	2,722	0	0	2,120,947	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,862	2,031	0	0	196,766	14.00
15.00	01500	PHARMACY	208,925	344,256	0	0	3,755,760	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	392,092	130	0	0	1,629,453	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	427,390	12,174	78,066	137,037	7,756,002	30.00
31.00	03100	INTENSIVE CARE UNIT	180,305	3,087	16,293	28,600	3,993,859	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	2,786	4,891	342,998	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	297,647	17,355	211,831	371,850	5,454,416	50.00
53.00	05300	ANESTHESIOLOGY	24,804	95	31,059	54,521	3,097,786	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	202,247	8,196	400,900	703,581	6,221,479	54.00
60.00	06000	LABORATORY	258,533	82,601	251,590	441,643	7,467,290	60.00
65.00	06500	RESPIRATORY THERAPY	158,363	10,318	33,704	59,163	2,827,499	65.00
66.00	06600	PHYSICAL THERAPY	59,148	575	22,948	40,284	1,596,079	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,356	0	7,694	13,507	481,284	67.00
68.00	06800	SPEECH PATHOLOGY	9,540	4	3,128	5,491	272,170	68.00
69.00	06900	ELECTROCARDIOLOGY	79,182	820	27,738	48,691	972,810	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7,632	57	551	968	78,864	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	183,936	68,530	120,298	3,828,935	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	37,314	65,502	2,876,185	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	224,466	394,029	9,072,945	73.00
76.00	03020	ONCOLOGY	77,274	1,601	9,379	16,465	1,089,361	76.00
76.97	07697	CARDIAC REHABILITATION	29,574	398	3,559	6,248	347,000	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	371,104	14,840	69,202	121,478	3,246,354	90.00
91.00	09100	EMERGENCY	364,426	10,635	236,039	414,344	5,678,804	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	6,678	39	7	12	122,582	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,707,016	710,047	1,736,784	3,048,603	90,858,428	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	40,068	438	0	0	365,922	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,231,604	0	0	0	2,425,851	192.00
192.01	19201	SOUTH CLINIC	32,436	22,963	0	0	181,976	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	10,494	18	0	0	125,509	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	0	0	0	1,813	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	2	0	0	894,192	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	0	55	0	0	9,682	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	20	0	0	20	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,021,618	733,543	1,736,784	3,048,603	94,863,393	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/31/2024 1:57 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL	7,913,472					5.00
7.00	00700	OPERATION OF PLANT	496,564	5,952,593				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	28,145	79,487	416,881			8.00
9.00	00900	HOUSEKEEPING	123,442	61,731	65,818	1,607,313		9.00
10.00	01000	DIETARY	70,319	129,513	7,464	35,821	1,015,749	10.00
11.00	01100	CAFETERIA	47,608	137,912	0	38,144	0	11.00
13.00	01300	NURSING ADMINISTRATION	193,032	326,247	0	90,234	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	17,908	56,177	0	15,537	0	14.00
15.00	01500	PHARMACY	341,819	67,650	0	18,711	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	148,300	128,257	0	35,473	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	705,889	911,818	119,399	252,191	772,950	30.00
31.00	03100	INTENSIVE CARE UNIT	363,489	260,746	32,814	72,117	242,799	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	31,217	20,665	0	5,716	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	496,417	1,513,064	55,410	418,483	0	50.00
53.00	05300	ANESTHESIOLOGY	281,936	13,027	0	3,603	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	566,229	546,621	20,868	151,185	0	54.00
60.00	06000	LABORATORY	679,613	266,136	0	73,608	0	60.00
65.00	06500	RESPIRATORY THERAPY	257,336	12,366	0	3,420	0	65.00
66.00	06600	PHYSICAL THERAPY	145,262	209,562	6,138	57,961	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	43,803	44,141	0	12,209	0	67.00
68.00	06800	SPEECH PATHOLOGY	24,771	2,744	0	759	0	68.00
69.00	06900	ELECTROCARDIOLOGY	88,537	35,710	2,411	9,877	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7,178	6,018	0	1,664	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	348,479	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	261,767	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	825,734	0	0	0	0	73.00
76.00	03020	ONCOLOGY	99,145	231,418	0	64,006	0	76.00
76.97	07697	CARDIAC REHABILITATION	31,581	83,025	0	22,963	0	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	295,457	380,770	1,818	105,314	0	90.00
91.00	09100	EMERGENCY	516,839	328,462	100,351	90,846	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	11,156	43,149	0	11,934	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,548,972	5,896,416	412,491	1,591,776	1,015,749	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	33,303	42,885	0	11,861	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	220,782	0	4,390	0	0	192.00
192.01	19201	SOUTH CLINIC	16,562	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	11,423	13,292	0	3,676	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	165	0	0	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	81,382	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	881	0	0	0	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	2	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,913,472	5,952,593	416,881	1,607,313	1,015,749	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/31/2024 1:57 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	746,760					11.00
13.00	01300	NURSING ADMINISTRATION	26,938	2,757,398				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,282	0	288,670			14.00
15.00	01500	PHARMACY	25,218	0	0	4,209,158		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	28,427	0	0	0	1,969,910	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	136,566	1,130,311	0	0	88,545	30.00
31.00	03100	INTENSIVE CARE UNIT	51,723	428,084	0	0	18,480	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	6,403	52,995	0	0	3,160	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	51,287	424,475	0	0	240,267	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	35,228	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	74,077	0	0	0	454,703	54.00
60.00	06000	LABORATORY	91,913	0	0	0	285,362	60.00
65.00	06500	RESPIRATORY THERAPY	37,439	0	0	0	38,228	65.00
66.00	06600	PHYSICAL THERAPY	29,231	0	0	0	26,029	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,444	0	0	0	8,727	67.00
68.00	06800	SPEECH PATHOLOGY	2,846	0	0	0	3,548	68.00
69.00	06900	ELECTROCARDIOLOGY	13,211	0	0	0	31,461	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,580	0	0	0	625	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	288,670	0	77,729	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	42,323	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,209,158	254,597	73.00
76.00	03020	ONCOLOGY	19,213	0	0	0	10,638	76.00
76.97	07697	CARDIAC REHABILITATION	4,528	0	0	0	4,037	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	35,920	0	0	0	78,492	90.00
91.00	09100	EMERGENCY	87,179	721,533	0	0	267,723	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	57	0	0	0	8	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	733,482	2,757,398	288,670	4,209,158	1,969,910	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,278	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	0	0	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	0	0	0	0	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	746,760	2,757,398	288,670	4,209,158	1,969,910	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/31/2024 1:57 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
4.01	00401	COMMUNICATIONS					4.01
4.02	00402	DATA PROCESSING					4.02
4.03	00403	MATERIALS MANAGEMENT					4.03
4.04	00404	ADMITTING					4.04
4.05	00405	PATIENT ACCOUNTING					4.05
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	11,873,671	0	11,873,671		30.00
31.00	03100	INTENSIVE CARE UNIT	5,464,111	0	5,464,111		31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0		41.00
43.00	04300	NURSERY	463,154	0	463,154		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	8,653,819	0	8,653,819		50.00
53.00	05300	ANESTHESIOLOGY	3,431,580	0	3,431,580		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,035,162	0	8,035,162		54.00
60.00	06000	LABORATORY	8,863,922	0	8,863,922		60.00
65.00	06500	RESPIRATORY THERAPY	3,176,288	0	3,176,288		65.00
66.00	06600	PHYSICAL THERAPY	2,070,262	0	2,070,262		66.00
67.00	06700	OCCUPATIONAL THERAPY	597,608	0	597,608		67.00
68.00	06800	SPEECH PATHOLOGY	306,838	0	306,838		68.00
69.00	06900	ELECTROCARDIOLOGY	1,154,017	0	1,154,017		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	95,929	0	95,929		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,543,813	0	4,543,813		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,180,275	0	3,180,275		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,362,434	0	14,362,434		73.00
76.00	03020	ONCOLOGY	1,513,781	0	1,513,781		76.00
76.97	07697	CARDIAC REHABILITATION	493,134	0	493,134		76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	4,144,125	0	4,144,125		90.00
91.00	09100	EMERGENCY	7,791,737	0	7,791,737		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	188,886	0	188,886		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	90,404,546	0	90,404,546		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	467,249	0	467,249		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,651,023	0	2,651,023		192.00
192.01	19201	SOUTH CLINIC	198,538	0	198,538		192.01
192.02	19202	WEST CLINIC	0	0	0		192.02
192.03	19203	DIABETES CENTER	153,900	0	153,900		192.03
193.00	19300	NONPAID WORKERS	0	0	0		193.00
193.01	19301	ADULT/CHILD CARE	1,978	0	1,978		193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	975,574	0	975,574		193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0		193.03
194.00	07950	PARTNERSHIP HFC	10,563	0	10,563		194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0		194.01
194.02	07952	EDINBURGH	0	0	0		194.02
194.03	07953	JAIL	22	0	22		194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0		194.04
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	94,863,393	0	94,863,393		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/31/2024 1:57 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	37,950	1,683	39,633	39,633	4.00
4.01	00401	COMMUNICATIONS	0	4,998	0	4,998	219	4.01
4.02	00402	DATA PROCESSING	0	79,613	1,771,925	1,851,538	674	4.02
4.03	00403	MATERIALS MANAGEMENT	0	48,658	8,394	57,052	458	4.03
4.04	00404	ADMITTING	0	28,475	0	28,475	1,148	4.04
4.05	00405	PATIENT ACCOUNTING	0	84,573	14,816	99,389	1,113	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	0	121,149	37,189	158,338	2,755	5.00
7.00	00700	OPERATION OF PLANT	0	429,056	57,042	486,098	1,075	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	30,573	6,281	36,854	150	8.00
9.00	00900	HOUSEKEEPING	0	23,744	5,652	29,396	926	9.00
10.00	01000	DIETARY	0	49,815	26,306	76,121	346	10.00
11.00	01100	CAFETERIA	0	53,045	0	53,045	397	11.00
13.00	01300	NURSING ADMINISTRATION	0	125,485	41,464	166,949	1,222	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	21,607	41,822	63,429	98	14.00
15.00	01500	PHARMACY	0	26,020	7,069	33,089	1,191	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	49,332	10,214	59,546	742	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	350,716	189,987	540,703	6,148	30.00
31.00	03100	INTENSIVE CARE UNIT	0	100,292	45,114	145,406	1,749	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	7,949	0	7,949	225	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	581,971	564,920	1,146,891	2,403	50.00
53.00	05300	ANESTHESIOLOGY	0	5,011	17,988	22,999	2,204	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	210,249	435,323	645,572	2,642	54.00
60.00	06000	LABORATORY	0	102,365	178,980	281,345	2,364	60.00
65.00	06500	RESPIRATORY THERAPY	0	4,756	19,624	24,380	1,426	65.00
66.00	06600	PHYSICAL THERAPY	0	80,605	12,800	93,405	1,086	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	16,978	3,025	20,003	340	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,056	474	1,530	200	68.00
69.00	06900	ELECTROCARDIOLOGY	0	13,735	43,018	56,753	450	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,315	2,344	4,659	51	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	17,782	17,782	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	0	89,011	2,741	91,752	637	76.00
76.97	07697	CARDIAC REHABILITATION	0	31,934	13,091	45,025	177	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	146,457	20,935	167,392	889	90.00
91.00	09100	EMERGENCY	0	126,337	39,411	165,748	3,392	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	16,597	82	16,679	26	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,102,427	3,637,496	6,739,923	38,923	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,495	5,656	22,151	214	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	135,774	135,774	323	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	87	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	0	5,113	688	5,801	86	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	0	0	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	0	0	0	0	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	3,124,035	3,779,614	6,903,649	39,633	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/31/2024 1:57 pm

		Cost Center Description	COMMUNICATIONS	DATA PROCESSING	MATERIALS MANAGEMENT	ADMITTING	PATIENT ACCOUNTING	
			4.01	4.02	4.03	4.04	4.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS	5,217					4.01
4.02	00402	DATA PROCESSING	519	1,852,731				4.02
4.03	00403	MATERIALS MANAGEMENT	111	18,199	75,820			4.03
4.04	00404	ADMITTING	131	75,142	36	104,932		4.04
4.05	00405	PATIENT ACCOUNTING	338	125,629	29	0	226,498	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	296	142,066	253	0	0	5.00
7.00	00700	OPERATION OF PLANT	188	22,601	4	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	19	1,468	4	0	0	8.00
9.00	00900	HOUSEKEEPING	54	14,676	62	0	0	9.00
10.00	01000	DIETARY	100	19,960	1,078	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	177	52,835	281	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	881	210	0	0	14.00
15.00	01500	PHARMACY	88	64,282	35,587	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	142	120,639	13	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	473	131,499	1,258	4,712	10,180	30.00
31.00	03100	INTENSIVE CARE UNIT	108	55,476	319	983	2,125	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	168	363	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	338	91,580	1,794	12,786	27,624	50.00
53.00	05300	ANESTHESIOLOGY	0	7,632	10	1,875	4,050	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	200	62,227	847	24,301	52,291	54.00
60.00	06000	LABORATORY	261	79,545	8,537	15,186	32,809	60.00
65.00	06500	RESPIRATORY THERAPY	69	48,725	1,066	2,034	4,395	65.00
66.00	06600	PHYSICAL THERAPY	96	18,199	59	1,385	2,993	66.00
67.00	06700	OCCUPATIONAL THERAPY	23	4,109	0	464	1,003	67.00
68.00	06800	SPEECH PATHOLOGY	23	2,935	0	189	408	68.00
69.00	06900	ELECTROCARDIOLOGY	165	24,363	85	1,674	3,617	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8	2,348	6	33	72	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	19,011	4,136	8,937	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,252	4,866	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	13,549	29,272	73.00
76.00	03020	ONCOLOGY	142	23,776	165	566	1,223	76.00
76.97	07697	CARDIAC REHABILITATION	0	9,099	41	215	464	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	81	114,181	1,534	4,177	9,024	90.00
91.00	09100	EMERGENCY	227	112,127	1,099	14,247	30,781	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	88	2,055	4	0	1	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,465	1,448,254	73,392	104,932	226,498	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	58	12,328	45	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	632	378,940	0	0	0	192.00
192.01	19201	SOUTH CLINIC	0	9,980	2,373	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	12	3,229	2	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	19	0	0	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	31	0	6	0	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	2	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,217	1,852,731	75,820	104,932	226,498	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/31/2024 1:57 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL	303,708					5.00
7.00	00700	OPERATION OF PLANT	19,058	529,024				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,080	7,064	46,639			8.00
9.00	00900	HOUSEKEEPING	4,738	5,486	7,363	62,701		9.00
10.00	01000	DIETARY	2,699	11,510	835	1,397	114,046	10.00
11.00	01100	CAFETERIA	1,827	12,257	0	1,488	0	11.00
13.00	01300	NURSING ADMINISTRATION	7,408	28,994	0	3,520	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	687	4,993	0	606	0	14.00
15.00	01500	PHARMACY	13,119	6,012	0	730	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,692	11,399	0	1,384	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,092	81,036	13,358	9,838	86,785	30.00
31.00	03100	INTENSIVE CARE UNIT	13,951	23,173	3,671	2,813	27,261	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	1,198	1,837	0	223	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,052	134,470	6,199	16,325	0	50.00
53.00	05300	ANESTHESIOLOGY	10,821	1,158	0	141	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,732	48,580	2,335	5,898	0	54.00
60.00	06000	LABORATORY	26,083	23,652	0	2,871	0	60.00
65.00	06500	RESPIRATORY THERAPY	9,876	1,099	0	133	0	65.00
66.00	06600	PHYSICAL THERAPY	5,575	18,624	687	2,261	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,681	3,923	0	476	0	67.00
68.00	06800	SPEECH PATHOLOGY	951	244	0	30	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,398	3,174	270	385	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	275	535	0	65	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,374	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	10,047	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,685	0	0	0	0	73.00
76.00	03020	ONCOLOGY	3,805	20,567	0	2,497	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,212	7,379	0	896	0	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	11,340	33,840	203	4,108	0	90.00
91.00	09100	EMERGENCY	19,836	29,191	11,227	3,544	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	428	3,835	0	466	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	289,720	524,032	46,148	62,095	114,046	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,278	3,811	0	463	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,473	0	491	0	0	192.00
192.01	19201	SOUTH CLINIC	636	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	438	1,181	0	143	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	6	0	0	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	3,123	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	34	0	0	0	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	303,708	529,024	46,639	62,701	114,046	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/31/2024 1:57 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	69,014					11.00
13.00	01300	NURSING ADMINISTRATION	2,490	263,876				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	211	0	71,115			14.00
15.00	01500	PHARMACY	2,331	0	0	156,429		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,627	0	0	0	202,184	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,621	108,168	0	0	9,090	30.00
31.00	03100	INTENSIVE CARE UNIT	4,780	40,967	0	0	1,897	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	592	5,071	0	0	324	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,740	40,621	0	0	24,666	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	3,617	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,846	0	0	0	46,632	54.00
60.00	06000	LABORATORY	8,494	0	0	0	29,296	60.00
65.00	06500	RESPIRATORY THERAPY	3,460	0	0	0	3,924	65.00
66.00	06600	PHYSICAL THERAPY	2,701	0	0	0	2,672	66.00
67.00	06700	OCCUPATIONAL THERAPY	688	0	0	0	896	67.00
68.00	06800	SPEECH PATHOLOGY	263	0	0	0	364	68.00
69.00	06900	ELECTROCARDIOLOGY	1,221	0	0	0	3,230	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	146	0	0	0	64	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71,115	0	7,980	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	4,345	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	156,429	26,137	73.00
76.00	03020	ONCOLOGY	1,776	0	0	0	1,092	76.00
76.97	07697	CARDIAC REHABILITATION	418	0	0	0	414	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,320	0	0	0	8,058	90.00
91.00	09100	EMERGENCY	8,057	69,049	0	0	27,485	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	5	0	0	0	1	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	67,787	263,876	71,115	156,429	202,184	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,227	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	0	0	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	0	0	0	0	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	69,014	263,876	71,115	156,429	202,184	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/31/2024 1:57 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
4.01	00401	COMMUNICATIONS					4.01
4.02	00402	DATA PROCESSING					4.02
4.03	00403	MATERIALS MANAGEMENT					4.03
4.04	00404	ADMITTING					4.04
4.05	00405	PATIENT ACCOUNTING					4.05
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,042,961	0	1,042,961		30.00
31.00	03100	INTENSIVE CARE UNIT	324,679	0	324,679		31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0		41.00
43.00	04300	NURSERY	17,950	0	17,950		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,529,489	0	1,529,489		50.00
53.00	05300	ANESTHESIOLOGY	54,507	0	54,507		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	920,103	0	920,103		54.00
60.00	06000	LABORATORY	510,443	0	510,443		60.00
65.00	06500	RESPIRATORY THERAPY	100,587	0	100,587		65.00
66.00	06600	PHYSICAL THERAPY	149,743	0	149,743		66.00
67.00	06700	OCCUPATIONAL THERAPY	33,606	0	33,606		67.00
68.00	06800	SPEECH PATHOLOGY	7,137	0	7,137		68.00
69.00	06900	ELECTROCARDIOLOGY	98,785	0	98,785		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,262	0	8,262		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	142,335	0	142,335		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	21,510	0	21,510		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	257,072	0	257,072		73.00
76.00	03020	ONCOLOGY	147,998	0	147,998		76.00
76.97	07697	CARDIAC REHABILITATION	65,340	0	65,340		76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	358,147	0	358,147		90.00
91.00	09100	EMERGENCY	496,010	0	496,010		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	23,588	0	23,588		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,310,252	0	6,310,252		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	41,575	0	41,575		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	524,633	0	524,633		192.00
192.01	19201	SOUTH CLINIC	13,076	0	13,076		192.01
192.02	19202	WEST CLINIC	0	0	0		192.02
192.03	19203	DIABETES CENTER	10,892	0	10,892		192.03
193.00	19300	NONPAID WORKERS	0	0	0		193.00
193.01	19301	ADULT/CHILD CARE	25	0	25		193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	3,123	0	3,123		193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0		193.03
194.00	07950	PARTNERSHIP HFC	71	0	71		194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0		194.01
194.02	07952	EDINBURGH	0	0	0		194.02
194.03	07953	JAIL	2	0	2		194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0		194.04
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	6,903,649	0	6,903,649		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 1:57 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (# NON PT PHONES)	DATA PROCESSING (WORK ORDERS)	
			1.00	2.00	4.00	4.01	4.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	245,645					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,575,451				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,984	1,147	38,083,867			4.00
4.01	00401	COMMUNICATIONS	393	0	210,012	1,357		4.01
4.02	00402	DATA PROCESSING	6,260	1,207,398	647,298	135	6,312	4.02
4.03	00403	MATERIALS MANAGEMENT	3,826	5,720	439,979	29	62	4.03
4.04	00404	ADMITTING	2,239	0	1,102,364	34	256	4.04
4.05	00405	PATIENT ACCOUNTING	6,650	10,096	1,068,986	88	428	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	9,526	25,341	2,646,773	77	484	5.00
7.00	00700	OPERATION OF PLANT	33,737	38,869	1,032,829	49	77	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,404	4,280	144,552	5	5	8.00
9.00	00900	HOUSEKEEPING	1,867	3,851	889,733	14	50	9.00
10.00	01000	DIETARY	3,917	17,925	332,719	26	68	10.00
11.00	01100	CAFETERIA	4,171	0	381,819	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	9,867	28,254	1,174,233	46	180	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,699	28,498	93,767	0	3	14.00
15.00	01500	PHARMACY	2,046	4,817	1,144,226	23	219	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,879	6,960	712,495	37	411	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,577	129,458	5,918,213	123	448	30.00
31.00	03100	INTENSIVE CARE UNIT	7,886	30,741	1,680,414	28	189	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	625	0	215,999	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,761	384,940	2,308,020	88	312	50.00
53.00	05300	ANESTHESIOLOGY	394	12,257	2,116,910	0	26	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,532	296,632	2,537,615	52	212	54.00
60.00	06000	LABORATORY	8,049	121,958	2,270,747	68	271	60.00
65.00	06500	RESPIRATORY THERAPY	374	13,372	1,370,098	18	166	65.00
66.00	06600	PHYSICAL THERAPY	6,338	8,722	1,043,432	25	62	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,335	2,061	326,377	6	14	67.00
68.00	06800	SPEECH PATHOLOGY	83	323	192,311	6	10	68.00
69.00	06900	ELECTROCARDIOLOGY	1,080	29,313	431,972	43	83	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	182	1,597	49,439	2	8	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,117	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	6,999	1,868	611,907	37	81	76.00
76.97	07697	CARDIAC REHABILITATION	2,511	8,920	170,197	0	31	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	11,516	14,265	853,771	21	389	90.00
91.00	09100	EMERGENCY	9,934	26,855	3,258,488	59	382	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,305	56	24,744	23	7	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	243,946	2,478,611	37,402,439	1,162	4,934	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,297	3,854	205,389	15	42	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	92,517	309,975	164	1,291	192.00
192.01	19201	SOUTH CLINIC	0	0	83,261	0	34	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	402	469	82,803	3	11	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	0	0	5	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	0	0	0	8	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 1:57 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (# NON PT PHONES)	DATA PROCESSING (WORK ORDERS)	
			1.00	2.00	4.00	4.01	4.02	
202.00		Cost to be allocated (per Wkst. B, Part I)	3,124,035	3,779,614	11,426,096	492,111	6,021,618	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.717682	1.467554	0.300025	362.646279	953.995247	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			39,633	5,217	1,852,731	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001041	3.844510	293.525190	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 1:57 pm

		Cost Center Description	MATERIALS MANAGEMENT (SUPPLY USAGE)	ADMITTING (GROSS CHARGES)	PATIENT ACCOUNTING (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			4.03	4.04	4.05	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT	18,719,946					4.03
4.04	00404	ADMITTING	8,973	391,166,123				4.04
4.05	00405	PATIENT ACCOUNTING	7,051	0	391,166,123			4.05
5.00	00500	ADMINISTRATIVE & GENERAL	62,367	0	0	-7,913,472	86,949,921	5.00
7.00	00700	OPERATION OF PLANT	1,043	0	0	0	5,456,029	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,010	0	0	0	309,249	8.00
9.00	00900	HOUSEKEEPING	15,242	0	0	0	1,356,322	9.00
10.00	01000	DIETARY	266,100	0	0	0	772,632	10.00
11.00	01100	CAFETERIA	0	0	0	0	523,096	11.00
13.00	01300	NURSING ADMINISTRATION	69,470	0	0	0	2,120,947	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	51,834	0	0	0	196,766	14.00
15.00	01500	PHARMACY	8,785,352	0	0	0	3,755,760	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,315	0	0	0	1,629,453	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	310,681	17,582,401	17,582,401	0	7,756,002	30.00
31.00	03100	INTENSIVE CARE UNIT	78,787	3,669,515	3,669,515	0	3,993,859	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	627,495	627,495	0	342,998	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	442,904	47,709,792	47,709,792	0	5,454,416	50.00
53.00	05300	ANESTHESIOLOGY	2,416	6,995,286	6,995,286	0	3,097,786	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	209,151	90,291,064	90,291,064	0	6,221,479	54.00
60.00	06000	LABORATORY	2,107,981	56,664,428	56,664,428	0	7,467,290	60.00
65.00	06500	RESPIRATORY THERAPY	263,313	7,590,880	7,590,880	0	2,827,499	65.00
66.00	06600	PHYSICAL THERAPY	14,672	5,168,557	5,168,557	0	1,596,079	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,732,978	1,732,978	0	481,284	67.00
68.00	06800	SPEECH PATHOLOGY	92	704,514	704,514	0	272,170	68.00
69.00	06900	ELECTROCARDIOLOGY	20,920	6,247,208	6,247,208	0	972,810	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,464	124,153	124,153	0	78,864	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,694,036	15,434,685	15,434,685	0	3,828,935	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	8,404,148	8,404,148	0	2,876,185	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	50,555,401	50,555,401	0	9,072,945	73.00
76.00	03020	ONCOLOGY	40,862	2,112,464	2,112,464	0	1,089,361	76.00
76.97	07697	CARDIAC REHABILITATION	10,161	801,579	801,579	0	347,000	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	378,722	15,586,108	15,586,108	0	3,246,354	90.00
91.00	09100	EMERGENCY	271,406	53,161,895	53,161,895	0	5,678,804	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	989	1,572	1,572	0	122,582	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,120,314	391,166,123	391,166,123	-7,913,472	82,944,956	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,182	0	0	0	365,922	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	2,425,851	192.00
192.01	19201	SOUTH CLINIC	586,004	0	0	0	181,976	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	462	0	0	0	125,509	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	0	0	0	1,813	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	57	0	0	0	894,192	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	1,410	0	0	0	9,682	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	517	0	0	0	20	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	733,543	1,736,784	3,048,603		7,913,472	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.039185	0.004440	0.007794		0.091012	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 1:57 pm

	Cost Center Description	MATERIALS MANAGEMENT (SUPPLY USAGE)	ADMITTING (GROSS CHARGES)	PATIENT ACCOUNTING (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		4.03	4.04	4.05	5A	5.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	75,820	104,932	226,498		303,708	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.004050	0.000268	0.000579		0.003493	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 1:57 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS PAID)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	180,030					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,404	444,286				8.00
9.00	00900	HOUSEKEEPING	1,867	70,145	175,759			9.00
10.00	01000	DIETARY	3,917	7,955	3,917	19,014		10.00
11.00	01100	CAFETERIA	4,171	0	4,171	0	685,055	11.00
13.00	01300	NURSING ADMINISTRATION	9,867	0	9,867	0	24,712	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,699	0	1,699	0	2,093	14.00
15.00	01500	PHARMACY	2,046	0	2,046	0	23,134	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,879	0	3,879	0	26,078	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,577	127,246	27,577	14,469	125,284	30.00
31.00	03100	INTENSIVE CARE UNIT	7,886	34,971	7,886	4,545	47,449	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	625	0	625	0	5,874	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,761	59,053	45,761	0	47,049	50.00
53.00	05300	ANESTHESIOLOGY	394	0	394	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,532	22,240	16,532	0	67,956	54.00
60.00	06000	LABORATORY	8,049	0	8,049	0	84,318	60.00
65.00	06500	RESPIRATORY THERAPY	374	0	374	0	34,345	65.00
66.00	06600	PHYSICAL THERAPY	6,338	6,542	6,338	0	26,816	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,335	0	1,335	0	6,829	67.00
68.00	06800	SPEECH PATHOLOGY	83	0	83	0	2,611	68.00
69.00	06900	ELECTROCARDIOLOGY	1,080	2,570	1,080	0	12,119	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	182	0	182	0	1,449	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	6,999	0	6,999	0	17,625	76.00
76.97	07697	CARDIAC REHABILITATION	2,511	0	2,511	0	4,154	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	11,516	1,937	11,516	0	32,952	90.00
91.00	09100	EMERGENCY	9,934	106,948	9,934	0	79,975	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,305	0	1,305	0	52	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	178,331	439,607	174,060	19,014	672,874	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,297	0	1,297	0	12,181	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,679	0	0	0	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	402	0	402	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	0	0	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	0	0	0	0	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,952,593	416,881	1,607,313	1,015,749	746,760	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	33.064450	0.938317	9.144983	53.421111	1.090073	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 1:57 pm

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS PAID)	
		7.00	8.00	9.00	10.00	11.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	529,024	46,639	62,701	114,046	69,014	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	2.938532	0.104975	0.356744	5.998001	0.100742	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 1:57 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	305,631					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	100				14.00
15.00	01500	PHARMACY	0	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	391,166,123		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	125,284	0	0	17,582,401		30.00
31.00	03100	INTENSIVE CARE UNIT	47,449	0	0	3,669,515		31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0		41.00
43.00	04300	NURSERY	5,874	0	0	627,495		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	47,049	0	0	47,709,792		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	6,995,286		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	90,291,064		54.00
60.00	06000	LABORATORY	0	0	0	56,664,428		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,590,880		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,168,557		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,732,978		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	704,514		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	6,247,208		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	124,153		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	100	0	15,434,685		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	8,404,148		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	50,555,401		73.00
76.00	03020	ONCOLOGY	0	0	0	2,112,464		76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	801,579		76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	15,586,108		90.00
91.00	09100	EMERGENCY	79,975	0	0	53,161,895		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	1,572		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	305,631	100	100	391,166,123		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.01	19201	SOUTH CLINIC	0	0	0	0		192.01
192.02	19202	WEST CLINIC	0	0	0	0		192.02
192.03	19203	DIABETES CENTER	0	0	0	0		192.03
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	ADULT/CHILD CARE	0	0	0	0		193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0		193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0		193.03
194.00	07950	PARTNERSHIP HFC	0	0	0	0		194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0		194.01
194.02	07952	EDINBURGH	0	0	0	0		194.02
194.03	07953	JAIL	0	0	0	0		194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0		194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,757,398	288,670	4,209,158	1,969,910		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 1:57 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
203.00		Unit cost multiplier (Wkst. B, Part I)	9.021984	2,886.700000	42,091.580000	0.005036		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	263,876	71,115	156,429	202,184		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.863381	711.150000	1,564.290000	0.000517		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/31/2024 1:57 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,873,671		11,873,671	0	11,873,671	30.00
31.00	03100	INTENSIVE CARE UNIT	5,464,111		5,464,111	0	5,464,111	31.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
43.00	04300	NURSERY	463,154		463,154	0	463,154	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,653,819		8,653,819	0	8,653,819	50.00
53.00	05300	ANESTHESIOLOGY	3,431,580		3,431,580	0	3,431,580	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,035,162		8,035,162	0	8,035,162	54.00
60.00	06000	LABORATORY	8,863,922		8,863,922	0	8,863,922	60.00
65.00	06500	RESPIRATORY THERAPY	3,176,288	0	3,176,288	0	3,176,288	65.00
66.00	06600	PHYSICAL THERAPY	2,070,262	0	2,070,262	0	2,070,262	66.00
67.00	06700	OCCUPATIONAL THERAPY	597,608	0	597,608	0	597,608	67.00
68.00	06800	SPEECH PATHOLOGY	306,838	0	306,838	0	306,838	68.00
69.00	06900	ELECTROCARDIOLOGY	1,154,017		1,154,017	0	1,154,017	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	95,929		95,929	0	95,929	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,543,813		4,543,813	0	4,543,813	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,180,275		3,180,275	0	3,180,275	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,362,434		14,362,434	0	14,362,434	73.00
76.00	03020	ONCOLOGY	1,513,781		1,513,781	14,387	1,528,168	76.00
76.97	07697	CARDIAC REHABILITATION	493,134		493,134	0	493,134	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,144,125		4,144,125	0	4,144,125	90.00
91.00	09100	EMERGENCY	7,791,737		7,791,737	0	7,791,737	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,620,750		4,620,750		4,620,750	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	188,886		188,886		188,886	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	95,025,296	0	95,025,296	14,387	95,039,683	200.00
201.00		Less Observation Beds	4,620,750		4,620,750		4,620,750	201.00
202.00		Total (see instructions)	90,404,546	0	90,404,546	14,387	90,418,933	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/31/2024 1:57 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,462,172		12,462,172			30.00
31.00	03100	INTENSIVE CARE UNIT	3,669,515		3,669,515			31.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
43.00	04300	NURSERY	627,495		627,495			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,079,272	41,630,520	47,709,792	0.181385	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	1,034,027	5,961,259	6,995,286	0.490556	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,343,000	79,948,064	90,291,064	0.088992	0.000000	54.00
60.00	06000	LABORATORY	11,649,246	45,015,182	56,664,428	0.156428	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,391,297	5,199,583	7,590,880	0.418435	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	555,150	4,613,407	5,168,557	0.400549	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	558,415	1,174,563	1,732,978	0.344845	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	240,668	463,846	704,514	0.435531	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,702,735	4,544,473	6,247,208	0.184725	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	40,348	83,805	124,153	0.772668	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,155,138	12,279,547	15,434,685	0.294390	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,591,071	6,813,077	8,404,148	0.378417	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,019,654	43,535,747	50,555,401	0.284093	0.000000	73.00
76.00	03020	ONCOLOGY	21,450	2,091,014	2,112,464	0.716595	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	801,579	801,579	0.615203	0.000000	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0.000000	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	38,044	15,548,064	15,586,108	0.265886	0.000000	90.00
91.00	09100	EMERGENCY	5,093,825	48,068,070	53,161,895	0.146566	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	750,000	4,370,229	5,120,229	0.902450	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,572	1,572			101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	69,022,522	322,143,601	391,166,123			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	69,022,522	322,143,601	391,166,123			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/31/2024 1:57 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.181385		50.00
53.00	05300	ANESTHESIOLOGY	0.490556		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.088992		54.00
60.00	06000	LABORATORY	0.156428		60.00
65.00	06500	RESPIRATORY THERAPY	0.418435		65.00
66.00	06600	PHYSICAL THERAPY	0.400549		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.344845		67.00
68.00	06800	SPEECH PATHOLOGY	0.435531		68.00
69.00	06900	ELECTROCARDIOLOGY	0.184725		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.772668		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.294390		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.378417		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.284093		73.00
76.00	03020	ONCOLOGY	0.723405		76.00
76.97	07697	CARDIAC REHABILITATION	0.615203		76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000		78.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.265886		90.00
91.00	09100	EMERGENCY	0.146566		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.902450		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/31/2024 1:57 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,873,671		11,873,671	0	11,873,671	30.00
31.00	03100	INTENSIVE CARE UNIT	5,464,111		5,464,111	0	5,464,111	31.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
43.00	04300	NURSERY	463,154		463,154	0	463,154	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,653,819		8,653,819	0	8,653,819	50.00
53.00	05300	ANESTHESIOLOGY	3,431,580		3,431,580	0	3,431,580	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,035,162		8,035,162	0	8,035,162	54.00
60.00	06000	LABORATORY	8,863,922		8,863,922	0	8,863,922	60.00
65.00	06500	RESPIRATORY THERAPY	3,176,288	0	3,176,288	0	3,176,288	65.00
66.00	06600	PHYSICAL THERAPY	2,070,262	0	2,070,262	0	2,070,262	66.00
67.00	06700	OCCUPATIONAL THERAPY	597,608	0	597,608	0	597,608	67.00
68.00	06800	SPEECH PATHOLOGY	306,838	0	306,838	0	306,838	68.00
69.00	06900	ELECTROCARDIOLOGY	1,154,017		1,154,017	0	1,154,017	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	95,929		95,929	0	95,929	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,543,813		4,543,813	0	4,543,813	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,180,275		3,180,275	0	3,180,275	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,362,434		14,362,434	0	14,362,434	73.00
76.00	03020	ONCOLOGY	1,513,781		1,513,781	14,387	1,528,168	76.00
76.97	07697	CARDIAC REHABILITATION	493,134		493,134	0	493,134	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,144,125		4,144,125	0	4,144,125	90.00
91.00	09100	EMERGENCY	7,791,737		7,791,737	0	7,791,737	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,620,750		4,620,750		4,620,750	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	188,886		188,886		188,886	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	95,025,296	0	95,025,296	14,387	95,039,683	200.00
201.00		Less Observation Beds	4,620,750		4,620,750		4,620,750	201.00
202.00		Total (see instructions)	90,404,546	0	90,404,546	14,387	90,418,933	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/31/2024 1:57 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,462,172		12,462,172			30.00
31.00	03100	INTENSIVE CARE UNIT	3,669,515		3,669,515			31.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
43.00	04300	NURSERY	627,495		627,495			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,079,272	41,630,520	47,709,792	0.181385	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	1,034,027	5,961,259	6,995,286	0.490556	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,343,000	79,948,064	90,291,064	0.088992	0.000000	54.00
60.00	06000	LABORATORY	11,649,246	45,015,182	56,664,428	0.156428	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,391,297	5,199,583	7,590,880	0.418435	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	555,150	4,613,407	5,168,557	0.400549	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	558,415	1,174,563	1,732,978	0.344845	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	240,668	463,846	704,514	0.435531	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,702,735	4,544,473	6,247,208	0.184725	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	40,348	83,805	124,153	0.772668	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,155,138	12,279,547	15,434,685	0.294390	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,591,071	6,813,077	8,404,148	0.378417	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,019,654	43,535,747	50,555,401	0.284093	0.000000	73.00
76.00	03020	ONCOLOGY	21,450	2,091,014	2,112,464	0.716595	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	801,579	801,579	0.615203	0.000000	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0.000000	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	38,044	15,548,064	15,586,108	0.265886	0.000000	90.00
91.00	09100	EMERGENCY	5,093,825	48,068,070	53,161,895	0.146566	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	750,000	4,370,229	5,120,229	0.902450	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,572	1,572			101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	69,022,522	322,143,601	391,166,123			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	69,022,522	322,143,601	391,166,123			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/31/2024 1:57 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	ONCOLOGY	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000		78.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part I Date/Time Prepared: 5/31/2024 1:57 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,042,961	0	1,042,961	7,786	133.95	30.00
31.00	INTENSIVE CARE UNIT	324,679		324,679	1,515	214.31	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
43.00	NURSERY	17,950		17,950	480	37.40	43.00
200.00	Total (lines 30 through 199)	1,385,590		1,385,590	9,781		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	1,407	188,468	30.00
31.00	INTENSIVE CARE UNIT	379	81,223	31.00
41.00	SUBPROVIDER - IRF	0	0	41.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	1,786	269,691	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/31/2024 1:57 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,529,489	47,709,792	0.032058	1,381,748	44,296	50.00
53.00	05300	ANESTHESIOLOGY	54,507	6,995,286	0.007792	227,133	1,770	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	920,103	90,291,064	0.010190	3,324,210	33,874	54.00
60.00	06000	LABORATORY	510,443	56,664,428	0.009008	3,785,135	34,096	60.00
65.00	06500	RESPIRATORY THERAPY	100,587	7,590,880	0.013251	526,264	6,974	65.00
66.00	06600	PHYSICAL THERAPY	149,743	5,168,557	0.028972	213,859	6,196	66.00
67.00	06700	OCCUPATIONAL THERAPY	33,606	1,732,978	0.019392	218,474	4,237	67.00
68.00	06800	SPEECH PATHOLOGY	7,137	704,514	0.010130	107,153	1,085	68.00
69.00	06900	ELECTROCARDIOLOGY	98,785	6,247,208	0.015813	954,824	15,099	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,262	124,153	0.066547	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	142,335	15,434,685	0.009222	856,044	7,894	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	21,510	8,404,148	0.002559	587,693	1,504	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	257,072	50,555,401	0.005085	2,253,408	11,459	73.00
76.00	03020	ONCOLOGY	147,998	2,112,464	0.070059	724	51	76.00
76.97	07697	CARDIAC REHABILITATION	65,340	801,579	0.081514	0	0	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	358,147	15,586,108	0.022979	32,833	754	90.00
91.00	09100	EMERGENCY	496,010	53,161,895	0.009330	1,773,126	16,543	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	405,877	5,120,229	0.079269	737,615	58,470	92.00
200.00		Total (lines 50 through 199)	5,306,951	374,405,369		16,980,243	244,302	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part III Date/Time Prepared: 5/31/2024 1:57 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	7,786	0.00	1,407	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,515	0.00	379	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0	41.00
43.00	04300	NURSERY		0	480	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	9,781		1,786	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/31/2024 1:57 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/31/2024 1:57 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	47,709,792	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	6,995,286	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	90,291,064	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	56,664,428	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,590,880	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,168,557	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,732,978	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	704,514	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	6,247,208	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	124,153	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	15,434,685	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	8,404,148	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	50,555,401	0.000000	73.00
76.00	03020	ONCOLOGY	0	0	0	2,112,464	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	801,579	0.000000	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	15,586,108	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	53,161,895	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	5,120,229	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	374,405,369		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/31/2024 1:57 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	1,381,748	0	6,417,481	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	227,133	0	781,628	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	3,324,210	0	14,244,884	0	54.00
60.00	06000	LABORATORY	0.000000	3,785,135	0	3,531,839	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	526,264	0	341,454	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	213,859	0	3,974	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	218,474	0	3,221	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	107,153	0	2,726	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	954,824	0	1,638,751	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	856,044	0	1,760,458	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	587,693	0	1,117,837	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,253,408	0	13,825,055	0	73.00
76.00	03020	ONCOLOGY	0.000000	724	0	143,664	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	89,486	0	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	32,833	0	3,756,109	0	90.00
91.00	09100	EMERGENCY	0.000000	1,773,126	0	5,433,125	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	737,615	0	563,244	0	92.00
200.00		Total (lines 50 through 199)		16,980,243	0	53,654,936	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/31/2024 1:57 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.181385	6,417,481	0	0	1,164,035	50.00
53.00	05300	ANESTHESIOLOGY	0.490556	781,628	0	0	383,432	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.088992	14,244,884	0	0	1,267,681	54.00
60.00	06000	LABORATORY	0.156428	3,531,839	0	0	552,479	60.00
65.00	06500	RESPIRATORY THERAPY	0.418435	341,454	0	0	142,876	65.00
66.00	06600	PHYSICAL THERAPY	0.400549	3,974	0	0	1,592	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.344845	3,221	0	0	1,111	67.00
68.00	06800	SPEECH PATHOLOGY	0.435531	2,726	0	0	1,187	68.00
69.00	06900	ELECTROCARDIOLOGY	0.184725	1,638,751	0	0	302,718	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.772668	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.294390	1,760,458	0	0	518,261	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.378417	1,117,837	0	0	423,009	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.284093	13,825,055	0	0	3,927,601	73.00
76.00	03020	ONCOLOGY	0.716595	143,664	0	0	102,949	76.00
76.97	07697	CARDIAC REHABILITATION	0.615203	89,486	0	0	55,052	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.265886	3,756,109	0	0	998,697	90.00
91.00	09100	EMERGENCY	0.146566	5,433,125	0	0	796,311	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.902450	563,244	1,516	0	508,300	92.00
200.00		Subtotal (see instructions)		53,654,936	1,516	0	11,147,291	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		53,654,936	1,516	0	11,147,291	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/31/2024 1:57 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	ONCOLOGY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,368	0		92.00
200.00		Subtotal (see instructions)	1,368	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	1,368	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 1:57 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,786	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,786	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,756	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,407	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	11,873,671	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	11,873,671	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	11,873,671	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,525.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,145,675	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,145,675	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 1:57 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	5,464,111	1,515	3,606.67	379	1,366,928	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	3,903,610	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	7,416,213	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	269,691	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	244,302	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	513,993	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	6,902,220	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	3,030	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,525.00	88.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 1:57 pm

Title XVIII | Hospital | PPS

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	4,620,750	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,042,961	11,873,671	0.087838	4,620,750	405,877	90.00
91.00	Nursing Program cost	0	11,873,671	0.000000	4,620,750	0	91.00
92.00	Allied health cost	0	11,873,671	0.000000	4,620,750	0	92.00
93.00	All other Medical Education	0	11,873,671	0.000000	4,620,750	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 1:57 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,786	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,786	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,756	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	126	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	480	15.00
16.00	Nursery days (title V or XIX only)	25	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	11,873,671	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	11,873,671	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	11,873,671	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,525.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	192,150	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	192,150	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 1:57 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	463,154	480	964.90	25	24,123	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	5,464,111	1,515	3,606.67	11	39,673	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	169,925	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	425,871	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	3,030	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,525.00	88.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 1:57 pm

Title XIX | Hospital | Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	4,620,750	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,042,961	11,873,671	0.087838	4,620,750	405,877	90.00
91.00	Nursing Program cost	0	11,873,671	0.000000	4,620,750	0	91.00
92.00	Allied health cost	0	11,873,671	0.000000	4,620,750	0	92.00
93.00	All other Medical Education	0	11,873,671	0.000000	4,620,750	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/31/2024 1:57 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		3,145,561		30.00
31.00	03100	INTENSIVE CARE UNIT		417,722		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.181385	1,381,748	250,628	50.00
53.00	05300	ANESTHESIOLOGY	0.490556	227,133	111,421	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.088992	3,324,210	295,828	54.00
60.00	06000	LABORATORY	0.156428	3,785,135	592,101	60.00
65.00	06500	RESPIRATORY THERAPY	0.418435	526,264	220,207	65.00
66.00	06600	PHYSICAL THERAPY	0.400549	213,859	85,661	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.344845	218,474	75,340	67.00
68.00	06800	SPEECH PATHOLOGY	0.435531	107,153	46,668	68.00
69.00	06900	ELECTROCARDIOLOGY	0.184725	954,824	176,380	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.772668	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.294390	856,044	252,011	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.378417	587,693	222,393	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.284093	2,253,408	640,177	73.00
76.00	03020	ONCOLOGY	0.723405	724	524	76.00
76.97	07697	CARDIAC REHABILITATION	0.615203	0	0	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.265886	32,833	8,730	90.00
91.00	09100	EMERGENCY	0.146566	1,773,126	259,880	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.902450	737,615	665,661	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		16,980,243	3,903,610	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		16,980,243		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/31/2024 1:57 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		590,683		30.00
31.00	03100	INTENSIVE CARE UNIT		11,283		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.181385	304,621	55,254	50.00
53.00	05300	ANESTHESIOLOGY	0.490556	41,283	20,252	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.088992	68,194	6,069	54.00
60.00	06000	LABORATORY	0.156428	151,774	23,742	60.00
65.00	06500	RESPIRATORY THERAPY	0.418435	28,957	12,117	65.00
66.00	06600	PHYSICAL THERAPY	0.400549	2,529	1,013	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.344845	2,099	724	67.00
68.00	06800	SPEECH PATHOLOGY	0.435531	528	230	68.00
69.00	06900	ELECTROCARDIOLOGY	0.184725	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.772668	181	140	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.294390	37,416	11,015	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.378417	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.284093	103,824	29,496	73.00
76.00	03020	ONCOLOGY	0.716595	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.615203	0	0	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.265886	0	0	90.00
91.00	09100	EMERGENCY	0.146566	67,365	9,873	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.902450	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		808,771	169,925	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		808,771		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/31/2024 1:57 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	3,113,623	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	974,098	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	22,151	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	0	2.04
3.00	Managed Care Simulated Payments	1,929,268	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	49.70	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
5.01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)	0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)	0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	1.94	30.00
31.00	Percentage of Medicaid patient days (see instructions)	22.29	31.00
32.00	Sum of lines 30 and 31	24.23	32.00
33.00	Allowable disproportionate share percentage (see instructions)	9.20	33.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/31/2024 1:57 pm
	Title XVIII	Hospital	PPS

			1.00	
34.00	Disproportionate share adjustment (see instructions)		94,017	34.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Payment Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital UCP, including supplemental UCP (see instructions)	368,115	385,043	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	275,330	96,787	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	372,117		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	4,576,006		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		4,576,006	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		311,716	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		43,359	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
55.01	Cellular therapy acquisition cost (see instructions)		0	55.01
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		4,931,081	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		4,931,081	61.00
62.00	Deductibles billed to program beneficiaries		636,404	62.00
63.00	Coinsurance billed to program beneficiaries		3,200	63.00
64.00	Allowable bad debts (see instructions)		12,738	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		8,280	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		12,738	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		4,299,757	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)		0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)		0	70.75
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		2,243	70.93
70.94	HRR adjustment amount (see instructions)		-947	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/31/2024 1:57 pm
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3	0	0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		4,301,053	71.00
71.01	Sequestration adjustment (see instructions)		86,021	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		4,130,529	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		84,503	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		89,180	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part B Date/Time Prepared: 5/31/2024 1:57 pm

Title XVIII | Hospital | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,368	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	11,147,291	2.00
3.00	OPPS or REH payments	7,213,584	3.00
4.00	Outlier payment (see instructions)	45,324	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	1,368	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	1,516	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	1,516	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	1,516	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	148	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	1,368	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	7,258,908	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,302,473	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	5,957,803	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount (see instructions)		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	5,957,803	30.00
31.00	Primary payer payments	1,293	31.00
32.00	Subtotal (line 30 minus line 31)	5,956,510	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	64,580	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	41,977	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	64,580	36.00
37.00	Subtotal (see instructions)	5,998,487	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-27	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	5,998,514	40.00
40.01	Sequestration adjustment (see instructions)	119,970	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	5,886,083	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-7,539	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/31/2024 1:57 pm
	Title XVIII	Hospital	PPS

		1.00	
94.00	Total (sum of lines 91 and 93)	0	94.00
		1.00	
	MEDICARE PART B ANCILLARY COSTS		
200.00	Part B Combined Billed Days	0	200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/31/2024 1:57 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,130,529		5,836,074	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0	12/31/2023	50,009	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		50,009	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,130,529		5,886,083	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		84,503		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		7,539	6.02
7.00	Total Medicare program liability (see instructions)		4,215,032		5,878,544	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0001	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/31/2024 1:57 pm
	Title XVIII	Hospital	PPS

			1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days (see instructions)		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days (see instructions)		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-3 Part VII | Date/Time Prepared: 5/31/2024 1:57 pm

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	425,871		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	425,871	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	425,871	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	601,966		8.00
9.00	Ancillary service charges	808,771	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	1,410,737	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	1,410,737	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	984,866	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	425,871	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	425,871	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	425,871	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	425,871	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	425,871	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	425,871	0	40.00
41.00	Interim payments	682,180	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-256,309	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0001	Period: From 01/01/2023 To 12/31/2023	Worksheet E-5 Date/Time Prepared: 5/31/2024 1:57 pm
	Title XVIII		PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR		
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2	0	2.00
3.00	Operating outlier reconciliation adjustment amount (see instructions)	0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instructions)	0	4.00
5.00	The rate used to calculate the time value of money (see instructions)	0.00	5.00
6.00	Time value of money for operating expenses (see instructions)	0	6.00
7.00	Time value of money for capital related expenses (see instructions)	0	7.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G | Date/Time Prepared: 5/31/2024 1:57 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-1,098,064	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	13,519,530	0	0	0	4.00
5.00	Other receivable	3,215,460	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,643,539	0	0	0	7.00
8.00	Prepaid expenses	225,024,227	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	243,304,692	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	4,926,609	0	0	0	12.00
13.00	Land improvements	3,132,780	0	0	0	13.00
14.00	Accumulated depreciation	-1,766,076	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	-39,652,054	0	0	0	16.00
17.00	Leasehold improvements	105,909,523	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	15,028,171	0	0	0	19.00
20.00	Accumulated depreciation	-12,825,965	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	42,641,758	0	0	0	23.00
24.00	Accumulated depreciation	-32,763,654	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	84,631,092	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	-29,204,902	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	17,318,488	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	-11,886,414	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	316,049,370	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,458,852	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,821,808	0	0	0	38.00
39.00	Payroll taxes payable	245,634	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	104,735,274	0	0	0	43.00
44.00	Other current liabilities	3,147,988	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	114,409,556	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	11,850,287	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	3,006,648	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	14,856,935	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	129,266,491	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	186,782,879				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	186,782,879	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	316,049,370	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 5/31/2024 1:57 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		217,928,340		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-32,576,697				2.00
3.00	Total (sum of line 1 and line 2)		185,351,643		0		3.00
4.00	MISC	1,431,236		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		1,431,236		0		10.00
11.00	Subtotal (line 3 plus line 10)		186,782,879		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		186,782,879		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	MISC		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/31/2024 1:57 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	18,788,767		18,788,767	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	18,788,767		18,788,767	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	3,857,935		3,857,935	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	3,857,935		3,857,935	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	22,646,702		22,646,702	17.00
18.00	Ancillary services	45,672,116	252,729,505	298,401,621	18.00
19.00	Outpatient services	5,283,611	64,832,617	70,116,228	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,572	1,572	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER OUTPATIENT	1,225,036	1,549,533	2,774,569	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	74,827,465	319,113,227	393,940,692	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		108,410,702		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		108,410,702		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0001 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-3 | Date/Time Prepared: 5/31/2024 1:57 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	393,940,692	1.00
2.00	Less contractual allowances and discounts on patients' accounts	312,819,601	2.00
3.00	Net patient revenues (line 1 minus line 2)	81,121,091	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	108,410,702	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-27,289,611	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	-5,776,911	24.00
24.01	NON-OPERATING INCOME	489,825	24.01
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	-5,287,086	25.00
26.00	Total (line 5 plus line 25)	-32,576,697	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-32,576,697	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2023 To 12/31/2023 | Worksheet H | Date/Time Prepared: 5/31/2024 1:57 pm

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	22,758	0	317	0	58,341	81,416	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	1,986	0	0	0	0	1,986	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	24,744	0	317	0	58,341	83,402	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	81,416	0	81,416			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	1,986	0	1,986			6.00
7.00	Physical Therapy	0	0	0	0			7.00
8.00	Occupational Therapy	0	0	0	0			8.00
9.00	Speech Pathology	0	0	0	0			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	0	0	0			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	0	83,402	0	83,402			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2023 To 12/31/2023 | Worksheet H-1 Part I | Date/Time Prepared: 5/31/2024 1:57 pm

Home Health Agency I | PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	81,416	0	0	0	0	81,416	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	1,986	0	0	0	0	1,986	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	83,402	0	0	0	0	83,402	24.00

		Administrative & General	Total (cols. 4A + 5)		
		5.00	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related - Bldg. & Fixtures				1.00
2.00	Capital Related - Movable Equipment				2.00
3.00	Plant Operation & Maintenance				3.00
4.00	Transportation				4.00
5.00	Administrative and General	81,416			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	81,416	83,402		6.00
7.00	Physical Therapy	0	0		7.00
8.00	Occupational Therapy	0	0		8.00
9.00	Speech Pathology	0	0		9.00
10.00	Medical Social Services	0	0		10.00
11.00	Home Health Aide	0	0		11.00
12.00	Supplies (see instructions)	0	0		12.00
13.00	Drugs	0	0		13.00
14.00	DME	0	0		14.00
	HHA NONREIMBURSABLE SERVICES				
15.00	Home Dialysis Aide Services	0	0		15.00
16.00	Respiratory Therapy	0	0		16.00
17.00	Private Duty Nursing	0	0		17.00
18.00	Clinic	0	0		18.00
19.00	Health Promotion Activities	0	0		19.00
20.00	Day Care Program	0	0		20.00
21.00	Home Delivered Meals Program	0	0		21.00
22.00	Homemaker Service	0	0		22.00
23.00	All Others (specify)	0	0		23.00
23.50	Telemedicine	0	0		23.50
24.00	Total (sum of lines 1-23)		83,402		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2023 To 12/31/2023 | Worksheet H-1 Part II Date/Time Prepared: 5/31/2024 1:57 pm

Home Health Agency I | PPS

		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-81,416	1,986	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	1,986	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-81,416	1,986	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		81,416	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		40.994965	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0001 HHA CCN: 15-7510

Period: From 01/01/2023 To 12/31/2023

Worksheet H-2 Part I Date/Time Prepared: 5/31/2024 1:57 pm

Home Health Agency I

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	DATA PROCESSING	
		0	1.00	2.00	4.00	4.01	4.02	
1.00	Administrative and General	0	16,597	82	7,424	8,341	6,678	1.00
2.00	Skilled Nursing Care	83,402	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	83,402	16,597	82	7,424	8,341	6,678	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	MATERIALS MANAGEMENT	ADMITTING	PATIENT ACCOUNTING	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
		4.03	4.04	4.05	4A.05	5.00	7.00	
1.00	Administrative and General	39	7	12	39,180	3,566	43,149	1.00
2.00	Skilled Nursing Care	0	0	0	83,402	7,590	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	39	7	12	122,582	11,156	43,149	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.000000			21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2023 To 12/31/2023 | Worksheet H-2 Part I | Date/Time Prepared: 5/31/2024 1:57 pm

Home Health Agency I | PPS

	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	11,934	0	57	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	11,934	0	57	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	
		15.00	16.00	24.00	25.00	26.00	27.00	
1.00	Administrative and General	0	8	97,894	0	97,894		1.00
2.00	Skilled Nursing Care	0	0	90,992	0	90,992	97,894	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	8	188,886	0	188,886	97,894	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						1.075853	21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0001 | HHA CCN: 15-7510

Period: From 01/01/2023 To 12/31/2023

Worksheet H-2 Part I

Date/Time Prepared: 5/31/2024 1:57 pm

Home Health Agency I | PPS

	Cost Center Description	Total HHA Costs	
		28.00	
1.00	Administrative and General		1.00
2.00	Skilled Nursing Care	188,886	2.00
3.00	Physical Therapy	0	3.00
4.00	Occupational Therapy	0	4.00
5.00	Speech Pathology	0	5.00
6.00	Medical Social Services	0	6.00
7.00	Home Health Aide	0	7.00
8.00	Supplies (see instructions)	0	8.00
9.00	Drugs	0	9.00
10.00	DME	0	10.00
11.00	Home Dialysis Aide Services	0	11.00
12.00	Respiratory Therapy	0	12.00
13.00	Private Duty Nursing	0	13.00
14.00	Clinic	0	14.00
15.00	Health Promotion Activities	0	15.00
16.00	Day Care Program	0	16.00
17.00	Home Delivered Meals Program	0	17.00
18.00	Homemaker Service	0	18.00
19.00	All Others (specify)	0	19.00
19.50	Telemedicine	0	19.50
20.00	Total (sum of lines 1-19) (2)	188,886	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2023 To 12/31/2023 | Worksheet H-2 Part II | Date/Time Prepared: 5/31/2024 1:57 pm

Home Health Agency I | PPS

	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (# NON PT PHONES)	DATA PROCESSING (WORK ORDERS)	MATERIALS MANAGEMENT (SUPPLY USAGE)	
		1.00	2.00	4.00	4.01	4.02	4.03	
1.00	Administrative and General	1,305	56	24,744	23	7	989	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,305	56	24,744	23	7	989	20.00
21.00	Total cost to be allocated	16,597	82	7,424	8,341	6,678	39	21.00
22.00	Unit cost multiplier	12.718008	1.464286	0.300032	362.652174	954.000000	0.039434	22.00

	Cost Center Description	ADMITTING (GROSS CHARGES)	PATIENT ACCOUNTING (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		4.04	4.05	5A	5.00	7.00	8.00	
1.00	Administrative and General	1,572	1,572	0	39,180	1,305	0	1.00
2.00	Skilled Nursing Care	0	0	0	83,402	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,572	1,572		122,582	1,305	0	20.00
21.00	Total cost to be allocated	7	12		11,156	43,149	0	21.00
22.00	Unit cost multiplier	0.004453	0.007634		0.091008	33.064368	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2023 To 12/31/2023 | Worksheet H-2 Part II | Date/Time Prepared: 5/31/2024 1:57 pm

Home Health Agency I | PPS

	Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS PAID)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	1,305	0	52	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,305	0	52	0	0	0	20.00
21.00	Total cost to be allocated	11,934	0	57	0	0	0	21.00
22.00	Unit cost multiplier	9.144828	0.000000	1.096154	0.000000	0.000000	0.000000	22.00

	Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		16.00	
1.00	Administrative and General	1,572	1.00
2.00	Skilled Nursing Care	0	2.00
3.00	Physical Therapy	0	3.00
4.00	Occupational Therapy	0	4.00
5.00	Speech Pathology	0	5.00
6.00	Medical Social Services	0	6.00
7.00	Home Health Aide	0	7.00
8.00	Supplies (see instructions)	0	8.00
9.00	Drugs	0	9.00
10.00	DME	0	10.00
11.00	Home Dialysis Aide Services	0	11.00
12.00	Respiratory Therapy	0	12.00
13.00	Private Duty Nursing	0	13.00
14.00	Clinic	0	14.00
15.00	Health Promotion Activities	0	15.00
16.00	Day Care Program	0	16.00
17.00	Home Delivered Meals Program	0	17.00
18.00	Homemaker Service	0	18.00
19.00	All Others (specify)	0	19.00
19.50	Telemedicine	0	19.50
20.00	Total (sum of lines 1-19)	1,572	20.00
21.00	Total cost to be allocated	8	21.00
22.00	Unit cost multiplier	0.005089	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2023 To 12/31/2023 | Worksheet H-3 Part I | Date/Time Prepared: 5/31/2024 1:57 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	188,886		188,886	2	94,443.00	1.00
2.00	Physical Therapy	3.00	0	0	0	4	0.00	2.00
3.00	Occupational Therapy	4.00	0	0	0	0	0.00	3.00
4.00	Speech Pathology	5.00	0	0	0	0	0.00	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	0		0	0	0.00	6.00
7.00	Total (sum of lines 1-6)		188,886	0	188,886	6		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		18020	0	2			8.00
9.00	Physical Therapy		18020	0	1			9.00
10.00	Occupational Therapy		18020	0	0			10.00
11.00	Speech Pathology		18020	0	0			11.00
12.00	Medical Social Services		18020	0	0			12.00
13.00	Home Health Aide		18020	0	0			13.00
14.00	Total (sum of lines 8-13)			0	3			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	2		0	188,886		1.00
2.00	Physical Therapy	0	1		0	0		2.00
3.00	Occupational Therapy	0	0		0	0		3.00
4.00	Speech Pathology	0	0		0	0		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	0		0	0		6.00
7.00	Total (sum of lines 1-6)	0	3		0	188,886		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2023 To 12/31/2023 | Worksheet H-3 Part I | Date/Time Prepared: 5/31/2024 1:57 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)		
		12.00		
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION			
	Cost Per Visit Computation			
1.00	Skilled Nursing Care	188,886		1.00
2.00	Physical Therapy	0		2.00
3.00	Occupational Therapy	0		3.00
4.00	Speech Pathology	0		4.00
5.00	Medical Social Services	0		5.00
6.00	Home Health Aide	0		6.00
7.00	Total (sum of lines 1-6)	188,886		7.00

	Cost Center Description			
		12.00		
	Limitation Cost Computation			
8.00	Skilled Nursing Care			8.00
9.00	Physical Therapy			9.00
10.00	Occupational Therapy			10.00
11.00	Speech Pathology			11.00
12.00	Medical Social Services			12.00
13.00	Home Health Aide			13.00
14.00	Total (sum of lines 8-13)			14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0001
HHA CCN: 15-7510

Period: From 01/01/2023 To 12/31/2023

Worksheet H-3 Part II
Date/Time Prepared: 5/31/2024 1:57 pm

Home Health Agency I

PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.400549	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.344845	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.435531	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.294390	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.284093	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2023 To 12/31/2023 | Worksheet H-4 Part I-II | Date/Time Prepared: 5/31/2024 1:57 pm

Title XVIII | Home Health Agency I | PPS

		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	1,175	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	0	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	0	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	0	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	1,175	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	1,175	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	1,175	26.00
27.00	Allowable bad debts (from your records)		0	27.00
27.01	Adjusted reimbursable bad debts (see instructions)		0	27.01
28.00	Allowable bad debts for dual eligible (see instructions)		0	28.00
29.00	Total costs - current cost reporting period (see instructions)	0	1,175	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	1,175	31.00
31.01	Sequestration adjustment (see instructions)	0	23	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
31.75	Sequestration adjustment for non-claims based amounts (see instructions)	0	0	31.75
32.00	Interim payments (see instructions)	0	1,151	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 31.75, 32, and 33)	0	1	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2023 To 12/31/2023 | Worksheet H-5 | Date/Time Prepared: 5/31/2024 1:57 pm

Home Health Agency I | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		1,151	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		1,151	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		1	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		1,152	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0001	Period: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III Date/Time Prepared: 5/31/2024 1:57 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	309,286	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	2,430	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	17.36	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	311,716	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00