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: 15-0035	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/29/2024 4:45 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/29/2024 Time: 4:45 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PORTER REGIONAL HOSPITAL (15-0035) 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				I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name				2
3	Signatory Title				3
4	Date				4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	581,167	9,017	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	-84,312	-166		0	3.00
5.00	SWING BED - SNF	0	45	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	496,900	8,851	0	0	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: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2024 4:45 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 85 EAST US HIGHWAY 6	PO Box:			1.00
2.00	City: VALPARAISO	State: IN	Zip Code: 46383	County: PORTER	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	PORTER REGIONAL HOSPITAL	150035	23844	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	PORTER REHAB UNIT	15T035	23844	5	01/01/2009	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	PORTER SWING BEDS	15U035	23844		01/01/2020	N	P	O	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									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)	4		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)	N	N		22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0035	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 4:45 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	930	18	490	854	9,144	280	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.	19	9	0	29	174		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.	2		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.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	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 are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	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
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

		V	XVIII	XIX	
		1.00	2.00	3.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	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	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N	63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0035	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 4:45 pm

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

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

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

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	FAMILY MEDICINE	1350	0.53	2.12	0.200000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0035	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 4:45 pm

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			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: 15-0035	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 4:45 pm

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

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

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

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

		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			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: 15-0035	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 4:45 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	196,194	362,471	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	Y	Y	123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB1848	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: CHS/COMMUNITY HEALTH SYSTEMS INC	Contractor's Name: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 52280	141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	143.00

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

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

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2024 4:45 pm

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

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			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.	N			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?	Y	Y	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.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	04/10/2024	Y	04/10/2024	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0035	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/29/2024 4:45 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00

		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	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.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	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.	N	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	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	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.	Y	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.	Y	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.	Y	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		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.	Y		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	12/31/2022	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.	VICTORIA	ROMANKO	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-925-4333	VICTORIA_ROMANKO@CHS.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0035	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/29/2024 4:45 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I Date/Time Prepared: 5/29/2024 4:45 pm

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	152	65,500	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)		152	65,500	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	32	11,680	0.00	0	8.00
8.01	NEONATAL INTENSIVE CARE UNIT	31.01	14	5,110	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)		198	82,290	0.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	13	4,745		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						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)		211				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)		9	3,285			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: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2024 4:45 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	16,826	506	46,359			1.00
2.00	HMO and other (see instructions)	15,461	9,573				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	660	174				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	4	0	6			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	16,830	506	46,365			7.00
8.00	INTENSIVE CARE UNIT	1,811	164	5,116			8.00
8.01	NEONATAL INTENSIVE CARE UNIT	0	162	3,707			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		1,031	2,101			13.00
14.00	Total (see instructions)	18,641	1,863	57,289	2.65	1,161.78	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits	0	0	0			15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	2,398	57	3,797	0.00	16.63	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						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			54			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				2.65	1,178.41	27.00
28.00	Observation Bed Days		0	6,561			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			503			30.00
31.00	Employee discount days - IRF			41			31.00
32.00	Labor & delivery days (see instructions)	0	280	585			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			638			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: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2024 4:45 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	3,719	1,954	10,764	1.00
2.00	HMO and other (see instructions)			2,384	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
8.01	NEONATAL INTENSIVE CARE UNIT						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						13.00
14.00	Total (see instructions)	0.00	0	3,719	1,954	10,764	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	223	17	346	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						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

		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	95,847,494	0	95,847,494	2,451,083.00	39.10	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		288,554	0	288,554	1,320.00	218.60	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	241,726	0	241,726	7,831.00	30.87	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		1,521,214	0	1,521,214	34,580.00	43.99	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		11,344,247	0	11,344,247	117,988.00	96.15	11.00
12.00	Contract labor: Top level management and other management and administrative services		247,190	0	247,190	2,262.00	109.28	12.00
13.00	Contract labor: Physician-Part A - Administrative		1,067,997	0	1,067,997	5,710.00	187.04	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		13,970,434	0	13,970,434	360,140.00	38.79	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		25,614,569	0	25,614,569			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		389,674	0	389,674			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		18,793	0	18,793			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		78,522	0	78,522			25.00
25.50	Home office wage-related (core)		3,195,954	0	3,195,954			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

		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	435,403	0	435,403	10,619.00	41.00	26.00
27.00	Administrative & General	5.00	8,463,520	-306,264	8,157,256	287,348.00	28.39	27.00
28.00	Administrative & General under contract (see inst.)		611,269	0	611,269	6,185.00	98.83	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,613,493	0	2,613,493	92,471.00	28.26	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1,998,737	0	1,998,737	110,590.00	18.07	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		2,903,069	0	2,903,069	85,674.00	33.89	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	4,942,198	306,264	5,248,462	125,300.00	41.89	38.00
39.00	Central Services and Supply	14.00	1,018,466	0	1,018,466	45,350.00	22.46	39.00
40.00	Pharmacy	15.00	2,943,932	0	2,943,932	55,896.00	52.67	40.00
41.00	Medical Records & Medical Records Library	16.00	842,529	0	842,529	31,411.00	26.82	41.00
42.00	Social Service	17.00	1,006,665	0	1,006,665	26,302.00	38.27	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part III Date/Time Prepared: 5/29/2024 4:45 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		101,118,843	0	101,118,843	2,645,701.00	38.22	1.00
2.00	Excluded area salaries (see instructions)		1,521,214	0	1,521,214	34,580.00	43.99	2.00
3.00	Subtotal salaries (line 1 minus line 2)		99,597,629	0	99,597,629	2,611,121.00	38.14	3.00
4.00	Subtotal other wages & related costs (see inst.)		26,629,868	0	26,629,868	486,100.00	54.78	4.00
5.00	Subtotal wage-related costs (see inst.)		28,829,316	0	28,829,316	0.00	28.95	5.00
6.00	Total (sum of lines 3 thru 5)		155,056,813	0	155,056,813	3,097,221.00	50.06	6.00
7.00	Total overhead cost (see instructions)		27,779,281	0	27,779,281	877,146.00	31.67	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part IV Date/Time Prepared: 5/29/2024 4:45 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,736,885	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	15,954,888	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	174,922	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	64,958	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)	191,676	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	843,650	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	5,580,384	17.00
18.00	Medicare Taxes - Employers Portion Only	1,305,090	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	187,978	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	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	26,040,431	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: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part V | Date/Time Prepared: 5/29/2024 4:45 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	11,344,247	26,040,431	1.00
2.00	Hospital	11,344,247	26,040,431	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0035	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/29/2024 4:45 pm

		1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.118339	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	52,379,021	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	363,401,080	6.00
7.00	Medicaid cost (line 1 times line 6)	43,004,520	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	0	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)	0	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)	21,914,685	103,014	22,017,699	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,593,362	103,014	2,696,376	21.00
22.00	Payments received from patients for amounts previously written off as charity care	27,486	0	27,486	22.00
23.00	Cost of charity care (see instructions)	2,565,876	103,014	2,668,890	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)	10,880,092	26.00
27.00	Medicare reimbursable bad debts (see instructions)	229,706	27.00
27.01	Medicare allowable bad debts (see instructions)	353,395	27.01
28.00	Non-Medicare bad debt amount (see instructions)	10,526,697	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	1,369,408	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	4,038,298	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,038,298	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0035	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/29/2024 4:45 pm

		1.00	
	PART II - HOSPITAL DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.116962	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)	21,754,418	103,014	21,857,432	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,544,440	103,014	2,647,454	21.00
22.00	Payments received from patients for amounts previously written off as charity care	27,486	0	27,486	22.00
23.00	Cost of charity care (see instructions)	2,516,954	103,014	2,619,968	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)	10,851,042	26.00
27.00	Medicare reimbursable bad debts (see instructions)	225,806	27.00
27.01	Medicare allowable bad debts (see instructions)	347,395	27.01
28.00	Non-Medicare bad debt amount (see instructions)	10,503,647	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	1,350,117	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	3,970,085	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,970,085	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/29/2024 4:45 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		-1,020,028	-1,020,028	5,720,504	4,700,476	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		9,373,813	9,373,813	1,146,221	10,520,034	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	435,403	233,538	668,941	19,449,065	20,118,006	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,463,520	89,705,487	98,169,007	-23,367,647	74,801,360	5.00
7.00	00700	OPERATION OF PLANT	2,613,493	5,369,782	7,983,275	5,934,565	13,917,840	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,548,224	1,548,224	-1,438	1,546,786	8.00
9.00	00900	HOUSEKEEPING	0	5,416,309	5,416,309	-10,848	5,405,461	9.00
10.00	01000	DIETARY	0	6,499,177	6,499,177	-3,970,499	2,528,678	10.00
11.00	01100	CAFETERIA	0	0	0	3,765,486	3,765,486	11.00
13.00	01300	NURSING ADMINISTRATION	4,942,198	623,114	5,565,312	274,730	5,840,042	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,018,466	29,827,365	30,845,831	-28,329,891	2,515,940	14.00
15.00	01500	PHARMACY	2,943,932	34,309,414	37,253,346	-33,862,187	3,391,159	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	842,529	1,482,348	2,324,877	-2,542	2,322,335	16.00
17.00	01700	SOCIAL SERVICE	1,006,665	805,754	1,812,419	-592	1,811,827	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	241,726	376,468	618,194	-6,172	612,022	21.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,009,441	14,829,215	33,838,656	-155,709	33,682,947	30.00
31.00	03100	INTENSIVE CARE UNIT	5,969,098	5,340,354	11,309,452	-121,357	11,188,095	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	2,504,997	1,182,160	3,687,157	-40,470	3,646,687	31.01
41.00	04100	SUBPROVIDER - IRF	1,521,214	405,282	1,926,496	-13,183	1,913,313	41.00
43.00	04300	NURSERY	0	46,090	46,090	-929	45,161	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,386,197	10,337,120	19,723,317	-2,125,520	17,597,797	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,298,561	1,404,836	3,703,397	-98,370	3,605,027	52.00
53.00	05300	ANESTHESIOLOGY	308	4,346,777	4,347,085	0	4,347,085	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,722,503	4,600,490	13,322,993	-1,846,985	11,476,008	54.00
60.00	06000	LABORATORY	5,493,858	7,425,069	12,918,927	-701,952	12,216,975	60.00
65.00	06500	RESPIRATORY THERAPY	1,952,365	1,850,526	3,802,891	-309,955	3,492,936	65.00
66.00	06600	PHYSICAL THERAPY	1,583,257	204,620	1,787,877	-10,468	1,777,409	66.00
67.00	06700	OCCUPATIONAL THERAPY	935,982	149,122	1,085,104	0	1,085,104	67.00
68.00	06800	SPEECH PATHOLOGY	469,925	50,360	520,285	-40	520,245	68.00
69.00	06900	ELECTROCARDIOLOGY	4,309,266	4,432,505	8,741,771	-1,975,426	6,766,345	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,575,462	2,575,462	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	25,225,666	25,225,666	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	128,645	13,569	142,214	32,980,234	33,122,448	73.00
74.00	07400	RENAL DIALYSIS	826,167	240,675	1,066,842	-19,911	1,046,931	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	704,153	701,634	1,405,787	-1,295	1,404,492	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	7,523,625	7,248,161	14,771,786	-98,547	14,673,239	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	95,847,494	249,359,330	345,206,824	0	345,206,824	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,548	4,548	0	4,548	192.00
192.01	19201	GUEST MEALS	0	0	0	0	0	192.01
200.00		TOTAL (SUM OF LINES 118 through 199)	95,847,494	249,363,878	345,211,372	0	345,211,372	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/29/2024 4:45 pm

		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	434,401	5,134,877	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	425,249	10,945,283	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	20,118,006	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,571,322	72,230,038	5.00
7.00	00700	OPERATION OF PLANT	-210,139	13,707,701	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,546,786	8.00
9.00	00900	HOUSEKEEPING	0	5,405,461	9.00
10.00	01000	DIETARY	0	2,528,678	10.00
11.00	01100	CAFETERIA	-12	3,765,474	11.00
13.00	01300	NURSING ADMINISTRATION	-4,071	5,835,971	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,515,940	14.00
15.00	01500	PHARMACY	0	3,391,159	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-83	2,322,252	16.00
17.00	01700	SOCIAL SERVICE	0	1,811,827	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	612,022	21.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-5,579,951	28,102,996	30.00
31.00	03100	INTENSIVE CARE UNIT	-3,146,842	8,041,253	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	-755,400	2,891,287	31.01
41.00	04100	SUBPROVIDER - IRF	0	1,913,313	41.00
43.00	04300	NURSERY	0	45,161	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-1,355,397	16,242,400	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-501,827	3,103,200	52.00
53.00	05300	ANESTHESIOLOGY	-4,343,139	3,946	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-331,648	11,144,360	54.00
60.00	06000	LABORATORY	-798	12,216,177	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,492,936	65.00
66.00	06600	PHYSICAL THERAPY	0	1,777,409	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,085,104	67.00
68.00	06800	SPEECH PATHOLOGY	0	520,245	68.00
69.00	06900	ELECTROCARDIOLOGY	-264,930	6,501,415	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,575,462	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	25,225,666	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	33,122,448	73.00
74.00	07400	RENAL DIALYSIS	0	1,046,931	74.00
76.00	03950	ANCILLARY	0	0	76.00
76.01	03610	SLEEP LAB	0	0	76.01
76.03	03951	WOUND CARE	0	1,404,492	76.03
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	-4,438,629	10,234,610	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-22,644,538	322,562,286	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,548	192.00
192.01	19201	GUEST MEALS	0	0	192.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-22,644,538	322,566,834	200.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	19,449,220	1.00
	0		0	19,449,220	
	C - RENTAL AND LEASE EXPENSES				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,457,659	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,074,972	2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	348,140	3.00
4.00	OPERATION OF PLANT	7.00	0	95,218	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
	0		0	3,975,989	
	D - OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	582,446	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,696,939	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	71,249	3.00
	0		0	3,350,634	
	E - REPAIRS AND MAINTENANCE COSTS				
1.00	OPERATION OF PLANT	7.00	0	5,034,595	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
	0		0	5,034,595	
	F - CHIEF NURSING OFFICER COST				
1.00	NURSING ADMINISTRATION	13.00	306,264	0	1.00
	0		306,264	0	
	G - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,575,462	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	25,225,666	2.00
3.00	OPERATING ROOM	50.00	0	859,695	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	30,458	4.00
	0		0	28,691,281	
	H - COST OF DRUGS/IV SOLUTIONS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	32,984,228	1.00
	0		0	32,984,228	
	L - INTEREST EXPENSE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	16,540	1.00
	TOTALS		0	16,540	
	M - DIETARY COSTS TO CAFETERIA				
1.00	CAFETERIA	11.00	0	3,765,486	1.00
	0		0	3,765,486	
	P - NON-CAPITALIZED EQUIPMENT				
1.00	OPERATION OF PLANT	7.00	0	804,752	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

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	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
	0		0	804,752	
500.00	Grand Total: Increases		306,264	98,072,725	500.00

RECLASSIFICATIONS | Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/29/2024 4:45 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - EMPLOYEE BENEFITS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	19,449,220	0	1.00
	0		0	19,449,220		
	C - RENTAL AND LEASE EXPENSES					
1.00	DIETARY	10.00	0	24,822	10	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	173,748	10	2.00
3.00	PHARMACY	15.00	0	717,664	0	3.00
4.00	ADULTS & PEDIATRICS	30.00	0	99,015	0	4.00
5.00	INTENSIVE CARE UNIT	31.00	0	80,862	0	5.00
6.00	OPERATING ROOM	50.00	0	1,411,647	0	6.00
7.00	LABORATORY	60.00	0	321,710	0	7.00
8.00	RESPIRATORY THERAPY	65.00	0	233,977	0	8.00
9.00	ELECTROCARDIOLOGY	69.00	0	278,598	0	9.00
10.00	EMERGENCY	91.00	0	45,984	0	10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	576,437	0	11.00
12.00	SUBPROVIDER - IRF	41.00	0	3,365	0	12.00
13.00	PHYSICAL THERAPY	66.00	0	8,160	0	13.00
	0		0	3,975,989		
	D - OTHER CAPITAL COSTS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,350,634	12	1.00
2.00		0.00	0	0	13	2.00
3.00		0.00	0	0	12	3.00
	0		0	3,350,634		
	E - REPAIRS AND MAINTENANCE COSTS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	552,712	0	1.00
2.00	HOUSEKEEPING	9.00	0	5,909	0	2.00
3.00	DIETARY	10.00	0	109,998	0	3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	267,229	0	4.00
5.00	PHARMACY	15.00	0	159,920	0	5.00
6.00	ADULTS & PEDIATRICS	30.00	0	7,739	0	6.00
7.00	INTENSIVE CARE UNIT	31.00	0	30,436	0	7.00
8.00	NEONATAL INTENSIVE CARE UNIT	31.01	0	18,071	0	8.00
9.00	NURSERY	43.00	0	48	0	9.00
10.00	OPERATING ROOM	50.00	0	1,370,003	0	10.00
11.00	I&R SERVICES-SALARY & FRINGES APPRVD	21.00	0	645	0	11.00
12.00	DELIVERY ROOM & LABOR ROOM	52.00	0	80,099	0	12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,274,765	0	13.00
14.00	LABORATORY	60.00	0	334,672	0	14.00
15.00	RESPIRATORY THERAPY	65.00	0	68,308	0	15.00
16.00	SPEECH PATHOLOGY	68.00	0	40	0	16.00
17.00	ELECTROCARDIOLOGY	69.00	0	712,948	0	17.00
18.00	SUBPROVIDER - IRF	41.00	0	2,681	0	18.00
19.00	PHYSICAL THERAPY	66.00	0	75	0	19.00
20.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,994	0	20.00
21.00	RENAL DIALYSIS	74.00	0	18,750	0	21.00
22.00	SOCIAL SERVICE	17.00	0	210	0	22.00
23.00	EMERGENCY	91.00	0	15,343	0	23.00
	0		0	5,034,595		
	F - CHIEF NURSING OFFICER COST					
1.00	ADMINISTRATIVE & GENERAL	5.00	306,264	0	0	1.00
	0		306,264	0		
	G - MEDICAL SUPPLIES					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	27,739,494	0	1.00
2.00	ELECTROCARDIOLOGY	69.00	0	951,787	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
	0		0	28,691,281		
	H - COST OF DRUGS/IV SOLUTIONS					
1.00	PHARMACY	15.00	0	32,984,228	0	1.00
	0		0	32,984,228		
	L - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	16,540	11	1.00
	TOTALS		0	16,540		
	M - DIETARY COSTS TO CAFETERIA					
1.00	DIETARY	10.00	0	3,765,486	0	1.00
	0		0	3,765,486		
	P - NON-CAPITALIZED EQUIPMENT					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	73,497	0	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	149,420	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	48,955	0	3.00
4.00	OPERATING ROOM	50.00	0	203,565	0	4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	0	18,271	0	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	26,241	0	6.00

RECLASSIFICATIONS | Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/29/2024 4:45 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
7.00	LABORATORY	60.00	0	45,570	0		7.00
8.00	PHYSICAL THERAPY	66.00	0	2,233	0		8.00
9.00	ELECTROCARDIOLOGY	69.00	0	32,093	0		9.00
10.00	SUBPROVIDER - IRF	41.00	0	7,137	0		10.00
11.00	NURSERY	43.00	0	881	0		11.00
12.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	155	0		12.00
13.00	HOUSEKEEPING	9.00	0	4,939	0		13.00
14.00	DIETARY	10.00	0	70,193	0		14.00
15.00	NURSING ADMINISTRATION	13.00	0	31,534	0		15.00
16.00	PHARMACY	15.00	0	375	0		16.00
17.00	INTENSIVE CARE UNIT	31.00	0	10,059	0		17.00
18.00	NEONATAL INTENSIVE CARE UNIT	31.01	0	22,399	0		18.00
19.00	RESPIRATORY THERAPY	65.00	0	7,670	0		19.00
20.00	I&R SERVICES-SALARY & FRINGES APPRVD	21.00	0	5,527	0		20.00
21.00	SOCIAL SERVICE	17.00	0	382	0		21.00
22.00	RENAL DIALYSIS	74.00	0	1,161	0		22.00
23.00	WOUND CARE	76.03	0	1,295	0		23.00
24.00	EMERGENCY	91.00	0	37,220	0		24.00
25.00	LAUNDRY & LINEN SERVICE	8.00	0	1,438	0		25.00
26.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,542	0		26.00
	O		0	804,752			
500.00	Grand Total: Decreases		306,264	98,072,725			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I Date/Time Prepared: 5/29/2024 4:45 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,949,373	8,594,314	0	8,594,314	0	1.00
2.00	Land Improvements	4,203,722	1,156,891	0	1,156,891	0	2.00
3.00	Buildings and Fixtures	166,742,103	25,154,910	0	25,154,910	0	3.00
4.00	Building Improvements	12,166,365	0	0	0	1,970,772	4.00
5.00	Fixed Equipment	7,482,041	3,267,446	0	3,267,446	0	5.00
6.00	Movable Equipment	70,049,820	0	0	0	7,325,347	6.00
7.00	HIT designated Assets	16,991,300	0	0	0	10,314,571	7.00
8.00	Subtotal (sum of lines 1-7)	280,584,724	38,173,561	0	38,173,561	19,610,690	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	280,584,724	38,173,561	0	38,173,561	19,610,690	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	11,543,687	0	1.00
2.00	Land Improvements	5,360,613	0	2.00
3.00	Buildings and Fixtures	191,897,013	0	3.00
4.00	Building Improvements	10,195,593	0	4.00
5.00	Fixed Equipment	10,749,487	0	5.00
6.00	Movable Equipment	62,724,473	0	6.00
7.00	HIT designated Assets	6,676,729	0	7.00
8.00	Subtotal (sum of lines 1-7)	299,147,595	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	299,147,595	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part II | Date/Time Prepared: 5/29/2024 4:45 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	-1,020,028	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	9,373,813	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	8,353,785	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	-1,020,028	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	9,373,813	2.00
3.00	Total (sum of lines 1-2)	0	8,353,785	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part III | Date/Time Prepared: 5/29/2024 4:45 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	218,996,905	0	218,996,905	0.732070	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	80,150,690	0	80,150,690	0.267930	0	2.00
3.00	Total (sum of lines 1-2)	299,147,595	0	299,147,595	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	-712,224	1,855,158	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	9,799,062	1,074,972	2.00
3.00	Total (sum of lines 1-2)	0	0	0	9,086,838	2,930,130	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	712,558	582,446	2,696,939	0	5,134,877	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	71,249	0	0	10,945,283	2.00
3.00	Total (sum of lines 1-2)	712,558	653,695	2,696,939	0	16,080,160	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/29/2024 4:45 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-602,501	CAP REL COSTS-BLDG & FIXT	1.00	10	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-210,139	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-20,772,882			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	0	RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	796,110			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-83	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-12	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)	A	-17,679	ADULTS & PEDIATRICS	30.00		30.99
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	TRAINING REVENUE	B	-4,071	NURSING ADMINISTRATION	13.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/29/2024 4:45 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MISC. NON PATIENT REVENUE	B	14,289	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.03	LEGAL FEES	A	-19,069	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.05	PATIENT TV DEPRECIATION	A	-1,593	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.05
33.06	MARKETING	A	-146,591	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	PHYSICIAN RECRUITING	A	-103,064	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	LOBBYING EXPENSE IN ASSOCIATION DUES	A	-22,339	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.11	MINORITY INTEREST	A	-1,416,965	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	CHARITY	A	-89,894	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.16	SENIOR CIRCLE	A	-1,261	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	COMMUNITY PROGRAMS	A	-46,794	ADMINISTRATIVE & GENERAL	5.00	0	33.17
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-22,644,538				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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2024 4:45 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	305,479	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	421,917	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL HOME OFFICE COST	11,446,147	0	3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT	Capital-Related Interest	729,098	0	4.00
4.01	1.00	CAP REL COSTS-BLDG & FIXT	PASI Capital Costs - Bldg &	2,325	0	4.01
4.02	2.00	CAP REL COSTS-MVBLE EQUIP	PASI Capital Costs - Moveabl	4,925	0	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	PASI Operating Costs	1,444,168	1,577,035	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	Shared Service Center Alloca	6,402,302	4,556,589	4.04
4.08	5.00	ADMINISTRATIVE & GENERAL	Malpractice Costs	558,665	1,896,132	4.08
4.09	5.00	ADMINISTRATIVE & GENERAL	Management Fees	0	7,942,251	4.09
4.10	5.00	ADMINISTRATIVE & GENERAL	401K Fees	0	5,151	4.10
4.11	5.00	ADMINISTRATIVE & GENERAL	Audit Fees	0	136,218	4.11
4.12	5.00	ADMINISTRATIVE & GENERAL	Corporate Overhead Allocatio	0	2,965,803	4.12
4.13	5.00	ADMINISTRATIVE & GENERAL	HIIM Allocation	0	1,231,978	4.13
4.14	5.00	ADMINISTRATIVE & GENERAL	Contract Management	0	303,128	4.14
4.15	5.00	ADMINISTRATIVE & GENERAL	PASI Lien Unit Collection Fe	0	-95,369	4.15
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			21,315,026	20,518,916	5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	B		0.00	CHS	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2024 4:45 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:		
1.00	305,479	9	1.00
2.00	421,917	9	2.00
3.00	11,446,147	0	3.00
4.00	729,098	11	4.00
4.01	2,325	9	4.01
4.02	4,925	9	4.02
4.03	-132,867	0	4.03
4.04	1,845,713	0	4.04
4.08	-1,337,467	0	4.08
4.09	-7,942,251	0	4.09
4.10	-5,151	0	4.10
4.11	-136,218	0	4.11
4.12	-2,965,803	0	4.12
4.13	-1,231,978	0	4.13
4.14	-303,128	0	4.14
4.15	95,369	0	4.15
5.00	796,110		5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate.Positive amounts increase cost and negative amounts decrease cost.For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

	Related Organization(s) and/or Home Office Type of Business	
	6.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:	

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

	Type of Business	
6.00	HOME OFFICE	6.00
7.00		7.00
8.00		8.00
9.00		9.00
10.00		10.00
100.00		100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2024 4:45 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	72,000	72,000	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	5,562,272	5,562,272	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	3,146,842	3,146,842	0	0	0	3.00
4.00	31.01	NEONATAL INTENSIVE CARE UNIT	755,400	755,400	0	0	0	4.00
5.00	50.00	OPERATING ROOM	1,355,397	1,355,397	0	0	0	5.00
6.00	52.00	DELIVERY ROOM & LABOR ROOM	501,827	501,827	0	0	0	6.00
7.00	53.00	ANESTHESIOLOGY	4,343,139	4,343,139	0	0	0	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	331,648	331,648	0	0	0	8.00
9.00	60.00	LABORATORY	798	798	0	0	0	9.00
10.00	69.00	ELECTROCARDIOLOGY	264,930	264,930	0	0	0	10.00
11.00	91.00	EMERGENCY	4,438,629	4,438,629	0	0	0	11.00
200.00			20,772,882	20,772,882	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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	31.01	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	6.00
7.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	8.00
9.00	60.00	LABORATORY	0	0	0	0	0	9.00
10.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	10.00
11.00	91.00	EMERGENCY	0	0	0	0	0	11.00
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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	72,000	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	5,562,272	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	3,146,842	3.00
4.00	31.01	NEONATAL INTENSIVE CARE UNIT	0	0	0	755,400	4.00
5.00	50.00	OPERATING ROOM	0	0	0	1,355,397	5.00
6.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	501,827	6.00
7.00	53.00	ANESTHESIOLOGY	0	0	0	4,343,139	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	331,648	8.00
9.00	60.00	LABORATORY	0	0	0	798	9.00
10.00	69.00	ELECTROCARDIOLOGY	0	0	0	264,930	10.00
11.00	91.00	EMERGENCY	0	0	0	4,438,629	11.00
200.00			0	0	0	20,772,882	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/29/2024 4:45 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	5,134,877	5,134,877				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	10,945,283		10,945,283			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	20,118,006	20,993	44,749	20,183,748		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	72,230,038	259,239	552,582	1,725,610	74,767,469	5.00
7.00	00700	OPERATION OF PLANT	13,707,701	1,570,925	3,348,518	552,866	19,180,010	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,546,786	7,522	16,034	0	1,570,342	8.00
9.00	00900	HOUSEKEEPING	5,405,461	47,448	101,137	0	5,554,046	9.00
10.00	01000	DIETARY	2,528,678	153,438	327,061	0	3,009,177	10.00
11.00	01100	CAFETERIA	3,765,474	0	0	0	3,765,474	11.00
13.00	01300	NURSING ADMINISTRATION	5,835,971	30,341	64,674	1,110,275	7,041,261	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,515,940	103,401	220,405	215,449	3,055,195	14.00
15.00	01500	PHARMACY	3,391,159	58,235	124,132	622,768	4,196,294	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,322,252	20,144	42,937	178,231	2,563,564	16.00
17.00	01700	SOCIAL SERVICE	1,811,827	2,313	4,931	212,953	2,032,024	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	612,022	0	0	51,135	663,157	21.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,102,996	810,599	1,727,837	4,021,306	34,662,738	30.00
31.00	03100	INTENSIVE CARE UNIT	8,041,253	152,108	324,226	1,262,721	9,780,308	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	2,891,287	59,282	126,363	529,915	3,606,847	31.01
41.00	04100	SUBPROVIDER - IRF	1,913,313	104,322	222,368	321,802	2,561,805	41.00
43.00	04300	NURSERY	45,161	18,798	40,069	0	104,028	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,242,400	515,519	1,098,857	1,985,584	19,842,360	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,103,200	102,606	218,711	486,244	3,910,761	52.00
53.00	05300	ANESTHESIOLOGY	3,946	8,899	18,970	65	31,880	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,144,360	338,853	722,284	1,845,184	14,050,681	54.00
60.00	06000	LABORATORY	12,216,177	110,805	236,188	1,162,187	13,725,357	60.00
65.00	06500	RESPIRATORY THERAPY	3,492,936	25,069	53,437	413,009	3,984,451	65.00
66.00	06600	PHYSICAL THERAPY	1,777,409	32,104	68,431	334,927	2,212,871	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,085,104	0	0	198,000	1,283,104	67.00
68.00	06800	SPEECH PATHOLOGY	520,245	0	0	99,409	619,654	68.00
69.00	06900	ELECTROCARDIOLOGY	6,501,415	212,664	453,306	911,595	8,078,980	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,575,462	0	0	0	2,575,462	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,225,666	0	0	0	25,225,666	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33,122,448	0	0	27,214	33,149,662	73.00
74.00	07400	RENAL DIALYSIS	1,046,931	5,178	11,036	174,770	1,237,915	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	1,404,492	53,963	115,025	148,959	1,722,439	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	10,234,610	310,109	661,015	1,591,570	12,797,304	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	322,562,286	5,134,877	10,945,283	20,183,748	322,562,286	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,548	0	0	0	4,548	192.00
192.01	19201	GUEST MEALS	0	0	0	0	0	192.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	322,566,834	5,134,877	10,945,283	20,183,748	322,566,834	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/29/2024 4:45 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	74,767,469					5.00
7.00	00700	OPERATION OF PLANT	5,787,108	24,967,118				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	473,813	57,195	2,101,350			8.00
9.00	00900	HOUSEKEEPING	1,675,800	360,758	0	7,590,604		9.00
10.00	01000	DIETARY	907,947	1,166,632	0	360,723	5,444,479	10.00
11.00	01100	CAFETERIA	1,136,141	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,124,532	230,694	0	71,331	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	921,832	786,190	8,620	243,090	0	14.00
15.00	01500	PHARMACY	1,266,131	442,782	0	136,908	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	773,494	153,158	0	47,356	0	16.00
17.00	01700	SOCIAL SERVICE	613,114	17,589	0	5,439	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	200,092	0	0	0	0	21.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,458,607	6,163,225	738,659	1,905,671	3,353,494	30.00
31.00	03100	INTENSIVE CARE UNIT	2,950,973	1,156,521	154,692	357,596	350,451	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	1,088,280	450,739	22,030	139,368	84,803	31.01
41.00	04100	SUBPROVIDER - IRF	772,963	793,190	50,214	245,254	315,055	41.00
43.00	04300	NURSERY	31,388	142,927	12,612	44,193	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,986,956	3,919,644	255,992	1,211,954	22,097	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,179,978	780,148	54,756	241,222	116,385	52.00
53.00	05300	ANESTHESIOLOGY	9,619	67,665	0	20,922	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,239,456	2,576,402	213,215	796,624	18,283	54.00
60.00	06000	LABORATORY	4,141,297	842,488	159	260,497	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,202,212	190,610	0	58,937	0	65.00
66.00	06600	PHYSICAL THERAPY	667,681	244,095	9,498	75,474	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	387,146	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	186,966	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,437,638	1,616,952	132,123	499,962	105,095	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	777,084	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,611,239	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,002,115	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	373,511	39,366	0	12,172	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	519,705	410,295	65,510	126,863	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,861,279	2,357,853	383,270	729,048	170,140	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	74,766,097	24,967,118	2,101,350	7,590,604	4,535,803	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,372	0	0	0	899,471	192.00
192.01	19201	GUEST MEALS	0	0	0	0	9,205	192.01
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)	74,767,469	24,967,118	2,101,350	7,590,604	5,444,479	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/29/2024 4:45 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	4,901,615					11.00
13.00	01300	NURSING ADMINISTRATION	298,045	9,765,863				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	107,858	0	5,122,785			14.00
15.00	01500	PHARMACY	132,943	0	0	6,175,058		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	74,709	0	594	0	3,612,875	16.00
17.00	01700	SOCIAL SERVICE	62,587	0	579	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	18,603	0	78	0	0	21.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,123,953	3,244,919	202,995	0	269,124	30.00
31.00	03100	INTENSIVE CARE UNIT	285,627	1,346,104	71,971	0	44,964	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	129,925	565,931	23,974	0	30,557	31.01
41.00	04100	SUBPROVIDER - IRF	82,279	228,628	8,155	0	17,216	41.00
43.00	04300	NURSERY	0	0	5,224	0	5,659	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	535,630	1,333,348	478,234	0	666,258	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	124,829	429,695	31,825	0	23,688	52.00
53.00	05300	ANESTHESIOLOGY	0	73	429	0	42,668	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	497,632	305,812	156,620	0	472,100	54.00
60.00	06000	LABORATORY	447,018	0	522,682	0	391,795	60.00
65.00	06500	RESPIRATORY THERAPY	109,145	0	49,975	0	88,137	65.00
66.00	06600	PHYSICAL THERAPY	87,820	0	371	0	28,888	66.00
67.00	06700	OCCUPATIONAL THERAPY	57,294	0	0	0	23,030	67.00
68.00	06800	SPEECH PATHOLOGY	23,848	0	0	0	9,353	68.00
69.00	06900	ELECTROCARDIOLOGY	243,225	464,354	112,006	0	306,160	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	305,903	0	77,434	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,996,221	0	305,586	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,700	643	0	6,175,058	504,568	73.00
74.00	07400	RENAL DIALYSIS	30,725	139,203	17,661	0	7,885	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	44,677	145,441	14,913	0	8,776	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	378,543	1,561,712	122,375	0	289,029	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,901,615	9,765,863	5,122,785	6,175,058	3,612,875	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	GUEST MEALS	0	0	0	0	0	192.01
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)	4,901,615	9,765,863	5,122,785	6,175,058	3,612,875	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/29/2024 4:45 pm

		Cost Center Description	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	21.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	2,731,332					17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	881,930				21.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,073,048	881,930	65,078,363	-881,930	64,196,433	30.00
31.00	03100	INTENSIVE CARE UNIT	228,774	0	16,727,981	0	16,727,981	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	165,767	0	6,308,221	0	6,308,221	31.01
41.00	04100	SUBPROVIDER - IRF	169,792	0	5,244,551	0	5,244,551	41.00
43.00	04300	NURSERY	93,951	0	439,982	0	439,982	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	34,252,473	0	34,252,473	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	6,893,287	0	6,893,287	52.00
53.00	05300	ANESTHESIOLOGY	0	0	173,256	0	173,256	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	23,326,825	0	23,326,825	54.00
60.00	06000	LABORATORY	0	0	20,331,293	0	20,331,293	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	5,683,467	0	5,683,467	65.00
66.00	06600	PHYSICAL THERAPY	0	0	3,326,698	0	3,326,698	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	1,750,574	0	1,750,574	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	839,821	0	839,821	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	13,996,495	0	13,996,495	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	3,735,883	0	3,735,883	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	36,138,712	0	36,138,712	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	49,836,746	0	49,836,746	73.00
74.00	07400	RENAL DIALYSIS	0	0	1,858,438	0	1,858,438	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	3,058,619	0	3,058,619	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	22,650,553	0	22,650,553	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,731,332	881,930	321,652,238	-881,930	320,770,308	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	905,391	0	905,391	192.00
192.01	19201	GUEST MEALS	0	0	9,205	0	9,205	192.01
200.00		Cross Foot Adjustments		0	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)	2,731,332	881,930	322,566,834	-881,930	321,684,904	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/29/2024 4:45 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	20,993	44,749	65,742	65,742	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	259,239	552,582	811,821	5,620	5.00
7.00	00700	OPERATION OF PLANT	0	1,570,925	3,348,518	4,919,443	1,801	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,522	16,034	23,556	0	8.00
9.00	00900	HOUSEKEEPING	0	47,448	101,137	148,585	0	9.00
10.00	01000	DIETARY	0	153,438	327,061	480,499	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	30,341	64,674	95,015	3,616	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	103,401	220,405	323,806	702	14.00
15.00	01500	PHARMACY	0	58,235	124,132	182,367	2,028	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	20,144	42,937	63,081	581	16.00
17.00	01700	SOCIAL SERVICE	0	2,313	4,931	7,244	694	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	167	21.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	810,599	1,727,837	2,538,436	13,099	30.00
31.00	03100	INTENSIVE CARE UNIT	0	152,108	324,226	476,334	4,113	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	59,282	126,363	185,645	1,726	31.01
41.00	04100	SUBPROVIDER - IRF	0	104,322	222,368	326,690	1,048	41.00
43.00	04300	NURSERY	0	18,798	40,069	58,867	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	515,519	1,098,857	1,614,376	6,467	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	102,606	218,711	321,317	1,584	52.00
53.00	05300	ANESTHESIOLOGY	0	8,899	18,970	27,869	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	338,853	722,284	1,061,137	6,010	54.00
60.00	06000	LABORATORY	0	110,805	236,188	346,993	3,785	60.00
65.00	06500	RESPIRATORY THERAPY	0	25,069	53,437	78,506	1,345	65.00
66.00	06600	PHYSICAL THERAPY	0	32,104	68,431	100,535	1,091	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	645	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	324	68.00
69.00	06900	ELECTROCARDIOLOGY	0	212,664	453,306	665,970	2,969	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	89	73.00
74.00	07400	RENAL DIALYSIS	0	5,178	11,036	16,214	569	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	53,963	115,025	168,988	485	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	310,109	661,015	971,124	5,184	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	5,134,877	10,945,283	16,080,160	65,742	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	GUEST MEALS	0	0	0	0	0	192.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	5,134,877	10,945,283	16,080,160	65,742	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/29/2024 4:45 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	817,441					5.00
7.00	00700	OPERATION OF PLANT	63,275	4,984,519				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,181	11,419	40,156			8.00
9.00	00900	HOUSEKEEPING	18,323	72,023	0	238,931		9.00
10.00	01000	DIETARY	9,927	232,910	0	11,355	734,691	10.00
11.00	01100	CAFETERIA	12,422	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	23,229	46,057	0	2,245	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,079	156,958	165	7,652	0	14.00
15.00	01500	PHARMACY	13,844	88,398	0	4,309	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,457	30,577	0	1,491	0	16.00
17.00	01700	SOCIAL SERVICE	6,704	3,512	0	171	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	2,188	0	0	0	0	21.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	114,304	1,230,446	14,115	59,986	452,528	30.00
31.00	03100	INTENSIVE CARE UNIT	32,265	230,892	2,956	11,256	47,291	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	11,899	89,987	421	4,387	11,444	31.01
41.00	04100	SUBPROVIDER - IRF	8,451	158,355	960	7,720	42,514	41.00
43.00	04300	NURSERY	343	28,534	241	1,391	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	65,460	782,531	4,892	38,149	2,982	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,902	155,751	1,046	7,593	15,705	52.00
53.00	05300	ANESTHESIOLOGY	105	13,509	0	659	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	46,353	514,361	4,074	25,075	2,467	54.00
60.00	06000	LABORATORY	45,280	168,197	3	8,200	0	60.00
65.00	06500	RESPIRATORY THERAPY	13,145	38,054	0	1,855	0	65.00
66.00	06600	PHYSICAL THERAPY	7,300	48,732	182	2,376	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,233	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,044	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	26,653	322,814	2,525	15,737	14,182	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,496	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	83,219	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	109,361	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	4,084	7,859	0	383	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	5,682	81,913	1,252	3,993	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	42,218	470,730	7,324	22,948	22,959	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	817,426	4,984,519	40,156	238,931	612,072	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15	0	0	0	121,377	192.00
192.01	19201	GUEST MEALS	0	0	0	0	1,242	192.01
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)	817,441	4,984,519	40,156	238,931	734,691	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/29/2024 4:45 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	12,422					11.00
13.00	01300	NURSING ADMINISTRATION	755	170,917				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	273	0	499,635			14.00
15.00	01500	PHARMACY	337	0	0	291,283		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	189	0	58	0	104,434	16.00
17.00	01700	SOCIAL SERVICE	159	0	56	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	47	0	8	0	0	21.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,850	56,796	19,798	0	7,874	30.00
31.00	03100	INTENSIVE CARE UNIT	724	23,558	7,019	0	1,316	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	329	9,904	2,338	0	894	31.01
41.00	04100	SUBPROVIDER - IRF	209	4,001	795	0	504	41.00
43.00	04300	NURSERY	0	0	509	0	166	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,357	23,335	46,641	0	18,222	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	316	7,520	3,104	0	693	52.00
53.00	05300	ANESTHESIOLOGY	0	1	42	0	1,248	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,261	5,352	15,275	0	13,812	54.00
60.00	06000	LABORATORY	1,133	0	50,976	0	11,463	60.00
65.00	06500	RESPIRATORY THERAPY	277	0	4,874	0	2,579	65.00
66.00	06600	PHYSICAL THERAPY	223	0	36	0	845	66.00
67.00	06700	OCCUPATIONAL THERAPY	145	0	0	0	674	67.00
68.00	06800	SPEECH PATHOLOGY	60	0	0	0	274	68.00
69.00	06900	ELECTROCARDIOLOGY	616	8,127	10,924	0	8,957	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	29,834	0	2,266	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	292,237	0	8,941	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12	11	0	291,283	14,762	73.00
74.00	07400	RENAL DIALYSIS	78	2,436	1,722	0	231	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	113	2,545	1,454	0	257	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	959	27,331	11,935	0	8,456	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,422	170,917	499,635	291,283	104,434	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	GUEST MEALS	0	0	0	0	0	192.01
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)	12,422	170,917	499,635	291,283	104,434	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/29/2024 4:45 pm

		Cost Center Description	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	21.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	18,540					17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	2,410				21.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,071		4,524,303	0	4,524,303	30.00
31.00	03100	INTENSIVE CARE UNIT	1,553		839,277	0	839,277	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	1,125		320,099	0	320,099	31.01
41.00	04100	SUBPROVIDER - IRF	1,153		552,400	0	552,400	41.00
43.00	04300	NURSERY	638		90,689	0	90,689	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0		2,604,412	0	2,604,412	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		527,531	0	527,531	52.00
53.00	05300	ANESTHESIOLOGY	0		43,433	0	43,433	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		1,695,177	0	1,695,177	54.00
60.00	06000	LABORATORY	0		636,030	0	636,030	60.00
65.00	06500	RESPIRATORY THERAPY	0		140,635	0	140,635	65.00
66.00	06600	PHYSICAL THERAPY	0		161,320	0	161,320	66.00
67.00	06700	OCCUPATIONAL THERAPY	0		5,697	0	5,697	67.00
68.00	06800	SPEECH PATHOLOGY	0		2,702	0	2,702	68.00
69.00	06900	ELECTROCARDIOLOGY	0		1,079,474	0	1,079,474	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		40,596	0	40,596	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		384,397	0	384,397	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		415,518	0	415,518	73.00
74.00	07400	RENAL DIALYSIS	0		33,576	0	33,576	74.00
76.00	03950	ANCILLARY	0		0	0	0	76.00
76.01	03610	SLEEP LAB	0		0	0	0	76.01
76.03	03951	WOUND CARE	0		266,682	0	266,682	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0		1,591,168	0	1,591,168	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,540	0	15,955,116	0	15,955,116	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		121,392	0	121,392	192.00
192.01	19201	GUEST MEALS	0		1,242	0	1,242	192.01
200.00		Cross Foot Adjustments		2,410	2,410	0	2,410	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	18,540	2,410	16,080,160	0	16,080,160	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 4:45 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	652,579					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		652,579				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,668	2,668	95,412,091			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	32,946	32,946	8,157,256	-74,767,469	247,799,365	5.00
7.00	00700	OPERATION OF PLANT	199,645	199,645	2,613,493	0	19,180,010	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	956	956	0	0	1,570,342	8.00
9.00	00900	HOUSEKEEPING	6,030	6,030	0	0	5,554,046	9.00
10.00	01000	DIETARY	19,500	19,500	0	0	3,009,177	10.00
11.00	01100	CAFETERIA	0	0	0	0	3,765,474	11.00
13.00	01300	NURSING ADMINISTRATION	3,856	3,856	5,248,462	0	7,041,261	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,141	13,141	1,018,466	0	3,055,195	14.00
15.00	01500	PHARMACY	7,401	7,401	2,943,932	0	4,196,294	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,560	2,560	842,529	0	2,563,564	16.00
17.00	01700	SOCIAL SERVICE	294	294	1,006,665	0	2,032,024	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	241,726	0	663,157	21.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	103,017	103,017	19,009,441	0	34,662,738	30.00
31.00	03100	INTENSIVE CARE UNIT	19,331	19,331	5,969,098	0	9,780,308	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	7,534	7,534	2,504,997	0	3,606,847	31.01
41.00	04100	SUBPROVIDER - IRF	13,258	13,258	1,521,214	0	2,561,805	41.00
43.00	04300	NURSERY	2,389	2,389	0	0	104,028	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	65,516	65,516	9,386,197	0	19,842,360	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,040	13,040	2,298,561	0	3,910,761	52.00
53.00	05300	ANESTHESIOLOGY	1,131	1,131	308	0	31,880	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	43,064	43,064	8,722,503	0	14,050,681	54.00
60.00	06000	LABORATORY	14,082	14,082	5,493,858	0	13,725,357	60.00
65.00	06500	RESPIRATORY THERAPY	3,186	3,186	1,952,365	0	3,984,451	65.00
66.00	06600	PHYSICAL THERAPY	4,080	4,080	1,583,257	0	2,212,871	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	935,982	0	1,283,104	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	469,925	0	619,654	68.00
69.00	06900	ELECTROCARDIOLOGY	27,027	27,027	4,309,266	0	8,078,980	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	2,575,462	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	25,225,666	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	128,645	0	33,149,662	73.00
74.00	07400	RENAL DIALYSIS	658	658	826,167	0	1,237,915	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	6,858	6,858	704,153	0	1,722,439	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	39,411	39,411	7,523,625	0	12,797,304	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	652,579	652,579	95,412,091	-74,767,469	247,794,817	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	4,548	192.00
192.01	19201	GUEST MEALS	0	0	0	0	0	192.01
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)	5,134,877	10,945,283	20,183,748		74,767,469	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.868591	16.772349	0.211543		0.301726	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			65,742		817,441	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000689		0.003299	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: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 4:45 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	417,320					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	956	1,625,199				8.00
9.00	00900	HOUSEKEEPING	6,030	0	410,334			9.00
10.00	01000	DIETARY	19,500	0	19,500	214,112		10.00
11.00	01100	CAFETERIA	0	0	0	0	99,070	11.00
13.00	01300	NURSING ADMINISTRATION	3,856	0	3,856	0	6,024	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,141	6,667	13,141	0	2,180	14.00
15.00	01500	PHARMACY	7,401	0	7,401	0	2,687	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,560	0	2,560	0	1,510	16.00
17.00	01700	SOCIAL SERVICE	294	0	294	0	1,265	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	376	21.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	103,017	571,283	103,017	131,881	22,717	30.00
31.00	03100	INTENSIVE CARE UNIT	19,331	119,640	19,331	13,782	5,773	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	7,534	17,038	7,534	3,335	2,626	31.01
41.00	04100	SUBPROVIDER - IRF	13,258	38,836	13,258	12,390	1,663	41.00
43.00	04300	NURSERY	2,389	9,754	2,389	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	65,516	197,986	65,516	869	10,826	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,040	42,349	13,040	4,577	2,523	52.00
53.00	05300	ANESTHESIOLOGY	1,131	0	1,131	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	43,064	164,902	43,064	719	10,058	54.00
60.00	06000	LABORATORY	14,082	123	14,082	0	9,035	60.00
65.00	06500	RESPIRATORY THERAPY	3,186	0	3,186	0	2,206	65.00
66.00	06600	PHYSICAL THERAPY	4,080	7,346	4,080	0	1,775	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	1,158	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	482	68.00
69.00	06900	ELECTROCARDIOLOGY	27,027	102,185	27,027	4,133	4,916	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	95	73.00
74.00	07400	RENAL DIALYSIS	658	0	658	0	621	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	6,858	50,666	6,858	0	903	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	39,411	296,424	39,411	6,691	7,651	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	417,320	1,625,199	410,334	178,377	99,070	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	35,373	0	192.00
192.01	19201	GUEST MEALS	0	0	0	362	0	192.01
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)	24,967,118	2,101,350	7,590,604	5,444,479	4,901,615	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	59.827274	1.292980	18.498599	25.428182	49.476279	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	4,984,519	40,156	238,931	734,691	12,422	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	11.944117	0.024708	0.582284	3.431340	0.125386	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: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 4:45 pm

		Cost Center Description	NURSING ADMINISTRATION (NURSING WAGES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	41,412,702					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	43,129,644				14.00
15.00	01500	PHARMACY	0	0	33,153,868			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,004	0	2,710,600,080		16.00
17.00	01700	SOCIAL SERVICE	0	4,874	0	0	61,080	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	654	0	0	0	21.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,760,259	1,709,060	0	201,893,415	46,359	30.00
31.00	03100	INTENSIVE CARE UNIT	5,708,232	605,938	0	33,731,332	5,116	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	2,399,864	201,840	0	22,923,458	3,707	31.01
41.00	04100	SUBPROVIDER - IRF	969,510	68,655	0	12,915,030	3,797	41.00
43.00	04300	NURSERY	0	43,983	0	4,244,990	2,101	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,654,139	4,026,350	0	500,084,080	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,822,146	267,938	0	17,770,568	0	52.00
53.00	05300	ANESTHESIOLOGY	308	3,616	0	32,008,878	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,296,815	1,318,618	0	354,163,773	0	54.00
60.00	06000	LABORATORY	0	4,400,569	0	293,919,860	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	420,749	0	66,119,062	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3,125	0	21,671,685	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	17,276,944	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	7,016,436	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,969,122	942,999	0	229,677,294	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,575,462	0	58,089,844	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	25,225,666	0	229,247,114	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,726	0	33,153,868	378,520,917	0	73.00
74.00	07400	RENAL DIALYSIS	590,300	148,688	0	5,915,562	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	616,749	125,557	0	6,583,556	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,622,532	1,030,299	0	216,826,282	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	41,412,702	43,129,644	33,153,868	2,710,600,080	61,080	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	GUEST MEALS	0	0	0	0	0	192.01
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)	9,765,863	5,122,785	6,175,058	3,612,875	2,731,332	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.235818	0.118776	0.186255	0.001333	44.717289	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	170,917	499,635	291,283	104,434	18,540	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.004127	0.011584	0.008786	0.000039	0.303536	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: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 4:45 pm

		Cost Center Description	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES (ASSIGNED TIME)	
			21.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	100	21.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	100	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	31.01
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	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
60.00	06000	LABORATORY	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
74.00	07400	RENAL DIALYSIS	0	74.00
76.00	03950	ANCILLARY	0	76.00
76.01	03610	SLEEP LAB	0	76.01
76.03	03951	WOUND CARE	0	76.03
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
		SPECIAL PURPOSE COST CENTERS		
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	19201	GUEST MEALS	0	192.01
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)	881,930	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8,819.300000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	2,410	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	24.100000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I | Date/Time Prepared: 5/29/2024 4:45 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	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	64,196,433		64,196,433	0	64,196,433	30.00
31.00	03100	INTENSIVE CARE UNIT	16,727,981		16,727,981	0	16,727,981	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	6,308,221		6,308,221	0	6,308,221	31.01
41.00	04100	SUBPROVIDER - IRF	5,244,551		5,244,551	0	5,244,551	41.00
43.00	04300	NURSERY	439,982		439,982	0	439,982	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	34,252,473		34,252,473	0	34,252,473	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,893,287		6,893,287	0	6,893,287	52.00
53.00	05300	ANESTHESIOLOGY	173,256		173,256	0	173,256	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,326,825		23,326,825	0	23,326,825	54.00
60.00	06000	LABORATORY	20,331,293		20,331,293	0	20,331,293	60.00
65.00	06500	RESPIRATORY THERAPY	5,683,467	0	5,683,467	0	5,683,467	65.00
66.00	06600	PHYSICAL THERAPY	3,326,698	0	3,326,698	0	3,326,698	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,750,574	0	1,750,574	0	1,750,574	67.00
68.00	06800	SPEECH PATHOLOGY	839,821	0	839,821	0	839,821	68.00
69.00	06900	ELECTROCARDIOLOGY	13,996,495		13,996,495	0	13,996,495	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,735,883		3,735,883	0	3,735,883	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	36,138,712		36,138,712	0	36,138,712	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	49,836,746		49,836,746	0	49,836,746	73.00
74.00	07400	RENAL DIALYSIS	1,858,438		1,858,438	0	1,858,438	74.00
76.00	03950	ANCILLARY	0		0	0	0	76.00
76.01	03610	SLEEP LAB	0		0	0	0	76.01
76.03	03951	WOUND CARE	3,058,619		3,058,619	0	3,058,619	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	22,650,553		22,650,553	0	22,650,553	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	7,959,018		7,959,018		7,959,018	92.00
200.00		Subtotal (see instructions)	328,729,326	0	328,729,326	0	328,729,326	200.00
201.00		Less Observation Beds	7,959,018		7,959,018		7,959,018	201.00
202.00		Total (see instructions)	320,770,308	0	320,770,308	0	320,770,308	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I | Date/Time Prepared: 5/29/2024 4:45 pm

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		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	185,398,030		185,398,030			30.00
31.00	03100	INTENSIVE CARE UNIT	33,731,332		33,731,332			31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	22,923,458		22,923,458			31.01
41.00	04100	SUBPROVIDER - IRF	12,915,030		12,915,030			41.00
43.00	04300	NURSERY	4,244,990		4,244,990			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	211,724,376	288,359,704	500,084,080	0.068493	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	17,605,875	164,693	17,770,568	0.387905	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	12,398,193	19,610,685	32,008,878	0.005413	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	90,202,191	263,961,582	354,163,773	0.065865	0.000000	54.00
60.00	06000	LABORATORY	129,144,739	164,775,121	293,919,860	0.069173	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	62,913,325	3,205,737	66,119,062	0.085958	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	20,312,808	1,358,877	21,671,685	0.153504	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	16,861,551	415,393	17,276,944	0.101324	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	6,672,364	344,072	7,016,436	0.119693	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	94,758,951	134,918,343	229,677,294	0.060940	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	31,203,609	26,886,235	58,089,844	0.064312	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	137,421,149	91,825,965	229,247,114	0.157641	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	90,329,102	288,191,815	378,520,917	0.131662	0.000000	73.00
74.00	07400	RENAL DIALYSIS	5,850,034	65,528	5,915,562	0.314161	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.03	03951	WOUND CARE	635,072	5,948,484	6,583,556	0.464585	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	55,390,629	161,435,653	216,826,282	0.104464	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,924,345	9,571,040	16,495,385	0.482500	0.000000	92.00
200.00		Subtotal (see instructions)	1,249,561,153	1,461,038,927	2,710,600,080			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	1,249,561,153	1,461,038,927	2,710,600,080			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 4:45 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		31.01
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.068493	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.387905	52.00
53.00	05300	ANESTHESIOLOGY	0.005413	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.065865	54.00
60.00	06000	LABORATORY	0.069173	60.00
65.00	06500	RESPIRATORY THERAPY	0.085958	65.00
66.00	06600	PHYSICAL THERAPY	0.153504	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.101324	67.00
68.00	06800	SPEECH PATHOLOGY	0.119693	68.00
69.00	06900	ELECTROCARDIOLOGY	0.060940	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.064312	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.157641	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.131662	73.00
74.00	07400	RENAL DIALYSIS	0.314161	74.00
76.00	03950	ANCILLARY	0.000000	76.00
76.01	03610	SLEEP LAB	0.000000	76.01
76.03	03951	WOUND CARE	0.464585	76.03
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.104464	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.482500	92.00
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: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I | Date/Time Prepared: 5/29/2024 4:45 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	64,196,433		64,196,433	0	64,196,433	30.00
31.00	03100	INTENSIVE CARE UNIT	16,727,981		16,727,981	0	16,727,981	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	6,308,221		6,308,221	0	6,308,221	31.01
41.00	04100	SUBPROVIDER - IRF	5,244,551		5,244,551	0	5,244,551	41.00
43.00	04300	NURSERY	439,982		439,982	0	439,982	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	34,252,473		34,252,473	0	34,252,473	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,893,287		6,893,287	0	6,893,287	52.00
53.00	05300	ANESTHESIOLOGY	173,256		173,256	0	173,256	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,326,825		23,326,825	0	23,326,825	54.00
60.00	06000	LABORATORY	20,331,293		20,331,293	0	20,331,293	60.00
65.00	06500	RESPIRATORY THERAPY	5,683,467	0	5,683,467	0	5,683,467	65.00
66.00	06600	PHYSICAL THERAPY	3,326,698	0	3,326,698	0	3,326,698	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,750,574	0	1,750,574	0	1,750,574	67.00
68.00	06800	SPEECH PATHOLOGY	839,821	0	839,821	0	839,821	68.00
69.00	06900	ELECTROCARDIOLOGY	13,996,495		13,996,495	0	13,996,495	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,735,883		3,735,883	0	3,735,883	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	36,138,712		36,138,712	0	36,138,712	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	49,836,746		49,836,746	0	49,836,746	73.00
74.00	07400	RENAL DIALYSIS	1,858,438		1,858,438	0	1,858,438	74.00
76.00	03950	ANCILLARY	0		0	0	0	76.00
76.01	03610	SLEEP LAB	0		0	0	0	76.01
76.03	03951	WOUND CARE	3,058,619		3,058,619	0	3,058,619	76.03
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	22,650,553		22,650,553	0	22,650,553	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	7,959,018		7,959,018		7,959,018	92.00
200.00		Subtotal (see instructions)	328,729,326	0	328,729,326	0	328,729,326	200.00
201.00		Less Observation Beds	7,959,018		7,959,018		7,959,018	201.00
202.00		Total (see instructions)	320,770,308	0	320,770,308	0	320,770,308	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I | Date/Time Prepared: 5/29/2024 4:45 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	185,398,030		185,398,030			30.00
31.00	03100	INTENSIVE CARE UNIT	33,731,332		33,731,332			31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	22,923,458		22,923,458			31.01
41.00	04100	SUBPROVIDER - IRF	12,915,030		12,915,030			41.00
43.00	04300	NURSERY	4,244,990		4,244,990			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	211,724,376	288,359,704	500,084,080	0.068493	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	17,605,875	164,693	17,770,568	0.387905	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	12,398,193	19,610,685	32,008,878	0.005413	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	90,202,191	263,961,582	354,163,773	0.065865	0.000000	54.00
60.00	06000	LABORATORY	129,144,739	164,775,121	293,919,860	0.069173	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	62,913,325	3,205,737	66,119,062	0.085958	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	20,312,808	1,358,877	21,671,685	0.153504	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	16,861,551	415,393	17,276,944	0.101324	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	6,672,364	344,072	7,016,436	0.119693	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	94,758,951	134,918,343	229,677,294	0.060940	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	31,203,609	26,886,235	58,089,844	0.064312	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	137,421,149	91,825,965	229,247,114	0.157641	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	90,329,102	288,191,815	378,520,917	0.131662	0.000000	73.00
74.00	07400	RENAL DIALYSIS	5,850,034	65,528	5,915,562	0.314161	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.03	03951	WOUND CARE	635,072	5,948,484	6,583,556	0.464585	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	55,390,629	161,435,653	216,826,282	0.104464	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,924,345	9,571,040	16,495,385	0.482500	0.000000	92.00
200.00		Subtotal (see instructions)	1,249,561,153	1,461,038,927	2,710,600,080			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	1,249,561,153	1,461,038,927	2,710,600,080			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 4:45 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		31.01
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
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
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.00	03950	ANCILLARY	0.000000	76.00
76.01	03610	SLEEP LAB	0.000000	76.01
76.03	03951	WOUND CARE	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
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: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part I | Date/Time Prepared: 5/29/2024 4:45 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	4,524,303	0	4,524,303	52,920	85.49	30.00
31.00	INTENSIVE CARE UNIT	839,277		839,277	5,116	164.05	31.00
31.01	NEONATAL INTENSIVE CARE UNIT	320,099		320,099	3,707	86.35	31.01
41.00	SUBPROVIDER - IRF	552,400	0	552,400	3,797	145.48	41.00
43.00	NURSERY	90,689		90,689	2,101	43.16	43.00
200.00	Total (lines 30 through 199)	6,326,768		6,326,768	67,641		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	16,826	1,438,455	30.00
31.00	INTENSIVE CARE UNIT	1,811	297,095	31.00
31.01	NEONATAL INTENSIVE CARE UNIT	0	0	31.01
41.00	SUBPROVIDER - IRF	2,398	348,861	41.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	21,035	2,084,411	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II | Date/Time Prepared: 5/29/2024 4:45 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,604,412	500,084,080	0.005208	72,034,426	375,155	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	527,531	17,770,568	0.029686	28,845	856	52.00
53.00	05300	ANESTHESIOLOGY	43,433	32,008,878	0.001357	3,454,612	4,688	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,695,177	354,163,773	0.004786	31,962,539	152,973	54.00
60.00	06000	LABORATORY	636,030	293,919,860	0.002164	42,629,999	92,251	60.00
65.00	06500	RESPIRATORY THERAPY	140,635	66,119,062	0.002127	21,663,434	46,078	65.00
66.00	06600	PHYSICAL THERAPY	161,320	21,671,685	0.007444	6,472,675	48,183	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,697	17,276,944	0.000330	5,218,651	1,722	67.00
68.00	06800	SPEECH PATHOLOGY	2,702	7,016,436	0.000385	1,928,302	742	68.00
69.00	06900	ELECTROCARDIOLOGY	1,079,474	229,677,294	0.004700	35,490,523	166,805	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	40,596	58,089,844	0.000699	10,136,173	7,085	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	384,397	229,247,114	0.001677	55,011,317	92,254	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	415,518	378,520,917	0.001098	27,922,465	30,659	73.00
74.00	07400	RENAL DIALYSIS	33,576	5,915,562	0.005676	2,181,904	12,384	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0	0	76.01
76.03	03951	WOUND CARE	266,682	6,583,556	0.040507	131,614	5,331	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,591,168	216,826,282	0.007338	18,500,902	135,760	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	560,920	16,495,385	0.034005	2,032,791	69,125	92.00
200.00		Total (lines 50 through 199)	10,189,268	2,451,387,240		336,801,172	1,242,051	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part III Date/Time Prepared: 5/29/2024 4:45 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	31.01
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	52,920	0.00	16,826	30.00
31.00	03100	INTENSIVE CARE UNIT		0	5,116	0.00	1,811	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		0	3,707	0.00	0	31.01
41.00	04100	SUBPROVIDER - IRF	0	0	3,797	0.00	2,398	41.00
43.00	04300	NURSERY		0	2,101	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	67,641		21,035	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	31.01
41.00	04100	SUBPROVIDER - IRF	0	41.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0035

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

Worksheet D Part IV

Date/Time Prepared: 5/29/2024 4:45 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0035

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

Worksheet D Part IV

Date/Time Prepared: 5/29/2024 4:45 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	500,084,080	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	17,770,568	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	32,008,878	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	354,163,773	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	293,919,860	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	66,119,062	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	21,671,685	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	17,276,944	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	7,016,436	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	229,677,294	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	58,089,844	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	229,247,114	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	378,520,917	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	5,915,562	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0.000000	76.01
76.03	03951	WOUND CARE	0	0	0	6,583,556	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	216,826,282	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	16,495,385	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	2,451,387,240		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/29/2024 4:45 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	72,034,426	0	75,565,751	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	28,845	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	3,454,612	0	5,031,568	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	31,962,539	0	62,771,391	0	54.00
60.00	06000	LABORATORY	0.000000	42,629,999	0	17,781,948	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	21,663,434	0	815,805	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	6,472,675	0	222,161	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	5,218,651	0	60,887	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	1,928,302	0	28,958	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	35,490,523	0	48,136,939	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	10,136,173	0	7,020,205	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	55,011,317	0	34,074,178	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	27,922,465	0	94,238,921	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	2,181,904	0	51,369	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03951	WOUND CARE	0.000000	131,614	0	1,276,601	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	18,500,902	0	21,428,125	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	2,032,791	0	2,025,102	0	92.00
200.00		Total (lines 50 through 199)		336,801,172	0	370,529,909	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V | Date/Time Prepared: 5/29/2024 4:45 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.068493	75,565,751	0	0	5,175,725	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.387905	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.005413	5,031,568	0	0	27,236	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.065865	62,771,391	0	0	4,134,438	54.00
60.00	06000	LABORATORY	0.069173	17,781,948	326	0	1,230,031	60.00
65.00	06500	RESPIRATORY THERAPY	0.085958	815,805	0	0	70,125	65.00
66.00	06600	PHYSICAL THERAPY	0.153504	222,161	0	0	34,103	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.101324	60,887	0	0	6,169	67.00
68.00	06800	SPEECH PATHOLOGY	0.119693	28,958	0	0	3,466	68.00
69.00	06900	ELECTROCARDIOLOGY	0.060940	48,136,939	0	0	2,933,465	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.064312	7,020,205	0	0	451,483	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.157641	34,074,178	0	0	5,371,487	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.131662	94,238,921	0	28,601	12,407,685	73.00
74.00	07400	RENAL DIALYSIS	0.314161	51,369	0	0	16,138	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03951	WOUND CARE	0.464585	1,276,601	0	0	593,090	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.104464	21,428,125	0	109	2,238,468	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.482500	2,025,102	0	0	977,112	92.00
200.00		Subtotal (see instructions)		370,529,909	326	28,710	35,670,221	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		370,529,909	326	28,710	35,670,221	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/29/2024 4:45 pm

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
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
60.00	06000	LABORATORY	23	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,766	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	ANCILLARY	0	0	76.00
76.01	03610	SLEEP LAB	0	0	76.01
76.03	03951	WOUND CARE	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0	11	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	23	3,777	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	23	3,777	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II | Date/Time Prepared: 5/29/2024 4:45 pm

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	2,604,412	500,084,080	0.005208	166,626	868	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	527,531	17,770,568	0.029686	0	0	52.00
53.00	05300	ANESTHESIOLOGY	43,433	32,008,878	0.001357	4,240	6	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,695,177	354,163,773	0.004786	258,540	1,237	54.00
60.00	06000	LABORATORY	636,030	293,919,860	0.002164	1,584,260	3,428	60.00
65.00	06500	RESPIRATORY THERAPY	140,635	66,119,062	0.002127	1,131	2	65.00
66.00	06600	PHYSICAL THERAPY	161,320	21,671,685	0.007444	2,602,745	19,375	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,697	17,276,944	0.000330	2,724,558	899	67.00
68.00	06800	SPEECH PATHOLOGY	2,702	7,016,436	0.000385	604,782	233	68.00
69.00	06900	ELECTROCARDIOLOGY	1,079,474	229,677,294	0.004700	291,190	1,369	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	40,596	58,089,844	0.000699	2,455	2	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	384,397	229,247,114	0.001677	31,509	53	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	415,518	378,520,917	0.001098	1,024,514	1,125	73.00
74.00	07400	RENAL DIALYSIS	33,576	5,915,562	0.005676	192,752	1,094	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0	0	76.01
76.03	03951	WOUND CARE	266,682	6,583,556	0.040507	2,285	93	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,591,168	216,826,282	0.007338	68,423	502	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	16,495,385	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	9,628,348	2,451,387,240		9,560,010	30,286	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0035 Component CCN: 15-T035	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/29/2024 4:45 pm
	Title XVIII	Subprovider - IRF	PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/29/2024 4:45 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	500,084,080	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	17,770,568	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	32,008,878	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	354,163,773	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	293,919,860	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	66,119,062	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	21,671,685	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	17,276,944	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	7,016,436	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	229,677,294	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	58,089,844	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	229,247,114	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	378,520,917	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	5,915,562	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0.000000	76.01
76.03	03951	WOUND CARE	0	0	0	6,583,556	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	216,826,282	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	16,495,385	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	2,451,387,240		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/29/2024 4:45 pm

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	0.000000	166,626	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	4,240	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	258,540	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	1,584,260	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,131	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	2,602,745	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	2,724,558	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	604,782	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	291,190	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	2,455	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	31,509	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,024,514	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	192,752	0	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03951	WOUND CARE	0.000000	2,285	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	68,423	0	327	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)		9,560,010	0	327	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V | Date/Time Prepared: 5/29/2024 4:45 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.068493	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.387905	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.005413	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.065865	0	0	0	0	54.00
60.00	06000	LABORATORY	0.069173	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.085958	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.153504	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.101324	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.119693	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.060940	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.064312	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.157641	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.131662	0	0	2,477	0	73.00
74.00	07400	RENAL DIALYSIS	0.314161	0	0	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03951	WOUND CARE	0.464585	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.104464	327	0	0	34	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.482500	0	0	0	0	92.00
200.00		Subtotal (see instructions)		327	0	2,477	34	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		327	0	2,477	34	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V | Date/Time Prepared: 5/29/2024 4:45 pm

Title XVIII | Subprovider - IRF | 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
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
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	326	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	ANCILLARY	0	0	76.00
76.01	03610	SLEEP LAB	0	0	76.01
76.03	03951	WOUND CARE	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS			
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	326	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	326	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V | Date/Time Prepared: 5/29/2024 4:45 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.068493	0	0	32,489,291	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.387905	0	0	45,350	0	52.00
53.00	05300	ANESTHESIOLOGY	0.005413	0	0	2,204,666	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.065865	0	0	39,262,356	0	54.00
60.00	06000	LABORATORY	0.069173	0	0	23,304,645	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.085958	0	0	635,280	0	65.00
66.00	06600	PHYSICAL THERAPY	0.153504	0	0	116,077	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.101324	0	0	40,322	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.119693	0	0	52,636	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.060940	0	0	10,465,507	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.064312	0	0	2,559,262	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.157641	0	0	6,390,675	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.131662	0	0	34,240,399	0	73.00
74.00	07400	RENAL DIALYSIS	0.314161	0	0	6,884	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03951	WOUND CARE	0.464585	0	0	790,069	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.104464	0	0	51,645,273	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.482500	0	0	1,788,638	0	92.00
200.00		Subtotal (see instructions)		0	0	206,037,330	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	206,037,330	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/29/2024 4:45 pm

Title XIX | Hospital | Cost

		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	2,225,289	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	17,591	52.00
53.00	05300	ANESTHESIOLOGY	0	11,934	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,586,015	54.00
60.00	06000	LABORATORY	0	1,612,052	60.00
65.00	06500	RESPIRATORY THERAPY	0	54,607	65.00
66.00	06600	PHYSICAL THERAPY	0	17,818	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,086	67.00
68.00	06800	SPEECH PATHOLOGY	0	6,300	68.00
69.00	06900	ELECTROCARDIOLOGY	0	637,768	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	164,591	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,007,432	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,508,159	73.00
74.00	07400	RENAL DIALYSIS	0	2,163	74.00
76.00	03950	ANCILLARY	0	0	76.00
76.01	03610	SLEEP LAB	0	0	76.01
76.03	03951	WOUND CARE	0	367,054	76.03
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0	5,395,072	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	863,018	92.00
200.00		Subtotal (see instructions)	0	19,480,949	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	19,480,949	202.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 4:45 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	52,926	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	52,920	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)	46,359	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	6	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)	16,826	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)	4	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)	64,196,433	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)	64,196,433	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)	64,196,433	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)	1,213.08	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	20,411,284	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)	20,411,284	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 4:45 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	16,727,981	5,116	3,269.74	1,811	5,921,499	43.00
43.01	NEONATAL INTENSIVE CARE UNIT	6,308,221	3,707	1,701.71	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)	32,456,259	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)	58,789,042	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)	1,735,550	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,242,051	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,977,601	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	55,811,441	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)	6,561	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,213.08	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0035	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/29/2024 4:45 pm
	Title XVIII	Hospital	PPS

	Cost Center Description	1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	7,959,018	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	4,524,303	64,196,433	0.070476	7,959,018	560,920	90.00
91.00	Nursing Program cost	0	64,196,433	0.000000	7,959,018	0	91.00
92.00	Allied health cost	0	64,196,433	0.000000	7,959,018	0	92.00
93.00	All other Medical Education	0	64,196,433	0.000000	7,959,018	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 4:45 pm

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)	3,797	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,797	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)	3,797	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)	2,398	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)	5,244,551	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)	5,244,551	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)	5,244,551	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)	1,381.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,312,214	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)	3,312,214	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 4:45 pm

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	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
43.01	NEONATAL INTENSIVE CARE UNIT	0	0	0.00	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)	1,112,658	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)	4,424,872	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)	348,861	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	30,286	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	379,147	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	4,045,725	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)	0	87.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0035 Component CCN: 15-T035	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/29/2024 4:45 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
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	552,400	5,244,551	0.105328	0	0	90.00
91.00	Nursing Program cost	0	5,244,551	0.000000	0	0	91.00
92.00	Allied health cost	0	5,244,551	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,244,551	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 4:45 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	52,926	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	52,920	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)	46,359	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	6	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)	506	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)	2,101	15.00
16.00	Nursery days (title V or XIX only)	1,031	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)	64,196,433	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)	64,196,433	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)	64,196,433	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)	1,213.08	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	613,818	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)	613,818	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 4:45 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	439,982	2,101	209.42	1,031	215,912	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	16,727,981	5,116	3,269.74	164	536,237	43.00
43.01	NEONATAL INTENSIVE CARE UNIT	6,308,221	3,707	1,701.71	162	275,677	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)	12,569,451	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)	14,211,095	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)	6,561	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,213.08	88.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 4:45 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	7,959,018	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	4,524,303	64,196,433	0.070476	7,959,018	560,920	90.00
91.00	Nursing Program cost	0	64,196,433	0.000000	7,959,018	0	91.00
92.00	Allied health cost	0	64,196,433	0.000000	7,959,018	0	92.00
93.00	All other Medical Education	0	64,196,433	0.000000	7,959,018	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 4:45 pm

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)	3,797	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,797	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)	3,797	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1	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)	57	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)	2,101	15.00
16.00	Nursery days (title V or XIX only)	1,031	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)	5,244,551	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)	5,244,551	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)	5,244,551	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)	1,381.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	78,731	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)	78,731	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 4:45 pm

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	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
43.01	NEONATAL INTENSIVE CARE UNIT	0	0	0.00	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)	81,337	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)	160,068	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)	0	87.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0035 Component CCN: 15-T035	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/29/2024 4:45 pm
	Title XIX	Subprovider - IRF	Cost

	Cost Center Description	1.00	
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	552,400	5,244,551	0.105328	0	0	90.00
91.00	Nursing Program cost	0	5,244,551	0.000000	0	0	91.00
92.00	Allied health cost	0	5,244,551	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,244,551	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0035	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 5/29/2024 4:45 pm
	Title XVIII	Hospital	PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		63,689,742		30.00
31.00	03100	INTENSIVE CARE UNIT		11,694,058		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		0		31.01
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.068493	72,034,426	4,933,854	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.387905	28,845	11,189	52.00
53.00	05300	ANESTHESIOLOGY	0.005413	3,454,612	18,700	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.065865	31,962,539	2,105,213	54.00
60.00	06000	LABORATORY	0.069173	42,629,999	2,948,845	60.00
65.00	06500	RESPIRATORY THERAPY	0.085958	21,663,434	1,862,145	65.00
66.00	06600	PHYSICAL THERAPY	0.153504	6,472,675	993,582	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.101324	5,218,651	528,775	67.00
68.00	06800	SPEECH PATHOLOGY	0.119693	1,928,302	230,804	68.00
69.00	06900	ELECTROCARDIOLOGY	0.060940	35,490,523	2,162,792	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.064312	10,136,173	651,878	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.157641	55,011,317	8,672,039	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.131662	27,922,465	3,676,328	73.00
74.00	07400	RENAL DIALYSIS	0.314161	2,181,904	685,469	74.00
76.00	03950	ANCILLARY	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	76.01
76.03	03951	WOUND CARE	0.464585	131,614	61,146	76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.104464	18,500,902	1,932,678	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.482500	2,032,791	980,822	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		336,801,172	32,456,259	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)		336,801,172		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/29/2024 4:45 pm

Title XVIII | Subprovider - IRF | 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 INTENSIVE CARE UNIT				31.01
41.00	04100	SUBPROVIDER - IRF		8,063,350		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.068493	166,626	11,413	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.387905	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.005413	4,240	23	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.065865	258,540	17,029	54.00
60.00	06000	LABORATORY	0.069173	1,584,260	109,588	60.00
65.00	06500	RESPIRATORY THERAPY	0.085958	1,131	97	65.00
66.00	06600	PHYSICAL THERAPY	0.153504	2,602,745	399,532	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.101324	2,724,558	276,063	67.00
68.00	06800	SPEECH PATHOLOGY	0.119693	604,782	72,388	68.00
69.00	06900	ELECTROCARDIOLOGY	0.060940	291,190	17,745	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.064312	2,455	158	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.157641	31,509	4,967	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.131662	1,024,514	134,890	73.00
74.00	07400	RENAL DIALYSIS	0.314161	192,752	60,555	74.00
76.00	03950	ANCILLARY	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	76.01
76.03	03951	WOUND CARE	0.464585	2,285	1,062	76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.104464	68,423	7,148	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.482500	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		9,560,010	1,112,658	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)		9,560,010		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0035 | Component CCN: 15-U035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/29/2024 4:45 pm

Title XVIII | Swing Beds - SNF | 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 INTENSIVE CARE UNIT				31.01
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.068493	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.387905	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.005413	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.065865	0	0	54.00
60.00	06000	LABORATORY	0.069173	1,108	77	60.00
65.00	06500	RESPIRATORY THERAPY	0.085958	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.153504	2,125	326	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.101324	2,803	284	67.00
68.00	06800	SPEECH PATHOLOGY	0.119693	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.060940	294	18	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.064312	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.157641	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.131662	1,391	183	73.00
74.00	07400	RENAL DIALYSIS	0.314161	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	76.01
76.03	03951	WOUND CARE	0.464585	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.104464	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.482500	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		7,721	888	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)		7,721		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/29/2024 4:45 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		22,925,701		30.00
31.00	03100	INTENSIVE CARE UNIT		5,085,594		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		11,080,218		31.01
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		1,656,092		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.068493	24,271,761	1,662,446	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.387905	5,719,108	2,218,471	52.00
53.00	05300	ANESTHESIOLOGY	0.005413	1,895,886	10,262	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.065865	12,491,480	822,751	54.00
60.00	06000	LABORATORY	0.069173	18,509,907	1,280,386	60.00
65.00	06500	RESPIRATORY THERAPY	0.085958	6,936,402	596,239	65.00
66.00	06600	PHYSICAL THERAPY	0.153504	1,223,645	187,834	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.101324	847,309	85,853	67.00
68.00	06800	SPEECH PATHOLOGY	0.119693	788,666	94,398	68.00
69.00	06900	ELECTROCARDIOLOGY	0.060940	8,607,837	524,562	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.064312	3,572,012	229,723	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.157641	9,253,354	1,458,708	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.131662	13,224,522	1,741,167	73.00
74.00	07400	RENAL DIALYSIS	0.314161	430,303	135,184	74.00
76.00	03950	ANCILLARY	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	76.01
76.03	03951	WOUND CARE	0.464585	153,726	71,419	76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.104464	8,820,933	921,470	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.482500	1,095,499	528,578	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		117,842,350	12,569,451	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)		117,842,350		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/29/2024 4:45 pm

Title XIX | Subprovider - IRF | 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 INTENSIVE CARE UNIT				31.01
41.00	04100	SUBPROVIDER - IRF		642,715		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.068493	600	41	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.387905	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.005413	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.065865	14,419	950	54.00
60.00	06000	LABORATORY	0.069173	102,128	7,065	60.00
65.00	06500	RESPIRATORY THERAPY	0.085958	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.153504	214,428	32,916	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.101324	209,890	21,267	67.00
68.00	06800	SPEECH PATHOLOGY	0.119693	88,453	10,587	68.00
69.00	06900	ELECTROCARDIOLOGY	0.060940	1,458	89	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.064312	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.157641	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.131662	63,964	8,422	73.00
74.00	07400	RENAL DIALYSIS	0.314161	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	76.01
76.03	03951	WOUND CARE	0.464585	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.104464	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.482500	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		695,340	81,337	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)		695,340		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0035 Component CCN: 15-U035	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 5/29/2024 4:45 pm
	Title XIX	Swing Beds - SNF	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 INTENSIVE CARE UNIT				31.01
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.068493	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.387905	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.005413	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.065865	0	0	54.00
60.00	06000	LABORATORY	0.069173	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.085958	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.153504	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.101324	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.119693	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.060940	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.064312	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.157641	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.131662	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.314161	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	76.01
76.03	03951	WOUND CARE	0.464585	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.104464	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.482500	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	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)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0035	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/29/2024 4:45 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	31,497,141	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	10,572,441	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)	345,825	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	224,783	2.04
3.00	Managed Care Simulated Payments	27,501,668	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	214.56	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
5.01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)	0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)	0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)	2.65	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	2.65	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.012351	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.012701	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.012351	21.00
22.00	IME payment adjustment (see instructions)	283,044	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	185,031	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	283,044	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	185,031	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	3.09	30.00
31.00	Percentage of Medicaid patient days (see instructions)	20.07	31.00
32.00	Sum of lines 30 and 31	23.16	32.00
33.00	Allowable disproportionate share percentage (see instructions)	8.32	33.00
34.00	Disproportionate share adjustment (see instructions)	875,048	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Date/Time Prepared: 5/29/2024 4:45 pm

Title XVIII | Hospital | PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Payment Adjustment			
35.00	Total uncompensated care amount (see instructions)	6,874,403,459	5,938,006,757	35.00
35.01	Factor 3 (see instructions)	0.000122773	0.000123796	35.01
35.02	Hospital UCP, including supplemental UCP (see instructions)	843,991	735,101	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	631,259	184,779	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	816,038		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)	44,614,320		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)	44,799,351	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	3,272,561	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).	131,572	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	116,383	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
55.01	Cellular therapy acquisition cost (see instructions)	0	55.01
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	48,319,867	59.00
60.00	Primary payer payments	52,712	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	48,267,155	61.00
62.00	Deductibles billed to program beneficiaries	4,153,220	62.00
63.00	Coinsurance billed to program beneficiaries	118,778	63.00
64.00	Allowable bad debts (see instructions)	128,859	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	83,758	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	20,461	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	44,078,915	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)	0	70.75
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	-54,445	70.93
70.94	HRR adjustment amount (see instructions)	-73,889	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A | Date/Time Prepared: 5/29/2024 4:45 pm

Title XVIII | Hospital | PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3	0	0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		43,950,581	71.00
71.01	Sequestration adjustment (see instructions)		879,012	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		42,490,402	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)		581,167	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		4,891,097	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part B Date/Time Prepared: 5/29/2024 4:45 pm

		Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,800	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	35,670,221	2.00
3.00	OPPS or REH payments	34,029,739	3.00
4.00	Outlier payment (see instructions)	71,139	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	3,800	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	29,036	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)	29,036	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	29,036	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	25,236	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)	3,800	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)	34,100,878	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	89,779	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	5,699,521	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)	28,315,378	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	74,302	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)	28,389,680	30.00
31.00	Primary payer payments	4,757	31.00
32.00	Subtotal (line 30 minus line 31)	28,384,923	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)	218,536	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	142,048	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	146,309	36.00
37.00	Subtotal (see instructions)	28,526,971	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-99	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	28,527,070	40.00
40.01	Sequestration adjustment (see instructions)	570,541	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	27,947,512	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	9,017	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: 15-0035	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/29/2024 4:45 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0035 Component CCN: 15-T035	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/29/2024 4:45 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	326	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	34	2.00
3.00	OPPS or REH payments	120	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	326	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	2,477	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)	2,477	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	2,477	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	2,151	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)	326	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)	120	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)	0	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)	446	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount (see instructions)		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	446	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	446	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	446	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	446	40.00
40.01	Sequestration adjustment (see instructions)	9	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	603	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-166	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0035 Component CCN: 15-T035	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/29/2024 4:45 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00
		1.00	
	MEDICARE PART B ANCILLARY COSTS		
200.00	Part B Combined Billed Days		200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I Date/Time Prepared: 5/29/2024 4:45 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		42,490,402		27,947,512	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		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)		42,490,402		27,947,512	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		581,167		9,017	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		43,071,569		27,956,529	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: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2024 4:45 pm

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		4,666,110		603	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		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)		4,666,110		603	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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		84,312		166	6.02
7.00	Total Medicare program liability (see instructions)		4,581,798		437	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: 15-0035 | Component CCN: 15-U035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2024 4:45 pm

Title XVIII | Swing Beds - SNF | 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		2,214		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		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		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)		2,214		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)					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		45		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,259		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0035	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/29/2024 4:45 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-0035 | Component CCN: 15-U035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-2 | Date/Time Prepared: 5/29/2024 4:45 pm

Title XVIII | Swing Beds - SNF | PPS

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	2,259	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	0	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	4	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	2,259	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,259	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	2,259	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	2,259	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	2,259	0	19.00
19.01	Sequestration adjustment (see instructions)	0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	2,214	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	45	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	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 swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-0035 | Component CCN: 15-U035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-2 | Date/Time Prepared: 5/29/2024 4:45 pm

Title XIX | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	0		3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)	0.00		4.00
5.00	Program days	0		5.00
6.00	Interns and residents not in approved teaching program (see instructions)	0		6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0		13.00
14.00	80% of Part B costs (line 12 x 80%)	0		14.00
15.00	Subtotal (see instructions)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)			16.55
16.99	Demonstration payment adjustment amount before sequestration	0		16.99
17.00	Allowable bad debts (see instructions)	0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		18.00
19.00	Total (see instructions)	0		19.00
19.01	Sequestration adjustment (see instructions)	0		19.01
19.02	Demonstration payment adjustment amount after sequestration)	0		19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0		19.25
20.00	Interim payments	0		20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0		21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	0		22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0		23.00
	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 swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0035 Component CCN: 15-T035	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part III Date/Time Prepared: 5/29/2024 4:45 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	4,529,972	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0103	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	99,206	3.00
4.00	Outlier Payments	77,826	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)	10.402740	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)	4,707,004	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)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	4,707,004	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	4,707,004	19.00
20.00	Deductibles	14,400	20.00
21.00	Subtotal (line 19 minus line 20)	4,692,604	21.00
22.00	Coinsurance	21,200	22.00
23.00	Subtotal (line 21 minus line 22)	4,671,404	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	6,000	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	3,900	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	6,000	26.00
27.00	Subtotal (sum of lines 23 and 25)	4,675,304	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)	0	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)	4,675,304	32.00
32.01	Sequestration adjustment (see instructions)	93,506	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	4,666,110	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)	-84,312	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	61,719	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	77,826	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: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-3 Part VII Date/Time Prepared: 5/29/2024 4:45 pm

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	14,211,095		1.00
2.00	Medical and other services		19,480,949	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	14,211,095	19,480,949	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)	14,211,095	19,480,949	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	40,747,605		8.00
9.00	Ancillary service charges	117,842,350	206,037,330	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)	158,589,955	206,037,330	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)	158,589,955	206,037,330	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	144,378,860	186,556,381	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)	14,211,095	19,480,949	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)	14,211,095	19,480,949	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)	14,211,095	19,480,949	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	14,211,095	19,480,949	36.00
37.00	SETTLEMENT ADJUSTMENT	-14,211,095	-19,480,949	37.00
38.00	Subtotal (line 36 ± line 37)	0	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)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	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: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-3 Part VII | Date/Time Prepared: 5/29/2024 4:45 pm

Title XIX | Subprovider - IRF | 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	160,068		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)	160,068	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)	160,068	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	695,340	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)	695,340	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)	695,340	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	535,272	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)	160,068	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)	160,068	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)	160,068	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	160,068	0	36.00
37.00	SETTLEMENT ADJUSTMENT	-160,068	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	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)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	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: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-4 | Date/Time Prepared: 5/29/2024 4:45 pm

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.	0.00	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	0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)	0.00	6.00
7.00	Enter the lesser of line 5 or line 6	0.00	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	0.00	0.00	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	0.00	0.00	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	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	2.65	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	2.65	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	2.65	0.00		17.00
18.00	Per resident amount	126,332.75	126,332.75		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	334,782	0	334,782	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)	0.00	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)	334,782	25.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS | Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-4 | Date/Time Prepared: 5/29/2024 4:45 pm

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)	21,035	16,121		26.00
27.00	Total Inpatient Days (see instructions)	59,564	59,564		27.00
28.00	Ratio of inpatient days to total inpatient days	0.353150	0.270650		28.00
29.00	Program direct GME amount	118,228	90,609	208,837	29.00
29.01	Percent reduction for MA DGME		3.27		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		2,963	2,963	30.00
31.00	Net Program direct GME amount			205,874	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)	5,915,562	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)	63,216,173	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)	52,712	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	63,163,461	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	35,674,381	42.00
43.00	Primary payer payments (see instructions)	4,757	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	35,669,624	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	98,833,085	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.639092	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.360908	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	205,874	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	131,572	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	74,302	50.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0035	Period: From 01/01/2023 To 12/31/2023	Worksheet E-5 Date/Time Prepared: 5/29/2024 4:45 pm
	Title XVIII		PPS

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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G | Date/Time Prepared: 5/29/2024 4:45 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-57,557	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	79,398,083	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-8,753,491	0	0	0	6.00
7.00	Inventory	11,247,122	0	0	0	7.00
8.00	Prepaid expenses	4,904,531	0	0	0	8.00
9.00	Other current assets	454,831	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	87,193,519	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	11,543,687	0	0	0	12.00
13.00	Land improvements	5,360,612	0	0	0	13.00
14.00	Accumulated depreciation	-3,208,542	0	0	0	14.00
15.00	Buildings	191,897,013	0	0	0	15.00
16.00	Accumulated depreciation	-49,743,987	0	0	0	16.00
17.00	Leasehold improvements	10,195,739	0	0	0	17.00
18.00	Accumulated depreciation	-5,090,323	0	0	0	18.00
19.00	Fixed equipment	7,638,085	0	0	0	19.00
20.00	Accumulated depreciation	-6,521,593	0	0	0	20.00
21.00	Automobiles and trucks	281,500	0	0	0	21.00
22.00	Accumulated depreciation	-228,507	0	0	0	22.00
23.00	Major movable equipment	55,384,249	0	0	0	23.00
24.00	Accumulated depreciation	-46,031,481	0	0	0	24.00
25.00	Minor equipment depreciable	16,846,709	0	0	0	25.00
26.00	Accumulated depreciation	-15,460,378	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)	172,862,783	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	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	19,001,180	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	19,001,180	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	279,057,482	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	16,577,412	0	0	0	37.00
38.00	Salaries, wages, and fees payable	14,853,318	0	0	0	38.00
39.00	Payroll taxes payable	954,129	0	0	0	39.00
40.00	Notes and loans payable (short term)	3,130,812	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	-510,167,945	0	0	0	43.00
44.00	Other current liabilities	2,733,311	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-471,918,963	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	29,091,768	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	29,091,768	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-442,827,195	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	721,884,677				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)	721,884,677	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	279,057,482	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 5/29/2024 4:45 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		680,264,098		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		41,620,579				2.00
3.00	Total (sum of line 1 and line 2)		721,884,677		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)		721,884,677		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)		721,884,677		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: 15-0035

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

Worksheet G-2 Parts I & II
Date/Time Prepared: 5/29/2024 4:45 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	189,643,020		189,643,020	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	12,915,030		12,915,030	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)	202,558,050		202,558,050	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	33,731,332		33,731,332	11.00
11.01	NEONATAL INTENSIVE CARE UNIT	22,923,458		22,923,458	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)	56,654,790		56,654,790	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	259,212,840		259,212,840	17.00
18.00	Ancillary services	928,033,339	1,290,032,234	2,218,065,573	18.00
19.00	Outpatient services	62,314,974	171,006,693	233,321,667	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				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	IP CONTRACTED HOSPICE	661,076	0	661,076	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	1,250,222,229	1,461,038,927	2,711,261,156	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		345,211,372		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)		345,211,372		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0035	Period: From 01/01/2023 To 12/31/2023	Worksheet G-3 Date/Time Prepared: 5/29/2024 4:45 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	2,711,261,156	1.00
2.00	Less contractual allowances and discounts on patients' accounts	2,325,432,776	2.00
3.00	Net patient revenues (line 1 minus line 2)	385,828,380	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	345,211,372	4.00
5.00	Net income from service to patients (line 3 minus line 4)	40,617,008	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	970,423	24.00
24.50	COVID-19 PHE Funding	33,148	24.50
25.00	Total other income (sum of lines 6-24)	1,003,571	25.00
26.00	Total (line 5 plus line 25)	41,620,579	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	41,620,579	29.00

CALCULATION OF CAPITAL PAYMENT | Provider CCN: 15-0035 | Period: From 01/01/2023 To 12/31/2023 | Worksheet L Parts I-III Date/Time Prepared: 5/29/2024 4:45 pm

Title XVIII | Hospital | PPS

		Urban Post 10/1	Rural Pre 10/1	
		1.00	1.01	
	PART I - FULLY PROSPECTIVE METHOD			
	CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier	814,606	2,377,968	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	0	1.01
2.00	Capital DRG outlier payments	25,242		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)	154.16		3.00
4.00	Number of interns & residents (see instructions)	2.65		4.00
5.00	Indirect medical education percentage (see instructions)	0.49		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)	15,644		6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	3.09		7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	20.07		8.00
9.00	Sum of lines 7 and 8	23.16		9.00
10.00	Allowable disproportionate share percentage (see instructions)	4.80		10.00
11.00	Disproportionate share adjustment (see instructions)	39,101		11.00
12.00	Total prospective capital payments (see instructions)	3,272,561		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