

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: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/29/2024 9:08 am
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report	Date: 5/29/2024	Time: 9:08 am
	2. <input type="checkbox"/> Manually prepared cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.		
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> 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 METHODIST HOSPITALS, INC (15-0002) 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	Matt Doyle	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification to be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Matt Doyle		2
3	Signatory Title	CEO		3
4	Date	(Dated when report is electronic)		4

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00		
		Part A 2.00	Part B 3.00				
PART III - SETTLEMENT SUMMARY							
1.00	HOSPITAL	0	906,869	-60,195	0	-1,583,443	1.00
2.00	SUBPROVIDER - IPF	0	2,212	0		-164,729	2.00
3.00	SUBPROVIDER - IRF	0	25,886	0		-143,658	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	934,967	-60,194	0	-1,891,830	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: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 9:08 am
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1.00 Hospital and Hospital Health Care Complex Address:		2.00		3.00		4.00				
1.00	Street: 600 GRANT STREET	PO Box:		Zip Code: 46402		County: LAKE				1.00
2.00	City: GARY	State: IN								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	METHODIST HOSPITALS, INC	150002	23844	1	01/01/1966	N	P	0	3.00
4.00	Subprovider - IPF	GERIATRIC PSYCH	15S002	23844	4	01/01/2012	N	P	0	4.00
5.00	Subprovider - IRF	REHABILITATION	15T002	23844	5	01/01/1984	N	P	0	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	METHODIST HOME CARE SERVICES	157536	23844		02/12/2002	N	P	0	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)					2			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)				N	N		N		22.03
22.04	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
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)									22.04
22.04	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: 15-0002			Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 9:08 am			
		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.	3,385	1,040	714	675	19,314	48		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.	48	51	12	45	812			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	Y		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	Y	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 impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					Y	Y			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.					Y			57.00	

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		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.	Y	Y		60.00		
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	2	60.01		
		Y/N	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)	N			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	
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 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	
63.00	Teaching Hospitals that Claim Residents in Nonprovider Settings 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	

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			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col . 1/ (col . 1 + col . 2))	
			1.00	2.00	3.00	
64.00	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			
		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)					65.00
	0.00	0.00	0.000000			
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col . 1/ (col . 1 + col . 2))	
			1.00	2.00	3.00	
66.00	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			
		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)					67.00
	0.00	0.00	0.000000			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 9:08 am			
			1.00				
68.00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) 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.			Y		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.			Y		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.			N	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: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 9:08 am	
		V 1.00	XIX 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. 1, 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. 1? 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. 1V, 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. 1, 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. 1 through 1V? 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 1.00	Occupational 2.00	Speech 3.00	Respiratory 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
					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
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
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			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.		1		118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 9:08 am
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	1,125,088	0	0
		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
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
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:	
142.00	Street:	PO Box:		
143.00	City:	State:	Zip Code:	
			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.		Y	N
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 REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0002		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part II Date/Time Prepared: 5/29/2024 9:08 am	
				Y/N	Date		
				1.00	2.00		
PART II - HOSPITAL AND HOSPITAL HEALTHCARE 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			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.	Y					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.	Y					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.	Y					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)	N			N		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)	Y	03/13/2024		Y	03/13/2024	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: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/29/2024 9:08 am	
		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 relieved for Medicare purposes? If yes, see instructions			N	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.			N	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.			N	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.			Y	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.			N	35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		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.		N		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.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		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.	MICHAEL		ALESSANDRINI	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.	317-713-7959		MALESSANDRINI@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 15-0002

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

Worksheet S-2
Part II
Date/Time Prepared:
5/29/2024 9:08 am

		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.	DIRECTOR	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: 15-0002

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

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2024 9:08 am

Component	Worksheet A Line No.	No. of Beds	Bed Days Avai l ab l e	CAH/REH Hours	I/P Days / O/P Vi s i t s / Tri ps		
						Ti t l e 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	331	120,815	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)		331	120,815	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	39	14,235	0.00	0	8.00
8.01	NEONATAL ICU	31.01	35	12,775	0.00	0	8.01
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)		405	147,825	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	40.00	12	4,380		0	16.00
17.00	SUBPROVIDER - IRF	41.00	24	8,760		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)		441				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: 15-0002

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

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2024 9:08 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII	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)	14,839	3,385	63,458		1.00
2.00	HMO and other (see instructions)	26,144	21,743			2.00
3.00	HMO IPF Subprovider	0	260			3.00
4.00	HMO IRF Subprovider	0	920			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	0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	14,839	3,385	63,458		7.00
8.00	INTENSIVE CARE UNIT	1,895	0	7,609		8.00
8.01	NEONATAL ICU	0	0	2,024		8.01
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		0	2,108		13.00
14.00	Total (see instructions)	16,734	3,385	75,199	2.86	1,844.95
15.00	CAH visits	0	0	0		15.00
15.10	REH hours and visits	0	0	0		15.10
16.00	SUBPROVIDER - IPF	256	41	1,312	0.00	10.46
17.00	SUBPROVIDER - IRF	808	48	3,461	0.00	17.34
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	0	16,540	0.00	23.39
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE					24.00
24.10	HOSPICE (non-distinct part)			176		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
27.00	Total (sum of lines 14-26)				2.86	1,896.14
28.00	Observation Bed Days		3,411	11,312		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	48	56		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: 15-0002

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

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2024 9:08 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
PART I - STATISTICAL DATA							
1.00			0	2,433	542	11,482	1.00
2.00				3,192	4,580		2.00
3.00					26		3.00
4.00					54		4.00
5.00							5.00
6.00							6.00
7.00							7.00
8.00							8.00
8.01							8.01
9.00							9.00
10.00							10.00
11.00							11.00
12.00							12.00
13.00							13.00
14.00	0.00	0	2,433		542	11,482	14.00
15.00							15.00
15.10							15.10
16.00	0.00	0	15		3	123	16.00
17.00	0.00	0	67		4	240	17.00
18.00							18.00
19.00							19.00
20.00							20.00
21.00							21.00
22.00	0.00						22.00
23.00							23.00
24.00							24.00
24.10							24.10
25.00							25.00
26.00							26.00
26.25	0.00						26.25
27.00	0.00						27.00
28.00							28.00
29.00							29.00
30.00							30.00
31.00							31.00
32.00							32.00
32.01							32.01
33.00				0			33.00
33.01				0			33.01
34.00							34.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0002

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

Worksheet S-3
Part II
Date/Time Prepared:
5/29/2024 9:08 am

	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	163,242,818	-415,172	162,827,646	3,942,742.00	41.30
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		430,755	0	430,755	2,080.00	207.09
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		297,137	0	297,137	5,949.00	49.95
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		30,952,460	1,511,276	32,463,736	589,471.00	55.07
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		17,166,517	0	17,166,517	164,996.00	104.04
12.00	Contract Labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		761,280	0	761,280	4,859.00	156.67
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		30,865,942	0	30,865,942		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		5,689,375	0	5,689,375		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		35,620	0	35,620		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0002

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

Worksheet S-3
Part II
Date/Time Prepared:
5/29/2024 9:08 am

		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	2,075,433	-75,014	2,000,419	29,785.00	67.16	26.00
27.00	Administrative & General	5.00	23,945,142	-1,665,207	22,279,935	624,783.00	35.66	27.00
28.00	Administrative & General under contract (see inst.)		2,280,643	0	2,280,643	11,750.00	194.10	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	5,282,304	-3,587	5,278,717	175,474.00	30.08	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	4,722,254	-28,001	4,694,253	245,885.00	19.09	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	4,021,138	-1,380,298	2,640,840	94,977.00	27.81	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	249,114	1,375,923	1,625,037	58,603.00	27.73	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	6,162,512	-11,841	6,150,671	96,642.00	63.64	38.00
39.00	Central Services and Supply	14.00	776,128	0	776,128	36,682.00	21.16	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	2,283,430	-1,788	2,281,642	83,950.00	27.18	41.00
42.00	Social Service	17.00	157,499	469,866	627,365	16,841.00	37.25	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0002

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

Worksheet S-3
Part III
Date/Time Prepared:
5/29/2024 9:08 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Sal ari es (from Worksheet A-6)	Adjusted Sal ari es (col . 2 ± col . 3)	Pai d Hours Related to Sal ari es i n 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)	164,795,569	-415,172	164,380,397	3,946,463.00	41.65	1.00
2.00	Excluded area salaries (see instructions)	30,952,460	1,511,276	32,463,736	589,471.00	55.07	2.00
3.00	Subtotal salaries (line 1 minus line 2)	133,843,109	-1,926,448	131,916,661	3,356,992.00	39.30	3.00
4.00	Subtotal other wages & related costs (see inst.)	17,927,797	0	17,927,797	169,855.00	105.55	4.00
5.00	Subtotal wage-related costs (see inst.)	30,865,942	0	30,865,942	0.00	23.40	5.00
6.00	Total (sum of lines 3 thru 5)	182,636,848	-1,926,448	180,710,400	3,526,847.00	51.24	6.00
7.00	Total overhead cost (see instructions)	51,955,597	-1,319,947	50,635,650	1,475,372.00	34.32	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part IV Date/Time Prepared: 5/29/2024 9:08 am
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	2,721,771	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	1,066,667	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)	15,198,586	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	4,097,969	9.00
10.00	Dental, Hearing and Vision Plan	666,468	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	772,477	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)	415,174	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	531,512	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	11,046,801	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	73,512	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	36,590,937	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: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part V Date/Time Prepared: 5/29/2024 9:08 am
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	17,166,517	36,590,937	1.00
2.00	Hospital	17,166,517	36,590,937	2.00
3.00	SUBPROVIDER - IPF	0	0	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	0	0	17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 15-0002 Component CCN: 15-7536	Period: From 01/01/2023 To 12/31/2023	Worksheet S-4 Date/Time Prepared: 5/29/2024 9:08 am
			Home Health Agency I	PPS

					1.00	
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0.00	County					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	144.00	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)	40.00			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				9.15	0.00	9.15	5.00
6.00	Direct Nursing Service				7.07	0.00	7.07	6.00
7.00	Nursing Supervisor				0.00	0.00	0.00	7.00
8.00	Physical Therapy Service				3.98	0.00	3.98	8.00
9.00	Physical Therapy Supervisor				0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service				1.37	0.00	1.37	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				0.08	0.00	0.08	14.00
15.00	Medical Social Service Supervisor				0.00	0.00	0.00	15.00
16.00	Home Health Aide				1.75	0.00	1.75	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).	23844					20.00

		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	

PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	1,039	253	30	0	1,322	21.00
22.00	Skilled Nursing Visit Charges	246,428	60,032	7,140	0	313,600	22.00
23.00	Physical Therapy Visits	611	298	6	0	915	23.00
24.00	Physical Therapy Visit Charges	158,365	77,255	1,560	0	237,180	24.00
25.00	Occupational Therapy Visits	153	171	1	0	325	25.00
26.00	Occupational Therapy Visit Charges	40,026	44,697	262	0	84,985	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	8	9	0	0	17	29.00
30.00	Medical Social Service Visit Charges	2,996	3,420	0	0	6,416	30.00
31.00	Home Health Aide Visits	330	103	1	0	434	31.00
32.00	Home Health Aide Visit Charges	35,521	11,124	108	0	46,753	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,141	834	38	0	3,013	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)	483,336	196,528	9,070	0	688,934	35.00
36.00	Total Number of Episodes (standard/non outlier)	223		28	0	251	36.00
37.00	Total Number of Outlier Episodes		35		0	35	37.00
38.00	Total Non-Routine Medical Supply Charges	53,833	10,470	3,562	0	67,865	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/29/2024 9:08 am
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				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)			0.203379	1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			79,608,456	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?			N	4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			12,338,717	5.00	
6.00	Medicaid charges			564,824,644	6.00	
7.00	Medicaid cost (line 1 times line 6)			114,873,471	7.00	
8.00	Difference between net revenue and costs for Medicaid program (see instructions)			22,926,298	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)			22,926,298	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)	16,837,367	1,057,795	17,895,162	20.00	
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	3,424,367	1,057,795	4,482,162	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)	3,424,367	1,057,795	4,482,162	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)			0	25.01	
26.00	Bad debt amount (see instructions)			33,451,647	26.00	
27.00	Medicare reimbursable bad debts (see instructions)			675,702	27.00	
27.01	Medicare allowable bad debts (see instructions)			1,039,541	27.01	
28.00	Non-Medicare bad debt amount (see instructions)			32,412,106	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)			6,955,781	29.00	
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)			11,437,943	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			34,364,241	31.00	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/29/2024 9:08 am
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				1.00	
PART II - HOSPITAL DATA					
Uncompensated and Indigent Care Cost-to-Charge Ratio					
1.00	Cost to charge ratio (see instructions)			0.198903	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)	16,837,367	1,009,035	17,846,402	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	3,349,003	1,009,035	4,358,038	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)	3,349,003	1,009,035	4,358,038	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)			0	25.01
26.00	Bad debt amount (see instructions)			33,339,065	26.00
27.00	Medicare reimbursable bad debts (see instructions)			666,995	27.00
27.01	Medicare allowable bad debts (see instructions)			1,026,145	27.01
28.00	Non-Medicare bad debt amount (see instructions)			32,312,920	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)			6,786,287	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)			11,144,325	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			11,144,325	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet A Date/Time Prepared: 5/29/2024 9:08 am		
Cost Center	Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassified (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	CAP REL COSTS-BLDG & FIXT	0	0	20,285,335	20,285,335	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,075,433	29,713,357	31,788,790	335,917	4.00
5.01	00550	DATA PROCESSING	4,389,933	11,286,540	15,676,473	-1,893,695	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	1,185,105	2,000,059	3,185,164	-96,108	5.02
5.03	00570	ADMINISTRATIVE	5,050,368	1,032,967	6,083,335	-477,574	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	3,636,060	4,425,734	8,061,794	-1,553,580	5.04
5.05	00590	OTHER A&G	9,128,992	25,434,372	34,563,364	-14,758,465	5.05
5.06	00592	PATIENT TRANSPORTATION	554,684	48,789	603,473	-8	5.06
7.00	00700	OPERATION OF PLANT	5,282,304	9,712,790	14,995,094	5,911,078	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,386,424	1,386,424	-9	8.00
9.00	00900	HOUSEKEEPING	4,722,254	1,302,918	6,025,172	-203,978	9.00
10.00	01000	DIETARY	4,021,138	3,598,760	7,619,898	-2,805,605	10.00
11.00	01100	CAFETERIA	249,114	36,013	285,127	2,728,346	11.00
13.00	01300	NURSING ADMINISTRATION	6,162,512	855,236	7,017,748	-128,619	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	776,128	2,336,368	3,112,496	-464,714	14.00
15.00	01500	PHARMACY	0	14,087,188	14,087,188	-8,027,697	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,283,430	931,322	3,214,752	-2,212	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	469,866	17.00
17.01	01701	STAFF EDUCATION	0	0	0	0	17.01
17.02	01702	MEDICAL EDUCATION	157,499	49,530	207,029	-3,412	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	297,137	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	31,168	22.00
23.00	02300	PARAMED PROGRAM	592,438	118,756	711,194	394,385	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	24,199,579	19,781,355	43,980,934	-1,040,181	30.00
31.00	03100	INTENSIVE CARE UNIT	6,849,882	2,501,917	9,351,799	-802,020	31.00
31.01	03101	NEONATAL ICU	1,731,093	2,383,408	4,114,501	-44,282	31.01
40.00	04000	SUBPROVIDER - I PF	968,593	89,404	1,057,997	-10,350	40.00
41.00	04100	SUBPROVIDER - I RF	1,628,726	357,696	1,986,422	-34,944	41.00
43.00	04300	NURSERY	1,296,492	375,555	1,672,047	-118,715	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,743,339	27,415,877	33,159,216	-15,670,627	50.00
50.01	05001	ENDOSCOPY	612,103	939,334	1,551,437	-542,616	50.01
51.00	05100	RECOVERY ROOM	1,191,406	295,678	1,487,084	-18,971	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,975,339	852,447	4,827,786	-268,513	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,859,813	3,429,010	6,288,823	-669,138	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	1,411,077	759,390	2,170,467	-25,287	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	473,412	2,474,696	2,948,108	-520,160	55.00
55.01	05501	INFUSION CENTER	716,079	24,634,366	25,350,445	-18,789,646	55.01
56.00	05600	RADIOISOTOPE	756,967	1,323,430	2,080,397	-74,570	56.00
57.00	05700	CT SCAN	1,324,407	1,253,252	2,577,659	-109,685	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	499,966	644,501	1,144,467	-106,069	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,616,381	8,949,865	11,566,246	-7,306,777	59.00
60.00	06000	LABORATORY	4,459,801	10,162,386	14,622,187	-185,662	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,238,124	361,469	1,599,593	-23,241	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,644,859	2,590,716	5,235,575	-311,190	65.00
66.00	06600	PHYSICAL THERAPY	1,722,283	248,140	1,970,423	-9,135	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,121,036	97,218	1,218,254	-1,344	67.00
68.00	06800	SPEECH PATHOLOGY	485,239	47,034	532,273	-8	68.00
69.00	06900	ELECTROCARDIOLOGY	838,421	246,233	1,084,654	-87,973	69.00
69.01	06901	CARDIAC REHAB	466,181	436,986	903,167	-201,452	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	1,276,080	14,128,413	15,404,493	-13,696,907	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	15,183,398	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14,331,609	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	448,590	7,651,134	8,099,724	34,602,496	73.00
74.00	07400	RENAL DIALYSIS	0	2,346,940	2,346,940	-10,162	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,559,117	2,077,389	4,636,506	-165,496	90.00
91.00	09100	EMERGENCY	9,098,338	7,463,735	16,562,073	-1,290,235	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	2,115,440	346,830	2,462,270	-40,111	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	137,595,555	255,022,927	392,618,482	1,979,592	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	25,571,496	19,568,507	45,140,003	918	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	2,328,938	2,328,938	-1,980,510	192.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 15-0002		Period: From 01/01/2023 To 12/31/2023		Worksheet A Date/Time Prepared: 5/29/2024 9:08 am	
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	
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	75,767	72,312	148,079	0	148,079	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	163,242,818	276,992,684	440,235,502	0	440,235,502	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0002

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

Worksheet A
Date/Time Prepared:
5/29/2024 9:08 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-3,501,200	16,784,135	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-3,039,301	29,085,406	4.00
5.01	00550	DATA PROCESSING	-252,060	13,530,718	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	3,089,056	5.02
5.03	00570	ADMITTING	0	5,605,761	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	-30,204	6,478,010	5.04
5.05	00590	OTHER A&G	-99,544	19,705,355	5.05
5.06	00592	PATIENT TRANSPORTATION	0	603,465	5.06
7.00	00700	OPERATION OF PLANT	0	20,906,172	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,386,415	8.00
9.00	00900	HOUSEKEEPING	-60	5,821,134	9.00
10.00	01000	DIETARY	0	4,814,293	10.00
11.00	01100	CAFETERIA	-1,203,412	1,810,061	11.00
13.00	01300	NURSING ADMINISTRATION	0	6,889,129	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,647,782	14.00
15.00	01500	PHARMACY	0	6,059,491	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-173,073	3,039,467	16.00
17.00	01700	SOCIAL SERVICE	0	469,866	17.00
17.01	01701	STAFF EDUCATION	0	0	17.01
17.02	01702	MEDICAL EDUCATION	0	203,617	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	297,137	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	31,168	22.00
23.00	02300	PARAMED ED PROGRAM	-249,020	856,559	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-3,747,144	39,193,609	30.00
31.00	03100	INTENSIVE CARE UNIT	0	8,549,779	31.00
31.01	03101	NEONATAL ICU	-2,111,003	1,959,216	31.01
40.00	04000	SUBPROVIDER - I/PF	0	1,047,647	40.00
41.00	04100	SUBPROVIDER - I/RF	0	1,951,478	41.00
43.00	04300	NURSERY	0	1,553,332	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-7,064,871	10,423,718	50.00
50.01	05001	ENDOSCOPY	0	1,008,821	50.01
51.00	05100	RECOVERY ROOM	0	1,468,113	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,559,273	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-429	5,619,256	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	-6,788	2,138,392	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	-187,612	2,240,336	55.00
55.01	05501	INFUSION CENTER	-5,429,954	1,130,845	55.01
56.00	05600	RADIOISOTOPE	0	2,005,827	56.00
57.00	05700	CT SCAN	-10,379	2,457,595	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,038,398	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	4,259,469	59.00
60.00	06000	LABORATORY	-50,092	14,386,433	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	-21,046	1,555,306	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	4,924,385	65.00
66.00	06600	PHYSICAL THERAPY	0	1,961,288	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,216,910	67.00
68.00	06800	SPEECH PATHOLOGY	0	532,265	68.00
69.00	06900	ELECTROCARDIOLOGY	0	996,681	69.00
69.01	06901	CARDIAC REHAB	-46,800	654,915	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	-58,433	1,649,153	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	15,183,398	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,331,609	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-179,765	42,522,455	73.00
74.00	07400	RENAL DIALYSIS	0	2,336,778	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-507,555	3,963,455	90.00
91.00	09100	EMERGENCY	0	15,271,838	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	2,422,159	101.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-27,969,745	366,628,329	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,966	2,966	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-31,014,365	14,126,556	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	348,428	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	-93,733	54,346	192.02

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0002

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

Worksheet A
Date/Time Prepared:
5/29/2024 9:08 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
193.00	19300	NONPAID WORKERS	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-59,074,877	381,160,625	200.00

RECLASSIFICATIONS

Provider CCN: 15-0002

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

Worksheet A-6
Date/Time Prepared:
5/29/2024 9:08 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - CAFETERIA					
1.00	CAFETERIA	11.00	1,382,357	1,352,670	1.00
	O		1,382,357	1,352,670	
B - CLINICAL TRAINING COST					
1.00	PARAMED PROGRAM	23.00	408,128	0	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
	O		408,128	0	
C - SOCIAL WORKERS					
1.00	SOCIAL SERVICE	17.00	469,866	0	1.00
	O		469,866	0	
E - RESIDENTS					
1.00	I&R SERVICES-SALARY & FRINGES APPRVD	21.00	0	297,137	1.00
2.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	0	31,168	2.00
	O		0	328,305	
F - MED SUPPLY					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	15,183,398	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	14,331,609	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
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
35.00		0.00	0	0	35.00
36.00		0.00	0	0	36.00
37.00		0.00	0	0	37.00
38.00		0.00	0	0	38.00
39.00		0.00	0	0	39.00
40.00		0.00	0	0	40.00
41.00		0.00	0	0	41.00
42.00		0.00	0	0	42.00
43.00		0.00	0	0	43.00
44.00		0.00	0	0	44.00
45.00		0.00	0	0	45.00
46.00		0.00	0	0	46.00
	O		0	29,515,007	
G - LIGHT DUTY					
1.00	OTHER A&G	5.05	8,771	0	1.00
2.00	DIETARY	10.00	2,785	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	21,087	0	3.00

RECLASSIFICATIONS

Provider CCN: 15-0002

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

Worksheet A-6
Date/Time Prepared:
5/29/2024 9:08 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
4.00	SUBPROVIDER - IRF	41.00	2,645	0	4.00
5.00	OPERATING ROOM	50.00	8,361	0	5.00
6.00	RECOVERY ROOM	51.00	1,193	0	6.00
7.00	RADIOLOGY - ULTRASOUND	54.01	658	0	7.00
8.00	CT SCAN	57.00	18,589	0	8.00
9.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	1,472	0	9.00
10.00	EMERGENCY	91.00	6,815	0	10.00
			72,376	0	
H - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3,482,115	1.00
2.00		0.00	0	0	2.00
			0	3,482,115	
I - CORPORATE EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,913,940	1.00
2.00	OPERATION OF PLANT	7.00	0	5,229,267	2.00
			0	11,143,207	
J - DRUG EXPENSE					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	35,023,378	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
			0	35,023,378	
K - PHYSICIAN RECLASS					
1.00	OTHER A&G	5.05	0	50,000	1.00
2.00	CLINIC	90.00	0	115,580	2.00
			0	165,580	
L - PSTD RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	415,172	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
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
35.00		0.00	0	0	35.00
36.00		0.00	0	0	36.00
37.00		0.00	0	0	37.00
			0	415,172	
M - DEPRECIATION RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	10,889,280	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

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
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
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
33.00		0.00	0	0		33.00
34.00		0.00	0	0		34.00
35.00		0.00	0	0		35.00
36.00		0.00	0	0		36.00
37.00		0.00	0	0		37.00
38.00		0.00	0	0		38.00
39.00		0.00	0	0		39.00
40.00		0.00	0	0		40.00
41.00		0.00	0	0		41.00
42.00		0.00	0	0		42.00
43.00		0.00	0	0		43.00
44.00		0.00	0	0		44.00
45.00		0.00	0	0		45.00
46.00		0.00	0	0		46.00
				0	10,889,280	
N - DEPT 9101 RECLASS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	1,171,295	319,701		1.00
			1,171,295	319,701		
O - UTILITIES RECLASS						
1.00	OPERATION OF PLANT	7.00	0	1,225,559		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
				0	1,225,559	
P - C SECTION RECLASS						
1.00	OPERATING ROOM	50.00	22,010	0		1.00
			22,010	0		
500.00	Grand Total: Increases		3,526,032	93,859,974		500.00

RECLASSIFICATIONS

Provider CCN: 15-0002

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

Worksheet A-6
Date/Time Prepared:
5/29/2024 9:08 am

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA						
1.00	DIETARY	10.00	1,382,357	1,352,670	0	1.00
	O		1,382,357	1,352,670		
B - CLINICAL TRAINING COST						
1.00	ADULTS & PEDIATRICS	30.00	20,379	0	0	1.00
2.00	OPERATING ROOM	50.00	19,626	0	0	2.00
3.00	CARDIAC CATHETERIZATION	59.00	9,358	0	0	3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	17,979	0	0	4.00
5.00	RESPIRATORY THERAPY	65.00	22,735	0	0	5.00
6.00	EMERGENCY	91.00	318,051	0	0	6.00
	O		408,128	0		
C - SOCIAL WORKERS						
1.00	ADMINISTRATIVE	5.03	469,866	0	0	1.00
	O		469,866	0		
E - RESIDENTS						
1.00	EMERGENCY	91.00	0	328,305	0	1.00
2.00		0.00	0	0	0	2.00
	O		0	328,305		
F - MED SUPPLY						
1.00	PURCHASING RECEIVING AND STORES	5.02	0	50,992	0	1.00
2.00	OTHER A&G	5.05	0	205	0	2.00
3.00	PATIENT TRANSPORTATION	5.06	0	8	0	3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	9	0	4.00
5.00	OPERATION OF PLANT	7.00	0	175	0	5.00
6.00	HOUSEKEEPING	9.00	0	3,008	0	6.00
7.00	DIETARY	10.00	0	22	0	7.00
8.00	CAFETERIA	11.00	0	247	0	8.00
9.00	NURSING ADMINISTRATION	13.00	0	5,390	0	9.00
10.00	CENTRAL SERVICES & SUPPLY	14.00	0	105,097	0	10.00
11.00	PHARMACY	15.00	0	7,365	0	11.00
12.00	MEDICAL RECORDS & LIBRARY	16.00	0	297	0	12.00
13.00	MEDICAL EDUCATION	17.02	0	3,412	0	13.00
14.00	PARAMEDICAL PROGRAM	23.00	0	584	0	14.00
15.00	ADULTS & PEDIATRICS	30.00	0	558,782	0	15.00
16.00	INTENSIVE CARE UNIT	31.00	0	169,468	0	16.00
17.00	NEONATAL ICU	31.01	0	701	0	17.00
18.00	SUBPROVIDER - IRF	41.00	0	27,402	0	18.00
19.00	NURSERY	43.00	0	40,076	0	19.00
20.00	OPERATING ROOM	50.00	0	14,962,795	0	20.00
21.00	ENDOSCOPY	50.01	0	313,824	0	21.00
22.00	RECOVERY ROOM	51.00	0	17,477	0	22.00
23.00	DELIVERY ROOM & LABOR ROOM	52.00	0	111,814	0	23.00
24.00	RADIOLOGY-DIAGNOSTIC	54.00	0	130,517	0	24.00
25.00	RADIOLOGY - ULTRASOUND	54.01	0	18,206	0	25.00
26.00	RADIOLOGY-THERAPEUTIC	55.00	0	9,206	0	26.00
27.00	INFUSION CENTER	55.01	0	23,982	0	27.00
28.00	RADIOISOTOPE	56.00	0	646	0	28.00
29.00	CT SCAN	57.00	0	1,118	0	29.00
30.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	308	0	30.00
31.00	CARDIAC CATHETERIZATION	59.00	0	7,087,681	0	31.00
32.00	LABORATORY	60.00	0	2,494	0	32.00
33.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	0	1,713	0	33.00
34.00	RESPIRATORY THERAPY	65.00	0	147,924	0	34.00
35.00	PHYSICAL THERAPY	66.00	0	383	0	35.00
36.00	OCCUPATIONAL THERAPY	67.00	0	400	0	36.00
37.00	SPEECH PATHOLOGY	68.00	0	8	0	37.00
38.00	ELECTROCARDIOLOGY	69.00	0	1,206	0	38.00
39.00	CARDIAC REHAB	69.01	0	1,641	0	39.00
40.00	ELECTROENCEPHALOGRAPHY	70.00	0	4,839,261	0	40.00
41.00	DRUGS CHARGED TO PATIENTS	73.00	0	384,156	0	41.00
42.00	RENAL DIALYSIS	74.00	0	9,873	0	42.00
43.00	CLINIC	90.00	0	104,499	0	43.00
44.00	EMERGENCY	91.00	0	332,715	0	44.00
45.00	HOME HEALTH AGENCY	101.00	0	17,493	0	45.00
46.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	20,427	0	46.00
	O		0	29,515,007		
G - LIGHT DUTY						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	72,376	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00

RECLASSIFICATIONS

Provider CCN: 15-0002

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

Worksheet A-6
Date/Time Prepared:
5/29/2024 9:08 am

Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
0			72,376	0			
H - INTEREST EXPENSE							
1.00	OTHER A&G	5.05	0	3,481,947	11		1.00
2.00	RADIOLOGY-THERAPEUTIC	55.00	0	168	0		2.00
0			0	3,482,115			
I - CORPORATE EXPENSE							
1.00	OTHER A&G	5.05	0	11,143,207	9		1.00
2.00		0.00	0	0	0		2.00
0			0	11,143,207			
J - DRUG EXPENSE							
1.00	PHARMACY	15.00	0	7,777,977	0		1.00
2.00	INFUSION CENTER	55.01	0	18,588,696	0		2.00
3.00	ELECTROENCEPHALOGRAPHY	70.00	0	8,656,705	0		3.00
0			0	35,023,378			
K - PHYSICIAN RECLASS							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	165,580	0		1.00
2.00		0.00	0	0	0		2.00
0			0	165,580			
L - PSTD RECLASS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	2,638	0	0		1.00
2.00	DATA PROCESSING	5.01	249	0	0		2.00
3.00	PURCHASING RECEIVING AND STORES	5.02	6,951	0	0		3.00
4.00	ADMINISTRATIVE	5.03	3,857	0	0		4.00
5.00	CASHIERING/ACCOUNTS RECEIVABLE	5.04	11,752	0	0		5.00
6.00	OTHER A&G	5.05	10,008	0	0		6.00
7.00	OPERATION OF PLANT	7.00	3,587	0	0		7.00
8.00	HOUSEKEEPING	9.00	28,001	0	0		8.00
9.00	DIETARY	10.00	726	0	0		9.00
10.00	CAFETERIA	11.00	6,434	0	0		10.00
11.00	NURSING ADMINISTRATION	13.00	11,841	0	0		11.00
12.00	MEDICAL RECORDS & LIBRARY	16.00	1,788	0	0		12.00
13.00	PARAMEDICAL PROGRAM	23.00	1,502	0	0		13.00
14.00	ADULTS & PEDIATRICS	30.00	39,708	0	0		14.00
15.00	INTENSIVE CARE UNIT	31.00	61,401	0	0		15.00
16.00	NEONATAL ICU	31.01	3,660	0	0		16.00
17.00	SUBPROVIDER - IRF	41.00	535	0	0		17.00
18.00	NURSERY	43.00	24,395	0	0		18.00
19.00	OPERATING ROOM	50.00	3,097	0	0		19.00
20.00	RECOVERY ROOM	51.00	1,905	0	0		20.00
21.00	DELIVERY ROOM & LABOR ROOM	52.00	6,314	0	0		21.00
22.00	RADIOLOGY-DIAGNOSTIC	54.00	7,723	0	0		22.00
23.00	RADIOLOGY - ULTRASOUND	54.01	3,698	0	0		23.00
24.00	RADIOLOGY-THERAPEUTIC	55.00	2,622	0	0		24.00
25.00	INFUSION CENTER	55.01	2,792	0	0		25.00
26.00	RADIOISOTOPE	56.00	1,726	0	0		26.00
27.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	3,268	0	0		27.00
28.00	CARDIAC CATHETERIZATION	59.00	8,920	0	0		28.00
29.00	LABORATORY	60.00	34,841	0	0		29.00
30.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	14,142	0	0		30.00
31.00	RESPIRATORY THERAPY	65.00	15,822	0	0		31.00
32.00	PHYSICAL THERAPY	66.00	8,378	0	0		32.00
33.00	OCCUPATIONAL THERAPY	67.00	482	0	0		33.00
34.00	CLINIC	90.00	10,305	0	0		34.00
35.00	EMERGENCY	91.00	1,349	0	0		35.00
36.00	HOME HEALTH AGENCY	101.00	22,618	0	0		36.00
37.00	PHYSICIANS' PRIVATE OFFICES	192.00	46,137	0	0		37.00
0			415,172	0			
M - DEPRECIATION RECLASS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4,241	9		1.00
2.00	DATA PROCESSING	5.01	0	1,722,196	0		2.00
3.00	PURCHASING RECEIVING AND STORES	5.02	0	38,165	0		3.00
4.00	ADMINISTRATIVE	5.03	0	3,851	0		4.00

RECLASSIFICATIONS

Provider CCN: 15-0002

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

Worksheet A-6

Date/Time Prepared:
5/29/2024 9:08 am

Decreases							
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
6.00	7.00	8.00	9.00	10.00			
5.00	CASHIERING/ACCOUNTS RECEIVABLE	5.04	0	31,120	0	5.00	
6.00	OTHER A&G	5.05	0	181,869	0	6.00	
7.00	OPERATION OF PLANT	7.00	0	539,986	0	7.00	
8.00	HOUSEKEEPING	9.00	0	33,790	0	8.00	
9.00	DIETARY	10.00	0	72,615	0	9.00	
10.00	NURSING ADMINISTRATION	13.00	0	111,388	0	10.00	
11.00	CENTRAL SERVICES & SUPPLY	14.00	0	359,617	0	11.00	
12.00	PHARMACY	15.00	0	242,355	0	12.00	
13.00	MEDICAL RECORDS & LIBRARY	16.00	0	127	0	13.00	
14.00	PARAMED PROGRAM	23.00	0	11,657	0	14.00	
15.00	ADULTS & PEDIATRICS	30.00	0	442,399	0	15.00	
16.00	INTENSIVE CARE UNIT	31.00	0	571,151	0	16.00	
17.00	NEONATAL ICU	31.01	0	39,921	0	17.00	
18.00	SUBPROVIDER - IPF	40.00	0	10,350	0	18.00	
19.00	SUBPROVIDER - IRF	41.00	0	9,652	0	19.00	
20.00	NURSERY	43.00	0	54,244	0	20.00	
21.00	OPERATING ROOM	50.00	0	715,480	0	21.00	
22.00	ENDOSCOPY	50.01	0	228,792	0	22.00	
23.00	RECOVERY ROOM	51.00	0	782	0	23.00	
24.00	DELIVERY ROOM & LABOR ROOM	52.00	0	110,396	0	24.00	
25.00	RADIOLOGY-DIAGNOSTIC	54.00	0	530,898	0	25.00	
26.00	RADIOLOGY - ULTRASOUND	54.01	0	4,041	0	26.00	
27.00	RADIOLOGY-THERAPEUTIC	55.00	0	508,164	0	27.00	
28.00	INFUSION CENTER	55.01	0	174,176	0	28.00	
29.00	RADIOISOTOPE	56.00	0	72,198	0	29.00	
30.00	CT SCAN	57.00	0	127,156	0	30.00	
31.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	102,493	0	31.00	
32.00	CARDIAC CATHETERIZATION	59.00	0	200,818	0	32.00	
33.00	LABORATORY	60.00	0	148,327	0	33.00	
34.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	0	8,858	0	34.00	
35.00	RESPIRATORY THERAPY	65.00	0	124,709	0	35.00	
36.00	PHYSICAL THERAPY	66.00	0	374	0	36.00	
37.00	OCCUPATIONAL THERAPY	67.00	0	462	0	37.00	
38.00	ELECTROCARDIOLOGY	69.00	0	86,767	0	38.00	
39.00	CARDIAC REHAB	69.01	0	145,733	0	39.00	
40.00	ELECTROENCEPHALOGRAPHY	70.00	0	200,941	0	40.00	
41.00	DRUGS CHARGED TO PATIENTS	73.00	0	36,726	0	41.00	
42.00	RENAL DIALYSIS	74.00	0	289	0	42.00	
43.00	CLINIC	90.00	0	166,272	0	43.00	
44.00	EMERGENCY	91.00	0	316,630	0	44.00	
45.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	935,266	0	45.00	
46.00	OTHER NON-REIMBURSABLE	192.01	0	1,461,838	0	46.00	
	O		0	10,889,280			
N - DEPT 9101 RECLASS							
1.00	CASHIERING/ACCOUNTS RECEIVABLE	5.04	1,171,295	319,701	0	1.00	
	O		1,171,295	319,701			
O - UTILITIES RECLASS							
1.00	DATA PROCESSING	5.01		171,250	0	1.00	
2.00	CASHIERING/ACCOUNTS RECEIVABLE	5.04		19,712	0	2.00	
3.00	HOUSEKEEPING	9.00		139,179	0	3.00	
4.00	CARDIAC REHAB	69.01		54,078	0	4.00	
5.00	PHYSICIANS' PRIVATE OFFICES	192.00		322,668	0	5.00	
6.00	OTHER NON-REIMBURSABLE	192.01		518,672	0	6.00	
	O			1,225,559			
P - C SECTION RECLASS							
1.00	DELIVERY ROOM & LABOR ROOM	52.00	22,010	0	0	1.00	
	O		22,010	0			
500.00	Grand Total: Decreases		3,941,204	93,444,802		500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0002

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

Worksheet A-7
Part I
Date/Time Prepared:
5/29/2024 9:08 am

		Acquisitions			Disposals and Retirements		
		Beginning Balances	Purchases	Donation			Total
		1.00	2.00	3.00			4.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	5,800,874	0	0	0	32,921 1.00	
2.00	Land Improvements	7,039,139	73,864	0	73,864	0 2.00	
3.00	Buildings and Fixtures	314,922,393	3,950,380	0	3,950,380	0 3.00	
4.00	Building Improvements	2,011,838	0	0	0	0 4.00	
5.00	Fixed Equipment	0	0	0	0	0 5.00	
6.00	Movable Equipment	212,060,196	13,453,935	0	13,453,935	0 6.00	
7.00	HIT designated Assets	0	0	0	0	0 7.00	
8.00	Subtotal (sum of lines 1-7)	541,834,440	17,478,179	0	17,478,179	32,921 8.00	
9.00	Reconciling Items	0	0	0	0	0 9.00	
10.00	Total (line 8 minus line 9)	541,834,440	17,478,179	0	17,478,179	32,921 10.00	
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	5,767,953	0				
2.00	Land Improvements	7,113,003	0				
3.00	Buildings and Fixtures	318,872,773	0				
4.00	Building Improvements	2,011,838	0				
5.00	Fixed Equipment	0	0				
6.00	Movable Equipment	225,514,131	0				
7.00	HIT designated Assets	0	0				
8.00	Subtotal (sum of lines 1-7)	559,279,698	0				
9.00	Reconciling Items	0	0				
10.00	Total (line 8 minus line 9)	559,279,698	0				

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0002

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

Worksheet A-7
Part II
Date/Time Prepared:
5/29/2024 9:08 am

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	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
3.00	Total (sum of lines 1-2)	0	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	CAP REL COSTS-BLDG & FIXT	0	0				1.00
3.00	Total (sum of lines 1-2)	0	0				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0002

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

Worksheet A-7
Part III
Date/Time Prepared:
5/29/2024 9:08 am

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	CAP REL COSTS-BLDG & FIXT	559,279,698	0	559,279,698	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	559,279,698	0	559,279,698	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	CAP REL COSTS-BLDG & FIXT	0	0	0	16,784,135	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	16,784,135	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	CAP REL COSTS-BLDG & FIXT	0	0	0	0	16,784,135	1.00
3.00	Total (sum of lines 1-2)	0	0	0	0	16,784,135	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0002

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

Worksheet A-8

Date/Time Prepared:
5/29/2024 9:08 am

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	5.00
				Cost Center	Line #		
				3.00	4.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-3,482,115	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00		2.00
3.00	Investment income - other (chapter 2)		0		0.00		3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00		4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00		5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00		6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00		7.00
8.00	Television and radio service (chapter 21)		0		0.00		8.00
9.00	Parking lot (chapter 21)		0		0.00		9.00
10.00	Provider-based physician adjustment	A-8-2	-19,065,735				10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00		11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0				12.00
13.00	Laundry and linen service		0		0.00		13.00
14.00	Cafeteria-employees and guests	B	-1,203,412	CAFETERIA	11.00		14.00
15.00	Rental of quarters to employees and others		0		0.00		15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00		16.00
17.00	Sale of drugs to other than patients		0		0.00		17.00
18.00	Sale of medical records and abstracts	B	-173,073	MEDICAL RECORDS & LIBRARY	16.00		18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00		19.00
20.00	Vending machines	B	0	DIETARY	10.00		20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00		21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00		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 - CAP REL COSTS-BLDG & FIXT	A	-19,085	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00		27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00		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

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center	Line #		
			1.00	2.00	3.00	
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 DATA PROCESSING OTHER INCOME	B	-252,060		DATA PROCESSING	5.01	0 33.00
33.01 CASH, A/R, COLLECTIONS OTHER INCOME	B	-30,204		CASHIERING/ACCOUNTS RECEIVABLE	5.04	0 33.01
33.02 A&G OTHER INCOME	B	-85,954		OTHER A&G	5.05	0 33.02
33.03 ENVIRONMENTAL SERVICES OTHER INCOME	B	-60		HOUSEKEEPING	9.00	0 33.03
33.04 PARAMED ED PROGRAM OTHER INCOME	B	-116,017		PARAMED ED PROGRAM	23.00	0 33.04
33.05 LAB OTHER INCOME	B	-50,092		LABORATORY	60.00	0 33.05
33.06 BLOOD OTHER INCOME	B	-21,046		WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	0 33.06
33.07 CARDIAC REHAB OTHER INCOME	B	-46,800		CARDIAC REHAB	69.01	0 33.07
33.08 ELECTROCEPHALOGRAPHY OTHER INCOME	B	-58,433		ELECTROENCEPHALOGRAPHY	70.00	0 33.08
33.09 GIFT, FLOWER, COFFEE SHOP & CANTEEN	B	2,966		GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0 33.09
33.10 PHYSICIAN OFFICE	B	-422,352		PHYSICIANS' PRIVATE OFFICES	192.00	0 33.10
33.11 FAMILY HEALTH	B	-93,733		FAMILY HEALTH/GARY COMM HEALTH	192.02	0 33.11
33.12 EMT OFFSET	B	-23,714		EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.12
33.13 EMT OFFSET	B	-133,003		PARAMED ED PROGRAM	23.00	0 33.13
33.14 DUES/LOBBYING	A	-13,590		OTHER A&G	5.05	0 33.14
33.15 RX PROGRAM	A	-179,765		DRUGS CHARGED TO PATIENTS	73.00	0 33.15
33.16 PENSION ADJUSTMENT	A	-3,015,587		EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.16
33.17 PHYSICIAN CONTRACT OFFSET	A	-11,469,228		PHYSICIANS' PRIVATE OFFICES	192.00	0 33.17
33.18 PHYSICIAN SALARY OFFSET	A	-19,122,785		PHYSICIANS' PRIVATE OFFICES	192.00	0 33.18
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-59,074,877				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: 15-0002

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

Worksheet A-8-2

Date/Time Prepared:
5/29/2024 9:08 am

	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	3,747,144	3,747,144	0	0	0	1.00
2.00	31.01	NEONATAL ICU	2,111,003	2,111,003	0	0	0	2.00
3.00	50.00	OPERATING ROOM	7,064,871	7,064,871	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	429	429	0	0	0	4.00
5.00	54.01	RADIOLOGY - ULTRASOUND	6,788	6,788	0	0	0	5.00
6.00	55.00	RADIOLOGY-THERAPEUTIC	187,612	187,612	0	0	0	6.00
7.00	55.01	INFUSION CENTER	5,429,954	5,429,954	0	0	0	7.00
8.00	57.00	CT SCAN	10,379	10,379	0	0	0	8.00
9.00	90.00	CLINIC	507,555	507,555	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			19,065,735	19,065,735	0	0	0	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	31.01	NEONATAL ICU	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	54.01	RADIOLOGY - ULTRASOUND	0	0	0	0	0	5.00
6.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	6.00
7.00	55.01	INFUSION CENTER	0	0	0	0	0	7.00
8.00	57.00	CT SCAN	0	0	0	0	0	8.00
9.00	90.00	CLINIC	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	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	3,747,144		1.00
2.00	31.01	NEONATAL ICU	0	0	0	2,111,003		2.00
3.00	50.00	OPERATING ROOM	0	0	0	7,064,871		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	429		4.00
5.00	54.01	RADIOLOGY - ULTRASOUND	0	0	0	6,788		5.00
6.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	187,612		6.00
7.00	55.01	INFUSION CENTER	0	0	0	5,429,954		7.00
8.00	57.00	CT SCAN	0	0	0	10,379		8.00
9.00	90.00	CLINIC	0	0	0	507,555		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	19,065,735		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2024 9:08 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPI TAL	EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	PURCHASING RECEIVING AND STORES		
		RELATED COSTS BLDG & FIXT					
	0	1.00	4.00	5.01	5.02		
GENERAL SERVICE COST CENTERS							
1.00 00100 CAP REL COSTS-BLDG & FIXT	16,784,135	16,784,135				1.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	29,085,406	70,296	29,155,702			4.00	
5.01 00550 DATA PROCESSING	13,530,718	109,384	795,788	14,435,890		5.01	
5.02 00560 PURCHASING RECEIVING AND STORES	3,089,056	87,269	213,583	0	3,389,908	5.02	
5.03 00570 ADMITTING	5,605,761	115,657	829,682	0	4,162	5.03	
5.04 00580 CASHIERING/ACCOUNTS RECEIVABLE	6,478,010	364,765	444,697	0	575	5.04	
5.05 00590 OTHER A&G	19,705,355	1,185,241	1,654,734	14,435,890	1,699	5.05	
5.06 00592 PATIENT TRANSPORTATION	603,465	0	100,556	0	66	5.06	
7.00 00700 OPERATION OF PLANT	20,906,172	3,562,769	956,957	0	33,401	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	1,386,415	212,162	0	0	12	8.00	
9.00 00900 HOUSEKEEPING	5,821,134	245,608	851,002	0	28,666	9.00	
10.00 01000 DIETARY	4,814,293	224,339	478,747	0	46,260	10.00	
11.00 01100 CAFETERIA	1,810,061	156,839	294,596	0	76	11.00	
13.00 01300 NURSING ADMINISTRATION	6,889,129	75,581	1,115,031	0	2,533	13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY	2,647,782	426,622	140,701	0	3,985	14.00	
15.00 01500 PHARMACY	6,059,491	225,636	0	0	13,932	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	3,039,467	134,582	413,630	0	495	16.00	
17.00 01700 SOCIAL SERVICE	469,866	19,389	85,180	0	0	17.00	
17.01 01701 STAFF EDUCATION	0	132,677	0	0	0	17.01	
17.02 01702 MEDICAL EDUCATION	203,617	4,452	28,552	0	567	17.02	
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	297,137	0	0	0	0	21.00	
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	31,168	53,169	0	0	0	22.00	
23.00 02300 PARAMED ED PROGRAM	856,559	40,040	181,116	0	336	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	39,193,609	3,728,074	4,379,975	0	161,211	30.00	
31.00 03100 INTENSIVE CARE UNIT	8,549,779	236,432	1,230,657	0	56,701	31.00	
31.01 03101 NEONATAL ICU	1,959,216	26,876	313,159	0	889	31.01	
40.00 04000 SUBPROVIDER - I PF	1,047,647	47,277	175,592	0	12	40.00	
41.00 04100 SUBPROVIDER - I RF	1,951,478	371,870	295,648	0	4,670	41.00	
43.00 04300 NURSERY	1,553,332	290,707	230,613	0	10,729	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	10,423,718	709,950	1,042,573	0	44,579	50.00	
50.01 05001 ENDOSCOPY	1,008,821	0	110,966	0	16,045	50.01	
51.00 05100 RECOVERY ROOM	1,468,113	173,134	215,856	0	8,995	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	4,559,273	83,353	712,279	0	12,170	52.00	
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	5,619,256	631,536	517,044	0	11,161	54.00	
54.01 05401 RADIOLOGY - ULTRASOUND	2,138,392	60,155	255,257	0	6,448	54.01	
55.00 05500 RADIOLOGY-THERAPEUTIC	2,240,336	99,874	85,348	0	1,145	55.00	
55.01 05501 INFUSION CENTER	1,130,845	60,631	129,309	0	12,901	55.01	
56.00 05600 RADIOISOTOPE	2,005,827	107,634	136,915	0	61,219	56.00	
57.00 05700 CT SCAN	2,457,595	101,921	243,466	0	20,444	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1,038,398	50,050	90,044	0	4,901	58.00	
59.00 05900 CARDIAC CATHETERIZATION	4,259,469	99,898	471,000	0	60,715	59.00	
60.00 06000 LABORATORY	14,386,433	279,923	802,183	0	379,352	60.00	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1,555,306	4,582	222,158	0	16,992	62.00	
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00	
65.00 06500 RESPIRATORY THERAPY	4,924,385	92,435	472,486	0	63,961	65.00	
66.00 06600 PHYSICAL THERAPY	1,961,288	146,044	310,707	0	951	66.00	
67.00 06700 OCCUPATIONAL THERAPY	1,216,910	125,512	203,141	0	753	67.00	
68.00 06800 SPEECH PATHOLOGY	532,265	21,377	87,967	0	541	68.00	
69.00 06900 ELECTROCARDIOLOGY	996,681	0	151,994	0	1,489	69.00	
69.01 06901 CARDIAC REHAB	654,915	0	84,512	0	423	69.01	
70.00 07000 ELECTROENCEPHALOGRAPHY	1,649,153	0	231,335	0	6,669	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	15,183,398	0	0	0	1,046,200	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	14,331,609	0	0	0	987,505	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	42,522,455	19,782	81,323	0	43,359	73.00	
74.00 07400 RENAL DIALYSIS	2,336,778	52,169	0	0	1,420	74.00	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	3,963,455	906,746	462,064	0	4,956	90.00	
91.00 09100 EMERGENCY	15,271,838	322,118	1,592,734	0	169,527	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00	
OTHER REIMBURSABLE COST CENTERS							
101.00 10100 HOME HEALTH AGENCY	2,422,159	0	379,399	0	3,851	101.00	
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	366,628,329	16,296,537	24,302,256	14,435,890	3,359,649	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,966	21,436	0	0	0	190.00	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2024 9:08 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	PURCHASING RECEIVING AND STORES	
				BLDG & FIXT					
			0	1.00		4.00	5.01	5.02	
191.00	19100	RESEARCH	0	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14,126,556	317,928	4,839,711	0	0	30,259	192.00
192.01	19201	OTHER NON-REIMBURSABLE	348,428	41,147	0	0	0	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	54,346	107,087	13,735	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	0	193.00
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)	381,160,625	16,784,135	29,155,702	14,435,890	3,389,908		202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2024 9:08 am

Cost Center Description			ADMINISTRATIVE	CASHIERING/AC COUNTS RECEIVABLE	Subtotal	OTHER A&G	PATIENT TRANSPORTATION	
			5.03	5.04	5A.04	5.05	5.06	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMINISTRATIVE	6,555,262					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	7,288,047				5.04
5.05	00590	OTHER A&G	0	0	36,982,919	36,982,919		5.05
5.06	00592	PATIENT TRANSPORTATION	0	0	704,087	75,656	779,743	5.06
7.00	00700	OPERATION OF PLANT	0	0	25,459,299	2,735,678	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,598,589	171,773	0	8.00
9.00	00900	HOUSEKEEPING	0	0	6,946,410	746,413	0	9.00
10.00	01000	DIETARY	0	0	5,563,639	597,830	0	10.00
11.00	01100	CAFETERIA	0	0	2,261,572	243,013	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	8,082,274	868,465	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	3,219,090	345,901	0	14.00
15.00	01500	PHARMACY	0	0	6,299,059	676,853	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	3,588,174	385,560	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	574,435	61,725	0	17.00
17.01	01701	STAFF EDUCATION	0	0	132,677	14,257	0	17.01
17.02	01702	MEDICAL EDUCATION	0	0	237,188	25,487	0	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	297,137	31,928	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	84,337	9,062	0	22.00
23.00	02300	PARAMED PROGRAM	0	0	1,078,051	115,840	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	417,165	463,728	48,343,762	5,194,674	263,294	30.00
31.00	03100	INTENSIVE CARE UNIT	82,014	91,168	10,246,751	1,101,044	2,402	31.00
31.01	03101	NEONATAL ICU	20,982	23,324	2,344,446	251,918	0	31.01
40.00	04000	SUBPROVIDER - I/PF	10,160	11,294	1,291,982	138,827	0	40.00
41.00	04100	SUBPROVIDER - I/RF	15,077	16,760	2,655,503	285,342	3,256	41.00
43.00	04300	NURSERY	8,584	9,542	2,103,507	226,028	27	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	740,511	823,165	13,784,496	1,481,185	27	50.00
50.01	05001	ENDOSCOPY	37,006	41,137	1,213,975	130,445	19,482	50.01
51.00	05100	RECOVERY ROOM	50,378	56,001	1,972,477	211,949	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	25,114	27,917	5,420,106	582,407	9,741	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	201,684	224,196	7,204,877	774,186	47,930	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	93,598	104,046	2,657,896	285,599	96,821	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	108,259	120,342	2,655,304	285,320	7,366	55.00
55.01	05501	INFUSION CENTER	65,727	73,064	1,472,477	158,222	0	55.01
56.00	05600	RADIOISOTOPE	83,123	92,401	2,487,119	267,248	44,247	56.00
57.00	05700	CT SCAN	634,645	705,482	4,163,553	447,386	185,208	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	130,069	144,587	1,458,049	156,672	52,920	58.00
59.00	05900	CARDIAC CATHETERIZATION	326,634	363,092	5,580,808	599,675	29,276	59.00
60.00	06000	LABORATORY	891,625	991,145	17,730,661	1,905,213	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	104,480	116,142	2,019,660	217,019	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	203,778	226,523	5,983,568	642,952	53	65.00
66.00	06600	PHYSICAL THERAPY	58,302	64,810	2,542,102	273,156	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	27,739	30,835	1,604,890	172,450	0	67.00
68.00	06800	SPEECH PATHOLOGY	11,238	12,492	665,880	71,551	0	68.00
69.00	06900	ELECTROCARDIOLOGY	121,894	135,499	1,407,557	151,246	3,656	69.00
69.01	06901	CARDIAC REHAB	7,104	7,897	754,851	81,111	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	171,061	190,155	2,248,373	241,594	2,535	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	172,692	191,967	16,594,257	1,783,103	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	161,665	179,709	15,660,488	1,682,766	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	976,016	1,086,062	44,728,997	4,806,265	0	73.00
74.00	07400	RENAL DIALYSIS	43,598	48,464	2,482,429	266,744	27	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	49,931	55,504	5,442,656	584,830	240	90.00
91.00	09100	EMERGENCY	489,916	544,598	18,390,731	1,976,139	11,235	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	13,493	14,999	2,833,901	304,511	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,555,262	7,288,047	361,257,026	34,844,218	779,743	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	24,402	2,622	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	19,314,454	2,075,396	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	0	389,575	41,861	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	175,168	18,822	0	192.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2024 9:08 am

Cost Center Description			ADMITTING	CASHIERING/AC COUNTS RECEIVABLE	Subtotal	OTHER A&G	PATIENT TRANSPORTATION	
			5.03	5.04	5A.04	5.05	5.06	
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	6,555,262	7,288,047	381,160,625	36,982,919	779,743	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2024 9:08 am

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	DATA PROCESSING					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00570	ADMITTING					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00590	OTHER A&G					5.05
5.06	00592	PATIENT TRANSPORTATION					5.06
7.00	00700	OPERATION OF PLANT	28,194,977				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	529,900	2,300,262			8.00
9.00	00900	HOUSEKEEPING	613,436	0	8,306,259		9.00
10.00	01000	DIETARY	560,312	0	172,045	6,893,826	10.00
11.00	01100	CAFETERIA	391,725	0	120,280	0	11.00
13.00	01300	NURSING ADMINISTRATION	188,772	0	57,963	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,065,538	2,072	327,176	0	14.00
15.00	01500	PHARMACY	563,552	0	173,040	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	336,134	0	103,210	0	16.00
17.00	01700	SOCIAL SERVICE	48,427	0	14,870	0	17.00
17.01	01701	STAFF EDUCATION	331,377	0	101,750	0	17.01
17.02	01702	MEDICAL EDUCATION	11,118	0	3,414	0	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	132,795	0	40,775	0	22.00
23.00	02300	PARAMED ED PROGRAM	100,005	0	30,707	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,311,292	1,074,763	2,859,047	5,604,122	748,106
31.00	03100	INTENSIVE CARE UNIT	590,516	147,989	181,319	281,683	175,431
31.01	03101	NEONATAL ICU	67,126	0	20,611	0	47,631
40.00	04000	SUBPROVIDER - IPF	118,079	0	36,256	103,617	29,903
41.00	04100	SUBPROVIDER - IRF	928,790	71,351	285,187	276,337	49,789
43.00	04300	NURSERY	726,075	28,463	222,943	0	31,534
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,773,182	239,998	544,459	0	189,103
50.01	05001	ENDOSCOPY	0	26,706	0	0	16,468
51.00	05100	RECOVERY ROOM	432,422	14,844	132,776	0	31,493
52.00	05200	DELIVERY ROOM & LABOR ROOM	208,185	63,745	63,924	166,221	115,540
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,577,334	52,743	484,324	0	115,426
54.01	05401	RADIOLOGY - ULTRASOUND	150,245	25,158	46,133	0	44,910
55.00	05500	RADIOLOGY-THERAPEUTIC	249,447	8,503	76,593	0	15,576
55.01	05501	INFUSION CENTER	151,434	0	46,498	0	29,427
56.00	05600	RADIOISOTOPE	268,830	16,876	82,545	0	20,060
57.00	05700	CT SCAN	254,560	31,758	78,163	0	43,539
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	125,006	13,335	38,383	0	19,395
59.00	05900	CARDIAC CATHETERIZATION	249,506	54,971	76,611	0	73,545
60.00	06000	LABORATORY	699,141	0	214,673	0	167,602
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	11,445	0	3,514	0	74,168
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	230,867	0	70,888	0	85,038
66.00	06600	PHYSICAL THERAPY	364,762	0	112,001	0	51,943
67.00	06700	OCCUPATIONAL THERAPY	313,481	0	96,255	0	34,885
68.00	06800	SPEECH PATHOLOGY	53,391	0	16,394	0	13,860
69.00	06900	ELECTROCARDIOLOGY	0	4,546	0	0	32,565
69.01	06901	CARDIAC REHAB	0	820	0	0	16,453
70.00	07000	ELECTROENCEPHALOGRAPHY	0	23,648	0	0	42,113
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	49,408	0	15,171	0	13,335
74.00	07400	RENAL DIALYSIS	130,298	22,437	40,008	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,264,703	57,985	695,382	0	78,313
91.00	09100	EMERGENCY	804,527	317,551	247,032	461,846	266,415
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,977,143	2,300,262	7,932,320	6,893,826	3,016,590
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	53,540	0	16,440	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	794,063	0	243,818	0	0
192.01	19201	OTHER NON-REIMBURSABLE	102,769	0	31,556	0	0
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	267,462	0	82,125	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2024 9:08 am

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
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)	28,194,977	2,300,262	8,306,259	6,893,826	3,016,590	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2024 9:08 am

Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER A&G						5.05
5.06	00592	PATIENT TRANSPORTATION						5.06
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	9,330,718					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,010,214				14.00
15.00	01500	PHARMACY	0	0	7,712,504			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	4,528,508		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	699,457	17.00
17.01	01701	STAFF EDUCATION	0	0	0	0	0	17.01
17.02	01702	MEDICAL EDUCATION	0	0	0	0	0	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED PROGRAM	233,175	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,972,422	0	0	288,197	638,635	30.00
31.00	03100	INTENSIVE CARE UNIT	931,531	0	0	56,659	0	31.00
31.01	03101	NEONATAL ICU	252,917	0	0	14,495	0	31.01
40.00	04000	SUBPROVIDER - IPF	158,784	0	0	7,019	0	40.00
41.00	04100	SUBPROVIDER - IRF	264,380	0	0	10,416	39,100	41.00
43.00	04300	NURSERY	167,443	0	0	5,930	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,004,125	0	0	511,579	0	50.00
50.01	05001	ENDOSCOPY	87,445	0	0	25,566	0	50.01
51.00	05100	RECOVERY ROOM	167,224	0	0	34,803	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	613,510	0	0	17,350	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	139,333	0	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0	0	0	64,662	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	74,790	0	55.00
55.01	05501	INFUSION CENTER	0	0	0	45,407	0	55.01
56.00	05600	RADIOISOTOPE	0	0	0	57,425	0	56.00
57.00	05700	CT SCAN	0	0	0	438,442	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	89,858	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	225,654	0	59.00
60.00	06000	LABORATORY	0	0	214,359	615,975	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	72,180	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	140,779	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	40,278	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	19,163	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	7,763	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	84,210	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	4,908	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	118,177	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,577,409	0	119,304	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,432,805	0	111,685	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	7,465,136	674,110	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	30,119	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	63,111	0	0	34,494	0	90.00
91.00	09100	EMERGENCY	1,414,651	0	0	338,456	21,722	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	9,322	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,330,718	5,010,214	7,679,495	4,528,508	699,457	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	33,009	0	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	0	0	0	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	0	0	0	192.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2024 9:08 am

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
193.00	19300 NONPAID WORKERS	0	0	0	0	0	193.00
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)	9,330,718	5,010,214	7,712,504	4,528,508	699,457	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Prepared: 5/29/2024 9:08 am
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Cost Center Description	STAFF EDUCATION 17.01	MEDICAL EDUCATION 17.02	INTERNS & RESIDENTS		PARAMED ED PROGRAM 23.00	
			SERVICES-SALARY & FRINGES 21.00	SERVICES-OTHER PRGM COSTS 22.00		
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 00550 DATA PROCESSING						5.01
5.02 00560 PURCHASING RECEIVING AND STORES						5.02
5.03 00570 ADMITTING						5.03
5.04 00580 CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05 00590 OTHER A&G						5.05
5.06 00592 PATIENT TRANSPORTATION						5.06
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
17.00 01700 SOCIAL SERVICE						17.00
17.01 01701 STAFF EDUCATION	580,061					17.01
17.02 01702 MEDICAL EDUCATION	40	277,247				17.02
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	329,065			21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0		266,969		22.00
23.00 02300 PARAMED PROGRAM	205	0			1,601,896	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	156,906	0	0	0	69,084	30.00
31.00 03100 INTENSIVE CARE UNIT	55,790	0	0	0	0	31.00
31.01 03101 NEONATAL ICU	14,572	0	0	0	0	31.01
40.00 04000 SUBPROVIDER - I/PF	419	0	0	0	0	40.00
41.00 04100 SUBPROVIDER - I/RF	10,494	0	0	0	0	41.00
43.00 04300 NURSERY	4,165	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	82,903	0	0	0	69,084	50.00
50.01 05001 ENDOSCOPY	5,690	0	0	0	0	50.01
51.00 05100 RECOVERY ROOM	14,438	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	40,736	0	0	0	69,084	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	2,086	0	0	0	0	54.00
54.01 05401 RADIOLOGY - ULTRASOUND	1,209	0	0	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	40	0	0	0	0	55.00
55.01 05501 INFUSION CENTER	79	0	0	0	0	55.01
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700 CT SCAN	15,560	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	158	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	17,006	0	0	0	34,542	59.00
60.00 06000 LABORATORY	988	0	0	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	735	0	0	0	0	62.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	7,057	0	0	0	103,627	65.00
66.00 06600 PHYSICAL THERAPY	680	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	411	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	300	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	3,896	0	0	0	0	69.00
69.01 06901 CARDIAC REHAB	0	0	0	0	0	69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	2,331	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 PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	4,773	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	2,039	0	0	0	0	90.00
91.00 09100 EMERGENCY	114,418	277,247	329,065	266,969	1,256,475	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	2,631	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	562,755	277,247	329,065	266,969	1,601,896	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 19100 RESEARCH	0	0	0	0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	17,243	0	0	0	0	192.00
192.01 19201 OTHER NON-REIMBURSABLE	0	0	0	0	0	192.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2024 9:08 am

Cost Center Description	STAFF EDUCATION	MEDICAL EDUCATION	INTERNS & RESIDENTS		PARAMED ED PROGRAM	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS		
			17.01	17.02		
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	63	0	0	0	0	192.02
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
200.00 Cross Foot Adjustments			0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	580,061	277,247	329,065	266,969	1,601,896	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Prepared: 5/29/2024 9:08 am
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00550	DATA PROCESSING				5.01
5.02	00560	PURCHASING RECEIVING AND STORES				5.02
5.03	00570	ADMITTING				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.04
5.05	00590	OTHER A&G				5.05
5.06	00592	PATIENT TRANSPORTATION				5.06
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
17.00	01700	SOCIAL SERVICE				17.00
17.01	01701	STAFF EDUCATION				17.01
17.02	01702	MEDICAL EDUCATION				17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD				22.00
23.00	02300	PARAMED ED PROGRAM				23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	78,524,304	0	78,524,304	30.00
31.00	03100	INTENSIVE CARE UNIT	13,771,115	0	13,771,115	31.00
31.01	03101	NEONATAL ICU	3,013,716	0	3,013,716	31.01
40.00	04000	SUBPROVIDER - IPF	1,884,886	0	1,884,886	40.00
41.00	04100	SUBPROVIDER - IRF	4,879,945	0	4,879,945	41.00
43.00	04300	NURSERY	3,516,115	0	3,516,115	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,680,141	0	19,680,141	50.00
50.01	05001	ENDOSCOPY	1,525,777	0	1,525,777	50.01
51.00	05100	RECOVERY ROOM	3,012,426	0	3,012,426	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,370,549	0	7,370,549	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,398,239	0	10,398,239	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	3,372,633	0	3,372,633	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	3,372,939	0	3,372,939	55.00
55.01	05501	INFUSION CENTER	1,903,544	0	1,903,544	55.01
56.00	05600	RADIOISOTOPE	3,244,350	0	3,244,350	56.00
57.00	05700	CT SCAN	5,658,169	0	5,658,169	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,953,776	0	1,953,776	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,941,594	0	6,941,594	59.00
60.00	06000	LABORATORY	21,548,612	0	21,548,612	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,398,721	0	2,398,721	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	7,264,829	0	7,264,829	65.00
66.00	06600	PHYSICAL THERAPY	3,384,922	0	3,384,922	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,241,535	0	2,241,535	67.00
68.00	06800	SPEECH PATHOLOGY	829,139	0	829,139	68.00
69.00	06900	ELECTROCARDIOLOGY	1,687,676	0	1,687,676	69.00
69.01	06901	CARDIAC REHAB	858,143	0	858,143	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	2,678,771	0	2,678,771	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,074,073	0	21,074,073	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,887,744	0	19,887,744	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	57,757,195	0	57,757,195	73.00
74.00	07400	RENAL DIALYSIS	2,972,062	0	2,972,062	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	9,223,753	0	9,223,753	90.00
91.00	09100	EMERGENCY	26,494,479	-596,034	25,898,445	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,150,365	0	3,150,365	101.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	357,476,237	-596,034	356,880,203	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	97,004	0	97,004	190.00
191.00	19100	RESEARCH	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	22,477,983	0	22,477,983	192.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2024 9:08 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
192.01	19201	OTHER NON-REIMBURSABLE	565,761	0	565,761	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	543,640	0	543,640	192.02
193.00	19300	NONPAID WORKERS	0	0	0	193.00
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)	381,160,625	-596,034	380,564,591	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0002

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

Worksheet B Part II Date/Time Prepared: 5/29/2024 9:08 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
		BLDG & FIXT					
	0	1.00		2A	4.00	5.01	
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	70,296	70,296	70,296		4.00
5.01 00550	DATA PROCESSING	0	109,384	109,384	1,918	111,302	5.01
5.02 00560	PURCHASING RECEIVING AND STORES	0	87,269	87,269	515	0	5.02
5.03 00570	ADMINISTRATIVE	0	115,657	115,657	2,000	0	5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	364,765	364,765	1,072	0	5.04
5.05 00590	OTHER A&G	0	1,185,241	1,185,241	3,989	111,302	5.05
5.06 00592	PATIENT TRANSPORTATION	0	0	0	242	0	5.06
7.00 00700	OPERATION OF PLANT	0	3,562,769	3,562,769	2,307	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	212,162	212,162	0	0	8.00
9.00 00900	HOUSEKEEPING	0	245,608	245,608	2,051	0	9.00
10.00 01000	DIETARY	0	224,339	224,339	1,154	0	10.00
11.00 01100	CAFETERIA	0	156,839	156,839	710	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	75,581	75,581	2,688	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	426,622	426,622	339	0	14.00
15.00 01500	PHARMACY	0	225,636	225,636	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	134,582	134,582	997	0	16.00
17.00 01700	SOCIAL SERVICE	0	19,389	19,389	205	0	17.00
17.01 01701	STAFF EDUCATION	0	132,677	132,677	0	0	17.01
17.02 01702	MEDICAL EDUCATION	0	4,452	4,452	69	0	17.02
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	53,169	53,169	0	0	22.00
23.00 02300	PARAMED PROGRAM	0	40,040	40,040	437	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	0	3,728,074	3,728,074	10,558	0	30.00
31.00 03100	INTENSIVE CARE UNIT	0	236,432	236,432	2,967	0	31.00
31.01 03101	NEONATAL ICU	0	26,876	26,876	755	0	31.01
40.00 04000	SUBPROVIDER - IPF	0	47,277	47,277	423	0	40.00
41.00 04100	SUBPROVIDER - IRF	0	371,870	371,870	713	0	41.00
43.00 04300	NURSERY	0	290,707	290,707	556	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	0	709,950	709,950	2,513	0	50.00
50.01 05001	ENDOSCOPY	0	0	0	267	0	50.01
51.00 05100	RECOVERY ROOM	0	173,134	173,134	520	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	83,353	83,353	1,717	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	631,536	631,536	1,246	0	54.00
54.01 05401	RADIOLOGY - ULTRASOUND	0	60,155	60,155	615	0	54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	0	99,874	99,874	206	0	55.00
55.01 05501	INFUSION CENTER	0	60,631	60,631	312	0	55.01
56.00 05600	RADIOISOTOPE	0	107,634	107,634	330	0	56.00
57.00 05700	CT SCAN	0	101,921	101,921	587	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	50,050	50,050	217	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	99,898	99,898	1,135	0	59.00
60.00 06000	LABORATORY	0	279,923	279,923	1,934	0	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	4,582	4,582	536	0	62.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	92,435	92,435	1,139	0	65.00
66.00 06600	PHYSICAL THERAPY	0	146,044	146,044	749	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	125,512	125,512	490	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	21,377	21,377	212	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	366	0	69.00
69.01 06901	CARDIAC REHAB	0	0	0	204	0	69.01
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	558	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 PATIENTS	0	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	19,782	19,782	196	0	73.00
74.00 07400	RENAL DIALYSIS	0	52,169	52,169	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	0	906,746	906,746	1,114	0	90.00
91.00 09100	EMERGENCY	0	322,118	322,118	3,839	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00 10100	HOME HEALTH AGENCY	0	0	0	915	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	16,296,537	16,296,537	58,582	111,302	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	21,436	21,436	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	0	191.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0002

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

Worksheet B
Part II
Date/Time Prepared:
5/29/2024 9:08 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
		0	1.00				
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	317,928	317,928	11,681	0	192.00	
192.01 19201 OTHER NON-REIMBURSABLE	0	41,147	41,147	0	0	192.01	
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	0	107,087	107,087	33	0	192.02	
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00	
200.00 Cross Foot Adjustments			0			200.00	
201.00 Negative Cost Centers			0		0	201.00	
202.00 TOTAL (sum lines 118 through 201)	0	16,784,135	16,784,135	70,296	111,302	202.00	

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0002		Period: From 01/01/2023 To 12/31/2023		Worksheet B Part II Date/Time Prepared: 5/29/2024 9:08 am	
Cost Center Description			PURCHASING RECEIVING AND STORES	ADMINITTING	CASHIERING/AC COUNTS RECEIVABLE	OTHER A&G	PATIENT TRANSPORTATION	
			5.02	5.03	5.04	5.05	5.06	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	87,784					5.02
5.03	00570	ADMINITTING	108	117,765				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	15	0	365,852			5.04
5.05	00590	OTHER A&G	44	0	0	1,300,576		5.05
5.06	00592	PATIENT TRANSPORTATION	2	0	0	2,661	2,905	5.06
7.00	00700	OPERATION OF PLANT	865	0	0	96,211	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	6,041	0	8.00
9.00	00900	HOUSEKEEPING	742	0	0	26,250	0	9.00
10.00	01000	DIETARY	1,198	0	0	21,025	0	10.00
11.00	01100	CAFETERIA	2	0	0	8,546	0	11.00
13.00	01300	NURSING ADMINISTRATION	66	0	0	30,543	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	103	0	0	12,165	0	14.00
15.00	01500	PHARMACY	361	0	0	23,804	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13	0	0	13,560	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	2,171	0	17.00
17.01	01701	STAFF EDUCATION	0	0	0	501	0	17.01
17.02	01702	MEDICAL EDUCATION	15	0	0	896	0	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	1,123	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	319	0	22.00
23.00	02300	PARAMED PROGRAM	9	0	0	4,074	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,174	7,481	23,225	182,620	981	30.00
31.00	03100	INTENSIVE CARE UNIT	1,468	1,471	4,566	38,722	9	31.00
31.01	03101	NEONATAL ICU	23	376	1,168	8,860	0	31.01
40.00	04000	SUBPROVIDER - I/PF	0	182	566	4,882	0	40.00
41.00	04100	SUBPROVIDER - I/RF	121	270	839	10,035	12	41.00
43.00	04300	NURSERY	278	154	478	7,949	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,154	13,280	41,228	52,092	0	50.00
50.01	05001	ENDOSCOPY	415	664	2,060	4,588	73	50.01
51.00	05100	RECOVERY ROOM	233	903	2,805	7,454	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	315	450	1,398	20,483	36	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	289	3,617	11,229	27,227	179	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	167	1,679	5,211	10,044	361	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	30	1,941	6,027	10,034	27	55.00
55.01	05501	INFUSION CENTER	334	1,179	3,659	5,564	0	55.01
56.00	05600	RADIOISOTOPE	1,585	1,491	4,628	9,399	165	56.00
57.00	05700	CT SCAN	529	11,381	35,334	15,734	690	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	127	2,333	7,242	5,510	197	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,572	5,858	18,185	21,090	109	59.00
60.00	06000	LABORATORY	9,822	15,990	49,641	67,004	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	440	1,874	5,817	7,632	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,656	3,654	11,345	22,612	0	65.00
66.00	06600	PHYSICAL THERAPY	25	1,046	3,246	9,607	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	20	497	1,544	6,065	0	67.00
68.00	06800	SPEECH PATHOLOGY	14	202	626	2,516	0	68.00
69.00	06900	ELECTROCARDIOLOGY	39	2,186	6,786	5,319	14	69.00
69.01	06901	CARDIAC REHAB	11	127	396	2,853	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	173	3,068	9,524	8,497	9	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	27,099	3,097	9,615	62,710	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,568	2,899	9,001	59,181	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,123	17,710	55,229	169,031	0	73.00
74.00	07400	RENAL DIALYSIS	37	782	2,427	9,381	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	128	895	2,780	20,568	1	90.00
91.00	09100	EMERGENCY	4,389	8,786	27,276	69,499	42	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	100	242	751	10,709	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	87,001	117,765	365,852	1,225,361	2,905	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	92	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	783	0	0	72,989	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	0	0	1,472	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	0	662	0	192.02

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0002

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

Worksheet B
Part II
Date/Time Prepared:
5/29/2024 9:08 am

Cost Center Description		PURCHASING RECEIVING AND STORES	ADMINISTRATIVE	CASHIERING/AC COUNTS RECEIVABLE	OTHER A&G	PATIENT TRANSPORTATION	
		5.02	5.03	5.04	5.05	5.06	
193.00	19300 NONPAID WORKERS	0	0	0	0	0	193.00
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)	87,784	117,765	365,852	1,300,576	2,905	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0002		Period: From 01/01/2023 To 12/31/2023		Worksheet B Part II Date/Time Prepared: 5/29/2024 9:08 am	
Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER A&G						5.05
5.06	00592	PATIENT TRANSPORTATION						5.06
7.00	00700	OPERATION OF PLANT	3,662,152					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	68,827	287,030				8.00
9.00	00900	HOUSEKEEPING	79,677	0	354,328			9.00
10.00	01000	DIETARY	72,777	0	7,339	327,832		10.00
11.00	01100	CAFETERIA	50,880	0	5,131	0	222,108	11.00
13.00	01300	NURSING ADMINISTRATION	24,519	0	2,473	0	9,811	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	138,399	259	13,957	0	3,714	14.00
15.00	01500	PHARMACY	73,198	0	7,382	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	43,659	0	4,403	0	8,499	16.00
17.00	01700	SOCIAL SERVICE	6,290	0	634	0	0	17.00
17.01	01701	STAFF EDUCATION	43,041	0	4,340	0	0	17.01
17.02	01702	MEDICAL EDUCATION	1,444	0	146	0	0	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	17,248	0	1,739	0	0	22.00
23.00	02300	PARAMED ED PROGRAM	12,989	0	1,310	0	3,233	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,209,414	134,112	121,960	266,501	55,080	30.00
31.00	03100	INTENSIVE CARE UNIT	76,700	18,466	7,735	13,395	12,917	31.00
31.01	03101	NEONATAL ICU	8,719	0	879	0	3,507	31.01
40.00	04000	SUBPROVIDER - IPF	15,337	0	1,547	4,927	2,202	40.00
41.00	04100	SUBPROVIDER - IRF	120,637	8,903	12,165	13,141	3,666	41.00
43.00	04300	NURSERY	94,307	3,552	9,510	0	2,322	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	230,313	29,947	23,226	0	13,923	50.00
50.01	05001	ENDOSCOPY	0	3,332	0	0	1,213	50.01
51.00	05100	RECOVERY ROOM	56,166	1,852	5,664	0	2,319	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	27,040	7,954	2,727	7,905	8,507	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	204,875	6,581	20,660	0	8,499	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	19,515	3,139	1,968	0	3,307	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	32,400	1,061	3,267	0	1,147	55.00
55.01	05501	INFUSION CENTER	19,669	0	1,984	0	2,167	55.01
56.00	05600	RADIOISOTOPE	34,917	2,106	3,521	0	1,477	56.00
57.00	05700	CT SCAN	33,064	3,963	3,334	0	3,206	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	16,237	1,664	1,637	0	1,428	58.00
59.00	05900	CARDIAC CATHETERIZATION	32,408	6,859	3,268	0	5,415	59.00
60.00	06000	LABORATORY	90,809	0	9,158	0	12,340	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,487	0	150	0	5,461	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	29,987	0	3,024	0	6,261	65.00
66.00	06600	PHYSICAL THERAPY	47,378	0	4,778	0	3,824	66.00
67.00	06700	OCCUPATIONAL THERAPY	40,717	0	4,106	0	2,569	67.00
68.00	06800	SPEECH PATHOLOGY	6,935	0	699	0	1,020	68.00
69.00	06900	ELECTROCARDIOLOGY	0	567	0	0	2,398	69.00
69.01	06901	CARDIAC REHAB	0	102	0	0	1,211	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,951	0	0	3,101	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,417	0	647	0	982	73.00
74.00	07400	RENAL DIALYSIS	16,924	2,800	1,707	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	294,155	7,235	29,664	0	5,766	90.00
91.00	09100	EMERGENCY	104,497	39,625	10,538	21,963	19,616	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	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,503,972	287,030	338,377	327,832	222,108	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,954	0	701	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	103,138	0	10,401	0	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	13,348	0	1,346	0	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	34,740	0	3,503	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0002

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

Worksheet B
Part II
Date/Time Prepared:
5/29/2024 9:08 am

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
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)	3,662,152	287,030	354,328	327,832	222,108	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 5/29/2024 9:08 am
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Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER A&G						5.05
5.06	00592	PATIENT TRANSPORTATION						5.06
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	145,681					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	595,558				14.00
15.00	01500	PHARMACY	0	0	330,381			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	205,713		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	28,689	17.00
17.01	01701	STAFF EDUCATION	0	0	0	0	0	17.01
17.02	01702	MEDICAL EDUCATION	0	0	0	0	0	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED PROGRAM	3,641	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	62,022	0	0	13,064	26,194	30.00
31.00	03100	INTENSIVE CARE UNIT	14,544	0	0	2,568	0	31.00
31.01	03101	NEONATAL ICU	3,949	0	0	657	0	31.01
40.00	04000	SUBPROVIDER - I/PF	2,479	0	0	318	0	40.00
41.00	04100	SUBPROVIDER - I/RF	4,128	0	0	472	1,604	41.00
43.00	04300	NURSERY	2,614	0	0	269	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	15,677	0	0	23,191	0	50.00
50.01	05001	ENDOSCOPY	1,365	0	0	1,159	0	50.01
51.00	05100	RECOVERY ROOM	2,611	0	0	1,578	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,579	0	0	786	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	6,316	0	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0	0	0	2,931	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	3,390	0	55.00
55.01	05501	INFUSION CENTER	0	0	0	2,058	0	55.01
56.00	05600	RADIOISOTOPE	0	0	0	2,603	0	56.00
57.00	05700	CT SCAN	0	0	0	19,875	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	4,073	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	10,229	0	59.00
60.00	06000	LABORATORY	0	0	9,182	27,923	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	3,272	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,382	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,826	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	869	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	352	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,817	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	222	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	5,357	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	306,375	0	5,408	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	289,183	0	5,063	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	319,785	30,990	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,365	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	985	0	0	1,564	0	90.00
91.00	09100	EMERGENCY	22,087	0	0	15,343	891	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	423	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	145,681	595,558	328,967	205,713	28,689	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,414	0	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	0	0	0	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	0	0	0	192.02

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0002

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

Worksheet B
Part II
Date/Time Prepared:
5/29/2024 9:08 am

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
193.00	19300 NONPAID WORKERS	0	0	0	0	0	193.00
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)	145,681	595,558	330,381	205,713	28,689	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 5/29/2024 9:08 am
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Cost Center Description	STAFF EDUCATION	MEDICAL EDUCATION	INTERNS & RESIDENTS		PARAMED PROGRAM	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS		
	17.01	17.02	21.00	22.00	23.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 00550	DATA PROCESSING					5.01
5.02 00560	PURCHASING RECEIVING AND STORES					5.02
5.03 00570	ADMITTING					5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05 00590	OTHER A&G					5.05
5.06 00592	PATIENT TRANSPORTATION					5.06
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
17.00 01700	SOCIAL SERVICE					17.00
17.01 01701	STAFF EDUCATION	180,559				17.01
17.02 01702	MEDICAL EDUCATION	12	7,034			17.02
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	1,123		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0		72,475	22.00
23.00 02300	PARAMED PROGRAM	64	0			23.00
						65,797
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	48,843	0			30.00
31.00 03100	INTENSIVE CARE UNIT	17,366	0			31.00
31.01 03101	NEONATAL ICU	4,536	0			31.01
40.00 04000	SUBPROVIDER - I PF	130	0			40.00
41.00 04100	SUBPROVIDER - I RF	3,267	0			41.00
43.00 04300	NURSERY	1,296	0			43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	25,806	0			50.00
50.01 05001	ENDOSCOPY	1,771	0			50.01
51.00 05100	RECOVERY ROOM	4,494	0			51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	12,680	0			52.00
53.00 05300	ANESTHESIOLOGY	0	0			53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	649	0			54.00
54.01 05401	RADIOLOGY - ULTRASOUND	376	0			54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	12	0			55.00
55.01 05501	INFUSION CENTER	25	0			55.01
56.00 05600	RADIOISOTOPE	0	0			56.00
57.00 05700	CT SCAN	4,843	0			57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	49	0			58.00
59.00 05900	CARDIAC CATHETERIZATION	5,293	0			59.00
60.00 06000	LABORATORY	307	0			60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	229	0			62.00
64.00 06400	INTRAVENOUS THERAPY	0	0			64.00
65.00 06500	RESPIRATORY THERAPY	2,197	0			65.00
66.00 06600	PHYSICAL THERAPY	212	0			66.00
67.00 06700	OCCUPATIONAL THERAPY	128	0			67.00
68.00 06800	SPEECH PATHOLOGY	93	0			68.00
69.00 06900	ELECTROCARDIOLOGY	1,213	0			69.00
69.01 06901	CARDIAC REHAB	0	0			69.01
70.00 07000	ELECTROENCEPHALOGRAPHY	726	0			70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,486	0			73.00
74.00 07400	RENAL DIALYSIS	0	0			74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	635	0			90.00
91.00 09100	EMERGENCY	35,615	7,034			91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	819	0			101.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	175,172	7,034	0	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			190.00
191.00 19100	RESEARCH	0	0			191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	5,367	0			192.00
192.01 19201	OTHER NON-REIMBURSABLE	0	0			192.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0002

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

Worksheet B
Part II
Date/Time Prepared:
5/29/2024 9:08 am

Cost Center Description	STAFF EDUCATION	MEDICAL EDUCATION	INTERNS & RESIDENTS		PARAMED ED PROGRAM	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS		
			17.01	17.02		
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	20	0				192.02
193.00 19300 NONPAID WORKERS	0	0				193.00
200.00 Cross Foot Adjustments			1,123	72,475	65,797	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	180,559	7,034	1,123	72,475	65,797	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 5/29/2024 9:08 am
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
4.00	00400				4.00
5.01	00550				5.01
5.02	00560				5.02
5.03	00570				5.03
5.04	00580				5.04
5.05	00590				5.05
5.06	00592				5.06
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
17.01	01701				17.01
17.02	01702				17.02
21.00	02100				21.00
22.00	02200				22.00
23.00	02300				23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	5,894,303	0	5,894,303	30.00
31.00	03100	449,326	0	449,326	31.00
31.01	03101	60,305	0	60,305	31.01
40.00	04000	80,270	0	80,270	40.00
41.00	04100	551,843	0	551,843	41.00
43.00	04300	413,992	0	413,992	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	1,182,300	0	1,182,300	50.00
50.01	05001	16,907	0	16,907	50.01
51.00	05100	259,733	0	259,733	51.00
52.00	05200	184,930	0	184,930	52.00
53.00	05300	0	0	0	53.00
54.00	05400	922,903	0	922,903	54.00
54.01	05401	109,468	0	109,468	54.01
55.00	05500	159,416	0	159,416	55.00
55.01	05501	97,582	0	97,582	55.01
56.00	05600	169,856	0	169,856	56.00
57.00	05700	234,461	0	234,461	57.00
58.00	05800	90,764	0	90,764	58.00
59.00	05900	211,319	0	211,319	59.00
60.00	06000	574,033	0	574,033	60.00
62.00	06200	31,480	0	31,480	62.00
64.00	06400	0	0	0	64.00
65.00	06500	180,692	0	180,692	65.00
66.00	06600	218,735	0	218,735	66.00
67.00	06700	182,517	0	182,517	67.00
68.00	06800	34,046	0	34,046	68.00
69.00	06900	22,705	0	22,705	69.00
69.01	06901	5,126	0	5,126	69.01
70.00	07000	33,964	0	33,964	70.00
71.00	07100	414,304	0	414,304	71.00
72.00	07200	390,895	0	390,895	72.00
73.00	07300	623,378	0	623,378	73.00
74.00	07400	87,592	0	87,592	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	1,272,236	0	1,272,236	90.00
91.00	09100	713,158	0	713,158	91.00
92.00	09200		0		92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	13,959	0	13,959	101.00
SPECIAL PURPOSE COST CENTERS					
118.00		15,888,498	0	15,888,498	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	29,183	0	29,183	190.00
191.00	19100	0	0	0	191.00
192.00	19200	523,701	0	523,701	192.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0002		Period: From 01/01/2023 To 12/31/2023		Worksheet B Part II Date/Time Prepared: 5/29/2024 9:08 am	
Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total			
			24.00	25.00	26.00			
192.01	19201	OTHER NON-REIMBURSABLE	57,313	0	57,313			192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	146,045	0	146,045			192.02
193.00	19300	NONPAID WORKERS	0	0	0			193.00
200.00		Cross Foot Adjustments	139,395	0	139,395			200.00
201.00		Negative Cost Centers	0	0	0			201.00
202.00		TOTAL (sum lines 118 through 201)	16,784,135	0	16,784,135			202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1
Date/Time Prepared:
5/29/2024 9:08 am

Cost Center Description	CAPI TAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (MACHI NE TIME)	PURCHASI NG RECEI VI NG AND STORES (PURCHASE REQUI SI TI ONS)	ADMI TTING (GROSS CHARGES)	
	BLDG & FIXT (SQUARE FEET)					
	1.00	4.00	5.01	5.02	5.03	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT	1,410,133					1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	5,906	160,827,227				4.00
5.01 00550 DATA PROCESSING	9,190	4,389,684	100			5.01
5.02 00560 PURCHASING RECEIVING AND STORES	7,332	1,178,154	0	49,197,529		5.02
5.03 00570 ADMITTING	9,717	4,576,645	0	60,403	1,754,756,267	5.03
5.04 00580 CASHIERING/ACCOUNTS RECEIVABLE	30,646	2,453,013	0	8,340	0	5.04
5.05 00590 OTHER A&G	99,579	9,127,755	100	24,664	0	5.05
5.06 00592 PATIENT TRANSPORTATION	0	554,684	0	962	0	5.06
7.00 00700 OPERATION OF PLANT	299,329	5,278,717	0	484,753	0	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	17,825	0	0	172	0	8.00
9.00 00900 HOUSEKEEPING	20,635	4,694,253	0	416,021	0	9.00
10.00 01000 DIETARY	18,848	2,640,840	0	671,373	0	10.00
11.00 01100 CAFETERIA	13,177	1,625,037	0	1,100	0	11.00
13.00 01300 NURSING ADMINISTRATION	6,350	6,150,671	0	36,761	0	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	35,843	776,128	0	57,841	0	14.00
15.00 01500 PHARMACY	18,957	0	0	202,192	0	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	11,307	2,281,642	0	7,180	0	16.00
17.00 01700 SOCIAL SERVICE	1,629	469,866	0	0	0	17.00
17.01 01701 STAFF EDUCATION	11,147	0	0	0	0	17.01
17.02 01702 MEDICAL EDUCATION	374	157,499	0	8,224	0	17.02
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	4,467	0	0	0	0	22.00
23.00 02300 PARAMED ED PROGRAM	3,364	999,064	0	4,873	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	313,217	24,160,579	0	2,339,643	111,660,931	30.00
31.00 03100 INTENSIVE CARE UNIT	19,864	6,788,481	0	822,892	21,952,331	31.00
31.01 03101 NEONATAL ICU	2,258	1,727,433	0	12,895	5,616,128	31.01
40.00 04000 SUBPROVIDER - I/PF	3,972	968,593	0	168	2,719,542	40.00
41.00 04100 SUBPROVIDER - I/RF	31,243	1,630,836	0	67,772	4,035,526	41.00
43.00 04300 NURSERY	24,424	1,272,097	0	155,707	2,297,605	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	59,647	5,750,987	0	646,973	198,209,654	50.00
50.01 05001 ENDOSCOPY	0	612,103	0	232,867	9,905,306	50.01
51.00 05100 RECOVERY ROOM	14,546	1,190,694	0	130,540	13,484,448	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	7,003	3,929,036	0	176,620	6,722,192	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	53,059	2,852,090	0	161,983	53,984,010	54.00
54.01 05401 RADIOLOGY - ULTRASOUND	5,054	1,408,037	0	93,578	25,053,114	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	8,391	470,790	0	16,618	28,977,173	55.00
55.01 05501 INFUSION CENTER	5,094	713,287	0	187,238	17,592,973	55.01
56.00 05600 RADIO SOTOPE	9,043	755,241	0	888,466	22,249,155	56.00
57.00 05700 CT SCAN	8,563	1,342,996	0	296,706	169,872,853	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	4,205	496,698	0	71,133	34,814,997	58.00
59.00 05900 CARDIAC CATHETERIZATION	8,393	2,598,103	0	881,158	87,428,837	59.00
60.00 06000 LABORATORY	23,518	4,424,960	0	5,505,519	238,657,576	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	385	1,225,454	0	246,611	27,965,735	62.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	7,766	2,606,302	0	928,261	54,544,456	65.00
66.00 06600 PHYSICAL THERAPY	12,270	1,713,905	0	13,807	15,605,528	66.00
67.00 06700 OCCUPATIONAL THERAPY	10,545	1,120,554	0	10,935	7,424,674	67.00
68.00 06800 SPEECH PATHOLOGY	1,796	485,239	0	7,855	3,007,899	68.00
69.00 06900 ELECTROCARDIOLOGY	0	838,421	0	21,615	32,626,784	69.00
69.01 06901 CARDIAC REHAB	0	466,181	0	6,136	1,901,575	69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0	1,276,080	0	96,781	45,787,304	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	15,183,405	46,223,757	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14,331,609	43,272,141	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1,662	448,590	0	629,269	261,382,357	73.00
74.00 07400 RENAL DIALYSIS	4,383	0	0	20,606	11,669,578	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	76,181	2,548,812	0	71,926	13,364,701	90.00
91.00 09100 EMERGENCY	27,063	8,785,753	0	2,460,330	131,133,709	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	2,092,822	0	55,894	3,611,718	101.00
SPECIAL PURPOSE COST CENTERS						
118.00 11800 SUBTOTALS (SUM OF LINES 1 through 117)	1,369,167	134,054,806	100	48,758,375	1,754,756,267	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,801	0	0	0	0	190.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1
Date/Time Prepared:
5/29/2024 9:08 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (MACHINE TIME)	PURCHASING RECEIVING AND STORES (PURCHASE REQUIREMENTS)	ADMITTING (GROSS CHARGES)	
			BLDG & FIXT (SQUARE FEET)						
			1.00	4.00	5.01	5.02	5.03		
191.00	19100	RESEARCH	0	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	26,711	26,696,654	0	0	439,154	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	3,457	0	0	0	0	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	8,997	75,767	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	0	193.00
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)	16,784,135	29,155,702	14,435,890	3,389,908	6,555,262	202.00	
203.00		Unit cost multiplier (Wkst. B, Part I)	11.902519	0.181286	144,358.900000	0.068904	0.003736	203.00	
204.00		Cost to be allocated (per Wkst. B, Part II)		70,296	111,302	87,784	117,765	204.00	
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000437	1,113.020000	0.001784	0.000067	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: 15-0002		Period: From 01/01/2023 To 12/31/2023		Worksheet B-1	
Date/Time Prepared: 5/29/2024 9:08 am							
Cost Center Description	CASHIERING/AC COUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER A&G (ACCUM. COST)	PATIENT TRANSPORTATION (NUMBER OF TRIPS)	OPERATION OF PLANT (SQUARE FEET)		
	5.04	5A.05	5.05	5.06	7.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	DATA PROCESSING					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00570	ADMITTING					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,754,756,267				5.04
5.05	00590	OTHER A&G	0	-36,982,919	344,177,706		5.05
5.06	00592	PATIENT TRANSPORTATION	0	0	704,087	29,218	5.06
7.00	00700	OPERATION OF PLANT	0	0	25,459,299	0	948,434
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,598,589	0	17,825
9.00	00900	HOUSEKEEPING	0	0	6,946,410	0	20,635
10.00	01000	DIETARY	0	0	5,563,639	0	18,848
11.00	01100	CAFETERIA	0	0	2,261,572	0	13,177
13.00	01300	NURSING ADMINISTRATION	0	0	8,082,274	0	6,350
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	3,219,090	0	35,843
15.00	01500	PHARMACY	0	0	6,299,059	0	18,957
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	3,588,174	0	11,307
17.00	01700	SOCIAL SERVICE	0	0	574,435	0	1,629
17.01	01701	STAFF EDUCATION	0	0	132,677	0	11,147
17.02	01702	MEDICAL EDUCATION	0	0	237,188	0	374
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	297,137	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	84,337	0	4,467
23.00	02300	PARAMED ED PROGRAM	0	0	1,078,051	0	3,364
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	111,660,931	0	48,343,762	9,866	313,217
31.00	03100	INTENSIVE CARE UNIT	21,952,331	0	10,246,751	90	19,864
31.01	03101	NEONATAL ICU	5,616,128	0	2,344,446	0	2,258
40.00	04000	SUBPROVIDER - IPF	2,719,542	0	1,291,982	0	3,972
41.00	04100	SUBPROVIDER - IRF	4,035,526	0	2,655,503	122	31,243
43.00	04300	NURSERY	2,297,605	0	2,103,507	1	24,424
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	198,209,654	0	13,784,496	1	59,647
50.01	05001	ENDOSCOPY	9,905,306	0	1,213,975	730	0
51.00	05100	RECOVERY ROOM	13,484,448	0	1,972,477	0	14,546
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,722,192	0	5,420,106	365	7,003
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	53,984,010	0	7,204,877	1,796	53,059
54.01	05401	RADIOLOGY - ULTRASOUND	25,053,114	0	2,657,896	3,628	5,054
55.00	05500	RADIOLOGY-THERAPEUTIC	28,977,173	0	2,655,304	276	8,391
55.01	05501	INFUSION CENTER	17,592,973	0	1,472,477	0	5,094
56.00	05600	RADIOISOTOPE	22,249,155	0	2,487,119	1,658	9,043
57.00	05700	CT SCAN	169,872,853	0	4,163,553	6,940	8,563
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	34,814,997	0	1,458,049	1,983	4,205
59.00	05900	CARDIAC CATHETERIZATION	87,428,837	0	5,580,808	1,097	8,393
60.00	06000	LABORATORY	238,657,576	0	17,730,661	0	23,518
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	27,965,735	0	2,019,660	0	385
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	54,544,456	0	5,983,568	2	7,766
66.00	06600	PHYSICAL THERAPY	15,605,528	0	2,542,102	0	12,270
67.00	06700	OCCUPATIONAL THERAPY	7,424,674	0	1,604,890	0	10,545
68.00	06800	SPEECH PATHOLOGY	3,007,899	0	665,880	0	1,796
69.00	06900	ELECTROCARDIOLOGY	32,626,784	0	1,407,557	137	0
69.01	06901	CARDIAC REHAB	1,901,575	0	754,851	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	45,787,304	0	2,248,373	95	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	46,223,757	0	16,594,257	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	43,272,141	0	15,660,488	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	261,382,357	0	44,728,997	0	1,662
74.00	07400	RENAL DIALYSIS	11,669,578	0	2,482,429	1	4,383
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	13,364,701	0	5,442,656	9	76,181
91.00	09100	EMERGENCY	131,133,709	0	18,390,731	421	27,063
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	3,611,718	0	2,833,901	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,754,756,267	-36,982,919	324,274,107	29,218	907,468
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	24,402	0	1,801
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	19,314,454	0	26,711

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1

Date/Time Prepared:
5/29/2024 9:08 am

Cost Center Description			CASHIERING/AC COUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER A&G (ACCUM. COST)	PATIENT TRANSPORTATION (NUMBER OF TRIPS)	OPERATION OF PLANT (SQUARE FEET)	
			5.04	5A.05	5.05	5.06	7.00	
192.01	19201	OTHER NON-REIMBURSABLE	0	0	389,575	0	3,457	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	175,168	0	8,997	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	7,288,047		36,982,919	779,743	28,194,977	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.004153		0.107453	26.687076	29.727927	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	365,852		1,300,576	2,905	3,662,152	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000208		0.003779	0.099425	3.861262	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: 15-0002		Period: From 01/01/2023 To 12/31/2023		Worksheet B-1	
Date/Time Prepared: 5/29/2024 9:08 am								
Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (PRODUCTIVE HOURS)	NURSING ADMINISTRATIVE (DIRECT NURS. HRS.)			
	8.00	9.00	10.00	11.00	13.00			
GENERAL SERVICE COST CENTERS								
1.00 00100	CAP REL COSTS-BLDG & FIXT							1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT							4.00
5.01 00550	DATA PROCESSING							5.01
5.02 00560	PURCHASING RECEIVING AND STORES							5.02
5.03 00570	ADMITTING							5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE							5.04
5.05 00590	OTHER A&G							5.05
5.06 00592	PATIENT TRANSPORTATION							5.06
7.00 00700	OPERATION OF PLANT							7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,689,669						8.00
9.00 00900	HOUSEKEEPING	0	909,974					9.00
10.00 01000	DIETARY	0	18,848	263,068				10.00
11.00 01100	CAFETERIA	0	13,177	0	2,193,914			11.00
13.00 01300	NURSING ADMINISTRATION	0	6,350	0	96,906	1,277,991		13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	1,522	35,843	0	36,682	0		14.00
15.00 01500	PHARMACY	0	18,957	0	0	0		15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	11,307	0	83,950	0		16.00
17.00 01700	SOCIAL SERVICE	0	1,629	0	0	0		17.00
17.01 01701	STAFF EDUCATION	0	11,147	0	0	0		17.01
17.02 01702	MEDICAL EDUCATION	0	374	0	0	0		17.02
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	4,467	0	0	0		22.00
23.00 02300	PARAMED PROGRAM	0	3,364	0	31,937	31,937		23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00 03000	ADULTS & PEDIATRICS	789,473	313,217	213,853	544,087	544,087		30.00
31.00 03100	INTENSIVE CARE UNIT	108,706	19,864	10,749	127,588	127,588		31.00
31.01 03101	NEONATAL ICU	0	2,258	0	34,641	34,641		31.01
40.00 04000	SUBPROVIDER - IPF	0	3,972	3,954	21,748	21,748		40.00
41.00 04100	SUBPROVIDER - IRF	52,411	31,243	10,545	36,211	36,211		41.00
43.00 04300	NURSERY	20,908	24,424	0	22,934	22,934		43.00
ANCILLARY SERVICE COST CENTERS								
50.00 05000	OPERATING ROOM	176,292	59,647	0	137,531	137,531		50.00
50.01 05001	ENDOSCOPY	19,617	0	0	11,977	11,977		50.01
51.00 05100	RECOVERY ROOM	10,904	14,546	0	22,904	22,904		51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	46,824	7,003	6,343	84,030	84,030		52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0		53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	38,743	53,059	0	83,947	0		54.00
54.01 05401	RADIOLOGY - ULTRASOUND	18,480	5,054	0	32,662	0		54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	6,246	8,391	0	11,328	0		55.00
55.01 05501	INFUSION CENTER	0	5,094	0	21,402	0		55.01
56.00 05600	RADIO SOTOP	12,396	9,043	0	14,589	0		56.00
57.00 05700	CT SCAN	23,328	8,563	0	31,665	0		57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	9,795	4,205	0	14,106	0		58.00
59.00 05900	CARDIAC CATHETERIZATION	40,379	8,393	0	53,488	0		59.00
60.00 06000	LABORATORY	0	23,518	0	121,894	0		60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	385	0	53,941	0		62.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0		64.00
65.00 06500	RESPIRATORY THERAPY	0	7,766	0	61,847	0		65.00
66.00 06600	PHYSICAL THERAPY	0	12,270	0	37,777	0		66.00
67.00 06700	OCCUPATIONAL THERAPY	0	10,545	0	25,371	0		67.00
68.00 06800	SPEECH PATHOLOGY	0	1,796	0	10,080	0		68.00
69.00 06900	ELECTROCARDIOLOGY	3,339	0	0	23,684	0		69.00
69.01 06901	CARDIAC REHAB	602	0	0	11,966	0		69.01
70.00 07000	ELECTROENCEPHALOGRAPHY	17,371	0	0	30,628	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 PATIENTS	0	0	0	0	0		72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	1,662	0	9,698	0		73.00
74.00 07400	RENAL DIALYSIS	16,481	4,383	0	0	0		74.00
OUTPATIENT SERVICE COST CENTERS								
90.00 09000	CLINIC	42,593	76,181	0	56,956	8,644		90.00
91.00 09100	EMERGENCY	233,259	27,063	17,624	193,759	193,759		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	0	0		101.00
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,689,669	869,008	263,068	2,193,914	1,277,991		118.00
NONREIMBURSABLE COST CENTERS								
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,801	0	0	0		190.00
191.00 19100	RESEARCH	0	0	0	0	0		191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	26,711	0	0	0		192.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1

Date/Time Prepared:
5/29/2024 9:08 am

Cost Center Description			LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (PRODUCTIVE HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
			8.00	9.00	10.00	11.00	13.00	
192.01	19201	OTHER NON-REIMBURSABLE	0	3,457	0	0	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	8,997	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	2,300,262	8,306,259	6,893,826	3,016,590	9,330,718	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.361368	9.128018	26.205491	1.374981	7.301083	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	287,030	354,328	327,832	222,108	145,681	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.169874	0.389383	1.246187	0.101238	0.113992	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: 15-0002

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

Worksheet B-1
Date/Time Prepared:
5/29/2024 9:08 am

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	STAFF EDUCATION (TIME SPENT)	
		14.00	15.00	16.00	17.00	17.01	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
4.00	00400						4.00
5.01	00550						5.01
5.02	00560						5.02
5.03	00570						5.03
5.04	00580						5.04
5.05	00590						5.05
5.06	00592						5.06
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300						13.00
14.00	01400	29,515,014					14.00
15.00	01500	0	41,744,096				15.00
16.00	01600	0	0	1,754,756,267			16.00
17.00	01700	0	0	0	805		17.00
17.01	01701	0	0	0	0	73,404	17.01
17.02	01702	0	0	0	0	5	17.02
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	26	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	0	111,660,931	735	19,856	30.00
31.00	03100	0	0	21,952,331	0	7,060	31.00
31.01	03101	0	0	5,616,128	0	1,844	31.01
40.00	04000	0	0	2,719,542	0	53	40.00
41.00	04100	0	0	4,035,526	45	1,328	41.00
43.00	04300	0	0	2,297,605	0	527	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	198,209,654	0	10,491	50.00
50.01	05001	0	0	9,905,306	0	720	50.01
51.00	05100	0	0	13,484,448	0	1,827	51.00
52.00	05200	0	0	6,722,192	0	5,155	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	0	53,984,010	0	264	54.00
54.01	05401	0	0	25,053,114	0	153	54.01
55.00	05500	0	0	28,977,173	0	5	55.00
55.01	05501	0	0	17,592,973	0	10	55.01
56.00	05600	0	0	22,249,155	0	0	56.00
57.00	05700	0	0	169,872,853	0	1,969	57.00
58.00	05800	0	0	34,814,997	0	20	58.00
59.00	05900	0	0	87,428,837	0	2,152	59.00
60.00	06000	0	1,160,220	238,657,576	0	125	60.00
62.00	06200	0	0	27,965,735	0	93	62.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	0	54,544,456	0	893	65.00
66.00	06600	0	0	15,605,528	0	86	66.00
67.00	06700	0	0	7,424,674	0	52	67.00
68.00	06800	0	0	3,007,899	0	38	68.00
69.00	06900	0	0	32,626,784	0	493	69.00
69.01	06901	0	0	1,901,575	0	0	69.01
70.00	07000	0	0	45,787,304	0	295	70.00
71.00	07100	15,183,405	0	46,223,757	0	0	71.00
72.00	07200	14,331,609	0	43,272,141	0	0	72.00
73.00	07300	0	40,405,215	261,382,357	0	604	73.00
74.00	07400	0	0	11,669,578	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	13,364,701	0	258	90.00
91.00	09100	0	0	131,133,709	25	14,479	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	3,611,718	0	333	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		29,515,014	41,565,435	1,754,756,267	805	71,214	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	178,661	0	0	2,182	192.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1

Date/Time Prepared:
5/29/2024 9:08 am

Cost Center Description			CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	STAFF EDUCATION (TIME SPENT)	
			14.00	15.00	16.00	17.00	17.01	
192.01	19201	OTHER NON-REIMBURSABLE	0	0	0	0	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	0	0	8	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	5,010,214	7,712,504	4,528,508	699,457	580,061	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.169751	0.184757	0.002581	868.890683	7.902308	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	595,558	330,381	205,713	28,689	180,559	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.020178	0.007914	0.000117	35.638509	2.459798	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: 15-0002

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

Worksheet B-1
Date/Time Prepared:
5/29/2024 9:08 am

Cost Center Description	MEDICAL EDUCATION (ASSIGNED TIME)	INTERNS & RESIDENTS		PARAMED PROGRAM (ASSIGNED TIME)	
		SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)		
		17.02	21.00		
GENERAL SERVICE COST CENTERS					
1.00 00100 CAP REL COSTS-BLDG & FIXT					1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 00550 DATA PROCESSING					5.01
5.02 00560 PURCHASING RECEIVING AND STORES					5.02
5.03 00570 ADMITTING					5.03
5.04 00580 CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05 00590 OTHER A&G					5.05
5.06 00592 PATIENT TRANSPORTATION					5.06
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
17.00 01700 SOCIAL SERVICE					17.00
17.01 01701 STAFF EDUCATION					17.01
17.02 01702 MEDICAL EDUCATION	100				17.02
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	100			21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0		100		22.00
23.00 02300 PARAMED PROGRAM	0			8,904	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000 ADULTS & PEDIATRICS	0	0	0	384	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	0	0	31.00
31.01 03101 NEONATAL ICU	0	0	0	0	31.01
40.00 04000 SUBPROVIDER - IPF	0	0	0	0	40.00
41.00 04100 SUBPROVIDER - IRF	0	0	0	0	41.00
43.00 04300 NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0	0	0	384	50.00
50.01 05001 ENDOSCOPY	0	0	0	0	50.01
51.00 05100 RECOVERY ROOM	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	384	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01 05401 RADIOLOGY - ULTRASOUND	0	0	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
55.01 05501 INFUSION CENTER	0	0	0	0	55.01
56.00 05600 RADIOISOTOPE	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	192	59.00
60.00 06000 LABORATORY	0	0	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	576	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01 06901 CARDIAC REHAB	0	0	0	0	69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0	0	0	0	90.00
91.00 09100 EMERGENCY	100	100	100	6,984	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	0	101.00
SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)				118.00
	100	100	100	8,904	
NONREIMBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00 19100 RESEARCH	0	0	0	0	191.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1

Date/Time Prepared:
5/29/2024 9:08 am

Cost Center Description	MEDICAL EDUCATION (ASSIGNED TIME)	INTERNS & RESIDENTS		PARAMETERED PROGRAM (ASSIGNED TIME)		
		SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)			
		17.02	21.00			
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.01 19201 OTHER NON-REIMBURSABLE	0	0	0	0		192.01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	0	0	0	0		192.02
193.00 19300 NONPAID WORKERS	0	0	0	0		193.00
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)	277,247	329,065	266,969	1,601,896		202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	2,772.470000	3,290.650000	2,669.690000	179.907457		203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	7,034	1,123	72,475	65,797		204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	70.340000	11.230000	724.750000	7.389600		205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/29/2024 9:08 am	
			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	78,524,304	78,524,304	0	78,524,304	30.00
31.00	03100 INTENSIVE CARE UNIT	13,771,115	13,771,115	0	13,771,115	31.00
31.01	03101 NEONATAL ICU	3,013,716	3,013,716	0	3,013,716	31.01
40.00	04000 SUBPROVIDER - IPF	1,884,886	1,884,886	0	1,884,886	40.00
41.00	04100 SUBPROVIDER - IRF	4,879,945	4,879,945	0	4,879,945	41.00
43.00	04300 NURSERY	3,516,115	3,516,115	0	3,516,115	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	19,680,141	19,680,141	0	19,680,141	50.00
50.01	05001 ENDOSCOPY	1,525,777	1,525,777	0	1,525,777	50.01
51.00	05100 RECOVERY ROOM	3,012,426	3,012,426	0	3,012,426	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	7,370,549	7,370,549	0	7,370,549	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	10,398,239	10,398,239	0	10,398,239	54.00
54.01	05401 RADIOLOGY - ULTRASOUND	3,372,633	3,372,633	0	3,372,633	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	3,372,939	3,372,939	0	3,372,939	55.00
55.01	05501 INFUSION CENTER	1,903,544	1,903,544	0	1,903,544	55.01
56.00	05600 RADIOISOTOPE	3,244,350	3,244,350	0	3,244,350	56.00
57.00	05700 CT SCAN	5,658,169	5,658,169	0	5,658,169	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,953,776	1,953,776	0	1,953,776	58.00
59.00	05900 CARDIAC CATHETERIZATION	6,941,594	6,941,594	0	6,941,594	59.00
60.00	06000 LABORATORY	21,548,612	21,548,612	0	21,548,612	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2,398,721	2,398,721	0	2,398,721	62.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	7,264,829	7,264,829	0	7,264,829	65.00
66.00	06600 PHYSICAL THERAPY	3,384,922	3,384,922	0	3,384,922	66.00
67.00	06700 OCCUPATIONAL THERAPY	2,241,535	2,241,535	0	2,241,535	67.00
68.00	06800 SPEECH PATHOLOGY	829,139	829,139	0	829,139	68.00
69.00	06900 ELECTROCARDIOLOGY	1,687,676	1,687,676	0	1,687,676	69.00
69.01	06901 CARDIAC REHAB	858,143	858,143	0	858,143	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	2,678,771	2,678,771	0	2,678,771	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	21,074,073	21,074,073	0	21,074,073	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	19,887,744	19,887,744	0	19,887,744	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	57,757,195	57,757,195	0	57,757,195	73.00
74.00	07400 RENAL DIALYSIS	2,972,062	2,972,062	0	2,972,062	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	9,223,753	9,223,753	0	9,223,753	90.00
91.00	09100 EMERGENCY	25,898,445	25,898,445	0	25,898,445	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	11,879,976	11,879,976	0	11,879,976	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	3,150,365	3,150,365	0	3,150,365	101.00
200.00	Subtotal (see instructions)	368,760,179	368,760,179	0	368,760,179	200.00
201.00	Less Observation Beds	11,879,976	11,879,976	0	11,879,976	201.00
202.00	Total (see instructions)	356,880,203	356,880,203	0	356,880,203	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0002		Period: From 01/01/2023 To 12/31/2023		Worksheet C Part I Date/Time Prepared: 5/29/2024 9:08 am		
			Title XVIII			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	87,880,095		87,880,095				30.00
31.00	03100	INTENSIVE CARE UNIT	21,952,331		21,952,331				31.00
31.01	03101	NEONATAL ICU	5,616,128		5,616,128				31.01
40.00	04000	SUBPROVIDER - IPF	2,719,542		2,719,542				40.00
41.00	04100	SUBPROVIDER - IRF	4,035,526		4,035,526				41.00
43.00	04300	NURSERY	2,297,605		2,297,605				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	72,844,794	125,364,860	198,209,654	0.099290	0.000000		50.00
50.01	05001	ENDOSCOPY	5,367,165	4,538,141	9,905,306	0.154036	0.000000		50.01
51.00	05100	RECOVERY ROOM	4,223,257	9,261,191	13,484,448	0.223400	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,365,530	3,356,662	6,722,192	1.096450	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,728,689	40,255,321	53,984,010	0.192617	0.000000		54.00
54.01	05401	RADIOLOGY - ULTRASOUND	6,009,408	19,043,706	25,053,114	0.134619	0.000000		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	906,751	28,070,422	28,977,173	0.116400	0.000000		55.00
55.01	05501	INFUSION CENTER	8,853	17,584,120	17,592,973	0.108199	0.000000		55.01
56.00	05600	RADIOISOTOPE	5,646,607	16,602,548	22,249,155	0.145819	0.000000		56.00
57.00	05700	CT SCAN	60,991,099	108,881,754	169,872,853	0.033308	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	12,849,674	21,965,323	34,814,997	0.056119	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	50,869,319	36,559,518	87,428,837	0.079397	0.000000		59.00
60.00	06000	LABORATORY	96,361,045	142,296,531	238,657,576	0.090291	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	12,940,165	15,025,570	27,965,735	0.085774	0.000000		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	51,287,462	3,256,994	54,544,456	0.133191	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	8,276,665	7,328,863	15,605,528	0.216905	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	5,667,087	1,757,587	7,424,674	0.301903	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	2,570,687	437,212	3,007,899	0.275654	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	15,980,433	16,646,351	32,626,784	0.051727	0.000000		69.00
69.01	06901	CARDIAC REHAB	515,991	1,385,584	1,901,575	0.451280	0.000000		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	15,257,987	30,529,317	45,787,304	0.058505	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	26,140,994	20,082,763	46,223,757	0.455914	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,318,034	18,954,107	43,272,141	0.459597	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	91,077,808	170,304,549	261,382,357	0.220968	0.000000		73.00
74.00	07400	RENAL DIALYSIS	10,655,370	1,014,208	11,669,578	0.254685	0.000000		74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	57,352	13,307,349	13,364,701	0.690158	0.000000		90.00
91.00	09100	EMERGENCY	22,495,507	108,638,202	131,133,709	0.197496	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	6,160,147	17,620,689	23,780,836	0.499561	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
101.00	10100	HOME HEALTH AGENCY	1,105	3,610,613	3,611,718				101.00
200.00		Subtotal (see instructions)	751,076,212	1,003,680,055	1,754,756,267				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	751,076,212	1,003,680,055	1,754,756,267				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/29/2024 9:08 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
31.01	03101 NEONATAL ICU			31.01
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.099290		50.00
50.01	05001 ENDOSCOPY	0.154036		50.01
51.00	05100 RECOVERY ROOM	0.223400		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.096450		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.192617		54.00
54.01	05401 RADIOLOGY - ULTRASOUND	0.134619		54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.116400		55.00
55.01	05501 INFUSION CENTER	0.108199		55.01
56.00	05600 RADIOISOTOPE	0.145819		56.00
57.00	05700 CT SCAN	0.033308		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.056119		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.079397		59.00
60.00	06000 LABORATORY	0.090291		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.085774		62.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.133191		65.00
66.00	06600 PHYSICAL THERAPY	0.216905		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.301903		67.00
68.00	06800 SPEECH PATHOLOGY	0.275654		68.00
69.00	06900 ELECTROCARDIOLOGY	0.051727		69.00
69.01	06901 CARDIAC REHAB	0.451280		69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.058505		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.455914		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.459597		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.220968		73.00
74.00	07400 RENAL DIALYSIS	0.254685		74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.690158		90.00
91.00	09100 EMERGENCY	0.197496		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.499561		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100 HOME HEALTH AGENCY			101.00
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: 15-0002

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2024 9:08 am

		Title XIX		Hospital		Cost		
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs		
				Total Costs	RCE Disallowance			
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	78,524,304		78,524,304	0	78,524,304	30.00
31.00	03100	INTENSIVE CARE UNIT	13,771,115		13,771,115	0	13,771,115	31.00
31.01	03101	NEONATAL ICU	3,013,716		3,013,716	0	3,013,716	31.01
40.00	04000	SUBPROVIDER - IPF	1,884,886		1,884,886	0	1,884,886	40.00
41.00	04100	SUBPROVIDER - IRF	4,879,945		4,879,945	0	4,879,945	41.00
43.00	04300	NURSERY	3,516,115		3,516,115	0	3,516,115	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	19,680,141		19,680,141	0	19,680,141	50.00
50.01	05001	ENDOSCOPY	1,525,777		1,525,777	0	1,525,777	50.01
51.00	05100	RECOVERY ROOM	3,012,426		3,012,426	0	3,012,426	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,370,549		7,370,549	0	7,370,549	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,398,239		10,398,239	0	10,398,239	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	3,372,633		3,372,633	0	3,372,633	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	3,372,939		3,372,939	0	3,372,939	55.00
55.01	05501	INFUSION CENTER	1,903,544		1,903,544	0	1,903,544	55.01
56.00	05600	RADIOISOTOPE	3,244,350		3,244,350	0	3,244,350	56.00
57.00	05700	CT SCAN	5,658,169		5,658,169	0	5,658,169	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,953,776		1,953,776	0	1,953,776	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,941,594		6,941,594	0	6,941,594	59.00
60.00	06000	LABORATORY	21,548,612		21,548,612	0	21,548,612	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,398,721		2,398,721	0	2,398,721	62.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	7,264,829	0	7,264,829	0	7,264,829	65.00
66.00	06600	PHYSICAL THERAPY	3,384,922	0	3,384,922	0	3,384,922	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,241,535	0	2,241,535	0	2,241,535	67.00
68.00	06800	SPEECH PATHOLOGY	829,139	0	829,139	0	829,139	68.00
69.00	06900	ELECTROCARDIOLOGY	1,687,676		1,687,676	0	1,687,676	69.00
69.01	06901	CARDIAC REHAB	858,143		858,143	0	858,143	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	2,678,771		2,678,771	0	2,678,771	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,074,073		21,074,073	0	21,074,073	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,887,744		19,887,744	0	19,887,744	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	57,757,195		57,757,195	0	57,757,195	73.00
74.00	07400	RENAL DIALYSIS	2,972,062		2,972,062	0	2,972,062	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	9,223,753		9,223,753	0	9,223,753	90.00
91.00	09100	EMERGENCY	25,898,445		25,898,445	0	25,898,445	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	11,879,976		11,879,976	0	11,879,976	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	3,150,365		3,150,365	0	3,150,365	101.00
200.00		Subtotal (see instructions)	368,760,179	0	368,760,179	0	368,760,179	200.00
201.00		Less Observation Beds	11,879,976		11,879,976		11,879,976	201.00
202.00		Total (see instructions)	356,880,203	0	356,880,203	0	356,880,203	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0002		Period: From 01/01/2023 To 12/31/2023		Worksheet C Part I Date/Time Prepared: 5/29/2024 9:08 am	
			Title XIX		Hospital		Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00				9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	87,880,095		87,880,095			30.00
31.00	03100	INTENSIVE CARE UNIT	21,952,331		21,952,331			31.00
31.01	03101	NEONATAL ICU	5,616,128		5,616,128			31.01
40.00	04000	SUBPROVIDER - IPF	2,719,542		2,719,542			40.00
41.00	04100	SUBPROVIDER - IRF	4,035,526		4,035,526			41.00
43.00	04300	NURSERY	2,297,605		2,297,605			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	72,844,794	125,364,860	198,209,654	0.099290	0.000000	50.00
50.01	05001	ENDOSCOPY	5,367,165	4,538,141	9,905,306	0.154036	0.000000	50.01
51.00	05100	RECOVERY ROOM	4,223,257	9,261,191	13,484,448	0.223400	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,365,530	3,356,662	6,722,192	1.096450	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,728,689	40,255,321	53,984,010	0.192617	0.000000	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	6,009,408	19,043,706	25,053,114	0.134619	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	906,751	28,070,422	28,977,173	0.116400	0.000000	55.00
55.01	05501	INFUSION CENTER	8,853	17,584,120	17,592,973	0.108199	0.000000	55.01
56.00	05600	RADIOISOTOPE	5,646,607	16,602,548	22,249,155	0.145819	0.000000	56.00
57.00	05700	CT SCAN	60,991,099	108,881,754	169,872,853	0.033308	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	12,849,674	21,965,323	34,814,997	0.056119	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	50,869,319	36,559,518	87,428,837	0.079397	0.000000	59.00
60.00	06000	LABORATORY	96,361,045	142,296,531	238,657,576	0.090291	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	12,940,165	15,025,570	27,965,735	0.085774	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	51,287,462	3,256,994	54,544,456	0.133191	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	8,276,665	7,328,863	15,605,528	0.216905	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,667,087	1,757,587	7,424,674	0.301903	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	2,570,687	437,212	3,007,899	0.275654	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	15,980,433	16,646,351	32,626,784	0.051727	0.000000	69.00
69.01	06901	CARDIAC REHAB	515,991	1,385,584	1,901,575	0.451280	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	15,257,987	30,529,317	45,787,304	0.058505	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	26,140,994	20,082,763	46,223,757	0.455914	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,318,034	18,954,107	43,272,141	0.459597	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	91,077,808	170,304,549	261,382,357	0.220968	0.000000	73.00
74.00	07400	RENAL DIALYSIS	10,655,370	1,014,208	11,669,578	0.254685	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	57,352	13,307,349	13,364,701	0.690158	0.000000	90.00
91.00	09100	EMERGENCY	22,495,507	108,638,202	131,133,709	0.197496	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	6,160,147	17,620,689	23,780,836	0.499561	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	1,105	3,610,613	3,611,718			101.00
200.00		Subtotal (see instructions)	751,076,212	1,003,680,055	1,754,756,267			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	751,076,212	1,003,680,055	1,754,756,267			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/29/2024 9:08 am
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital
		11.00		Cost
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
31.01	03101	NEONATAL ICU		31.01
40.00	04000	SUBPROVIDER - IPF		40.00
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
50.01	05001	ENDOSCOPY	0.000000	50.01
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	55.00
55.01	05501	INFUSION CENTER	0.000000	55.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
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
69.01	06901	CARDIAC REHAB	0.000000	69.01
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 PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
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
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: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part I Date/Time Prepared: 5/29/2024 9:08 am
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	5,894,303	0	5,894,303	74,770	30.00
31.00	INTENSIVE CARE UNIT	449,326		449,326	7,609	31.00
31.01	NEONATAL ICU	60,305		60,305	2,024	31.01
40.00	SUBPROVIDER - IPF	80,270	0	80,270	1,312	40.00
41.00	SUBPROVIDER - IRF	551,843	0	551,843	3,461	41.00
43.00	NURSERY	413,992		413,992	2,108	43.00
200.00	Total (lines 30 through 199)	7,450,039		7,450,039	91,284	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	14,839	30.00
31.00	INTENSIVE CARE UNIT	1,895	31.00
31.01	NEONATAL ICU	0	31.01
40.00	SUBPROVIDER - IPF	256	40.00
41.00	SUBPROVIDER - IRF	808	41.00
43.00	NURSERY	0	43.00
200.00	Total (lines 30 through 199)	17,798	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Prepared: 5/29/2024 9:08 am
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Cost Center Description		Title XVIII			Hospital	PPS	
		Capital Related Cost (from Wkst. C, 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	1,182,300	198,209,654	0.005965	12,509,094	74,617	50.00
50.01	05001 ENDOSCOPY	16,907	9,905,306	0.001707	1,451,420	2,478	50.01
51.00	05100 RECOVERY ROOM	259,733	13,484,448	0.019262	560,674	10,800	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	184,930	6,722,192	0.027510	260,512	7,167	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	922,903	53,984,010	0.017096	3,297,379	56,372	54.00
54.01	05401 RADIOLOGY - ULTRASOUND	109,468	25,053,114	0.004369	1,553,747	6,788	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	159,416	28,977,173	0.005501	310,019	1,705	55.00
55.01	05501 INFUSION CENTER	97,582	17,592,973	0.005547	0	0	55.01
56.00	05600 RADIOISOTOPE	169,856	22,249,155	0.007634	1,211,431	9,248	56.00
57.00	05700 CT SCAN	234,461	169,872,853	0.001380	14,644,117	20,209	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	90,764	34,814,997	0.002607	2,861,102	7,459	58.00
59.00	05900 CARDIAC CATHETERIZATION	211,319	87,428,837	0.002417	12,319,988	29,777	59.00
60.00	06000 LABORATORY	574,033	238,657,576	0.002405	22,302,883	53,638	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	31,480	27,965,735	0.001126	1,810,654	2,039	62.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	180,692	54,544,456	0.003313	10,878,081	36,039	65.00
66.00	06600 PHYSICAL THERAPY	218,735	15,605,528	0.014017	1,628,033	22,820	66.00
67.00	06700 OCCUPATIONAL THERAPY	182,517	7,424,674	0.024582	975,505	23,980	67.00
68.00	06800 SPEECH PATHOLOGY	34,046	3,007,899	0.011319	673,310	7,621	68.00
69.00	06900 ELECTROCARDIOLOGY	22,705	32,626,784	0.000696	3,806,996	2,650	69.00
69.01	06901 CARDIAC REHAB	5,126	1,901,575	0.002696	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	33,964	45,787,304	0.000742	3,343,258	2,481	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	414,304	46,223,757	0.008963	6,123,600	54,886	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	390,895	43,272,141	0.009033	6,398,801	57,800	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	623,378	261,382,357	0.002385	19,737,113	47,073	73.00
74.00	07400 RENAL DIALYSIS	87,592	11,669,578	0.007506	2,549,642	19,138	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	1,272,236	13,364,701	0.095194	2,238	213	90.00
91.00	09100 EMERGENCY	713,158	131,133,709	0.005438	5,332,062	28,996	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	891,747	23,780,836	0.037499	1,317,791	49,416	92.00
200.00	Total (lines 50 through 199)	9,316,247	1,626,643,322		137,859,450	635,410	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part III Date/Time Prepared: 5/29/2024 9:08 am
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Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	PPS	
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	69,084	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
31.01	03101	NEONATAL ICU	0	0	0	0	0	31.01	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00	
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	69,084	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of col.s. 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	69,084	74,770	0.92	14,839	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	7,609	0.00	1,895	31.00	
31.01	03101	NEONATAL ICU		0	2,024	0.00	0	31.01	
40.00	04000	SUBPROVIDER - IPF	0	0	1,312	0.00	256	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	3,461	0.00	808	41.00	
43.00	04300	NURSERY		0	2,108	0.00	0	43.00	
200.00		Total (lines 30 through 199)		69,084	91,284		17,798	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	13,652						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
31.01	03101	NEONATAL ICU	0						31.01
40.00	04000	SUBPROVIDER - IPF	0						40.00
41.00	04100	SUBPROVIDER - IRF	0						41.00
43.00	04300	NURSERY	0						43.00
200.00		Total (lines 30 through 199)	13,652						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/29/2024 9:08 am
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Cost Center Description	Title XVIII			Hospital				
	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	69,084	50.00
50.01	05001	ENDOSCOPY	0	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	69,084	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	INFUSION CENTER	0	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	34,542	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	103,627	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
69.01	06901	CARDIAC REHAB	0	0	0	0	0	69.01
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 PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	1,256,475	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	10,454	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	1,543,266	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/29/2024 9:08 am
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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)	Title XVIII		Hospital		PPS	
				Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)		
								4.00	5.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	69,084	69,084	198,209,654	0.000349		50.00
50.01	05001	ENDOSCOPY	0	0	0	9,905,306	0.000000		50.01
51.00	05100	RECOVERY ROOM	0	0	0	13,484,448	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	69,084	69,084	6,722,192	0.010277		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	53,984,010	0.000000		54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0	0	0	25,053,114	0.000000		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	28,977,173	0.000000		55.00
55.01	05501	INFUSION CENTER	0	0	0	17,592,973	0.000000		55.01
56.00	05600	RADIOISOTOPE	0	0	0	22,249,155	0.000000		56.00
57.00	05700	CT SCAN	0	0	0	169,872,853	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	34,814,997	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	34,542	34,542	87,428,837	0.000395		59.00
60.00	06000	LABORATORY	0	0	0	238,657,576	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	27,965,735	0.000000		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0	103,627	103,627	54,544,456	0.001900		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	15,605,528	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	7,424,674	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,007,899	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	32,626,784	0.000000		69.00
69.01	06901	CARDIAC REHAB	0	0	0	1,901,575	0.000000		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	45,787,304	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	46,223,757	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	43,272,141	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	261,382,357	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	11,669,578	0.000000		74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	13,364,701	0.000000		90.00
91.00	09100	EMERGENCY	0	1,256,475	1,256,475	131,133,709	0.009582		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	10,454	10,454	23,780,836	0.000440		92.00
200.00		Total (lines 50 through 199)	0	1,543,266	1,543,266	1,626,643,322			200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/29/2024 9:08 am
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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	0.000349	12,509,094	4,366	17,903,088	6,248	50.00
50.01	05001 ENDOSCOPY	0.000000	1,451,420	0	910,662	0	50.01
51.00	05100 RECOVERY ROOM	0.000000	560,674	0	1,042,262	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.010277	260,512	2,677	314,311	3,230	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	3,297,379	0	3,928,315	0	54.00
54.01	05401 RADIOLOGY - ULTRASOUND	0.000000	1,553,747	0	1,211,643	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	310,019	0	5,733,646	0	55.00
55.01	05501 INFUSION CENTER	0.000000	0	0	2,714,566	0	55.01
56.00	05600 RADIOISOTOPE	0.000000	1,211,431	0	2,836,549	0	56.00
57.00	05700 CT SCAN	0.000000	14,644,117	0	13,027,528	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	2,861,102	0	3,436,864	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000395	12,319,988	4,866	5,297,885	2,093	59.00
60.00	06000 LABORATORY	0.000000	22,302,883	0	8,431,811	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	1,810,654	0	436,217	0	62.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.001900	10,878,081	20,668	350,989	667	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	1,628,033	0	42,045	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	975,505	0	18,255	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	673,310	0	23,706	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	3,806,996	0	2,227,890	0	69.00
69.01	06901 CARDIAC REHAB	0.000000	0	0	363,757	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	3,343,258	0	6,160,519	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	6,123,600	0	4,329,004	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	6,398,801	0	3,667,888	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	19,737,113	0	40,803,256	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	2,549,642	0	255,944	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	2,238	0	2,323,188	0	90.00
91.00	09100 EMERGENCY	0.009582	5,332,062	51,092	10,100,603	96,784	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000440	1,317,791	580	1,234,716	543	92.00
200.00	Total (lines 50 through 199)		137,859,450	84,249	139,127,107	109,565	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 5/29/2024 9:08 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.099290	17,903,088	0	0	1,777,598	50.00
50.01	05001	ENDOSCOPY	0.154036	910,662	0	0	140,275	50.01
51.00	05100	RECOVERY ROOM	0.223400	1,042,262	0	0	232,841	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.096450	314,311	0	0	344,626	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.192617	3,928,315	0	0	756,660	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0.134619	1,211,643	0	0	163,110	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.116400	5,733,646	0	0	667,396	55.00
55.01	05501	INFUSION CENTER	0.108199	2,714,566	0	0	293,713	55.01
56.00	05600	RADIOISOTOPE	0.145819	2,836,549	0	0	413,623	56.00
57.00	05700	CT SCAN	0.033308	13,027,528	0	0	433,921	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.056119	3,436,864	0	0	192,873	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.079397	5,297,885	0	0	420,636	59.00
60.00	06000	LABORATORY	0.090291	8,431,811	0	0	761,317	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.085774	436,217	0	0	37,416	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.133191	350,989	0	0	46,749	65.00
66.00	06600	PHYSICAL THERAPY	0.216905	42,045	0	0	9,120	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.301903	18,255	0	0	5,511	67.00
68.00	06800	SPEECH PATHOLOGY	0.275654	23,706	0	0	6,535	68.00
69.00	06900	ELECTROCARDIOLOGY	0.051727	2,227,890	0	0	115,242	69.00
69.01	06901	CARDIAC REHAB	0.451280	363,757	0	0	164,156	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.058505	6,160,519	0	0	360,421	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.455914	4,329,004	0	0	1,973,654	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.459597	3,667,888	0	0	1,685,750	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.220968	40,803,256	0	27,780	9,016,214	73.00
74.00	07400	RENAL DIALYSIS	0.254685	255,944	0	0	65,185	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.690158	2,323,188	0	0	1,603,367	90.00
91.00	09100	EMERGENCY	0.197496	10,100,603	0	0	1,994,829	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.499561	1,234,716	0	0	616,816	92.00
200.00		Subtotal (see instructions)		139,127,107	0	27,780	24,299,554	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		139,127,107	0	27,780	24,299,554	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 5/29/2024 9:08 am
		Title XVIII	Hospital	PPS

Cost Center Description	Costs				
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	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
50.01	05001	ENDOSCOPY	0	0	50.01
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
55.01	05501	INFUSION CENTER	0	0	55.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
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
69.01	06901	CARDIAC REHAB	0	0	69.01
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 PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,138	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
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)	0	0	92.00
200.00		Subtotal (see instructions)	0	6,138	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	6,138	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0002 Component CCN: 15-S002		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part II Date/Time Prepared: 5/29/2024 9:08 am	
Title XVIII				Subprovider - IPF		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	1,182,300	198,209,654	0.005965	0	50.00
50.01	05001	ENDOSCOPY	16,907	9,905,306	0.001707	0	50.01
51.00	05100	RECOVERY ROOM	259,733	13,484,448	0.019262	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	184,930	6,722,192	0.027510	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	922,903	53,984,010	0.017096	8,109	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	109,468	25,053,114	0.004369	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	159,416	28,977,173	0.005501	0	55.00
55.01	05501	INFUSION CENTER	97,582	17,592,973	0.005547	0	55.01
56.00	05600	RADIO SOTOPE	169,856	22,249,155	0.007634	0	56.00
57.00	05700	CT SCAN	234,461	169,872,853	0.001380	21,077	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	90,764	34,814,997	0.002607	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	211,319	87,428,837	0.002417	0	59.00
60.00	06000	LABORATORY	574,033	238,657,576	0.002405	52,169	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	31,480	27,965,735	0.001126	2,533	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	180,692	54,544,456	0.003313	666	65.00
66.00	06600	PHYSICAL THERAPY	218,735	15,605,528	0.014017	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	182,517	7,424,674	0.024582	264	67.00
68.00	06800	SPEECH PATHOLOGY	34,046	3,007,899	0.011319	0	68.00
69.00	06900	ELECTROCARDIOLOGY	22,705	32,626,784	0.000696	16,654	69.00
69.01	06901	CARDIAC REHAB	5,126	1,901,575	0.002696	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	33,964	45,787,304	0.000742	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	414,304	46,223,757	0.008963	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	390,895	43,272,141	0.009033	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	623,378	261,382,357	0.002385	96,317	73.00
74.00	07400	RENAL DIALYSIS	87,592	11,669,578	0.007506	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,272,236	13,364,701	0.095194	0	90.00
91.00	09100	EMERGENCY	713,158	131,133,709	0.005438	29,164	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	23,780,836	0.000000	0	92.00
200.00		Total (lines 50 through 199)	8,424,500	1,626,643,322		226,953	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/29/2024 9:08 am
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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	69,084	50.00
50.01	05001 ENDOSCOPY	0	0	0	0	0	50.01
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	69,084	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401 RADIOLOGY - ULTRASOUND	0	0	0	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501 INFUSION CENTER	0	0	0	0	0	55.01
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	34,542	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	103,627	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
69.01	06901 CARDIAC REHAB	0	0	0	0	0	69.01
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 PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	1,256,475	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50 through 199)	0	0	0	0	1,532,812	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/29/2024 9:08 am
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Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 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	69,084	69,084	198,209,654	0.000349	50.00
50.01	05001 ENDOSCOPY	0	0	0	9,905,306	0.000000	50.01
51.00	05100 RECOVERY ROOM	0	0	0	13,484,448	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	69,084	69,084	6,722,192	0.010277	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	53,984,010	0.000000	54.00
54.01	05401 RADIOLOGY - ULTRASOUND	0	0	0	25,053,114	0.000000	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	28,977,173	0.000000	55.00
55.01	05501 INFUSION CENTER	0	0	0	17,592,973	0.000000	55.01
56.00	05600 RADIOISOTOPE	0	0	0	22,249,155	0.000000	56.00
57.00	05700 CT SCAN	0	0	0	169,872,853	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	34,814,997	0.000000	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	34,542	34,542	87,428,837	0.000395	59.00
60.00	06000 LABORATORY	0	0	0	238,657,576	0.000000	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	27,965,735	0.000000	62.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500 RESPIRATORY THERAPY	0	103,627	103,627	54,544,456	0.001900	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	15,605,528	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	7,424,674	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	3,007,899	0.000000	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	32,626,784	0.000000	69.00
69.01	06901 CARDIAC REHAB	0	0	0	1,901,575	0.000000	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	45,787,304	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	46,223,757	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	43,272,141	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	261,382,357	0.000000	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	11,669,578	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	13,364,701	0.000000	90.00
91.00	09100 EMERGENCY	0	1,256,475	1,256,475	131,133,709	0.009582	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	23,780,836	0.000000	92.00
200.00	Total (lines 50 through 199)	0	1,532,812	1,532,812	1,626,643,322		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/29/2024 9:08 am
Title XVIII		Subprovider - IPF	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	0.000349	0	0	0	0	50.00
50.01 05001 ENDOSCOPY	0.000000	0	0	0	0	50.01
51.00 05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.010277	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.000000	8,109	0	0	0	54.00
54.01 05401 RADIOLOGY - ULTRASOUND	0.000000	0	0	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01 05501 INFUSION CENTER	0.000000	0	0	0	0	55.01
56.00 05600 RADIO SOTOPE	0.000000	0	0	0	0	56.00
57.00 05700 CT SCAN	0.000000	21,077	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.000395	0	0	0	0	59.00
60.00 06000 LABORATORY	0.000000	52,169	0	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	2,533	0	0	0	62.00
64.00 06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0.001900	666	1	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.000000	264	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.000000	16,654	0	0	0	69.00
69.01 06901 CARDIAC REHAB	0.000000	0	0	0	0	69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000	96,317	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.000000	0	0	0	0	90.00
91.00 09100 EMERGENCY	0.009582	29,164	279	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00 Total (lines 50 through 199)		226,953	280	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Prepared: 5/29/2024 9:08 am
Title XVIII			Subprovider - IRF	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	1,182,300	198,209,654	0.005965	8,244	49	50.00
50.01	05001 ENDOSCOPY	16,907	9,905,306	0.001707	3,480	6	50.01
51.00	05100 RECOVERY ROOM	259,733	13,484,448	0.019262	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	184,930	6,722,192	0.027510	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	922,903	53,984,010	0.017096	19,012	325	54.00
54.01	05401 RADIOLOGY - ULTRASOUND	109,468	25,053,114	0.004369	3,523	15	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	159,416	28,977,173	0.005501	0	0	55.00
55.01	05501 INFUSION CENTER	97,582	17,592,973	0.005547	0	0	55.01
56.00	05600 RADIO SOTOPE	169,856	22,249,155	0.007634	0	0	56.00
57.00	05700 CT SCAN	234,461	169,872,853	0.001380	37,354	52	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	90,764	34,814,997	0.002607	4,792	12	58.00
59.00	05900 CARDIAC CATHETERIZATION	211,319	87,428,837	0.002417	0	0	59.00
60.00	06000 LABORATORY	574,033	238,657,576	0.002405	303,232	729	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	31,480	27,965,735	0.001126	17,058	19	62.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	180,692	54,544,456	0.003313	181,528	601	65.00
66.00	06600 PHYSICAL THERAPY	218,735	15,605,528	0.014017	486,885	6,825	66.00
67.00	06700 OCCUPATIONAL THERAPY	182,517	7,424,674	0.024582	430,123	10,573	67.00
68.00	06800 SPEECH PATHOLOGY	34,046	3,007,899	0.011319	68,140	771	68.00
69.00	06900 ELECTROCARDIOLOGY	22,705	32,626,784	0.000696	27,947	19	69.00
69.01	06901 CARDIAC REHAB	5,126	1,901,575	0.002696	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	33,964	45,787,304	0.000742	3,956	3	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	414,304	46,223,757	0.008963	36,202	324	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	390,895	43,272,141	0.009033	2,279	21	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	623,378	261,382,357	0.002385	373,248	890	73.00
74.00	07400 RENAL DIALYSIS	87,592	11,669,578	0.007506	95,680	718	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	1,272,236	13,364,701	0.095194	0	0	90.00
91.00	09100 EMERGENCY	713,158	131,133,709	0.005438	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	23,780,836	0.000000	0	0	92.00
200.00	Total (lines 50 through 199)	8,424,500	1,626,643,322		2,102,683	21,952	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/29/2024 9:08 am
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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	69,084	50.00
50.01	05001 ENDOSCOPY	0	0	0	0	0	50.01
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	69,084	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401 RADIOLOGY - ULTRASOUND	0	0	0	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501 INFUSION CENTER	0	0	0	0	0	55.01
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	34,542	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	103,627	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
69.01	06901 CARDIAC REHAB	0	0	0	0	0	69.01
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 PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	1,256,475	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50 through 199)	0	0	0	0	1,532,812	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/29/2024 9:08 am
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Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 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	69,084	69,084	198,209,654	0.000349	50.00
50.01	05001 ENDOSCOPY	0	0	0	9,905,306	0.000000	50.01
51.00	05100 RECOVERY ROOM	0	0	0	13,484,448	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	69,084	69,084	6,722,192	0.010277	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	53,984,010	0.000000	54.00
54.01	05401 RADIOLOGY - ULTRASOUND	0	0	0	25,053,114	0.000000	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	28,977,173	0.000000	55.00
55.01	05501 INFUSION CENTER	0	0	0	17,592,973	0.000000	55.01
56.00	05600 RADIOISOTOPE	0	0	0	22,249,155	0.000000	56.00
57.00	05700 CT SCAN	0	0	0	169,872,853	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	34,814,997	0.000000	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	34,542	34,542	87,428,837	0.000395	59.00
60.00	06000 LABORATORY	0	0	0	238,657,576	0.000000	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	27,965,735	0.000000	62.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500 RESPIRATORY THERAPY	0	103,627	103,627	54,544,456	0.001900	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	15,605,528	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	7,424,674	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	3,007,899	0.000000	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	32,626,784	0.000000	69.00
69.01	06901 CARDIAC REHAB	0	0	0	1,901,575	0.000000	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	45,787,304	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	46,223,757	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	43,272,141	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	261,382,357	0.000000	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	11,669,578	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	13,364,701	0.000000	90.00
91.00	09100 EMERGENCY	0	1,256,475	1,256,475	131,133,709	0.009582	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	23,780,836	0.000000	92.00
200.00	Total (lines 50 through 199)	0	1,532,812	1,532,812	1,626,643,322		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/29/2024 9:08 am
Title XVIII		Subprovider - IRF	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	0.000349	8,244	3	0	0	50.00
50.01 05001 ENDOSCOPY	0.000000	3,480	0	0	0	50.01
51.00 05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.010277	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.000000	19,012	0	0	0	54.00
54.01 05401 RADIOLOGY - ULTRASOUND	0.000000	3,523	0	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01 05501 INFUSION CENTER	0.000000	0	0	0	0	55.01
56.00 05600 RADIO SOTOPE	0.000000	0	0	0	0	56.00
57.00 05700 CT SCAN	0.000000	37,354	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	4,792	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.000395	0	0	0	0	59.00
60.00 06000 LABORATORY	0.000000	303,232	0	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	17,058	0	0	0	62.00
64.00 06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0.001900	181,528	345	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.000000	486,885	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.000000	430,123	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	68,140	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.000000	27,947	0	0	0	69.00
69.01 06901 CARDIAC REHAB	0.000000	0	0	0	0	69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	3,956	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	36,202	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	2,279	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000	373,248	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0.000000	95,680	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.000000	0	0	0	0	90.00
91.00 09100 EMERGENCY	0.009582	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00 Total (lines 50 through 199)		2,102,683	348	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/29/2024 9:08 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		74,770	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		74,770	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)		63,458	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)		14,839	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)		78,524,304	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)		78,524,304	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)		78,524,304	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)		1,050.21	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		15,584,066	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)		15,584,066	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002		Period: From 01/01/2023 To 12/31/2023		Worksheet D-1	
		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	13,771,115	7,609	1,809.85	1,895	3,429,666	43.00
43.01	NEONATAL ICU	3,013,716	2,024	1,488.99	0	0	43.01
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)					21,859,952	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)					40,873,684	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)					1,295,310	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					719,659	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,014,969	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					38,858,715	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)					11,312	87.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002		Period: From 01/01/2023 To 12/31/2023		Worksheet D-1 Date/Time Prepared: 5/29/2024 9:08 am	
Cost Center Description		Title XVIII		Hospital		PPS	
						1.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,050.21	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					11,879,976	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	5,894,303	78,524,304	0.075063	11,879,976	891,747	90.00
91.00	Nursing Program cost	0	78,524,304	0.000000	11,879,976	0	91.00
92.00	Allied health cost	69,084	78,524,304	0.000880	11,879,976	10,454	92.00
93.00	All other Medical Education	0	78,524,304	0.000000	11,879,976	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/29/2024 9:08 am
		Title XVIII	Subprovider - IPF	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)		1,312	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,312	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)		1,312	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)		256	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)		1,884,886	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)		1,884,886	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)		1,884,886	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)		1,436.65	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		367,782	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)		367,782	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1	
				Component CCN: 15-S002	Date/Time Prepared: 5/29/2024 9:08 am		
				Title XVIII	Subprovider - IPF	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	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
43.01 NEONATAL ICU	0	0	0.00	0	0	0	43.01
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)					35,264		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)					403,046		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)					15,662		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					985		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					16,647		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					386,399		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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/29/2024 9:08 am		
		Title XVIII	Subprovider - IPF	PPS		
Cost Center Description			1.00			
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)			0	87.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)			0.00	88.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)			0	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	80,270	1,884,886	0.042586	0	90.00
91.00	Nursing Program cost	0	1,884,886	0.000000	0	91.00
92.00	Allied health cost	0	1,884,886	0.000000	0	92.00
93.00	All other Medical Education	0	1,884,886	0.000000	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/29/2024 9:08 am
		Title XVIII	Subprovider - IRF	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)		3,461	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,461	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)		3,461	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)		808	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)		4,879,945	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)		4,879,945	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)		4,879,945	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)		1,409.98	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,139,264	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)		1,139,264	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1	
				Component CCN: 15-T002	Date/Time Prepared: 5/29/2024 9:08 am		
				Title XVIII	Subprovider - IRF	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	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
43.01 NEONATAL ICU	0	0	0.00	0	0	0	43.01
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)					440,343		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)					1,579,607		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)					128,836		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					22,300		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					151,136		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,428,471		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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/29/2024 9:08 am		
		Title XVIII	Subprovider - IRF	PPS		
Cost Center Description			1.00			
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)			0	87.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)			0.00	88.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)			0	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	551,843	4,879,945	0.113084	0	90.00
91.00	Nursing Program cost	0	4,879,945	0.000000	0	91.00
92.00	Allied health cost	0	4,879,945	0.000000	0	92.00
93.00	All other Medical Education	0	4,879,945	0.000000	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/29/2024 9:08 am
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			74,770 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			74,770 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)			63,458 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)			3,385 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)			2,108 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)			78,524,304 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)			78,524,304 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)			78,524,304 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)			1,050.21 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			3,554,961 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)			3,554,961 41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/29/2024 9:08 am	
			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)	3,516,115	2,108	1,667.99	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	13,771,115	7,609	1,809.85	0	0	43.00
43.01 NEONATAL ICU	3,013,716	2,024	1,488.99	0	0	43.01
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)					3,658,233	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)					7,213,194	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)					11,312	87.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002		Period: From 01/01/2023 To 12/31/2023		Worksheet D-1 Date/Time Prepared: 5/29/2024 9:08 am	
Cost Center Description		Title XIX		Hospital		Cost	
						1.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,050.21	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					11,879,976	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	5,894,303	78,524,304	0.075063	11,879,976	891,747	90.00
91.00	Nursing Program cost	0	78,524,304	0.000000	11,879,976	0	91.00
92.00	Allied health cost	0	78,524,304	0.000000	11,879,976	0	92.00
93.00	All other Medical Education	0	78,524,304	0.000000	11,879,976	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/29/2024 9:08 am
		Title XIX	Subprovider - IPF	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)			1,312 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,312 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)			1,312 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)			41 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)			2,108 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)			1,884,886 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)			1,884,886 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)			1,884,886 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)			1,436.65 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			58,903 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)			58,903 41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1	
				Component CCN: 15-S002		Date/Time Prepared: 5/29/2024 9:08 am	
				Title XIX	Subprovider - IPF	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)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
43.01 NEONATAL ICU	0	0	0.00	0	0	0	43.01
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)					48,589	0	48.00
48.01 Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0	0	48.01
49.00 Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					107,492	0	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	0.00	55.00
55.01 Permanent adjustment amount per discharge					0.00	0.00	55.01
55.02 Adjustment amount per discharge (contractor use only)					0.00	0.00	55.02
56.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02)					0	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	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	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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/29/2024 9:08 am		
		Title XIX	Subprovider - IPF	Cost		
Cost Center Description			1.00			
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)			0	87.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)			0.00	88.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)			0	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	80,270	1,884,886	0.042586	0	90.00
91.00	Nursing Program cost	0	1,884,886	0.000000	0	91.00
92.00	Allied health cost	0	1,884,886	0.000000	0	92.00
93.00	All other Medical Education	0	1,884,886	0.000000	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/29/2024 9:08 am
		Title XIX	Subprovider - IRF	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)			3,461 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,461 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)			3,461 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)			48 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)			2,108 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)			4,879,945 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)			4,879,945 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)			4,879,945 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)			1,409.98 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			67,679 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)			67,679 41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1	
				Component CCN: 15-T002	Date/Time Prepared: 5/29/2024 9:08 am		
				Title XIX	Subprovider - IRF	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)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
43.01 NEONATAL ICU	0	0	0.00	0	0	0	43.01
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)					192,612	0	48.00
48.01 Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0	0	48.01
49.00 Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					260,291	0	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	0.00	55.00
55.01 Permanent adjustment amount per discharge					0.00	0.00	55.01
55.02 Adjustment amount per discharge (contractor use only)					0.00	0.00	55.02
56.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02)					0	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	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	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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/29/2024 9:08 am		
		Title XIX	Subprovider - IRF	Cost		
Cost Center Description						
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)			0	87.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)			0.00	88.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)			0	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	551,843	4,879,945	0.113084	0	90.00
91.00	Nursing Program cost	0	4,879,945	0.000000	0	91.00
92.00	Allied health cost	0	4,879,945	0.000000	0	92.00
93.00	All other Medical Education	0	4,879,945	0.000000	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 5/29/2024 9:08 am	
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		19,014,874	30.00
31.00	03100	INTENSIVE CARE UNIT		5,428,809	31.00
31.01	03101	NEONATAL ICU		0	31.01
40.00	04000	SUBPROVIDER - IPF		445,868	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.099290	12,509,094	50.00
50.01	05001	ENDOSCOPY	0.154036	1,451,420	50.01
51.00	05100	RECOVERY ROOM	0.223400	560,674	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.096450	260,512	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.192617	3,297,379	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0.134619	1,553,747	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.116400	310,019	55.00
55.01	05501	INFUSION CENTER	0.108199	0	55.01
56.00	05600	RADIOISOTOPE	0.145819	1,211,431	56.00
57.00	05700	CT SCAN	0.033308	14,644,117	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.056119	2,861,102	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.079397	12,319,988	59.00
60.00	06000	LABORATORY	0.090291	22,302,883	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.085774	1,810,654	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.133191	10,878,081	65.00
66.00	06600	PHYSICAL THERAPY	0.216905	1,628,033	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.301903	975,505	67.00
68.00	06800	SPEECH PATHOLOGY	0.275654	673,310	68.00
69.00	06900	ELECTROCARDIOLOGY	0.051727	3,806,996	69.00
69.01	06901	CARDIAC REHAB	0.451280	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.058505	3,343,258	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.455914	6,123,600	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.459597	6,398,801	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.220968	19,737,113	73.00
74.00	07400	RENAL DIALYSIS	0.254685	2,549,642	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.690158	2,238	90.00
91.00	09100	EMERGENCY	0.197496	5,332,062	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.499561	1,317,791	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		137,859,450	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)		137,859,450	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 5/29/2024 9:08 am
		Title XVIII	Subprovider - IPF	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			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
31.01	03101 NEONATAL ICU			31.01
40.00	04000 SUBPROVIDER - IPF		527,577	40.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.099290	0	50.00
50.01	05001 ENDOSCOPY	0.154036	0	50.01
51.00	05100 RECOVERY ROOM	0.223400	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.096450	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.192617	8,109	54.00
54.01	05401 RADIOLOGY - ULTRASOUND	0.134619	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.116400	0	55.00
55.01	05501 INFUSION CENTER	0.108199	0	55.01
56.00	05600 RADIOISOTOPE	0.145819	0	56.00
57.00	05700 CT SCAN	0.033308	21,077	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.056119	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.079397	0	59.00
60.00	06000 LABORATORY	0.090291	52,169	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.085774	2,533	62.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.133191	666	65.00
66.00	06600 PHYSICAL THERAPY	0.216905	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.301903	264	67.00
68.00	06800 SPEECH PATHOLOGY	0.275654	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.051727	16,654	69.00
69.01	06901 CARDIAC REHAB	0.451280	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.058505	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.455914	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.459597	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.220968	96,317	73.00
74.00	07400 RENAL DIALYSIS	0.254685	0	74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.690158	0	90.00
91.00	09100 EMERGENCY	0.197496	29,164	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.499561	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		226,953	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)		226,953	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 5/29/2024 9:08 am
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			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
31.01	03101 NEONATAL ICU			31.01
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF		952,535	41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.099290	8,244	819 50.00
50.01	05001 ENDOSCOPY	0.154036	3,480	536 50.01
51.00	05100 RECOVERY ROOM	0.223400	0	0 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.096450	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.192617	19,012	3,662 54.00
54.01	05401 RADIOLOGY - ULTRASOUND	0.134619	3,523	474 54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.116400	0	0 55.00
55.01	05501 INFUSION CENTER	0.108199	0	0 55.01
56.00	05600 RADIOISOTOPE	0.145819	0	0 56.00
57.00	05700 CT SCAN	0.033308	37,354	1,244 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.056119	4,792	269 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.079397	0	0 59.00
60.00	06000 LABORATORY	0.090291	303,232	27,379 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.085774	17,058	1,463 62.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0 64.00
65.00	06500 RESPIRATORY THERAPY	0.133191	181,528	24,178 65.00
66.00	06600 PHYSICAL THERAPY	0.216905	486,885	105,608 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.301903	430,123	129,855 67.00
68.00	06800 SPEECH PATHOLOGY	0.275654	68,140	18,783 68.00
69.00	06900 ELECTROCARDIOLOGY	0.051727	27,947	1,446 69.00
69.01	06901 CARDIAC REHAB	0.451280	0	0 69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.058505	3,956	231 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.455914	36,202	16,505 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.459597	2,279	1,047 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.220968	373,248	82,476 73.00
74.00	07400 RENAL DIALYSIS	0.254685	95,680	24,368 74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.690158	0	0 90.00
91.00	09100 EMERGENCY	0.197496	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.499561	0	0 92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		2,102,683	440,343 200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00	Net charges (line 200 minus line 201)		2,102,683	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 5/29/2024 9:08 am	
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		3,475,468	30.00
31.00	03100	INTENSIVE CARE UNIT		815,930	31.00
31.01	03101	NEONATAL ICU		747,836	31.01
40.00	04000	SUBPROVIDER - IPF		88,590	40.00
41.00	04100	SUBPROVIDER - IRF		148,105	41.00
43.00	04300	NURSERY		321,749	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.099290	3,182,205	315,961 50.00
50.01	05001	ENDOSCOPY	0.154036	204,772	31,542 50.01
51.00	05100	RECOVERY ROOM	0.223400	184,901	41,307 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.096450	566,936	621,617 52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.192617	482,993	93,033 54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0.134619	262,576	35,348 54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.116400	47,568	5,537 55.00
55.01	05501	INFUSION CENTER	0.108199	1,156	125 55.01
56.00	05600	RADIOISOTOPE	0.145819	215,987	31,495 56.00
57.00	05700	CT SCAN	0.033308	2,275,596	75,796 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.056119	454,660	25,515 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.079397	2,197,488	174,474 59.00
60.00	06000	LABORATORY	0.090291	4,378,141	395,307 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.085774	160,848	13,797 62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0.133191	1,930,246	257,091 65.00
66.00	06600	PHYSICAL THERAPY	0.216905	243,804	52,882 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.301903	177,043	53,450 67.00
68.00	06800	SPEECH PATHOLOGY	0.275654	62,163	17,135 68.00
69.00	06900	ELECTROCARDIOLOGY	0.051727	563,437	29,145 69.00
69.01	06901	CARDIAC REHAB	0.451280	14,425	6,510 69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.058505	407,386	23,834 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.455914	349,266	159,235 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.459597	349,266	160,522 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.220968	3,598,112	795,068 73.00
74.00	07400	RENAL DIALYSIS	0.254685	248,505	63,290 74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.690158	464	320 90.00
91.00	09100	EMERGENCY	0.197496	905,827	178,897 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.499561	0	0 92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		23,465,771	3,658,233 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net charges (line 200 minus line 201)		23,465,771	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3	
		Component CCN: 15-S002		Date/Time Prepared: 5/29/2024 9:08 am	
		Title XIX	Subprovider - IPF	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			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
31.01	03101	NEONATAL ICU			31.01
40.00	04000	SUBPROVIDER - IPF		585,543	40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.099290	0	50.00
50.01	05001	ENDOSCOPY	0.154036	0	50.01
51.00	05100	RECOVERY ROOM	0.223400	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.096450	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.192617	19,893	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0.134619	323	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.116400	0	55.00
55.01	05501	INFUSION CENTER	0.108199	0	55.01
56.00	05600	RADIOISOTOPE	0.145819	0	56.00
57.00	05700	CT SCAN	0.033308	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.056119	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.079397	0	59.00
60.00	06000	LABORATORY	0.090291	106,176	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.085774	4,755	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.133191	0	65.00
66.00	06600	PHYSICAL THERAPY	0.216905	4,628	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.301903	1,576	67.00
68.00	06800	SPEECH PATHOLOGY	0.275654	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.051727	28,660	69.00
69.01	06901	CARDIAC REHAB	0.451280	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.058505	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.455914	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.459597	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.220968	108,996	73.00
74.00	07400	RENAL DIALYSIS	0.254685	0	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.690158	0	90.00
91.00	09100	EMERGENCY	0.197496	38,848	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.499561	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		313,855	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)		313,855	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 5/29/2024 9:08 am	
Cost Center Description		Title XIX	Subprovider - IRF	Cost	
		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			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
31.01	03101	NEONATAL ICU			31.01
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY		432,283	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.099290	3,304	328 50.00
50.01	05001	ENDOSCOPY	0.154036	0	0 50.01
51.00	05100	RECOVERY ROOM	0.223400	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.096450	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.192617	12,511	2,410 54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0.134619	2,126	286 54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.116400	0	0 55.00
55.01	05501	INFUSION CENTER	0.108199	0	0 55.01
56.00	05600	RADIOISOTOPE	0.145819	0	0 56.00
57.00	05700	CT SCAN	0.033308	19,901	663 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.056119	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.079397	0	0 59.00
60.00	06000	LABORATORY	0.090291	115,174	10,399 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.085774	3,346	287 62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0.133191	70,588	9,402 65.00
66.00	06600	PHYSICAL THERAPY	0.216905	227,062	49,251 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.301903	199,086	60,105 67.00
68.00	06800	SPEECH PATHOLOGY	0.275654	25,002	6,892 68.00
69.00	06900	ELECTROCARDIOLOGY	0.051727	410	21 69.00
69.01	06901	CARDIAC REHAB	0.451280	0	0 69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.058505	281	16 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.455914	12,266	5,592 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.459597	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.220968	203,122	44,883 73.00
74.00	07400	RENAL DIALYSIS	0.254685	8,155	2,077 74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.690158	0	0 90.00
91.00	09100	EMERGENCY	0.197496	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.499561	0	0 92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		902,334	192,612 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net charges (line 200 minus line 201)		902,334	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/29/2024 9:08 am
		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)		20,273,506	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		6,070,066	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)		1,298,509	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		138,968	2.04
3.00	Managed Care Simulated Payments		36,406,528	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		373.53	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)		8.53	5.00
5.01	FTE cap adjustment for qualifying 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)		8.53	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		2.86	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)		2.86	12.00
13.00	Total allowable FTE count for the prior year.		3.00	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.		3.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		2.95	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		2.95	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.007898	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.008043	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.007898	21.00
22.00	IME payment adjustment (see instructions)		113,488	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		156,839	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)		-5.67	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)		113,488	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		156,839	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		8.43	30.00
31.00	Percentage of Medicaid patient days (see instructions)		33.45	31.00
32.00	Sum of lines 30 and 31		41.88	32.00
33.00	Allowable disproportionate share percentage (see instructions)		23.77	33.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/29/2024 9:08 am
		Title XVIII	Hospital	PPS
				1.00
34.00	Disproportionate share adjustment (see instructions)			1,565,467 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)	3,397,293	2,666,360	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	2,540,988	670,232	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	3,211,220		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)	32,671,224		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)		32,828,063	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,233,437	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).		90,134	52.00
53.00	Nursing and Allied Health Managed Care payment		49,002	53.00
54.00	Special add-on payments for new technologies		227,700	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 instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		13,652	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		84,249	58.00
59.00	Total (sum of amounts on lines 49 through 58)		35,526,237	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		35,526,237	61.00
62.00	Deductibles billed to program beneficiaries		2,415,576	62.00
63.00	Coinsurance billed to program beneficiaries		357,810	63.00
64.00	Allowable bad debts (see instructions)		422,130	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		274,385	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		77,508	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		33,027,236	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)		0	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)		-71,780	70.93
70.94	HRR adjustment amount (see instructions)		-102,348	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/29/2024 9:08 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
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	1.00	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)			77,073	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			32,776,035	71.00
71.01	Sequestration adjustment (see instructions)			655,521	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			31,213,645	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)			906,869	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			921,851	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)				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	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	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	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
Comparison 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

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0002

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/29/2024 9:08 am

		Title XVIII			Hospital		PPS	
	W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)		
	0	1.00	2.00	3.00	4.00	5.00		
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	1.00	
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	20,273,506	0	20,273,506	20,273,506	1.01	
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	6,070,066	0	6,070,066	6,070,066	1.02	
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	1.03	
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	1.04	
2.00	Outlier payments for discharges (see instructions)	2.00					2.00	
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01	
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	1,298,509	0	1,298,509	1,298,509	2.02	
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	138,968	0	138,968	138,968	2.03	
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00	
4.00	Managed care simulated payments	3.00	36,406,528	0	27,801,104	8,605,424	4.00	
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.007898	0.007898	0.007898	0.007898	5.00	
6.00	IME payment adjustment (see instructions)	22.00	113,488	0	87,338	26,150	6.00	
6.01	IME payment adjustment for managed care (see instructions)	22.01	156,839	0	119,767	37,072	6.01	
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	7.00	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00	
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01	
9.00	Total IME payment (sum of lines 6 and 8)	29.00	113,488	0	87,338	26,150	9.00	
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	156,839	0	119,767	37,072	9.01	
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.2377	0.2377	0.2377	0.2377	10.00	
11.00	Disproportionate share adjustment (see instructions)	34.00	1,565,467	0	1,204,753	360,714	11.00	
11.01	Uncompensated care payments	36.00	3,211,220	0	2,540,988	670,232	11.01	
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00	
13.00	Subtotal (see instructions)	47.00	32,671,224	0	25,405,094	7,266,130	13.00	
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00	
15.00	Total payment for inpatient operating costs (see instructions)	49.00	32,828,063	0	25,524,861	7,303,202	15.00	

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0002

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/29/2024 9:08 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,233,437	0	1,718,163	515,274	2,233,437	16.00
17.00	Special add-on payments for new technologies	54.00	227,700	0	222,127	5,572	227,699	17.00
17.01	Net organ acquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	27,465,151	7,824,048	35,289,199	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,996,818	0	1,526,115	470,703	1,996,818	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	51,514	0	50,577	937	51,514	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0042	0.0042	0.0042	0.0042		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	8,387	0	6,410	1,977	8,387	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0885	0.0885	0.0885	0.0885		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	176,718	0	135,061	41,657	176,718	25.00
26.00	Total prospective capital payments (see instructions)	12.00	2,233,437	0	1,718,163	515,274	2,233,437	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 15-0002		Period: From 01/01/2023 To 12/31/2023		Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/29/2024 9:08 am	
		Title XVIII		Hospital		PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	20,273,506	20,273,506		20,273,506	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	6,070,066		6,070,066	6,070,066	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	1,298,509	1,298,509		1,298,509	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	138,968		138,968	138,968	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	36,406,528	27,801,105	8,605,423	36,406,528	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.007898	0.007898	0.007898		5.00
6.00	IME payment adjustment (see instructions)	22.00	113,488	87,338	26,150	113,488	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	156,839	119,767	37,072	156,839	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	113,488	87,338	26,150	113,488	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	156,839	119,767	37,072	156,839	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.2377	0.2377	0.2377		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	1,565,467	1,204,753	360,714	1,565,467	11.00
11.01	Uncompensated care payments	36.00	3,211,220	2,540,988	670,232	3,211,220	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	32,671,224	25,405,094	7,266,130	32,671,224	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	32,828,063	25,524,861	7,303,202	32,828,063	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,233,437	1,718,163	515,274	2,233,437	16.00
17.00	Special add-on payments for new technologies	54.00	227,700	222,128	5,572	227,700	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			27,465,152	7,824,048	35,289,200	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/29/2024 9:08 am
		Title XVIII	Hospital	PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,996,818	1,526,115	470,703	1,996,818	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	51,514	50,577	937	51,514	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0042	0.0042	0.0042		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	8,387	6,410	1,977	8,387	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0885	0.0885	0.0885		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	176,718	135,061	41,657	176,718	25.00
26.00	Total prospective capital payments (see instructions)	12.00	2,233,437	1,718,163	515,274	2,233,437	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-71,780	0	-71,780	-71,780	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-102,348	-57,388	-44,960	-102,348	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	77,073	77,073	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/29/2024 9:08 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		6,138	1.00
2.00	Medical and other services reimbursed under OPPTS (see instructions)		24,189,989	2.00
3.00	OPPTS or REH payments		24,335,945	3.00
4.00	Outlier payment (see instructions)		139,053	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		109,565	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		6,138	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		27,780	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)		27,780	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 charge basis 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)		27,780	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		21,642	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)		6,138	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)		24,584,563	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)		4,118,486	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)		20,472,215	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		51,107	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)		20,523,322	30.00
31.00	Primary payer payments		5,462	31.00
32.00	Subtotal (line 30 minus line 31)		20,517,860	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)		604,015	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		392,610	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		434,155	36.00
37.00	Subtotal (see instructions)		20,910,470	37.00
38.00	MSP-LCC reconciliation amount from PS&R		72	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	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)		20,910,398	40.00
40.01	Sequestration adjustment (see instructions)		418,208	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		20,552,385	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)		0	42.01
43.00	Balance due provider/program (see instructions)		-60,195	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: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/29/2024 9:08 am
		Title XVIII	Hospital	PPS
				1.00
94.00	Total (sum of lines 91 and 93)			0 94.00
				1.00
200.00	MEDICARE PART B ANCILLARY COSTS Part B Combined Billed Days			0 200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 15-0002		Period: From 01/01/2023 To 12/31/2023		Worksheet E-1 Part I Date/Time Prepared: 5/29/2024 9:08 am	
		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		30,332,151		19,947,554	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	12/31/2023	739,994	12/31/2023	447,931	3.01	
3.02		12/31/2023	141,500	12/31/2023	156,900	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)		881,494		604,831	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)		31,213,645		20,552,385	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		906,869		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		60,195	6.02	
7.00	Total Medicare program liability (see instructions)		32,120,514		20,492,190	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part I Date/Time Prepared: 5/29/2024 9:08 am	
		Title XVIII	Subprovider - IPF	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 1.00
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		214,145		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)				0 3.00
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		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	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		0 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)		214,145		0 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)				0 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)				0 6.00
6.01	SETTLEMENT TO PROVIDER		2,212		0 6.01
6.02	SETTLEMENT TO PROGRAM		0		0 6.02
7.00	Total Medicare program liability (see instructions)		216,357		0 7.00
				Contractor Number	NPR Date (Mo/Day/Yr)
			0	1.00	2.00
8.00	Name of Contractor				0 8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part I Date/Time Prepared: 5/29/2024 9:08 am	
		Title XVIII	Subprovider - IRF	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 1.00
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		1,645,637		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)				0 3.00
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		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	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		0 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)		1,645,637		0 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)				0 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)				0 6.00
6.01	SETTLEMENT TO PROVIDER		25,886		0 6.01
6.02	SETTLEMENT TO PROGRAM		0		0 6.02
7.00	Total Medicare program liability (see instructions)		1,671,523		0 7.00
				Contractor Number	NPR Date (Mo/Day/Yr)
			0	1.00	2.00
8.00	Name of Contractor				0 8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/29/2024 9:08 am
		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 IPSS & 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: 15-0002 Component CCN: 15-S002	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part II Date/Time Prepared: 5/29/2024 9:08 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		234,214	1.00
2.00	Net IPF PPS Outlier Payments		6,702	2.00
3.00	Net IPF PPS ECT Payments		0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		3.594521	9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1)\}$.		0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		240,916	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		0	14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00
16.00	Subtotal (see instructions)		240,916	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		240,916	18.00
19.00	Deductibles		17,600	19.00
20.00	Subtotal (line 18 minus line 19)		223,316	20.00
21.00	Coinsurance		4,800	21.00
22.00	Subtotal (line 20 minus line 21)		218,516	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		3,040	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		1,976	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	25.00
26.00	Subtotal (sum of lines 22 and 24)		220,492	26.00
27.00	Direct graduate medical education payments (see instructions)		0	27.00
28.00	Other pass through costs (see instructions)		280	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	30.50
30.98	Recovery of accelerated depreciation.		0	30.98
30.99	Demonstration payment adjustment amount before sequestration		0	30.99
31.00	Total amount payable to the provider (see instructions)		220,772	31.00
31.01	Sequestration adjustment (see instructions)		4,415	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	31.02
32.00	Interim payments		214,145	32.00
33.00	Tentative settlement (for contractor use only)		0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)		2,212	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		6,702	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00
FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)				
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.		0.000000	99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)		0.000000	99.01

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part III Date/Time Prepared: 5/29/2024 9:08 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			1,565,851 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0313 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			140,613 3.00
4.00	Outlier Payments			23,693 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			9.482192 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			1,730,157 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			1,730,157 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			1,730,157 19.00
20.00	Deductibles			16,000 20.00
21.00	Subtotal (line 19 minus line 20)			1,714,157 21.00
22.00	Coinurance			15,600 22.00
23.00	Subtotal (line 21 minus line 22)			1,698,557 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			10,356 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			6,731 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			8,800 26.00
27.00	Subtotal (sum of lines 23 and 25)			1,705,288 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			348 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.98	Recovery of accelerated depreciation.			0 31.98
31.99	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			1,705,636 32.00
32.01	Sequestration adjustment (see instructions)			34,113 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			1,645,637 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			25,886 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			23,693 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00
FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)				
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.			0.000000 99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)			0.000000 99.01

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/29/2024 9:08 am	
		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		7,213,194		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)		7,213,194	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)		7,213,194	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		5,597,680		8.00
9.00	Ancillary service charges		23,465,771	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)		29,063,451	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)		29,063,451	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		21,850,257	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)		7,213,194	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)		7,213,194	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)		7,213,194	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		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)		7,213,194	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		7,213,194	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)		7,213,194	0	40.00
41.00	Interim payments		8,796,637	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		-1,583,443	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/29/2024 9:08 am
		Title XIX	Subprovider - IPF	Cost
		Inpatient 1.00	Outpatient 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	107,492		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)	107,492	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)	107,492	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	585,543		8.00
9.00	Ancillary service charges	313,855	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)	899,398	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)	899,398	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	791,906	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)	107,492	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	0	24.00
25.00	Capital exception payments (see instructions)	0	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)	107,492	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)	107,492	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	107,492	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	107,492	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	107,492	0	40.00
41.00	Interim payments	272,221	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-164,729	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/29/2024 9:08 am
		Title XIX	Subprovider - IRF	Cost
		Inpatient 1.00	Outpatient 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	260,291		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)	260,291	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)	260,291	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	432,283		8.00
9.00	Ancillary service charges	902,334	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)	1,334,617	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)	1,334,617	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,074,326	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)	260,291	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	0	24.00
25.00	Capital exception payments (see instructions)	0	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)	260,291	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)	260,291	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	260,291	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	260,291	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	260,291	0	40.00
41.00	Interim payments	403,949	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-143,658	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

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet E-4 Date/Time Prepared: 5/29/2024 9:08 am	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			10.83	1.00
1.01	FTE cap adjustment under §131 of the CAA 2021 (see instructions)			0.00	1.01
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
2.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)			0.00	2.26
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
3.02	Adjustment (increase or decrease) to the hospital's rural track FTE limitation(s) for rural track programs with a rural track Medicare GME affiliation agreement in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)			0.00	3.02
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
4.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)			0.00	4.21
5.00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lines 2.26 through 2.49, minus lines 3 and 3.01, plus or minus line 3.02, plus or minus line 4, plus lines 4.01 through 4.27			10.83	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			2.86	6.00
7.00	Enter the lesser of line 5 or line 6			2.86	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	2.36	2.36	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6. For cost reporting periods beginning on or after October 1, 2022, or if Worksheet S-2, Part I, line 68, is "Y", see instructions.	0.00	2.36	2.36	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	2.36		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	2.50		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	2.50		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	2.45		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.00	2.45		17.00
18.00	Per resident amount	0.00	104,254.31		18.00
18.01	Per resident amount under §131 of the CAA 2021	0.00	0.00		18.01
19.00	Approved amount for resident costs	0	255,423	255,423	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			104,254.31	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			255,423	25.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet E-4 Date/Time Prepared: 5/29/2024 9:08 am
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		Title XVIII		Hospital		PPS	
		Inpatient Part A	Managed Care	Total			
		1.00	2.00	3.00			
COMPUTATION OF PROGRAM PATIENT LOAD							
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	17,798	26,144				26.00
27.00	Total Inpatient Days (see instructions)	77,920	77,920				27.00
28.00	Ratio of inpatient days to total inpatient days	0.228414	0.335524				28.00
29.00	Program direct GME amount	58,342	85,701		144,043		29.00
29.01	Percent reduction for MA DGME		3.27				29.01
30.00	Reduction for direct GME payments for Medicare Advantage		2,802		2,802		30.00
31.00	Net Program direct GME amount				141,241		31.00
						1.00	
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS)							
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)				0		32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)				11,669,578		33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)				0.000000		34.00
35.00	Medicare outpatient ESRD charges (see instructions)				0		35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)				0		36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY							
Part A Reasonable Cost							
37.00	Reasonable cost (see instructions)				42,856,337		37.00
38.00	Organ acquisition and HSCT acquisition costs (see instructions)				0		38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)				0		39.00
40.00	Primary payer payments (see instructions)				0		40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)				42,856,337		41.00
Part B Reasonable Cost							
42.00	Reasonable cost (see instructions)				24,305,692		42.00
43.00	Primary payer payments (see instructions)				5,462		43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)				24,300,230		44.00
45.00	Total reasonable cost (sum of lines 41 and 44)				67,156,567		45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)				0.638156		46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)				0.361844		47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B							
48.00	Total program GME payment (line 31)				141,241		48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)				90,134		49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)				51,107		50.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT		Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet E-5 Date/Time Prepared: 5/29/2024 9:08 am
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. 1, 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: 15-0002

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

Worksheet G

Date/Time Prepared:
5/29/2024 9:08 am

		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	9,134,727	0	0	0	1.00
2.00	Temporary investments	646,313	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	62,099,750	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	18,346,449	0	0	0	7.00
8.00	Prepaid expenses	6,777,079	0	0	0	8.00
9.00	Other current assets	18,151,917	0	0	0	9.00
10.00	Due from other funds	30,750	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	115,186,985	0	0	0	11.00
FIXED ASSETS						
12.00	Land	5,767,953	0	0	0	12.00
13.00	Land improvements	7,113,003	0	0	0	13.00
14.00	Accumulated depreciation	-420,841,010	0	0	0	14.00
15.00	Buildings	318,872,773	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	2,011,838	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	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	225,514,131	0	0	0	23.00
24.00	Accumulated depreciation	0	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)	138,438,688	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	117,603,050	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	305,949	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	117,908,999	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	371,534,672	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	28,374,086	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,845,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	19,600,482	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	50,819,568	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	25,495,434	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	37,574,555	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	63,069,989	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	113,889,557	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	257,645,115				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)	257,645,115	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	371,534,672	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0002

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

Worksheet G-1

Date/Time Prepared:
5/29/2024 9:08 am

		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		267,288,357		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-9,643,242				2.00
3.00	Total (sum of line 1 and line 2)		257,645,115		0		3.00
4.00	Additions (credit adjustments) (specify)	0		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)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		257,645,115		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)		257,645,115		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	Additions (credit adjustments) (specify)		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: 15-0002

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/29/2024 9:08 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	88,342,323		88,342,323	1.00
2.00	SUBPROVIDER - IPF	2,720,801		2,720,801	2.00
3.00	SUBPROVIDER - IRF	4,038,040		4,038,040	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)	95,101,164		95,101,164	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	27,799,829		27,799,829	11.00
11.01	NEONATAL ICU	5,727,734		5,727,734	11.01
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)	33,527,563		33,527,563	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	128,628,727		128,628,727	17.00
18.00	Ancillary services	593,009,006	883,820,689	1,476,829,695	18.00
19.00	Outpatient services	22,582,506	123,104,244	145,686,750	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		3,611,718	3,611,718	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	PROFESSIONAL REVENUES	2,095,678	62,878,188	64,973,866	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	746,315,917	1,073,414,839	1,819,730,756	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		440,235,502		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)		440,235,502		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet G-3 Date/Time Prepared: 5/29/2024 9:08 am
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		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,819,730,756	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,414,970,732	2.00
3.00	Net patient revenues (line 1 minus line 2)	404,760,024	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	440,235,502	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-35,475,478	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	6,291,832	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	15,863,014	24.00
24.01	NON OPERATING INCOME	378,318	24.01
24.02	CHANGE IN UNREALIZED GAIN/LOSS	3,247,727	24.02
24.03	REALIZED GAIN/LOSS ON INVESTMENT SAL	174,498	24.03
24.04	GAIN/LOSS ON ASSET DISPOSAL	117,075	24.04
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	26,072,464	25.00
26.00	Total (line 5 plus line 25)	-9,403,014	26.00
27.00	FOUNDATION SALARIES	223,605	27.00
27.01	FOUNDATION OTHER	16,623	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	240,228	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-9,643,242	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-0002

Period: From 01/01/2023

Worksheet H

HHA CCN: 15-7536

To 12/31/2023

Date/Time Prepared: 5/29/2024 9:08 am

Home Health Agency I

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	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col. 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	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	736,792	0	0	346,830	1,083,622	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	727,820	0	0	0	727,820	6.00
7.00	Physical Therapy	432,703	0	0	0	432,703	7.00
8.00	Occupational Therapy	146,489	0	0	0	146,489	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	5,855	0	0	0	5,855	10.00
11.00	Home Health Aide	65,781	0	0	0	65,781	11.00
12.00	Supplies (see instructions)	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	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Tel emedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	2,115,440	0	0	346,830	2,462,270	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	-40,111	1,043,511	0	1,043,511		5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	727,820	0	727,820		6.00
7.00	Physical Therapy	0	432,703	0	432,703		7.00
8.00	Occupational Therapy	0	146,489	0	146,489		8.00
9.00	Speech Pathology	0	0	0	0		9.00
10.00	Medical Social Services	0	5,855	0	5,855		10.00
11.00	Home Health Aide	0	65,781	0	65,781		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	Tel emedicine	0	0	0	0		23.50
24.00	Total (sum of lines 1-23)	-40,111	2,422,159	0	2,422,159		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: 15-0002 HHA CCN: 15-7536		Period: From 01/01/2023 To 12/31/2023		Worksheet H-1 Part I Date/Time Prepared: 5/29/2024 9:08 am	
				Home Health Agency I		PPS	
	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (col s. 0-4)	
		Bldgs & Fixtures	Movable Equipment				
	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	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	1,043,511	0	0	0	1,043,511	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	727,820	0	0	0	727,820	6.00
7.00	Physical Therapy	432,703	0	0	0	432,703	7.00
8.00	Occupational Therapy	146,489	0	0	0	146,489	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	5,855	0	0	0	5,855	10.00
11.00	Home Health Aide	65,781	0	0	0	65,781	11.00
12.00	Supplies (see instructions)	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	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Tel emedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	2,422,159	0	0	0	2,422,159	24.00
		Administrative & General	Total (col s. 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	1,043,511					5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	550,893	1,278,713				6.00
7.00	Physical Therapy	327,517	760,220				7.00
8.00	Occupational Therapy	110,879	257,368				8.00
9.00	Speech Pathology	0	0				9.00
10.00	Medical Social Services	4,432	10,287				10.00
11.00	Home Health Aide	49,790	115,571				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	Tel emedicine	0	0				23.50
24.00	Total (sum of lines 1-23)		2,422,159				24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 15-0002

Period: From 01/01/2023

Worksheet H-1

HHA CCN: 15-7536

To 12/31/2023

Part II
Date/Time Prepared:
5/29/2024 9:08 am

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	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
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	-1,043,511	1,378,648
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	727,820
7.00	Physical Therapy	0	0	0	0	0	432,703
8.00	Occupational Therapy	0	0	0	0	0	146,489
9.00	Speech Pathology	0	0	0	0	0	0
10.00	Medical Social Services	0	0	0	0	0	5,855
11.00	Home Health Aide	0	0	0	0	0	65,781
12.00	Supplies (see instructions)	0	0	0	0	0	0
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
23.50	Telemedicine	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	0	0	-1,043,511	1,378,648
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0	0	1,043,511
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.756909

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0002

Period: From 01/01/2023

Worksheet H-2

HHA CCN: 15-7536

To 12/31/2023

Part I
Date/Time Prepared:
5/29/2024 9:08 am

Home Health
Agency I

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Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	
		BLDG & FIXT						
	0	1.00		4.00	5.01	5.02	5.03	
1.00 Administrative and General	0	0	0	379,399	0	3,851	13,493	1.00
2.00 Skilled Nursing Care	1,278,713	0	0	0	0	0	0	2.00
3.00 Physical Therapy	760,220	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	257,368	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	0	5.00
6.00 Medical Social Services	10,287	0	0	0	0	0	0	6.00
7.00 Home Health Aide	115,571	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19) (2)	2,422,159	0	0	379,399	0	3,851	13,493	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	CASHIERING/AC COUNTS RECEIVABLE	Subtotal	OTHER A&G	PATIENT TRANSPORTATION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE		
	5.04	5A.04	5.05	5.06	7.00	8.00		
1.00 Administrative and General	14,999	411,742	44,243	0	0	0	0	1.00
2.00 Skilled Nursing Care	0	1,278,713	137,402	0	0	0	0	2.00
3.00 Physical Therapy	0	760,220	81,688	0	0	0	0	3.00
4.00 Occupational Therapy	0	257,368	27,655	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	10,287	1,105	0	0	0	0	6.00
7.00 Home Health Aide	0	115,571	12,418	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19) (2)	14,999	2,833,901	304,511	0	0	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.		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: 15-0002

Period: From 01/01/2023

Worksheet H-2

HHA CCN: 15-7536

To 12/31/2023

Part I
Date/Time Prepared: 5/29/2024 9:08 am

Home Health Agency I

PPS

Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	0	0	0	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) (2)	0	0	0	0	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		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	STAFF EDUCATION	MEDICAL EDUCATION	INTERNS & RESIDENTS SERVICES-SALA RY & FRINGES	SERVICES-OTHE R PRGM COSTS	
		16.00	17.00	17.01	17.02	21.00	22.00	
1.00	Administrative and General	9,322	0	2,631	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) (2)	9,322	0	2,631	0	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

(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: 15-0002

Period: From 01/01/2023

Worksheet H-2

HHA CCN: 15-7536

To 12/31/2023

Part I
Date/Time Prepared:
5/29/2024 9:08 am

Home Health Agency I

PPS

Cost Center Description	PARAMED ED PROGRAM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
	23.00	24.00	25.00	26.00	27.00	28.00	
1.00 Administrative and General	0	467,938	0	467,938			1.00
2.00 Skilled Nursing Care	0	1,416,115	0	1,416,115	247,036	1,663,151	2.00
3.00 Physical Therapy	0	841,908	0	841,908	146,867	988,775	3.00
4.00 Occupational Therapy	0	285,023	0	285,023	49,721	334,744	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	11,392	0	11,392	1,987	13,379	6.00
7.00 Home Health Aide	0	127,989	0	127,989	22,327	150,316	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	3,150,365	0	3,150,365	467,938	3,150,365	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.					0.174446		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: 15-0002 HHA CCN: 15-7536	Period: From 01/01/2023 To 12/31/2023	Worksheet H-2 Part II Date/Time Prepared: 5/29/2024 9:08 am
			Home Health Agency I	PPS

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (MACHINE TIME)	PURCHASING RECEIVING AND STORES (PURCHASE REQUISITIONS)	ADMINI TTING (GROSS CHARGES)	CASHIERING/AC COUNTS RECEI VABLE (GROSS CHARGES)	
	BLDG & FIXT (SQUARE FEET)							
	1.00	4.00						
1.00	Administrative and General	0	2,092,822	0	55,894	3,611,718	3,611,718	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	Tel emedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	2,092,822	0	55,894	3,611,718	3,611,718	20.00
21.00	Total cost to be allocated	0	379,399	0	3,851	13,493	14,999	21.00
22.00	Unit cost multiplier	0.000000	0.181286	0.000000	0.068898	0.003736	0.004153	22.00

Cost Center Description	Reconciliation	OTHER A&G (ACCUM. COST)	PATIENT TRANSPORTATION (NUMBER OF TRIPS)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)							
								5A.05	5.05	5.06	7.00	8.00	9.00
								1.00	Administrative and General	0	411,742	0	0
2.00	Skilled Nursing Care	0	1,278,713	0	0	0	0	2.00					
3.00	Physical Therapy	0	760,220	0	0	0	0	3.00					
4.00	Occupational Therapy	0	257,368	0	0	0	0	4.00					
5.00	Speech Pathology	0	0	0	0	0	0	5.00					
6.00	Medical Social Services	0	10,287	0	0	0	0	6.00					
7.00	Home Health Aide	0	115,571	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	Tel emedicine	0	0	0	0	0	0	19.50					
20.00	Total (sum of lines 1-19)	0	2,833,901	0	0	0	0	20.00					
21.00	Total cost to be allocated	0	304,511	0	0	0	0	21.00					
22.00	Unit cost multiplier	0.000000	0.107453	0.000000	0.000000	0.000000	0.000000	22.00					

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 15-0002 HHA CCN: 15-7536	Period: From 01/01/2023 To 12/31/2023	Worksheet H-2 Part II Date/Time Prepared: 5/29/2024 9:08 am
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Cost Center Description		DIETARY (MEALS SERVED)	CAFETERIA (PRODUCTIVE HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		10.00	11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	0	0	0	0	3,611,718	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	Tel emedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	0	0	0	3,611,718	20.00
21.00	Total cost to be allocated	0	0	0	0	0	9,322	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	0.002581	22.00

Cost Center Description		INTERNS & RESIDENTS						
		SOCIAL SERVICE (TIME SPENT)	STAFF EDUCATION (TIME SPENT)	MEDICAL EDUCATION (ASSIGNED TIME)	SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	PARAMED PROGRAM (ASSIGNED TIME)	
		17.00	17.01	17.02	21.00	22.00	23.00	
1.00	Administrative and General	0	333	0	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	Tel emedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	333	0	0	0	0	20.00
21.00	Total cost to be allocated	0	2,631	0	0	0	0	21.00
22.00	Unit cost multiplier	0.000000	7.900901	0.000000	0.000000	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 15-0002	Period: From 01/01/2023	Worksheet H-3
		HHA CCN: 15-7536	To 12/31/2023	Part I Date/Time Prepared: 5/29/2024 9:08 am

Title XVIII			Home Health Agency I	PPS
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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 (col. 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	1,663,151		1,663,151	8,919	186.47	1.00
2.00	Physical Therapy	3.00	988,775	0	988,775	4,614	214.30	2.00
3.00	Occupational Therapy	4.00	334,744	0	334,744	1,557	214.99	3.00
4.00	Speech Pathology	5.00	0	0	0	0	0.00	4.00
5.00	Medical Social Services	6.00	13,379		13,379	72	185.82	5.00
6.00	Home Health Aide	7.00	150,316		150,316	1,378	109.08	6.00
7.00	Total (sum of lines 1-6)		3,150,365	0	3,150,365	16,540		7.00

Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits		Ratio (col. 3 ÷ col. 4)	
			Part A	Part B		
				Not Subject to Deductibles & Coinsurance		Subject to Deductibles
0	1.00	2.00	3.00	4.00	5.00	

Limitation Cost Computation						
8.00	Skilled Nursing Care		23844	0	1,322	8.00
9.00	Physical Therapy		23844	0	915	9.00
10.00	Occupational Therapy		23844	0	325	10.00
11.00	Speech Pathology		23844	0	0	11.00
12.00	Medical Social Services		23844	0	17	12.00
13.00	Home Health Aide		23844	0	434	13.00
14.00	Total (sum of lines 8-13)			0	3,013	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 (col. 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	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0.000000	16.00

Cost Center Description	Part A	Part B		Part A	Part B	
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		6.00	7.00		8.00	9.00

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	1,322		0	246,513	1.00
2.00	Physical Therapy	0	915		0	196,085	2.00
3.00	Occupational Therapy	0	325		0	69,872	3.00
4.00	Speech Pathology	0	0		0	0	4.00
5.00	Medical Social Services	0	17		0	3,159	5.00
6.00	Home Health Aide	0	434		0	47,341	6.00
7.00	Total (sum of lines 1-6)	0	3,013		0	562,970	7.00

APPORTIONMENT OF PATIENT SERVICE COSTS			Provider CCN: 15-0002 HHA CCN: 15-7536		Period: From 01/01/2023 To 12/31/2023		Worksheet H-3 Part I Date/Time Prepared: 5/29/2024 9:08 am	
			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
Program Covered Charges			Part B		Cost of Services			
Cost Center Description			Part A	Part B		Part A	Part B	
				Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		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	67,865	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	246,513						1.00
2.00	Physical Therapy	196,085						2.00
3.00	Occupational Therapy	69,872						3.00
4.00	Speech Pathology	0						4.00
5.00	Medical Social Services	3,159						5.00
6.00	Home Health Aide	47,341						6.00
7.00	Total (sum of lines 1-6)	562,970						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: 15-0002
HHA CCN: 15-7536

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

Worksheet H-3
Part II
Date/Time Prepared:
5/29/2024 9:08 am
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	0.216905	0	0	col. 2, line 2.00	1.00
2.00	Occupational Therapy	67.00	0.301903	0	0	col. 2, line 3.00	2.00
3.00	Speech Pathology	68.00	0.275654	0	0	col. 2, line 4.00	3.00
4.00	Cost of Medical Supplies	71.00	0.455914	0	0	col. 2, line 15.00	4.00
5.00	Cost of Drugs	73.00	0.220968	0	0	col. 2, line 16.00	5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002 HHA CCN: 15-7536	Period: From 01/01/2023 To 12/31/2023	Worksheet H-4 Part I-II Date/Time Prepared: 5/29/2024 9:08 am
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	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
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
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
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			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
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	458,210
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	75,547
13.00	Total PPS Reimbursement - LUPA Episodes		0	6,483
14.00	Total PPS Reimbursement - PEP Episodes		0	0
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	18,982
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	559,222
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	559,222
25.00	Coinurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	559,222
27.00	Allowable bad debts (from your records)		0	0
27.01	Adjusted reimbursable bad debts (see instructions)		0	0
28.00	Allowable bad debts for dual eligible (see instructions)		0	0
29.00	Total costs - current cost reporting period (see instructions)		0	559,222
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
30.99	Demonstration payment adjustment amount before sequestration		0	0
31.00	Subtotal (see instructions)		0	559,222
31.01	Sequestration adjustment (see instructions)		0	11,184
31.02	Demonstration payment adjustment amount after sequestration		0	0
31.75	Sequestration adjustment for non-claims based amounts (see instructions)		0	0
32.00	Interim payments (see instructions)		0	548,037
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 31.75, 32, and 33)		0	1
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet H-5
	HHA CCN: 15-7536	Home Health Agency I	Date/Time Prepared: 5/29/2024 9:08 am 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		548,037	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		548,037	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		548,038	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: 15-0002	Period: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III Date/Time Prepared: 5/29/2024 9:08 am
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,996,818	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		51,514	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)		200.40	3.00
4.00	Number of interns & residents (see instructions)		2.95	4.00
5.00	Indirect medical education percentage (see instructions)		0.42	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)		8,387	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		8.43	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		33.45	8.00
9.00	Sum of lines 7 and 8		41.88	9.00
10.00	Allowable disproportionate share percentage (see instructions)		8.85	10.00
11.00	Disproportionate share adjustment (see instructions)		176,718	11.00
12.00	Total prospective capital payments (see instructions)		2,233,437	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