

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: 15-0009	Period: From 08/01/2022 To 07/31/2023	Worksheet S Parts I-III Date/Time Prepared: 12/29/2023 12:01 pm
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PART I - COST REPORT STATUS

Provider use only	1. [X] Electronically prepared cost report 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.	Date: 12/29/2023 Time: 12:01 pm
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. NPIR 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 CLARK MEMORIAL HOSPITAL (15-0009) for the cost reporting period beginning 08/01/2022 and ending 07/31/2023 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>Jason Schmiedt</i>		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Jason Schmiedt			2
3	Signatory Title	CHIEF FINANCIAL OFFICER			3
4	Date	(Dated when report is electronic)			4

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
		1.00	2.00			
PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	512,094	-1,835	0	-85,502
2.00	SUBPROVIDER - IPF	0	2,356	0	0	2.00
3.00	SUBPROVIDER - IRF	0	0	0	0	3.00
4.00	SUBPROVIDER (OTHER)	0	0	0	0	4.00
5.00	SWING BED - SNF	0	0	0	0	5.00
6.00	SWING BED - NF	0	0	0	0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0	0	7.00
200.00	TOTAL	0	514,450	-1,835	0	-85,502
200.00						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.

	1.00	2.00	3.00	4.00							
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1220 MISSOURI AVENUE	PO Box: 69	zip Code: 47130	County: CLARK							
2.00	City: JEFFERSONVILLE	State: IN		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	CLARK MEMORIAL HOSPITAL	150009	31140	1	07/01/1966	N	P	O	3.00	
4.00	Subprovider - IPF	BEHAVIORAL MEDICINE UNIT	15S009	31140	4	01/01/1992	N	P	P	4.00	
5.00	Subprovider - IRF									5.00	
6.00	Subprovider - (Other)									6.00	
7.00	Swing Beds - SNF									7.00	
8.00	Swing Beds - NF									8.00	
9.00	Hospital-Based SNF									9.00	
10.00	Hospital-Based NF									10.00	
11.00	Hospital-Based OLTC									11.00	
12.00	Hospital-Based HHA									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: 1.00	To: 2.00					
20.00	Cost Reporting Period (mm/dd/yyyy)				08/01/2022	07/31/2023	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)				Y		Y			22.01	
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period occurring 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: 15-000

Period:
From 08/01/2022
To 07/31/2023

Worksheet S-2
Part I
Date/Time Prepared:
12/29/2023 12:01 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.	0	1,551	0	125	8,837	27	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
							Urban/Rural S	Date of Geogr
							1.00	2.00
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.				1			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.				1			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.				0			35.00
					Beginning:	Ending:		
					1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.				0			37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N	Y/N		
					1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)				N	N		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)				Y	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.	Y	Y				60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)			23.00	1		60.01
		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 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

	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.	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)	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/(col. 1 + col. 2))	64.00
			1.00	2.00	3.00	
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
			1.00	2.00	3.00	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010	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
			1.00	2.00	3.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00
			1.00	2.00	3.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0009	Period: From 08/01/2022 To 07/31/2023	Worksheet S-2 Part I Date/Time Prepared: 12/29/2023 12:01 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)?			N 68.00
		1.00	2.00	3.00
Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			Y 70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N N 0 71.00
Inpatient Rehabilitation Facility PPS		1.00	2.00	3.00
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N 75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N 0 76.00
		1.00	2.00	3.00
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.			N 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.			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 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

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			V 1.00	XIX 2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. 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
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00
				1.00	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
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
				1.00	2.00
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			0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	1,092,089	0	0	118.01
				1.00	2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
119.00	DO NOT USE THIS LINE		N	N	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		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.				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	HB0616	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: LIFEPOINT HEALTH, INC.	Contractor's Name: PALMETTO GBA	Contractor's Number: 10001		141.00
142.00	Street: 330 SEVEN SPRINGS WAY	PO Box:			142.00
143.00	City: BRENTWOOD	State: TN	Zip Code: 37027		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0009	Period: From 08/01/2022 To 07/31/2023	Worksheet S-2 Part I Date/Time Prepared: 12/29/2023 12:01 pm
				1.00

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

	Part A	Part B	Title V	Title XIX
	1.00	2.00	3.00	4.00

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
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165.00	Multicampus 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
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	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
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						1.00
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167.00	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 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)	Y	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
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		Y/N	Date		
		1.00	2.00		
PART II - HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE					
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00	
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00	
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	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.	Y	A	12/31/2022	
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00	
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?	N		6.00	
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00	
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00	
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y		9.00	
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	Y		10.00	
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00	
		Y/N			
		1.00			
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00	
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00	
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.	N		14.00	
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00	
		Part A	Part B		
		Y/N	Date		
		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	11/02/2023	Y	11/02/2023
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	
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	
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	

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

COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)**Capital Related Cost**

22.00	Have assets been relieved for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	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.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00

Provider-Based Physicians

34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	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.	Y	12/31/2022
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
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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.	DANA	AYLWARD	41.00
42.00	Enter the employer/company name of the cost report preparer.	LIFEPOINT HEALTH, INC.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	203-260-7881	DANA.AYLWARD@LPNT.NET	43.00

	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.	REIMBURSEMENT 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

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
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	128	46,720	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)		128	46,720	0.00	0 7.00		
8.00	INTENSIVE CARE UNIT	31.00	22	8,030	0.00	0 8.00		
9.00	CORONARY CARE UNIT	32.00	0	0	0.00	0 9.00		
9.01	NEONATAL INTENSIVE CARE UNIT	32.01	3	1,095	0.00	0 9.01		
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)		153	55,845	0.00	0 14.00		
15.00	CAH visits					0 15.00		
15.10	REH hours and visits					15.10		
16.00	SUBPROVIDER - IPF	40.00	15	5,475		0 16.00		
17.00	SUBPROVIDER - IRF	41.00	0	0		0 17.00		
18.00	SUBPROVIDER	42.00	0	0		0 18.00		
19.00	SKILLED NURSING FACILITY	44.00	0	0		0 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)		168			0 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)					32.00		
32.01	Total ancillary labor & delivery room outpatient days (see instructions)		0	0		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		

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)	7,237	928	24,723		1.00
2.00 HMO and other (see instructions)	7,123	9,200			2.00
3.00 HMO IPF Subprovider	1,405	60			3.00
4.00 HMO IRF Subprovider	0	0			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0		5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	7,237	928	24,723		7.00
8.00 INTENSIVE CARE UNIT	465	170	4,437		8.00
9.00 CORONARY CARE UNIT	0	0	0		9.00
9.01 NEONATAL INTENSIVE CARE UNIT	0	66	706		9.01
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		149	2,085		13.00
14.00 Total (see instructions)	7,702	1,313	31,951	0.03	859.48
15.00 CAH visits	0	0	0		15.00
15.10 REH hours and visits					15.10
16.00 SUBPROVIDER - IPF	734	50	1,838	0.00	14.46
17.00 SUBPROVIDER - IRF	0	0	0	0.00	17.00
18.00 SUBPROVIDER		0	0	0.00	18.00
19.00 SKILLED NURSING FACILITY	0	0	0	0.00	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			60		24.00
24.10 HOSPICE (non-distinct part)			60		24.10
25.00 CMHC - CMHC					25.00
26.00 RURAL HEALTH CLINIC					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00
27.00 Total (sum of lines 14-26)				0.03	873.94
28.00 Observation Bed Days		55	2,348		28.00
29.00 Ambulance Trips	0				29.00
30.00 Employee discount days (see instruction)	0		92		30.00
31.00 Employee discount days - IRF			0		31.00
32.00 Labor & delivery days (see instructions)	0	27	48		32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0		32.01
33.00 LTCH non-covered days	0				33.00
33.01 LTCH site neutral days and discharges	0				33.01
34.00 Temporary Expansion COVID-19 PHE Acute Care	0	0	0		34.00

Component	Full Time Equivalents Nonpaid Workers	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		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	1,881	272	7,031	1.00
2.00 HMO and other (see instructions)			1,612	1,837		2.00
3.00 HMO IPF Subprovider				12		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
9.01 NEONATAL INTENSIVE CARE UNIT						9.01
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	1,881	272	7,031	14.00
15.00 CAH visits						15.00
15.10 REH hours and visits						15.10
16.00 SUBPROVIDER - IPF	0.00	0	84	7	190	16.00
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00 SUBPROVIDER	0.00	0		0	0	18.00
19.00 SKILLED NURSING FACILITY	0.00					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						
PART II - WAGE DATA														
SALARIES														
1.00	Total salaries (see instructions)	200.00	77,370,356	0	77,370,356	1,817,789.18	42.56	1.00						
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00						
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00						
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00						
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01						
5.00	Physician-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	0	0	0	0.00	0.00	7.00						
7.01	Contracted interns and residents (in an approved programs)		2,222	0	2,222	78.88	28.17	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)		19,878,604	27,548	19,906,152	368,309.51	54.05	10.00						
OTHER WAGES & RELATED COSTS														
11.00	Contract labor: Direct Patient Care		8,426,490	0	8,426,490	79,188.25	106.41	11.00						
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00						
13.00	Contract labor: Physician-Part A - Administrative		110,432	0	110,432	612.15	180.40	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		746,168	0	746,168	15,229.94	48.99	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)		10,199,472	0	10,199,472			17.00						
18.00	wage-related costs (other) (see instructions)							18.00						
19.00	Excluded areas		2,591,804	0	2,591,804			19.00						
20.00	Non-physician anesthetist Part A		0	0	0			20.00						
21.00	Non-physician anesthetist Part B		0	0	0			21.00						
22.00	Physician Part A - Administrative		0	0	0			22.00						
22.01	Physician Part A - Teaching		0	0	0			22.01						
23.00	Physician Part B		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)		0	0	0			25.00						
25.50	Home office wage-related (core)		612,460	0	612,460			25.50						
25.51	Related organization wage-related (core)		0	0	0			25.51						
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52						

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet S-3
Part II
Date/Time Prepared:
12/29/2023 12:01 pm

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
							1.00	2.00
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	742,552	0	742,552	19,568.11	37.95	26.00
27.00	Administrative & General	5.00	8,803,277	-210,933	8,592,344	261,861.84	32.81	27.00
28.00	Administrative & General under contract (see inst.)		8,803,282	0	8,803,282	3,097.97	2,841.63	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	989,687	0	989,687	35,502.00	27.88	30.00
31.00	Laundry & Linen Service	8.00	32,081	0	32,081	1,737.45	18.46	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,009,556	-661,896	347,660	17,191.20	20.22	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	661,896	661,896	33,817.45	19.57	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,033,997	210,933	1,244,930	21,796.56	57.12	38.00
39.00	Central Services and Supply	14.00	285,563	0	285,563	14,931.00	19.13	39.00
40.00	Pharmacy	15.00	2,249,683	0	2,249,683	51,711.42	43.50	40.00
41.00	Medical Records & Medical Records Library	16.00	519,613	-2,222	517,391	21,616.12	23.94	41.00
42.00	Social Service	17.00	1,145,366	0	1,145,366	32,017.22	35.77	42.00
43.00	other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet S-3
Part III
Date/Time Prepared:
12/29/2023 12:01 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)	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	86,171,416	0	86,171,416	1,820,808.27	47.33	1.00
2.00	Excluded area salaries (see instructions)	19,878,604	27,548	19,906,152	368,309.51	54.05	2.00
3.00	Subtotal salaries (line 1 minus line 2)	66,292,812	-27,548	66,265,264	1,452,498.76	45.62	3.00
4.00	Subtotal other wages & related costs (see inst.)	9,283,090	0	9,283,090	95,030.34	97.69	4.00
5.00	Subtotal wage-related costs (see inst.)	10,811,932	0	10,811,932	0.00	16.32	5.00
6.00	Total (sum of lines 3 thru 5)	86,387,834	-27,548	86,360,286	1,547,529.10	55.81	6.00
7.00	Total overhead cost (see instructions)	25,614,657	-2,222	25,612,435	514,848.34	49.75	7.00

		Amount Reported	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	500,322	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)	6,407,693	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	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	49,892	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	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)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	316,248	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	5,229,258	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	63,552	19.00
20.00	State or Federal Unemployment Taxes	57,533	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	121,050	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	46,283	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	12,791,831	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet S-3
Part V
Date/Time Prepared:
12/29/2023 12:01 pm

Cost Center Description		Contract Labor	Benefit Cost
PART V - Contract Labor and Benefit Cost		1.00	2.00
Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	8,426,490	12,791,831
2.00	Hospital	8,426,490	10,199,472
3.00	SUBPROVIDER - IPF	0	169,772
4.00	SUBPROVIDER - IRF	0	0
5.00	Subprovider - (Other)	0	4.00
6.00	Swing Beds - SNF	0	5.00
7.00	Swing Beds - NF	0	6.00
8.00	SKILLED NURSING FACILITY	0	7.00
9.00	NURSING FACILITY	0	8.00
10.00	OTHER LONG TERM CARE I		9.00
11.00	Hospital-Based HHA		10.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I		11.00
13.00	Hospital-Based Hospice		12.00
14.00	Hospital-Based Health Clinic RHC		13.00
15.00	Hospital-Based Health Clinic FQHC		14.00
16.00	Hospital-Based-CMHC		15.00
17.00	RENAL DIALYSIS I	0	16.00
18.00	other	0	17.00
			2,422,587
			18.00

Period: From 08/01/2022 To 07/31/2023	Worksheet S-10
	Date/Time Prepared: 12/29/2023 12:01 pm

			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.192583	1.00	
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	39,483,319	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	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	0	5.00	
6.00	Medicaid charges	155,936,074	6.00	
7.00	Medicaid cost (line 1 times line 6)	30,030,637	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	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 (line 11 minus line 9; if < zero then enter zero)	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 (line 15 minus line 13; if < zero then enter zero)	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 (see instructions for each line)				
20.00	charity care charges and uninsured discounts for the entire facility (see instructions)	9,869,426	10,867	9,880,293
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,900,684	10,867	1,911,551
22.00	Payments received from patients for amounts previously written off as charity care	0	44	44
23.00	Cost of charity care (line 21 minus line 22)	1,900,684	10,823	1,911,507
			1.00	
24.00	Does the amount on line 20 column 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
26.00	Total bad debt expense for the entire hospital complex (see instructions)		10,504,727	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		244,923	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		376,804	27.01
28.00	Non-Medicare bad debt expense (see instructions)		10,127,923	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		2,082,347	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		3,993,854	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		3,993,854	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023

Worksheet A

Date/Time Prepared:
12/29/2023 12:01 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
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT		5,222,905	5,222,905	1,291,911	6,514,816
2.00 00200	CAP REL COSTS-MVBLE EQUIP		0	0	4,403,971	4,403,971
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	742,552	6,916,318	7,658,870	-143,875	7,514,995
5.01 00540	NONPATIENT TELEPHONES	223,572	741,366	964,938	10	964,948
5.02 00590	PURCHASING	552,744	6,635,370	7,188,114	-6,388,846	799,268
5.03 00570	ADMITTING	2,246,755	585,333	2,832,088	-3,685	2,828,403
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	3,561,869	3,561,869	-6,070	3,555,799
5.05 00591	OTHER A&G	5,780,206	29,407,646	35,187,852	-1,694,916	33,492,936
7.00 00700	OPERATION OF PLANT	989,687	3,782,441	4,772,128	34,423	4,806,551
8.00 00800	LAUNDRY & LINEN SERVICE	32,081	906,446	938,527	-77,202	861,325
9.00 00900	HOUSEKEEPING	0	2,588,917	2,588,917	-758	2,588,159
10.00 01000	DIETARY	1,009,556	1,781,796	2,791,352	-1,942,083	849,269
11.00 01100	CAFETERIA	0	0	0	1,830,097	1,830,097
13.00 01300	NURSING ADMINISTRATION	1,033,997	786,680	1,820,677	246,838	2,067,515
14.00 01400	CENTRAL SERVICES & SUPPLY	285,563	309,402	594,965	-7,756	587,209
15.00 01500	PHARMACY	2,249,683	4,782,851	7,032,534	-3,866,340	3,166,194
16.00 01600	MEDICAL RECORDS & LIBRARY	519,613	1,194,057	1,713,670	-5,954	1,707,716
17.00 01700	SOCIAL SERVICE	1,145,366	350,338	1,495,704	-4,443	1,491,261
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	2,222	2,222
23.00 02300	PHARMACY PROGRAM	44,895	13,498	58,393	0	58,393
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	11,937,483	4,327,482	16,264,965	2,421,618	18,686,583
31.00 03100	INTENSIVE CARE UNIT	2,614,077	2,186,740	4,800,817	-2,829,377	1,971,440
32.00 03200	CORONARY CARE UNIT	0	0	0	0	0
32.01 02060	NEONATAL INTENSIVE CARE UNIT	860,355	759,789	1,620,144	-495,413	1,124,731
40.00 04000	SUBPROVIDER - IPF	1,276,375	135,904	1,412,279	30,355	1,442,634
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00 04200	SUBPROVIDER	0	0	0	0	0
43.00 04300	NURSERY	480,241	205,457	685,698	-138,663	547,035
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	3,839,240	7,399,476	11,238,716	-498,294	10,740,422
51.00 05100	RECOVERY ROOM	967,358	478,361	1,445,719	106,696	1,552,415
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,668,146	309,397	1,977,543	-616,056	1,361,487
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,813,569	5,528,936	10,342,505	-1,161,652	9,180,853
59.00 05900	CARDIAC CATHETERIZATION	1,592,573	336,780	1,929,353	734,706	2,664,059
60.00 06000	LABORATORY	2,450,457	3,417,444	5,867,901	-1,130,660	4,737,241
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	405,169	405,169	340,202	745,371
64.00 06400	INTRAVENOUS THERAPY	62,981	36,030	99,011	923,366	1,022,377
65.00 06500	RESPIRATORY THERAPY	1,682,060	636,545	2,318,605	306,748	2,625,353
66.00 06600	PHYSICAL THERAPY	687,132	54,850	741,982	-296	741,686
69.00 06900	ELECTROCARDIOLOGY	705,566	100,559	806,125	-109,866	696,259
70.00 07000	ELECTROENCEPHALOGRAPHY	101,305	24,102	125,407	19,986	145,393
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	6,864,568	6,864,568
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,655,310	7,655,310	653,564	8,308,874
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,316,861	4,316,861
74.00 07400	RENAL DIALYSIS	0	333,809	333,809	-78	333,731
76.00 03950	ANCILLARY	0	0	0	0	0
76.01 03951	PARTIAL HOSPITALIZATION	936,116	104,245	1,040,361	112	1,040,473
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	5,281,718	3,020,033	8,301,751	-414,725	7,887,026
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					91.00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE		2,991,246	2,991,246	-2,991,246	0
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	58,813,022	110,014,897	168,827,919	0	168,827,919
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	41,555	3,784	45,339	0	45,339
190.01 19001	MARKETING	0	202,752	202,752	0	202,752
192.00 19200	PHYSICIANS' PRIVATE OFFICES	18,451,522	10,608,570	29,060,092	0	29,060,092
194.00 07950	SIRH	0	0	0	0	0
194.01 07951	OTHER NRCC	64,257	683,576	747,833	0	747,833
200.00	TOTAL (SUM OF LINES 118 through 199)	77,370,356	121,513,579	198,883,935	0	198,883,935

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	-3,049,682	3,465,134	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	591,257	4,995,228	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-79,551	7,435,444	4.00
5.01	00540 NONPATIENT TELEPHONES	0	964,948	5.01
5.02	00590 PURCHASING	-498	798,770	5.02
5.03	00570 ADMITTING	-1,147	2,827,256	5.03
5.04	00580 CASHIERING/ACCOUNTS RECEIVABLE	0	3,555,799	5.04
5.05	00591 OTHER A&G	-15,884,186	17,608,750	5.05
7.00	00700 OPERATION OF PLANT	-59,239	4,747,312	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	861,325	8.00
9.00	00900 HOUSEKEEPING	0	2,588,159	9.00
10.00	01000 DIETARY	-436,437	412,832	10.00
11.00	01100 CAFETERIA	0	1,830,097	11.00
13.00	01300 NURSING ADMINISTRATION	-513,619	1,553,896	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	-103,331	483,878	14.00
15.00	01500 PHARMACY	0	3,166,194	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-4,734	1,702,982	16.00
17.00	01700 SOCIAL SERVICE	0	1,491,261	17.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	2,222	22.00
23.00	02300 PHARMACY PROGRAM	0	58,393	23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-941,076	17,745,507	30.00
31.00	03100 INTENSIVE CARE UNIT	-110,633	1,860,807	31.00
32.00	03200 CORONARY CARE UNIT	0	0	32.00
32.01	02060 NEONATAL INTENSIVE CARE UNIT	-475,000	649,731	32.01
40.00	04000 SUBPROVIDER - IPF	-10,000	1,432,634	40.00
41.00	04100 SUBPROVIDER - IRF	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	42.00
43.00	04300 NURSERY	96	547,131	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-2,072,293	8,668,129	50.00
51.00	05100 RECOVERY ROOM	0	1,552,415	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	331	1,361,818	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	-1,153,559	8,027,294	54.00
59.00	05900 CARDIAC CATHETERIZATION	0	2,664,059	59.00
60.00	06000 LABORATORY	-85,000	4,652,241	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	745,371	63.00
64.00	06400 INTRAVENOUS THERAPY	0	1,022,377	64.00
65.00	06500 RESPIRATORY THERAPY	-2,228	2,623,125	65.00
66.00	06600 PHYSICAL THERAPY	0	741,686	66.00
69.00	06900 ELECTROCARDIOLOGY	0	696,259	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	-6,800	138,593	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,864,568	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	8,308,874	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	4,316,861	73.00
74.00	07400 RENAL DIALYSIS	0	333,731	74.00
76.00	03950 ANCILLARY	0	0	76.00
76.01	03951 PARTIAL HOSPITALIZATION	-142	1,040,331	76.01
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	77.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	-431,693	7,455,333	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS				
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	102.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	-24,829,164	143,998,755	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	45,339	190.00
190.01	19001 MARKETING	0	202,752	190.01
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	29,060,092	192.00
194.00	07950 SIRH	0	0	194.00
194.01	07951 OTHER NRCC	0	747,833	194.01
200.00	TOTAL (SUM OF LINES 118 through 199)	-24,829,164	174,054,771	200.00

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - LEASES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,416	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,239,102	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
0			0	1,241,518	
B - CNO RECLASS					
1.00	NURSING ADMINISTRATION	13.00	210,933	14,786	1.00
0		210,933		14,786	
C - CAFETERIA					
1.00	CAFETERIA	11.00	661,896	1,168,201	1.00
0		661,896		1,168,201	
D - MEDICAL SUPPLIES, DRUGS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,301	1.00
2.00	NONPATIENT TELEPHONES	5.01	0	10	2.00
3.00	OPERATION OF PLANT	7.00	0	52,150	3.00
4.00	DIETARY	10.00	0	452	4.00
5.00	ADULTS & PEDIATRICS	30.00	0	9,944	5.00
6.00	SUBPROVIDER - IPF	40.00	0	340	6.00
7.00	NURSERY	43.00	0	1,868	7.00
8.00	OPERATING ROOM	50.00	0	53,028	8.00
9.00	RECOVERY ROOM	51.00	0	2,677	9.00
10.00	DELIVERY ROOM & LABOR ROOM	52.00	0	7,977	10.00
11.00	INTRAVENOUS THERAPY	64.00	0	2,667	11.00
12.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	6,864,568	12.00
13.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	653,564	13.00
14.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,316,861	14.00
15.00	PARTIAL HOSPITALIZATION	76.01	0	112	15.00
16.00	EMERGENCY	91.00	0	3,100	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
0			0	11,970,619	
E - CORP BENEFITS PAID					
1.00	OTHER A&G	5.05	0	93,609	1.00
2.00	NURSING ADMINISTRATION	13.00	0	30,926	2.00
0		0		124,535	
F - GENERAL LIABILITY INSURANCE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	173,623	1.00
0		0		173,623	

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
G - REV CODE RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	2,057,098	468,481	1.00
2.00	SUBPROVIDER - IPF	40.00	27,548	3,905	2.00
3.00	OPERATING ROOM	50.00	257,127	0	3.00
4.00	RECOVERY ROOM	51.00	66,353	38,236	4.00
5.00	CARDIAC CATHETERIZATION	59.00	301,691	465,288	5.00
6.00	BLOOD STORING, PROCESSING & TRANS.	63.00	159,814	180,388	6.00
7.00	INTRAVENOUS THERAPY	64.00	809,525	243,221	7.00
8.00	RESPIRATORY THERAPY	65.00	411,706	142,964	8.00
9.00	ELECTROENCEPHALOGRAPHY	70.00	18,216	2,538	9.00
			4,109,078	1,545,021	
H - INTERNS AND RESIDENTS SALARY					
1.00	I&R SERVICES-OTHER PRGM	22.00	2,222	0	1.00
	COSTS APPRV				
			2,222	0	
I - PROPERTY TAX RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,289,495	1.00
	0		0	1,289,495	
J - INTEREST EXPENSE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,991,246	1.00
	TOTALS			0	
500.00	Grand Total: Increases		4,984,129	20,519,044	500.00

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - LEASES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	839	10	1.00
2.00	PURCHASING	5.02	0	255,115	10	2.00
3.00	ADMITTING	5.03	0	3,685	0	3.00
4.00	CASHIERING/ACCOUNTS RECEIVABLE	5.04	0	6,070	0	4.00
5.00	OTHER A&G	5.05	0	92,122	0	5.00
6.00	OPERATION OF PLANT	7.00	0	17,642	0	6.00
7.00	LAUNDRY & LINEN SERVICE	8.00	0	77,202	0	7.00
8.00	HOUSEKEEPING	9.00	0	155	0	8.00
9.00	DIETARY	10.00	0	112,438	0	9.00
10.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,023	0	10.00
11.00	PHARMACY	15.00	0	663	0	11.00
12.00	MEDICAL RECORDS & LIBRARY	16.00	0	3,732	0	12.00
13.00	SOCIAL SERVICE	17.00	0	663	0	13.00
14.00	ADULTS & PEDIATRICS	30.00	0	113,259	0	14.00
15.00	INTENSIVE CARE UNIT	31.00	0	43,722	0	15.00
16.00	NEONATAL INTENSIVE CARE UNIT	32.01	0	95,848	0	16.00
17.00	SUBPROVIDER - IPF	40.00	0	1,393	0	17.00
18.00	NURSERY	43.00	0	3,322	0	18.00
19.00	OPERATING ROOM	50.00	0	32,155	0	19.00
20.00	RECOVERY ROOM	51.00	0	570	0	20.00
21.00	DELIVERY ROOM & LABOR ROOM	52.00	0	36,947	0	21.00
22.00	RADIOLOGY-DIAGNOSTIC	54.00	0	179,239	0	22.00
23.00	CARDIAC CATHETERIZATION	59.00	0	746	0	23.00
24.00	LABORATORY	60.00	0	4,053	0	24.00
25.00	INTRAVENOUS THERAPY	64.00	0	580	0	25.00
26.00	RESPIRATORY THERAPY	65.00	0	154,755	0	26.00
27.00	PHYSICAL THERAPY	66.00	0	278	0	27.00
28.00	ELECTROCARDIOLOGY	69.00	0	1,936	0	28.00
29.00	EMERGENCY	91.00	0	366	0	29.00
0			0	1,241,518		
B - CNO RECLASS						
1.00	OTHER A&G	5.05	210,933	14,786	0	1.00
0			210,933	14,786		
C - CAFETERIA						
1.00	DIETARY	10.00	661,896	1,168,201	0	1.00
0			661,896	1,168,201		
D - MEDICAL SUPPLIES, DRUGS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	19,802	0	1.00
2.00	PURCHASING	5.02	0	6,133,731	0	2.00
3.00	OTHER A&G	5.05	0	7,566	0	3.00
4.00	OPERATION OF PLANT	7.00	0	85	0	4.00
5.00	HOUSEKEEPING	9.00	0	603	0	5.00
6.00	NURSING ADMINISTRATION	13.00	0	9,807	0	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	5,733	0	7.00
8.00	PHARMACY	15.00	0	3,865,677	0	8.00
9.00	SOCIAL SERVICE	17.00	0	3,780	0	9.00
10.00	ADULTS & PEDIATRICS	30.00	0	646	0	10.00
11.00	INTENSIVE CARE UNIT	31.00	0	4,738	0	11.00
12.00	SUBPROVIDER - IPF	40.00	0	45	0	12.00
13.00	NURSERY	43.00	0	93	0	13.00
14.00	OPERATING ROOM	50.00	0	388,435	0	14.00
15.00	DELIVERY ROOM & LABOR ROOM	52.00	0	1,574	0	15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	379,522	0	16.00
17.00	CARDIAC CATHETERIZATION	59.00	0	31,527	0	17.00
18.00	LABORATORY	60.00	0	890,361	0	18.00
19.00	INTRAVENOUS THERAPY	64.00	0	131,467	0	19.00
20.00	RESPIRATORY THERAPY	65.00	0	93,167	0	20.00
21.00	PHYSICAL THERAPY	66.00	0	18	0	21.00
22.00	ELECTROCARDIOLOGY	69.00	0	416	0	22.00
23.00	ELECTROENCEPHALOGRAPHY	70.00	0	768	0	23.00
24.00	RENAL DIALYSIS	74.00	0	78	0	24.00
25.00	EMERGENCY	91.00	0	980	0	25.00
0			0	11,970,619		
E - CORP BENEFITS PAID						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	124,535	0	1.00
2.00		0.00	0	0	0	2.00
0			0	124,535		
F - GENERAL LIABILITY INSURANCE						
1.00	OTHER A&G	5.05	0	173,623	12	1.00
0			0	173,623		

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
G - REV CODE RECLASS						
1.00	INTENSIVE CARE UNIT	31.00	2,250,534	530,383	0	1.00
2.00	NEONATAL INTENSIVE CARE UNIT	32.01	315,788	83,777	0	2.00
3.00	NURSERY	43.00	108,409	28,707	0	3.00
4.00	OPERATING ROOM	50.00	0	387,859	0	4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	461,312	124,200	0	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	470,086	132,805	0	6.00
7.00	LABORATORY	60.00	79,836	156,410	0	7.00
8.00	ELECTROCARDIOLOGY	69.00	92,247	15,267	0	8.00
9.00	EMERGENCY	91.00	330,866	85,613	0	9.00
			0	4,109,078	1,545,021	
H - INTERNS AND RESIDENTS SALARY						
1.00	MEDICAL RECORDS & LIBRARY	16.00	2,222	0	0	1.00
0			2,222		0	
I - PROPERTY TAX RECLASS						
1.00	OTHER A&G	5.05	0	1,289,495	13	1.00
0			0	1,289,495		
J - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	2,991,246	11	1.00
	TOTALS		0	2,991,246		
500.00	Grand Total: Decreases		4,984,129	20,519,044		500.00

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00	4.00	5.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	5,945,943	0	0	0	0	1.00
2.00	Land Improvements	1,714,775	0	0	0	0	2.00
3.00	Buildings and Fixtures	90,049,676	7,441,300	0	7,441,300	0	3.00
4.00	Building Improvements	656,183	0	0	0	0	4.00
5.00	Fixed Equipment	97,814,665	3,525,839	0	3,525,839	0	5.00
6.00	Movable Equipment	62,515,635	4,107,068	0	4,107,068	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	258,696,877	15,074,207	0	15,074,207	0	8.00
9.00	Reconciling Items	196,350,483	835,489	0	835,489	0	9.00
10.00	Total (line 8 minus line 9)	62,346,394	14,238,718	0	14,238,718	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	5,945,943	0	0	0	0	1.00
2.00	Land Improvements	1,714,775	0	0	0	0	2.00
3.00	Buildings and Fixtures	97,490,976	0	0	0	0	3.00
4.00	Building Improvements	656,183	0	0	0	0	4.00
5.00	Fixed Equipment	101,340,504	0	0	0	0	5.00
6.00	Movable Equipment	66,622,703	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	273,771,084	0	0	0	0	8.00
9.00	Reconciling Items	197,185,972	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	76,585,112	0	0	0	0	10.00

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	5,222,905	0	0	0	0 1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0 2.00
3.00	Total (sum of lines 1-2)	5,222,905	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	5,222,905			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0			2.00
3.00	Total (sum of lines 1-2)	0	5,222,905			3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet A-7
Part III
Date/Time Prepared:
12/29/2023 12:01 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	57,947,982	0	57,947,982	0.756648	0 1.00
2.00 CAP REL COSTS-MVBLE EQUIP	18,637,130	0	18,637,130	0.243352	0 2.00
3.00 Total (sum of lines 1-2)	76,585,112	0	76,585,112	1.000000	0 3.00
ALLOCATION OF OTHER CAPITAL					
Cost Center Description	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	2,173,223	2,416 1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0	0	3,582,503	1,239,102 2.00
3.00 Total (sum of lines 1-2)	0	0	0	5,755,726	1,241,518 3.00
SUMMARY OF CAPITAL					
Cost Center Description	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)
	11.00	12.00	13.00	14.00	15.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS					
1.00 CAP REL COSTS-BLDG & FIXT	0	0	1,289,495	0	3,465,134 1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	173,623	0	0	4,995,228 2.00
3.00 Total (sum of lines 1-2)	0	173,623	1,289,495	0	8,460,362 3.00

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From which the Amount is to be Adjusted			Wkst. A-7 Ref.	
				Cost Center		Line #		
				1.00	2.00	3.00	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)	B		0	OTHER A&G	5.05	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A		0	CAP REL COSTS-MVBLE EQUIP	2.00	9	7.00
8.00	Television and radio service (chapter 21)			0		0.00	9	8.00
9.00	Parking lot (chapter 21)			0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-5,222,653			0.00	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)			0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-3,945,748				0	12.00
13.00	Laundry and linen service	B		0		0.00	0	13.00
14.00	Cafeteria-employees and guests			0	DIETARY	10.00	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		0	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		0	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	B		0	OTHER A&G	5.05	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	A	-3,049,682	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00	
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	3,582,503	CAP REL COSTS-MVBLE EQUIP	2.00	9	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	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)	A	-68,470	ADULTS & PEDIATRICS	30.00		30.99	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00	CAFETERIA	B	-434,933	DIETARY	10.00	0	33.00	

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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From which the Amount is to be Adjusted			Wkst. A-7 Ref.	
			Cost Center		Line #		
			1.00	2.00	3.00	4.00	5.00
36.00 MEDICAL RECORD TRANSCRIP	B	-154	MEDICAL RECORDS & LIBRARY		16.00	0	36.00
37.00 VENDING MACHINES	B	-1,504	DIETARY		10.00	0	37.00
37.01 OTHER MISCELLANEOUS INCOME	B	-65,317	OTHER A&G		5.05	0	37.01
38.00 INTEREST INCOME	B	-6,543	OTHER A&G		5.05	0	38.00
39.00 PATIENT TV ELECTRICITY	A	-6,734	OPERATION OF PLANT		7.00	0	39.00
40.00 PATIENT TV - CABLE	A	-51,651	OPERATION OF PLANT		7.00	0	40.00
42.00 TELEPHONE SERVICES	A	-31,284	OTHER A&G		5.05	0	42.00
43.00 PATIENT PHONE MAINTENANCE	A	-854	OPERATION OF PLANT		7.00	0	43.00
44.00 PATIENT TELEPHONE SALARIES	A	-36,954	OTHER A&G		5.05	0	44.00
46.00 PATIENT TELEPHONE - BENEFITS	A	-6,204	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	46.00
48.00 OTHER A&G ADVERTISING	A	-655,725	OTHER A&G		5.05	0	48.00
49.00 LOBBYING	A	-14,127	OTHER A&G		5.05	0	49.00
49.01 LOST CHARGES	A	357	OPERATING ROOM		50.00	0	49.01
49.02 LOST CHARGES	A	132	EMERGENCY		91.00	0	49.02
49.03 NON PATIENT GIFTS	A	-945	OTHER A&G		5.05	0	49.03
49.04 PARTIES/BANQUETS	A	-9,861	OTHER A&G		5.05	0	49.04
49.05 ALCOHOLIC BEVERAGES	A	-1,360	OTHER A&G		5.05	0	49.05
49.06 DONATIONS	A	-137,565	OTHER A&G		5.05	0	49.06
49.07 LEGAL SETTLEMENT	A	-351,155	OTHER A&G		5.05	0	49.07
49.08 LOST CHARGES	A	96	NURSERY		43.00	0	49.08
49.09 LOST CHARGES	A	331	DELIVERY ROOM & LABOR ROOM		52.00	0	49.09
49.10 LOST CHARGES	A	-8	OTHER A&G		5.05	0	49.10
49.11 LOST CHARGES	A	375	NURSING ADMINISTRATION		13.00	0	49.11
49.12 LOST CHARGES	A	-2,228	RESPIRATORY THERAPY		65.00	0	49.12
49.13 PARTIES/BANQUETS	A	-43	NURSING ADMINISTRATION		13.00	0	49.13
49.14 NON PATIENT GIFTS	A	-188	PURCHASING		5.02	0	49.14
49.15 NON PATIENT GIFTS	A	-1,147	ADMITTING		5.03	0	49.15
49.16 NON PATIENT GIFTS	A	-142	PARTIAL HOSPITALIZATION		76.01	0	49.16
49.17 LEGAL SETTLEMENT	A	-310	PURCHASING		5.02	0	49.17
49.18 PROVIDER TAX	A	-13,248,823	OTHER A&G		5.05	0	49.18
49.19 NON-EMERGENT AMBULANCE	A	-513,951	NURSING ADMINISTRATION		13.00	0	49.19
49.20 PHYSICIAN RECRUITING	A	-546,695	OTHER A&G		5.05	0	49.20
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-24,829,164					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: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet A-8-1
Date/Time Prepared:
12/29/2023 12:01 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
					1.00	2.00
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE INTEREST	0	2,991,246	1.00
2.00	5.05	OTHER A&G	HOME OFFICE MANAGEMENT	4,675,505	5,062,611	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	C SUITE PAYROLL TAXES	-73,347	0	3.00
4.00	14.00	CENTRAL SERVICES & SUPPLY	HPG PURCHASING	102,329	205,660	4.00
4.01	5.05	OTHER A&G	MALPRACTICE	194,348	585,066	4.01
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			4,898,835	8,844,583	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
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.

6.00	B		0.00	LIFEPOINT HEALT	100.00	6.00
7.00	B		0.00	HEALTHTRUST HPG	4.58	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.

	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	-2,991,246	11	1.00
2.00	-387,106	0	2.00
3.00	-73,347	0	3.00
4.00	-103,331	0	4.00
4.01	-390,718	0	4.01
5.00	-3,945,748		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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	HOSPITAL MGMT	6.00
7.00	PURCHASING	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.

	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	31.00	AGGREGATE-INTENSIVE CARE UNIT	45,833	45,833	0	0	0 1.00
2.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	64,800	64,800	0	0	0 2.00
3.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	66,006	66,006	0	0	0 3.00
4.00	40.00	AGGREGATE-SUBPROVIDER - IPF	10,000	10,000	0	0	0 4.00
5.00	32.01	AGGREGATE-NEONATAL INTENSIVE CARE UN	475,000	475,000	0	0	0 5.00
6.00	50.00	AGGREGATE-OPERATING ROOM	127,400	127,400	0	0	0 6.00
7.00	50.00	AGGREGATE-OPERATING ROOM	1,945,250	1,945,250	0	0	0 7.00
8.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	171,725	171,725	0	0	0 8.00
9.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	942,668	942,668	0	0	0 9.00
10.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	39,166	39,166	0	0	0 10.00
11.00	60.00	AGGREGATE-LABORATORY	85,000	85,000	0	0	0 11.00
12.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY	6,800	6,800	0	0	0 12.00
13.00	91.00	AGGREGATE-EMERGENCY	197,450	197,450	0	0	0 13.00
14.00	91.00	AGGREGATE-EMERGENCY	234,375	234,375	0	0	0 14.00
15.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	806,600	806,600	0	0	0 15.00
16.00	16.00	AGGREGATE-MEDICAL RECORDS & LIBRARY	-16,799	-16,799	0	0	0 16.00
17.00	16.00	AGGREGATE-MEDICAL RECORDS & LIBRARY	21,379	21,379	0	0	0 17.00
200.00			5,222,653	5,222,653	0	0	0 200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance
	1.00	2.00	8.00	9.00	12.00	13.00	14.00
1.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	0	0 1.00
2.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	0	0 2.00
3.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0 3.00
4.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	0	0	0 4.00
5.00	32.01	AGGREGATE-NEONATAL INTENSIVE CARE UN	0	0	0	0	0 5.00
6.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0 6.00
7.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0 7.00
8.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 8.00
9.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 9.00
10.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 10.00
11.00	60.00	AGGREGATE-LABORATORY	0	0	0	0	0 11.00
12.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY	0	0	0	0	0 12.00
13.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0 13.00
14.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0 14.00
15.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0 15.00
16.00	16.00	AGGREGATE-MEDICAL RECORDS & LIBRARY	0	0	0	0	0 16.00
17.00	16.00	AGGREGATE-MEDICAL RECORDS & LIBRARY	0	0	0	0	0 17.00
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	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	45,833	1.00
2.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	64,800	2.00
3.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	66,006	3.00
4.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	0	10,000	4.00

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	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	
5.00	32.01	AGGREGATE-NEONATAL INTENSIVE CARE UN		0	0	0	475,000	5.00
6.00	50.00	AGGREGATE-OPERATING ROOM		0	0	0	127,400	6.00
7.00	50.00	AGGREGATE-OPERATING ROOM		0	0	0	1,945,250	7.00
8.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC		0	0	0	171,725	8.00
9.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC		0	0	0	942,668	9.00
10.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC		0	0	0	39,166	10.00
11.00	60.00	AGGREGATE-LABORATORY		0	0	0	85,000	11.00
12.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY		0	0	0	6,800	12.00
13.00	91.00	AGGREGATE-EMERGENCY		0	0	0	197,450	13.00
14.00	91.00	AGGREGATE-EMERGENCY		0	0	0	234,375	14.00
15.00	30.00	AGGREGATE-ADULTS & PEDIATRICS		0	0	0	806,600	15.00
16.00	16.00	AGGREGATE-MEDICAL RECORDS & LIBRARY		0	0	0	-16,799	16.00
17.00	16.00	AGGREGATE-MEDICAL RECORDS & LIBRARY		0	0	0	21,379	17.00
200.00				0	0	0	5,222,653	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet B
Part I
Date/Time Prepared:
12/29/2023 12:01 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	5.01
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	3,465,134	3,465,134			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	4,995,228		4,995,228		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	7,435,444	0	0	7,435,444	4.00
5.01 00540	NONPATIENT TELEPHONES	964,948	0	0	21,694	986,642
5.02 00590	PURCHASING	798,770	17,529	25,270	53,634	14,595
5.03 00570	ADMITTING	2,827,256	129,342	186,455	218,009	13,622
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE	3,555,799	191,272	275,732	0	44,759
5.05 00591	OTHER A&G	17,608,750	310,856	448,120	540,403	286,070
7.00 00700	OPERATION OF PLANT	4,747,312	517,581	746,129	96,032	27,245
8.00 00800	LAUNDRY & LINEN SERVICE	861,325	0	0	3,113	1,946
9.00 00900	HOUSEKEEPING	2,588,159	0	0	0	9.00
10.00 01000	DIETARY	412,832	162,636	234,450	33,734	16,541
11.00 01100	CAFETERIA	1,830,097	0	0	64,226	0
13.00 01300	NURSING ADMINISTRATION	1,553,896	27,820	40,105	120,799	4,865
14.00 01400	CENTRAL SERVICES & SUPPLY	483,878	53,866	77,651	27,709	7,784
15.00 01500	PHARMACY	3,166,194	33,214	47,880	218,293	13,622
16.00 01600	MEDICAL RECORDS & LIBRARY	1,702,982	0	0	50,204	44,759
17.00 01700	SOCIAL SERVICE	1,491,261	0	0	111,138	16,541
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	2,222	0	0	216	0
23.00 02300	PHARMACY PROGRAM	58,393	0	0	4,356	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	17,745,507	675,717	974,094	1,357,936	79,788
31.00 03100	INTENSIVE CARE UNIT	1,860,807	65,390	94,264	35,276	26,272
32.00 03200	CORONARY CARE UNIT	0	0	0	0	0
32.01 02060	NEONATAL INTENSIVE CARE UNIT	649,731	0	0	52,841	9,730
40.00 04000	SUBPROVIDER - IPF	1,432,634	144,991	209,014	126,524	40.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00 04200	SUBPROVIDER	0	0	0	0	0
43.00 04300	NURSERY	547,131	0	0	36,080	0
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	8,668,129	347,760	501,320	397,483	0
51.00 05100	RECOVERY ROOM	1,552,415	0	0	100,304	0
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,361,818	135,490	195,318	117,103	68,111
54.00 05400	RADIOLOGY-DIAGNOSTIC	8,027,294	246,965	356,017	421,461	0
59.00 05900	CARDIAC CATHETERIZATION	2,664,059	56,776	81,846	183,806	13,622
60.00 06000	LABORATORY	4,652,241	101,557	146,402	230,028	13,622
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	745,371	0	0	15,507	48,651
64.00 06400	INTRAVENOUS THERAPY	1,022,377	0	0	84,662	20,433
65.00 06500	RESPIRATORY THERAPY	2,623,125	0	0	203,164	35,029
66.00 06600	PHYSICAL THERAPY	741,686	0	0	66,674	0
69.00 06900	ELECTROCARDIOLOGY	696,259	33,640	48,494	59,512	2,919
70.00 07000	ELECTROENCEPHALOGRAPHY	138,593	5,465	7,878	11,597	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,864,568	0	0	0	6,811
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	8,308,874	0	0	0	11,676
73.00 07300	DRUGS CHARGED TO PATIENTS	4,316,861	0	0	0	4,865
74.00 07400	RENAL DIALYSIS	333,731	0	0	0	0
76.00 03950	ANCILLARY	0	0	0	0	0
76.01 03951	PARTIAL HOSPITALIZATION	1,040,331	0	0	90,834	0
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	7,455,333	179,908	259,350	480,396	49,624
92.00 09200	OBSEERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	143,998,755	3,437,775	4,955,789	5,634,748	883,502
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	45,339	7,239	10,435	4,032	0
190.01 19001	MARKETING	202,752	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	29,060,092	0	0	1,790,429	0
194.00 07950	SIRH	0	0	0	0	103,140
194.01 07951	OTHER NRCC	747,833	20,120	29,004	6,235	194.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					0201.00
202.00	TOTAL (sum lines 118 through 201)	174,054,771	3,465,134	4,995,228	7,435,444	986,642

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COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet B
Part I
Date/Time Prepared:
12/29/2023 12:01 pm

Cost Center Description	PURCHASING	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER A&G	
	5.02	5.03	5.04	5A.04	5.05	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBL EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 00540 NONPATIENT TELEPHONES						5.01
5.02 00590 PURCHASING	909,798					5.02
5.03 00570 ADMITTING	8,274	3,382,958				5.03
5.04 00580 CASHIERING/ACCOUNTS RECEIVABLE	0	0	4,067,562			5.04
5.05 00591 OTHER A&G	17,948	0	0	19,212,147	19,212,147	5.05
7.00 00700 OPERATION OF PLANT	62	0	0	6,134,361	761,121	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	3,343	0	0	869,727	107,911	8.00
9.00 00900 HOUSEKEEPING	12	0	0	2,588,171	321,127	9.00
10.00 01000 DIETARY	4,531	0	0	864,724	107,291	10.00
11.00 01100 CAFETERIA	0	0	0	1,894,323	235,038	11.00
13.00 01300 NURSING ADMINISTRATION	29,460	0	0	1,776,945	220,474	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	39,615	0	0	690,503	85,674	14.00
15.00 01500 PHARMACY	24,171	0	0	3,503,374	434,681	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	86	0	0	1,798,031	223,091	16.00
17.00 01700 SOCIAL SERVICE	3	0	0	1,618,943	200,870	17.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	2,438	302	22.00
23.00 02300 PHARMACY PROGRAM	0	0	0	62,749	7,786	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	72,151	314,873	378,539	21,598,605	2,679,847	30.00
31.00 03100 INTENSIVE CARE UNIT	42,191	28,331	34,060	2,186,591	271,301	31.00
32.00 03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
32.01 02060 NEONATAL INTENSIVE CARE UNIT	0	8,407	10,107	730,816	90,676	32.01
40.00 04000 SUBPROVIDER - IPF	2,809	16,909	20,328	1,953,209	242,344	40.00
41.00 04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300 NURSERY	9,165	12,045	14,481	618,902	76,790	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	95,727	466,383	560,684	11,037,486	1,369,476	50.00
51.00 05100 RECOVERY ROOM	4,909	40,715	48,947	1,747,290	216,795	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	18,514	14,097	16,947	1,927,398	239,142	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	47,934	547,083	658,286	10,305,040	1,278,598	54.00
59.00 05900 CARDIAC CATHETERIZATION	4,024	88,848	106,813	3,199,794	397,014	59.00
60.00 06000 LABORATORY	347,599	405,698	487,728	6,384,875	792,203	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	74,147	89,140	972,816	120,702	63.00
64.00 06400 INTRAVENOUS THERAPY	457	25,888	31,122	1,184,939	147,021	64.00
65.00 06500 RESPIRATORY THERAPY	16,871	193,788	232,971	3,304,948	410,061	65.00
66.00 06600 PHYSICAL THERAPY	254	19,044	22,894	850,552	105,532	66.00
69.00 06900 ELECTROCARDIOLOGY	2,896	78,590	94,481	1,016,791	126,158	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	2,546	20,504	24,650	211,233	26,209	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	281,626	338,569	7,491,574	929,517	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	118,057	141,928	8,580,535	1,064,630	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	309,407	371,967	5,003,100	620,760	73.00
74.00 07400 RENAL DIALYSIS	0	1,767	2,125	337,623	41,891	74.00
76.00 03950 ANCILLARY	0	0	0	0	0	76.00
76.01 03951 PARTIAL HOSPITALIZATION	751	16,304	19,600	1,167,820	144,897	76.01
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	60,932	300,447	361,195	9,147,185	1,134,937	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART				0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	857,235	3,382,958	4,067,562	141,975,558	15,231,867	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	67,045	8,319	190.00
190.01 19001 MARKETING	0	0	0	202,752	25,156	190.01
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	30,850,521	3,827,830	192.00
194.00 07950 SIRH	52,563	0	0	155,703	19,319	194.00
194.01 07951 OTHER NRCC	0	0	0	803,192	99,656	194.01
200.00 Cross Foot Adjustments				0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	909,798	3,382,958	4,067,562	174,054,771	19,212,147	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet B
Part I
Date/Time Prepared:
12/29/2023 12:01 pm

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBL EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540 NONPATIENT TELEPHONES						5.01
5.02	00590 PURCHASING						5.02
5.03	00570 ADMITTING						5.03
5.04	00580 CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00591 OTHER A&G						5.05
7.00	00700 OPERATION OF PLANT	6,895,482					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	977,638				8.00
9.00	00900 HOUSEKEEPING	0	0	2,909,298			9.00
10.00	01000 DIETARY	487,894	0	10,104	1,470,013		10.00
11.00	01100 CAFETERIA	0	0	0	0	2,129,361	11.00
13.00	01300 NURSING ADMINISTRATION	83,458	0	2,887	0	38,575	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	161,594	0	36,087	0	0	14.00
15.00	01500 PHARMACY	99,639	0	10,104	0	96,438	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	5,774	0	38,575	16.00
17.00	01700 SOCIAL SERVICE	0	0	0	0	57,863	17.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300 PHARMACY PROGRAM	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	2,027,104	335,756	1,416,038	1,049,365	632,639	30.00
31.00	03100 INTENSIVE CARE UNIT	196,164	158,002	391,900	191,041	38,575	31.00
32.00	03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
32.01	02060 NEONATAL INTENSIVE CARE UNIT	0	0	0	0	23,145	32.01
40.00	04000 SUBPROVIDER - IPF	434,961	39,501	184,041	33,510	57,863	40.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300 NURSERY	0	9,875	722	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,043,252	246,878	124,859	0	196,734	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	46,290	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	406,459	29,625	184,041	26,800	54,006	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	740,876	29,625	143,624	0	200,592	54.00
59.00	05900 CARDIAC CATHETERIZATION	170,323	19,750	36,087	0	57,863	59.00
60.00	06000 LABORATORY	304,664	0	64,956	0	115,726	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	38,575	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	722	0	104,154	65.00
66.00	06600 PHYSICAL THERAPY	0	0	1,443	0	30,860	66.00
69.00	06900 ELECTROCARDIOLOGY	100,916	0	3,609	0	27,003	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	16,394	0	1,443	0	7,715	70.00
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	03951 PARTIAL HOSPITALIZATION	0	0	2,165	0	50,148	76.01
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	539,710	108,626	288,692	169,297	216,022	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS							
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	6,813,408	977,638	2,909,298	1,470,013	2,129,361	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	21,716	0	0	0	0	190.00
190.01	19001 MARKETING	0	0	0	0	0	190.01
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950 SIRH	0	0	0	0	0	194.00
194.01	07951 OTHER NRCC	60,358	0	0	0	0	194.01
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)	6,895,482	977,638	2,909,298	1,470,013	2,129,361	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet B
Part I
Date/Time Prepared:
12/29/2023 12:01 pm

Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal					
					13.00	14.00	15.00	16.00	16A	
GENERAL SERVICE COST CENTERS										
1.00 00100	CAP REL COSTS-BLDG & FIXT									1.00
2.00 00200	CAP REL COSTS-MVBL EQUIP									2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT									4.00
5.01 00540	NONPATIENT TELEPHONES									5.01
5.02 00590	PURCHASING									5.02
5.03 00570	ADMITTING									5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE									5.04
5.05 00591	OTHER A&G									5.05
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	2,122,339								13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	973,858							14.00
15.00 01500	PHARMACY	138,534	0	4,282,770						15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	2,065,471					16.00
17.00 01700	SOCIAL SERVICE	0	0	3,774	0					17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0					21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0					22.00
23.00 02300	PHARMACY PROGRAM	0	0	0	0					23.00
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00 03000	ADULTS & PEDIATRICS	908,782	70	225	1,605,178	32,253,609				30.00
31.00 03100	INTENSIVE CARE UNIT	55,414	330	1,694	0	3,491,012				31.00
32.00 03200	CORONARY CARE UNIT	0	0	0	0	0				32.00
32.01 02060	NEONATAL INTENSIVE CARE UNIT	33,248	0	0	0	877,885				32.01
40.00 04000	SUBPROVIDER - IPF	83,120	0	45	197,590	3,226,184				40.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0				41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0				42.00
43.00 04300	NURSERY	27,707	0	32	0	734,028				43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0				44.00
ANCILLARY SERVICE COST CENTERS										
50.00 05000	OPERATING ROOM	282,609	7,711	263,981	1,650	14,574,636				50.00
51.00 05100	RECOVERY ROOM	66,496	0	0	0	2,076,871				51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	77,579	0	1,572	258,803	3,205,425				52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	41,125	767	600	12,740,847				54.00
59.00 05900	CARDIAC CATHETERIZATION	83,120	3,373	457	600	3,968,381				59.00
60.00 06000	LABORATORY	0	94,780	17,420	0	7,774,624				60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	1,093,518				63.00
64.00 06400	INTRAVENOUS THERAPY	55,414	0	131,265	0	1,557,214				64.00
65.00 06500	RESPIRATORY THERAPY	0	10,025	833	0	3,830,743				65.00
66.00 06600	PHYSICAL THERAPY	0	2	0	0	988,389				66.00
69.00 06900	ELECTROCARDIOLOGY	0	45	0	0	1,274,522				69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	83	0	0	263,077				70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	745,351	0	0	9,166,442				71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	70,963	0	0	9,716,128				72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	3,859,727	0	9,483,587				73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	379,514				74.00
76.00 03950	ANCILLARY	0	0	0	0	0				76.00
76.01 03951	PARTIAL HOSPITALIZATION	0	0	0	0	1,365,030				76.01
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0				77.00
OUTPATIENT SERVICE COST CENTERS										
91.00 09100	EMERGENCY	310,316	0	978	1,050	11,916,813				91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					0				92.00
OTHER REIMBURSABLE COST CENTERS										
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0				102.00
SPECIAL PURPOSE COST CENTERS										
113.00 11300	INTEREST EXPENSE									113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	2,122,339	973,858	4,282,770	2,065,471	137,913,204				118.00
NONREIMBURSABLE COST CENTERS										
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	97,080				190.00
190.01 19001	MARKETING	0	0	0	0	227,908				190.01
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	34,678,351				192.00
194.00 07950	SIRH	0	0	0	0	175,022				194.00
194.01 07951	OTHER NRCC	0	0	0	0	963,206				194.01
200.00	Cross Foot Adjustments					0				200.00
201.00	Negative Cost Centers	0	0	0	0	0				201.00
202.00	TOTAL (sum lines 118 through 201)	2,122,339	973,858	4,282,770	2,065,471	174,054,771				202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0009

Period:

From 08/01/2022

To 07/31/2023

Worksheet B

Part I

Date/Time Prepared:

12/29/2023 12:01 pm

Cost Center Description	SOCIAL SERVICE	INTERNS & RESIDENTS		PHARMACY PROGRAM	Subtotal
		SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV		
		17.00	21.00	22.00	23.00
GENERAL SERVICE COST CENTERS					
1.00 00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200	CAP REL COSTS-MVBL EQUIP				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01 00540	NONPATIENT TELEPHONES				5.01
5.02 00590	PURCHASING				5.02
5.03 00570	ADMITTING				5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE				5.04
5.05 00591	OTHER A&G				5.05
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	1,881,450	0		17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	2,770	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	30			22.00
23.00 02300	PHARMACY PROGRAM	771			23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	352,467	0	2,770	32,608,846
31.00 03100	INTENSIVE CARE UNIT	38,150	0	0	3,529,162
32.00 03200	CORONARY CARE UNIT	0	0	0	0
32.01 02060	NEONATAL INTENSIVE CARE UNIT	9,594	0	0	887,479
40.00 04000	SUBPROVIDER - IPP	35,256	0	0	3,261,440
41.00 04100	SUBPROVIDER - IRF	0	0	0	0
42.00 04200	SUBPROVIDER	0	0	0	0
43.00 04300	NURSERY	8,021	0	0	742,049
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	159,272	0	0	14,733,908
51.00 05100	RECOVERY ROOM	22,696	0	0	2,099,567
52.00 05200	DELIVERY ROOM & LABOR ROOM	35,029	0	0	3,240,454
54.00 05400	RADIOLOGY-DIAGNOSTIC	139,232	0	0	12,880,079
59.00 05900	CARDIAC CATHETERIZATION	43,366	0	0	4,011,747
60.00 06000	LABORATORY	84,961	0	0	7,859,585
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	11,950	0	0	1,105,468
64.00 06400	INTRAVENOUS THERAPY	17,017	0	0	1,574,231
65.00 06500	RESPIRATORY THERAPY	41,862	0	0	3,872,605
66.00 06600	PHYSICAL THERAPY	10,801	0	0	999,190
69.00 06900	ELECTROCARDIOLOGY	13,928	0	0	1,288,450
70.00 07000	ELECTROENCEPHALOGRAPHY	2,875	0	0	265,952
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	100,171	0	0	9,266,613
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	106,178	0	0	9,822,306
73.00 07300	DRUGS CHARGED TO PATIENTS	103,637	0	0	9,658,530
74.00 07400	RENAL DIALYSIS	4,147	0	0	383,661
76.00 03950	ANCILLARY	0	0	0	0
76.01 03951	PARTIAL HOSPITALIZATION	14,917	0	0	1,379,947
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0
OUTPATIENT SERVICE COST CENTERS					
91.00 09100	EMERGENCY	130,227	0	0	12,047,040
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				91.00
OTHER REIMBURSABLE COST CENTERS					
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0	0
SPECIAL PURPOSE COST CENTERS					
113.00 11300	INTEREST EXPENSE				113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,486,555	0	2,770	71,306
NONREIMBURSABLE COST CENTERS					
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,061	0	0	98,141
190.01 19001	MARKETING	2,491	0	0	230,399
192.00 19200	PHYSICIANS' PRIVATE OFFICES	378,904	0	0	35,057,255
194.00 07950	SIRH	1,913	0	0	176,935
194.01 07951	OTHER NRCC	10,526	0	0	973,732
200.00	Cross Foot Adjustments		0	0	0
201.00	Negative Cost Centers	0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	1,881,450	0	2,770	71,306
					174,054,771

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200 CAP REL COSTS-MVBL EQUIP			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00540 NONPATIENT TELEPHONES			5.01
5.02	00590 PURCHASING			5.02
5.03	00570 ADMITTING			5.03
5.04	00580 CASHIERING/ACCOUNTS RECEIVABLE			5.04
5.05	00591 OTHER A&G			5.05
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 APPRV			21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV			22.00
23.00	02300 PHARMACY PROGRAM			23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-2,770	32,606,076	30.00
31.00	03100 INTENSIVE CARE UNIT	0	3,529,162	31.00
32.00	03200 CORONARY CARE UNIT	0	0	32.00
32.01	02060 NEONATAL INTENSIVE CARE UNIT	0	887,479	32.01
40.00	04000 SUBPROVIDER - IPP	0	3,261,440	40.00
41.00	04100 SUBPROVIDER - IRF	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	42.00
43.00	04300 NURSERY	0	742,049	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	14,733,908	50.00
51.00	05100 RECOVERY ROOM	0	2,099,567	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	3,240,454	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	12,880,079	54.00
59.00	05900 CARDIAC CATHETERIZATION	0	4,011,747	59.00
60.00	06000 LABORATORY	0	7,859,585	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	1,105,468	63.00
64.00	06400 INTRAVENOUS THERAPY	0	1,574,231	64.00
65.00	06500 RESPIRATORY THERAPY	0	3,872,605	65.00
66.00	06600 PHYSICAL THERAPY	0	999,190	66.00
69.00	06900 ELECTROCARDIOLOGY	0	1,288,450	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	265,952	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,266,613	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	9,822,306	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	9,658,530	73.00
74.00	07400 RENAL DIALYSIS	0	383,661	74.00
76.00	03950 ANCILLARY	0	0	76.00
76.01	03951 PARTIAL HOSPITALIZATION	0	1,379,947	76.01
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	77.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0	12,047,040	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	102.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	-2,770	137,515,539	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	98,141	190.00
190.01	19001 MARKETING	0	230,399	190.01
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	35,057,255	192.00
194.00	07950 SIRH	0	176,935	194.00
194.01	07951 OTHER NRCC	0	973,732	194.01
200.00	Cross Foot Adjustments	0	0	200.00
201.00	Negative Cost Centers	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	-2,770	174,052,001	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet B
Part II
Date/Time Prepared:
12/29/2023 12:01 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	0	0	0	4.00
5.01 00540	NONPATIENT TELEPHONES	0	0	0	0	5.01
5.02 00590	PURCHASING	0	17,529	25,270	42,799	5.02
5.03 00570	ADMITTING	0	129,342	186,455	315,797	5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	191,272	275,732	467,004	5.04
5.05 00591	OTHER A&G	1,184,436	310,856	448,120	1,943,412	5.05
7.00 00700	OPERATION OF PLANT	0	517,581	746,129	1,263,710	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	0	0	0	9.00
10.00 01000	DIETARY	0	162,636	234,450	397,086	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	27,820	40,105	67,925	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	53,866	77,651	131,517	14.00
15.00 01500	PHARMACY	0	33,214	47,880	81,094	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00 02300	PHARMACY PROGRAM	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	675,717	974,094	1,649,811	30.00
31.00 03100	INTENSIVE CARE UNIT	0	65,390	94,264	159,654	31.00
32.00 03200	CORONARY CARE UNIT	0	0	0	0	32.00
32.01 02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	32.01
40.00 04000	SUBPROVIDER - IPF	0	144,991	209,014	354,005	40.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
43.00 04300	NURSERY	0	0	0	0	43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	347,760	501,320	849,080	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	135,490	195,318	330,808	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	246,965	356,017	602,982	54.00
59.00 05900	CARDIAC CATHETERIZATION	0	56,776	81,846	138,622	59.00
60.00 06000	LABORATORY	0	101,557	146,402	247,959	60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00 06900	ELECTROCARDIOLOGY	0	33,640	48,494	82,134	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	5,465	7,878	13,343	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,833	0	0	6,833	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00 03950	ANCILLARY	0	0	0	0	76.00
76.01 03951	PARTIAL HOSPITALIZATION	0	0	0	0	76.01
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	0	179,908	259,350	439,258	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,191,269	3,437,775	4,955,789	9,584,833	0118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,239	10,435	17,674	0190.00
190.01 19001	MARKETING	0	0	0	0	0190.01
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0192.00
194.00 07950	SIRH	0	0	0	0	0194.00
194.01 07951	OTHER NRCC	0	20,120	29,004	49,124	0194.01
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	0201.00
202.00	TOTAL (sum lines 118 through 201)	1,191,269	3,465,134	4,995,228	9,651,631	0202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet B
Part II
Date/Time Prepared:
12/29/2023 12:01 pm

Cost Center Description	NONPATIENT TELEPHONES	PURCHASING	ADMITTING	CASHIERING/ACC OUNTS RECEIVABLE	OTHER A&G	
					5.01	5.02
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBL EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 00540	NONPATIENT TELEPHONES	0				5.01
5.02 00590	PURCHASING	0	42,799			5.02
5.03 00570	ADMITTING	0	389	316,186		5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	467,004	5.04
5.05 00591	OTHER A&G	0	844	0	0	1,944,256
7.00 00700	OPERATION OF PLANT	0	3	0	0	77,023
8.00 00800	LAUNDRY & LINEN SERVICE	0	157	0	0	10,920
9.00 00900	HOUSEKEEPING	0	1	0	0	32,497
10.00 01000	DIETARY	0	213	0	0	10,857
11.00 01100	CAFETERIA	0	0	0	0	23,785
13.00 01300	NURSING ADMINISTRATION	0	1,386	0	0	22,311
14.00 01400	CENTRAL SERVICES & SUPPLY	0	1,864	0	0	8,670
15.00 01500	PHARMACY	0	1,137	0	0	43,988
16.00 01600	MEDICAL RECORDS & LIBRARY	0	4	0	0	22,576
17.00 01700	SOCIAL SERVICE	0	0	0	0	20,327
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	31
23.00 02300	PHARMACY PROGRAM	0	0	0	0	788
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	3,394	29,440	43,463	271,192
31.00 03100	INTENSIVE CARE UNIT	0	1,985	2,649	3,911	27,455
32.00 03200	CORONARY CARE UNIT	0	0	0	0	0
32.01 02060	NEONATAL INTENSIVE CARE UNIT	0	0	786	1,160	9,176
40.00 04000	SUBPROVIDER - IPF	0	132	1,581	2,334	24,524
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00 04200	SUBPROVIDER	0	0	0	0	0
43.00 04300	NURSERY	0	431	1,126	1,663	7,771
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	4,503	43,607	64,376	138,587
51.00 05100	RECOVERY ROOM	0	231	3,807	5,620	21,939
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	871	1,318	1,946	24,200
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	2,255	51,035	75,559	129,390
59.00 05900	CARDIAC CATHETERIZATION	0	189	8,307	12,264	40,177
60.00 06000	LABORATORY	0	16,353	37,932	56,000	80,168
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	6,933	10,235	12,215
64.00 06400	INTRAVENOUS THERAPY	0	21	2,420	3,573	14,878
65.00 06500	RESPIRATORY THERAPY	0	794	18,119	26,749	41,497
66.00 06600	PHYSICAL THERAPY	0	12	1,781	2,629	10,680
69.00 06900	ELECTROCARDIOLOGY	0	136	7,348	10,848	12,767
70.00 07000	ELECTROENCEPHALOGRAPHY	0	120	1,917	2,830	2,652
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	26,332	38,874	94,064
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	11,038	16,296	107,737
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	28,929	42,708	62,819
74.00 07400	RENAL DIALYSIS	0	0	165	244	4,239
76.00 03950	ANCILLARY	0	0	0	0	0
76.01 03951	PARTIAL HOSPITALIZATION	0	35	1,524	2,250	14,663
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	0	2,866	28,092	41,472	114,852
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	40,326	316,186	467,004	1,541,415
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	842
190.01 19001	MARKETING	0	0	0	0	2,546
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	387,413
194.00 07950	SIRH	0	2,473	0	0	1,955
194.01 07951	OTHER NRCC	0	0	0	0	10,085
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	0	42,799	316,186	467,004	1,944,256
						202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet B
Part II
Date/Time Prepared:
12/29/2023 12:01 pm

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540 NONPATIENT TELEPHONES						5.01
5.02	00590 PURCHASING						5.02
5.03	00570 ADMITTING						5.03
5.04	00580 CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00591 OTHER A&G						5.05
7.00	00700 OPERATION OF PLANT	1,340,736					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	11,077				8.00
9.00	00900 HOUSEKEEPING	0	0	32,498			9.00
10.00	01000 DIETARY	94,865	0	113	503,134		10.00
11.00	01100 CAFETERIA	0	0	0	0	23,785	11.00
13.00	01300 NURSING ADMINISTRATION	16,227	0	32	0	431	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	31,420	0	403	0	0	14.00
15.00	01500 PHARMACY	19,373	0	113	0	1,077	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	64	0	431	16.00
17.00	01700 SOCIAL SERVICE	0	0	0	0	646	17.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300 PHARMACY PROGRAM	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	394,143	3,803	15,818	359,161	7,066	30.00
31.00	03100 INTENSIVE CARE UNIT	38,141	1,790	4,378	65,387	431	31.00
32.00	03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
32.01	02060 NEONATAL INTENSIVE CARE UNIT	0	0	0	0	259	32.01
40.00	04000 SUBPROVIDER - IPF	84,573	448	2,056	11,469	646	40.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300 NURSERY	0	112	8	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	202,847	2,797	1,395	0	2,198	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	517	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	79,031	336	2,056	9,173	603	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	144,054	336	1,604	0	2,241	54.00
59.00	05900 CARDIAC CATHETERIZATION	33,117	224	403	0	646	59.00
60.00	06000 LABORATORY	59,238	0	726	0	1,293	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	431	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	8	0	1,163	65.00
66.00	06600 PHYSICAL THERAPY	0	0	16	0	345	66.00
69.00	06900 ELECTROCARDIOLOGY	19,622	0	40	0	302	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	3,188	0	16	0	86	70.00
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	03951 PARTIAL HOSPITALIZATION	0	0	24	0	560	76.01
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	104,939	1,231	3,225	57,944	2,413	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS							
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,324,778	11,077	32,498	503,134	23,785	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,222	0	0	0	0	190.00
190.01	19001 MARKETING	0	0	0	0	0	190.01
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950 SIRH	0	0	0	0	0	194.00
194.01	07951 OTHER NRCC	11,736	0	0	0	0	194.01
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)	1,340,736	11,077	32,498	503,134	23,785	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet B
Part II
Date/Time Prepared:
12/29/2023 12:01 pm

Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
						13.00
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBL EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 00540	NONPATIENT TELEPHONES					5.01
5.02 00590	PURCHASING					5.02
5.03 00570	ADMITTING					5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05 00591	OTHER A&G					5.05
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	108,312				13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	173,874			14.00
15.00 01500	PHARMACY	7,070	0	153,852		15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	23,075	16.00
17.00 01700	SOCIAL SERVICE	0	0	136	0	21,109
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
23.00 02300	PHARMACY PROGRAM	0	0	0	0	9
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	46,378	13	8	17,933	3,967
31.00 03100	INTENSIVE CARE UNIT	2,828	59	61	0	429
32.00 03200	CORONARY CARE UNIT	0	0	0	0	0
32.01 02060	NEONATAL INTENSIVE CARE UNIT	1,697	0	0	0	108
40.00 04000	SUBPROVIDER - IPF	4,242	0	2	2,207	397
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00 04200	SUBPROVIDER	0	0	0	0	0
43.00 04300	NURSERY	1,414	0	1	0	90
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	14,423	1,377	9,483	18	1,793
51.00 05100	RECOVERY ROOM	3,394	0	0	0	255
52.00 05200	DELIVERY ROOM & LABOR ROOM	3,959	0	56	2,891	394
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	7,343	28	7	1,567
59.00 05900	CARDIAC CATHETERIZATION	4,242	602	16	7	488
60.00 06000	LABORATORY	0	16,922	626	0	956
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	135
64.00 06400	INTRAVENOUS THERAPY	2,828	0	4,715	0	192
65.00 06500	RESPIRATORY THERAPY	0	1,790	30	0	471
66.00 06600	PHYSICAL THERAPY	0	0	0	0	122
69.00 06900	ELECTROCARDIOLOGY	0	8	0	0	157
70.00 07000	ELECTROENCEPHALOGRAPHY	0	15	0	0	32
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	133,075	0	0	1,127
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	12,670	0	0	1,195
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	138,655	0	1,166
74.00 07400	RENAL DIALYSIS	0	0	0	0	47
76.00 03950	ANCILLARY	0	0	0	0	0
76.01 03951	PARTIAL HOSPITALIZATION	0	0	0	0	168
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	15,837	0	35	12	1,466
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	108,312	173,874	153,852	23,075	16,731
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	12
190.01 19001	MARKETING	0	0	0	0	28
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	4,198
194.00 07950	SIRH	0	0	0	0	22
194.01 07951	OTHER NRCC	0	0	0	0	118
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	108,312	173,874	153,852	23,075	21,109
						202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet B
Part II
Date/Time Prepared:
12/29/2023 12:01 pm

Cost Center Description	INTERNS & RESIDENTS		PHARMACY PROGRAM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
	21.00	22.00				
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
5.01 00540 NONPATIENT TELEPHONES						5.01
5.02 00590 PURCHASING						5.02
5.03 00570 ADMITTING						5.03
5.04 00580 CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05 00591 OTHER A&G						5.05
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 APPRV	0					21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV		31				22.00
23.00 02300 PHARMACY PROGRAM				797		23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS					2,845,590	0
31.00 03100 INTENSIVE CARE UNIT					309,158	0
32.00 03200 CORONARY CARE UNIT					0	0
32.01 02060 NEONATAL INTENSIVE CARE UNIT					13,186	0
40.00 04000 SUBPROVIDER - IPF					488,616	0
41.00 04100 SUBPROVIDER - IRF					0	0
42.00 04200 SUBPROVIDER					0	0
43.00 04300 NURSERY					12,616	0
44.00 04400 SKILLED NURSING FACILITY					0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM					1,336,484	0
51.00 05100 RECOVERY ROOM					35,763	0
52.00 05200 DELIVERY ROOM & LABOR ROOM					457,642	0
54.00 05400 RADIOLOGY-DIAGNOSTIC					1,018,401	0
59.00 05900 CARDIAC CATHETERIZATION					239,304	0
60.00 06000 LABORATORY					518,173	0
63.00 06300 BLOOD STORING, PROCESSING & TRANS.					29,518	0
64.00 06400 INTRAVENOUS THERAPY					29,058	0
65.00 06500 RESPIRATORY THERAPY					90,621	0
66.00 06600 PHYSICAL THERAPY					15,585	0
69.00 06900 ELECTROCARDIOLOGY					133,362	0
70.00 07000 ELECTROENCEPHALOGRAPHY					24,199	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT					300,305	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS					148,936	0
73.00 07300 DRUGS CHARGED TO PATIENTS					274,277	0
74.00 07400 RENAL DIALYSIS					4,695	0
76.00 03950 ANCILLARY					0	0
76.01 03951 PARTIAL HOSPITALIZATION					19,224	0
77.00 07700 ALLOGENEIC HSCT ACQUISITION					0	0
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY					813,642	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART					0	91.00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200 OPIOID TREATMENT PROGRAM					0	0
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	0	9,158,355	0
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN					22,750	0
190.01 19001 MARKETING					2,574	0
192.00 19200 PHYSICIANS' PRIVATE OFFICES					391,611	0
194.00 07950 SIRH					4,450	0
194.01 07951 OTHER NRCC					71,063	0
200.00 Cross Foot Adjustments	0	31	797		828	0
201.00 Negative Cost Centers	0	0	0		0	0
202.00 TOTAL (sum lines 118 through 201)	0	31	797	9,651,631		0

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Cost Center Description		Total		
		26.00		
GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200 CAP REL COSTS-MVBL EQUIP			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00540 NONPATIENT TELEPHONES			5.01
5.02	00590 PURCHASING			5.02
5.03	00570 ADMITTING			5.03
5.04	00580 CASHIERING/ACCOUNTS RECEIVABLE			5.04
5.05	00591 OTHER A&G			5.05
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 APPRV			21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV			22.00
23.00	02300 PHARMACY PROGRAM			23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	2,845,590		30.00
31.00	03100 INTENSIVE CARE UNIT	309,158		31.00
32.00	03200 CORONARY CARE UNIT	0		32.00
32.01	02060 NEONATAL INTENSIVE CARE UNIT	13,186		32.01
40.00	04000 SUBPROVIDER - IPF	488,616		40.00
41.00	04100 SUBPROVIDER - IRF	0		41.00
42.00	04200 SUBPROVIDER	0		42.00
43.00	04300 NURSERY	12,616		43.00
44.00	04400 SKILLED NURSING FACILITY	0		44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	1,336,484		50.00
51.00	05100 RECOVERY ROOM	35,763		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	457,642		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,018,401		54.00
59.00	05900 CARDIAC CATHETERIZATION	239,304		59.00
60.00	06000 LABORATORY	518,173		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	29,518		63.00
64.00	06400 INTRAVENOUS THERAPY	29,058		64.00
65.00	06500 RESPIRATORY THERAPY	90,621		65.00
66.00	06600 PHYSICAL THERAPY	15,585		66.00
69.00	06900 ELECTROCARDIOLOGY	133,362		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	24,199		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	300,305		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	148,936		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	274,277		73.00
74.00	07400 RENAL DIALYSIS	4,695		74.00
76.00	03950 ANCILLARY	0		76.00
76.01	03951 PARTIAL HOSPITALIZATION	19,224		76.01
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0		77.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	813,642		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS				
102.00	10200 OPIOID TREATMENT PROGRAM	0		102.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	9,158,355		118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	22,750		190.00
190.01	19001 MARKETING	2,574		190.01
192.00	19200 PHYSICIANS' PRIVATE OFFICES	391,611		192.00
194.00	07950 SIRH	4,450		194.00
194.01	07951 OTHER NRCC	71,063		194.01
200.00	Cross Foot Adjustments	828		200.00
201.00	Negative Cost Centers	0		201.00
202.00	TOTAL (sum lines 118 through 201)	9,651,631		202.00

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (# OF PHONES)	PURCHASING (SUPPLIES)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	390,605				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		390,605			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	76,627,804		4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	223,572	1,014	5.01
5.02	00590	PURCHASING	1,976	1,976	552,744	15	2,662,868
5.03	00570	ADMITTING	14,580	14,580	2,246,755	14	24,216
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	21,561	21,561	0	46	0
5.05	00591	OTHER A&G	35,041	35,041	5,569,273	294	52,533
7.00	00700	OPERATION OF PLANT	58,344	58,344	989,687	28	182
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	32,081	2	9,786
9.00	00900	HOUSEKEEPING	0	0	0	0	36
10.00	01000	DIETARY	18,333	18,333	347,660	17	13,262
11.00	01100	CAFETERIA	0	0	661,896	0	0
13.00	01300	NURSING ADMINISTRATION	3,136	3,136	1,244,930	5	86,225
14.00	01400	CENTRAL SERVICES & SUPPLY	6,072	6,072	285,563	8	115,947
15.00	01500	PHARMACY	3,744	3,744	2,249,683	14	70,745
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	517,391	46	252
17.00	01700	SOCIAL SERVICE	0	0	1,145,366	17	10
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	2,222	0	0
23.00	02300	PHARMACY PROGRAM	0	0	44,895	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	76,170	76,170	13,994,581	82	211,176
31.00	03100	INTENSIVE CARE UNIT	7,371	7,371	363,543	27	123,487
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0
32.01	02060	NEONATAL INTENSIVE CARE UNIT	0	0	544,567	10	0
40.00	04000	SUBPROVIDER - IPF	16,344	16,344	1,303,923	0	8,222
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	0	371,832	0	26,826
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	39,201	39,201	4,096,367	0	280,180
51.00	05100	RECOVERY ROOM	0	0	1,033,711	0	14,367
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,273	15,273	1,206,834	70	54,188
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,839	27,839	4,343,483	0	140,298
59.00	05900	CARDIAC CATHETERIZATION	6,400	6,400	1,894,264	14	11,779
60.00	06000	LABORATORY	11,448	11,448	2,370,621	14	1,017,382
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	159,814	50	0
64.00	06400	INTRAVENOUS THERAPY	0	0	872,506	21	1,337
65.00	06500	RESPIRATORY THERAPY	0	0	2,093,766	36	49,378
66.00	06600	PHYSICAL THERAPY	0	0	687,132	0	742
69.00	06900	ELECTROCARDIOLOGY	3,792	3,792	613,319	3	8,475
70.00	07000	ELECTROENCEPHALOGRAPHY	616	616	119,521	0	7,452
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	7	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	12	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
76.00	03950	ANCILLARY	0	0	0	0	0
76.01	03951	PARTIAL HOSPITALIZATION	0	0	936,116	0	2,199
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	20,280	20,280	4,950,852	51	178,340
92.00	09200	OBSEERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		Subtotals (sum of lines 1 through 117)	387,521	387,521	58,070,470	908	2,509,022
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	816	816	41,555	0	0
190.01	19001	MARKETING	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	18,451,522	0	0
194.00	07950	SIRH	0	0	0	106	153,846
194.01	07951	OTHER NRCC	2,268	2,268	64,257	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (# OF PHONE S)	PURCHASING (SUPPLIES)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00				
202.00	Cost to be allocated (per Wkst. B, Part I)	3,465,134	4,995,228	7,435,444	986,642	909,798	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	8.871197	12.788438	0.097033	973.019724	0.341661	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0	0	42,799	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000	0.000000	0.016073	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 Center Description		ADMITTING (GROSS CHAR GES)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS CHAR GES)	Reconciliation	OTHER A&G (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		5.03	5.04	5A.05	5.05	7.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBL EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540 NONPATIENT TELEPHONES						5.01
5.02	00590 PURCHASING						5.02
5.03	00570 ADMITTING	714,059,407					5.03
5.04	00580 CASHIERING/ACCOUNTS RECEIVABLE	0	714,059,407				5.04
5.05	00591 OTHER A&G	0	0	-19,212,147	154,842,624		5.05
7.00	00700 OPERATION OF PLANT	0	0	0	6,134,361	259,103	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	0	869,727	0	8.00
9.00	00900 HOUSEKEEPING	0	0	0	2,588,171	0	9.00
10.00	01000 DIETARY	0	0	0	864,724	18,333	10.00
11.00	01100 CAFETERIA	0	0	0	1,894,323	0	11.00
13.00	01300 NURSING ADMINISTRATION	0	0	0	1,776,945	3,136	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	690,503	6,072	14.00
15.00	01500 PHARMACY	0	0	0	3,503,374	3,744	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	1,798,031	0	16.00
17.00	01700 SOCIAL SERVICE	0	0	0	1,618,943	0	17.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	2,438	0	22.00
23.00	02300 PHARMACY PROGRAM	0	0	0	62,749	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	66,456,984	66,456,984	0	21,598,605	76,170	30.00
31.00	03100 INTENSIVE CARE UNIT	5,979,592	5,979,592	0	2,186,591	7,371	31.00
32.00	03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
32.01	02060 NEONATAL INTENSIVE CARE UNIT	1,774,359	1,774,359	0	730,816	0	32.01
40.00	04000 SUBPROVIDER - IPP	3,568,893	3,568,893	0	1,953,209	16,344	40.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300 NURSERY	2,542,267	2,542,267	0	618,902	0	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	98,434,656	98,434,656	0	11,037,486	39,201	50.00
51.00	05100 RECOVERY ROOM	8,593,190	8,593,190	0	1,747,290	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2,975,325	2,975,325	0	1,927,398	15,273	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	115,520,840	115,520,840	0	10,305,040	27,839	54.00
59.00	05900 CARDIAC CATHETERIZATION	18,752,294	18,752,294	0	3,199,794	6,400	59.00
60.00	06000 LABORATORY	85,626,346	85,626,346	0	6,384,875	11,448	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	15,649,514	15,649,514	0	972,816	0	63.00
64.00	06400 INTRAVENOUS THERAPY	5,463,876	5,463,876	0	1,184,939	0	64.00
65.00	06500 RESPIRATORY THERAPY	40,900,740	40,900,740	0	3,304,948	0	65.00
66.00	06600 PHYSICAL THERAPY	4,019,341	4,019,341	0	850,552	0	66.00
69.00	06900 ELECTROCARDIOLOGY	16,587,245	16,587,245	0	1,016,791	3,792	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	4,327,642	4,327,642	0	211,233	616	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	59,439,795	59,439,795	0	7,491,574	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	24,917,073	24,917,073	0	8,580,535	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	65,303,237	65,303,237	0	5,003,100	0	73.00
74.00	07400 RENAL DIALYSIS	373,029	373,029	0	337,623	0	74.00
76.00	03950 ANCILLARY	0	0	0	0	0	76.00
76.01	03951 PARTIAL HOSPITALIZATION	3,441,060	3,441,060	0	1,167,820	0	76.01
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	63,412,109	63,412,109	0	9,147,185	20,280	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS							
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	714,059,407	714,059,407	-19,212,147	122,763,411	256,019	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	67,045	816	190.00
190.01	19001 MARKETING	0	0	0	202,752	0	190.01
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	30,850,521	0	192.00
194.00	07950 SIRH	0	0	0	155,703	0	194.00
194.01	07951 OTHER NRCC	0	0	0	803,192	2,268	194.01
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)	3,382,958	4,067,562		19,212,147	6,895,482	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.004738	0.005696		0.124075	26.612899	203.00

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Cost Center Description		ADMITTING (GROSS CHAR GES)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS CHAR GES)	Reconciliation	OTHER A&G (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		5.03	5.04	5A.05	5.05	7.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	316,186	467,004		1,944,256	1,340,736	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000443	0.000654		0.012556	5.174529	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 Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRS ING)	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBL EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540 NONPATIENT TELEPHONES						5.01
5.02	00590 PURCHASING						5.02
5.03	00570 ADMITTING						5.03
5.04	00580 CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00591 OTHER A&G						5.05
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE	679,041					8.00
9.00	00900 HOUSEKEEPING	0	4,031	78,217			9.00
10.00	01000 DIETARY	0	14				10.00
11.00	01100 CAFETERIA	0	0	0	552		11.00
13.00	01300 NURSING ADMINISTRATION	0	4	0	10		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	50	0	0		14.00
15.00	01500 PHARMACY	0	14	0	25		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	8	0	10		16.00
17.00	01700 SOCIAL SERVICE	0	0	0	15		17.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0		21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0		22.00
23.00	02300 PHARMACY PROGRAM	0	0	0	0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	233,206	1,962	55,835	164	164	30.00
31.00	03100 INTENSIVE CARE UNIT	109,744	543	10,165	10	10	31.00
32.00	03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
32.01	02060 NEONATAL INTENSIVE CARE UNIT	0	0	0	6	6	32.01
40.00	04000 SUBPROVIDER - IPP	27,436	255	1,783	15	15	40.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300 NURSERY	6,859	1	0	0	5	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	171,475	173	0	51	51	50.00
51.00	05100 RECOVERY ROOM	0	0	0	12	12	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	20,577	255	1,426	14	14	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	20,577	199	0	52	0	54.00
59.00	05900 CARDIAC CATHETERIZATION	13,718	50	0	15	15	59.00
60.00	06000 LABORATORY	0	90	0	30	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	10	10	64.00
65.00	06500 RESPIRATORY THERAPY	0	1	0	27	0	65.00
66.00	06600 PHYSICAL THERAPY	0	2	0	8	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	5	0	7	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2	0	2	0	70.00
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	03951 PARTIAL HOSPITALIZATION	0	3	0	13	0	76.01
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	75,449	400	9,008	56	56	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS							
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
118.00	118.00 SUBTOTALS (SUM OF LINES 1 through 117)	679,041	4,031	78,217	552	383	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001 MARKETING	0	0	0	0	0	190.01
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950 SIRH	0	0	0	0	0	194.00
194.01	07951 OTHER NRCC	0	0	0	0	0	194.01
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)	977,638	2,909,298	1,470,013	2,129,361	2,122,339	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	1.439733	721.731084	18.794035	3,857.538043	5,541.355091	203.00

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Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRS ING)	
		8.00	9.00	10.00	11.00	13.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	11,077	32,498	503,134	23,785	108,312	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.016313	8.062019	6.432540	43.088768	282.798956	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 Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	Reconciliation	SOCIAL SERVICE (ACCUM. COST)	
		14.00	15.00	16.00	17A	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBL EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540 NONPATIENT TELEPHONES						5.01
5.02	00590 PURCHASING						5.02
5.03	00570 ADMITTING						5.03
5.04	00580 CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00591 OTHER A&G						5.05
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	8,969,110					14.00
15.00	01500 PHARMACY	0	4,289,372				15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	13,767			16.00
17.00	01700 SOCIAL SERVICE	0	3,780	0	-1,881,450	172,173,321	17.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	2,740	22.00
23.00	02300 PHARMACY PROGRAM	0	0	0	0	70,535	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	646	225	10,699	0	32,253,609	30.00
31.00	03100 INTENSIVE CARE UNIT	3,041	1,697	0	0	3,491,012	31.00
32.00	03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
32.01	02060 NEONATAL INTENSIVE CARE UNIT	0	0	0	0	877,885	32.01
40.00	04000 SUBPROVIDER - IPP	0	45	1,317	0	3,226,184	40.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300 NURSERY	0	32	0	0	734,028	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	71,019	264,388	11	0	14,574,636	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	2,076,871	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1,574	1,725	0	3,205,425	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	378,754	768	4	0	12,740,847	54.00
59.00	05900 CARDIAC CATHETERIZATION	31,069	458	4	0	3,968,381	59.00
60.00	06000 LABORATORY	872,914	17,447	0	0	7,774,624	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	1,093,518	63.00
64.00	06400 INTRAVENOUS THERAPY	0	131,467	0	0	1,557,214	64.00
65.00	06500 RESPIRATORY THERAPY	92,333	834	0	0	3,830,743	65.00
66.00	06600 PHYSICAL THERAPY	18	0	0	0	988,389	66.00
69.00	06900 ELECTROCARDIOLOGY	416	0	0	0	1,274,522	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	768	0	0	0	263,077	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	6,864,568	0	0	0	9,166,442	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	653,564	0	0	0	9,716,128	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	3,865,677	0	0	9,483,587	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	379,514	74.00
76.00	03950 ANCILLARY	0	0	0	0	0	76.00
76.01	03951 PARTIAL HOSPITALIZATION	0	0	0	0	1,365,030	76.01
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0	980	7	0	11,916,813	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS							
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
118.00	118.00 SUBTOTALS (SUM OF LINES 1 through 117)	8,969,110	4,289,372	13,767	-1,881,450	136,031,754	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	97,080	190.00
190.01	19001 MARKETING	0	0	0	0	227,908	190.01
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	34,678,351	192.00
194.00	07950 SIRH	0	0	0	0	175,022	194.00
194.01	07951 OTHER NRCC	0	0	0	0	963,206	194.01
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)	973,858	4,282,770	2,065,471		1,881,450	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.108579	0.998461	150.030580		0.010928	203.00

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Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	Reconciliation	SOCIAL SERVICE (ACCUM. COST)	
		14.00	15.00	16.00	17A	17.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	173,874	153,852	23,075		21,109	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.019386	0.035868	1.676110		0.000123	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 Center Description		INTERNS & RESIDENTS			
		SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	PHARMACY PROGRAM (ASSIGNED TIME)	
		21.00	22.00	23.00	
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
5.01	00540	NONPATIENT TELEPHONES			5.01
5.02	00590	PURCHASING			5.02
5.03	00570	ADMITTING			5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.04
5.05	00591	OTHER A&G			5.05
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 APPRV	100		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		100	22.00
23.00	02300	PHARMACY PROGRAM			23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	100	100	0
31.00	03100	INTENSIVE CARE UNIT	0	0	0
32.00	03200	CORONARY CARE UNIT	0	0	0
32.01	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0
40.00	04000	SUBPROVIDER - IPF	0	0	0
41.00	04100	SUBPROVIDER - IRF	0	0	0
42.00	04200	SUBPROVIDER	0	0	0
43.00	04300	NURSERY	0	0	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0
51.00	05100	RECOVERY ROOM	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0
60.00	06000	LABORATORY	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	0
66.00	06600	PHYSICAL THERAPY	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100
74.00	07400	RENAL DIALYSIS	0	0	0
76.00	03950	ANCILLARY	0	0	0
76.01	03951	PARTIAL HOSPITALIZATION	0	0	0
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	100	100
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0
190.01	19001	MARKETING	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0
194.00	07950	SIRH	0	0	0
194.01	07951	OTHER NRCC	0	0	0
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00

Cost Center Description		INTERNS & RESIDENTS			
		SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	PHARMACY PROGRAM (ASSIGNED TIME)	
		21.00	22.00	23.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	0	2,770	71,306	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	27.700000	713.060000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	31	797	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	0.310000	7.970000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)			0	206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)			0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet C
Part I
Date/Time Prepared:
12/29/2023 12:01 pm

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XVIII		Hospital	PPS
			Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	32,606,076		32,606,076	0	32,606,076 30.00
31.00 03100	INTENSIVE CARE UNIT	3,529,162		3,529,162	0	3,529,162 31.00
32.00 03200	CORONARY CARE UNIT	0		0	0	0 32.00
32.01 02060	NEONATAL INTENSIVE CARE UNIT	887,479		887,479	0	887,479 32.01
40.00 04000	SUBPROVIDER - IPF	3,261,440		3,261,440	0	3,261,440 40.00
41.00 04100	SUBPROVIDER - IRF	0		0	0	0 41.00
42.00 04200	SUBPROVIDER	0		0	0	0 42.00
43.00 04300	NURSERY	742,049		742,049	0	742,049 43.00
44.00 04400	SKILLED NURSING FACILITY	0		0	0	0 44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	14,733,908		14,733,908	0	14,733,908 50.00
51.00 05100	RECOVERY ROOM	2,099,567		2,099,567	0	2,099,567 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	3,240,454		3,240,454	0	3,240,454 52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	12,880,079		12,880,079	0	12,880,079 54.00
59.00 05900	CARDIAC CATHETERIZATION	4,011,747		4,011,747	0	4,011,747 59.00
60.00 06000	LABORATORY	7,859,585		7,859,585	0	7,859,585 60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	1,105,468		1,105,468	0	1,105,468 63.00
64.00 06400	INTRAVENOUS THERAPY	1,574,231		1,574,231	0	1,574,231 64.00
65.00 06500	RESPIRATORY THERAPY	3,872,605	0	3,872,605	0	3,872,605 65.00
66.00 06600	PHYSICAL THERAPY	999,190	0	999,190	0	999,190 66.00
69.00 06900	ELECTROCARDIOLOGY	1,288,450		1,288,450	0	1,288,450 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	265,952		265,952	0	265,952 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,266,613		9,266,613	0	9,266,613 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	9,822,306		9,822,306	0	9,822,306 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	9,658,530		9,658,530	0	9,658,530 73.00
74.00 07400	RENAL DIALYSIS	383,661		383,661	0	383,661 74.00
76.00 03950	ANCILLARY	0		0	0	0 76.00
76.01 03951	PARTIAL HOSPITALIZATION	1,379,947		1,379,947	0	1,379,947 76.01
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0 77.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	12,047,040		12,047,040	0	12,047,040 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	2,828,096		2,828,096	0	2,828,096 92.00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200	OPIOID TREATMENT PROGRAM	0		0	0	0 102.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	140,343,635	0	140,343,635	0	140,343,635 200.00
201.00	Less Observation Beds	2,828,096		2,828,096	0	2,828,096 201.00
202.00	Total (see instructions)	137,515,539	0	137,515,539	0	137,515,539 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0009

Period:

From 08/01/2022

To 07/31/2023

Worksheet C

Part I

Date/Time Prepared:

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			Title XVIII		Hospital	PPS
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
		Inpatient	Outpatient	Total (col. 6 + col. 7)		
		6.00	7.00	8.00	9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	52,982,328		52,982,328	
31.00	03100	INTENSIVE CARE UNIT	5,979,592		5,979,592	
32.00	03200	CORONARY CARE UNIT	0		0	
32.01	02060	NEONATAL INTENSIVE CARE UNIT	1,774,359		1,774,359	
40.00	04000	SUBPROVIDER - IPF	3,568,893		3,568,893	
41.00	04100	SUBPROVIDER - IRF	0		0	
42.00	04200	SUBPROVIDER	0		0	
43.00	04300	NURSERY	2,542,267		2,542,267	
44.00	04400	SKILLED NURSING FACILITY	0		0	
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,552,415	78,882,241	98,434,656	0.149682
51.00	05100	RECOVERY ROOM	1,587,673	7,005,517	8,593,190	0.244329
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,641,040	334,285	2,975,325	1.089109
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,749,613	86,771,227	115,520,840	0.111496
59.00	05900	CARDIAC CATHETERIZATION	10,072,599	8,679,695	18,752,294	0.213934
60.00	06000	LABORATORY	44,673,687	40,952,659	85,626,346	0.091789
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	9,070,370	6,579,144	15,649,514	0.070639
64.00	06400	INTRAVENOUS THERAPY	2,239,456	3,224,420	5,463,876	0.288116
65.00	06500	RESPIRATORY THERAPY	26,770,879	14,129,861	40,900,740	0.094683
66.00	06600	PHYSICAL THERAPY	3,180,693	838,648	4,019,341	0.248595
69.00	06900	ELECTROCARDIOLOGY	6,615,757	9,971,488	16,587,245	0.077677
70.00	07000	ELECTROENCEPHALOGRAPHY	612,651	3,714,991	4,327,642	0.061454
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	28,625,163	30,814,632	59,439,795	0.155899
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,529,351	15,387,722	24,917,073	0.394200
73.00	07300	DRUGS CHARGED TO PATIENTS	28,538,247	36,764,990	65,303,237	0.147903
74.00	07400	RENAL DIALYSIS	373,029	0	373,029	1.028502
76.00	03950	ANCILLARY	0	0	0	0.000000
76.01	03951	PARTIAL HOSPITALIZATION	8,859	3,432,201	3,441,060	0.401024
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	21,693,290	41,718,819	63,412,109	0.189980
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,229,365	9,245,291	13,474,656	0.209883
OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				
200.00		Subtotal (see instructions)	315,611,576	398,447,831	714,059,407	
201.00		Less Observation Beds				
202.00		Total (see instructions)	315,611,576	398,447,831	714,059,407	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet C
Part I
Date/Time Prepared:
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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
32.00	03200 CORONARY CARE UNIT		32.00
32.01	02060 NEONATAL INTENSIVE CARE UNIT		32.01
40.00	04000 SUBPROVIDER - IPF		40.00
41.00	04100 SUBPROVIDER - IRF		41.00
42.00	04200 SUBPROVIDER		42.00
43.00	04300 NURSERY		43.00
44.00	04400 SKILLED NURSING FACILITY		44.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.149682	50.00
51.00	05100 RECOVERY ROOM	0.244329	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.089109	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.111496	54.00
59.00	05900 CARDIAC CATHETERIZATION	0.213934	59.00
60.00	06000 LABORATORY	0.091789	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.070639	63.00
64.00	06400 INTRAVENOUS THERAPY	0.288116	64.00
65.00	06500 RESPIRATORY THERAPY	0.094683	65.00
66.00	06600 PHYSICAL THERAPY	0.248595	66.00
69.00	06900 ELECTROCARDIOLOGY	0.077677	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.061454	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.155899	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.394200	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.147903	73.00
74.00	07400 RENAL DIALYSIS	1.028502	74.00
76.00	03950 ANCILLARY	0.000000	76.00
76.01	03951 PARTIAL HOSPITALIZATION	0.401024	76.01
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	77.00
OUTPATIENT SERVICE COST CENTERS			
91.00	09100 EMERGENCY	0.189980	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.209883	92.00
OTHER REIMBURSABLE COST CENTERS			
102.00	10200 OPIOID TREATMENT PROGRAM		102.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE		113.00
200.00	Subtotal (see instructions)		200.00
201.00	Less Observation Beds		201.00
202.00	Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet C
Part I
Date/Time Prepared:
12/29/2023 12:01 pm

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XIX		Hospital	Cost
			Costs		Total Costs	RCE Disallowance
			Total Costs	RCE Disallowance		
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	32,606,076		32,606,076	0	32,606,076
31.00 03100	INTENSIVE CARE UNIT	3,529,162		3,529,162	0	3,529,162
32.00 03200	CORONARY CARE UNIT	0		0	0	0
32.01 02060	NEONATAL INTENSIVE CARE UNIT	887,479		887,479	0	887,479
40.00 04000	SUBPROVIDER - IPF	3,261,440		3,261,440	0	3,261,440
41.00 04100	SUBPROVIDER - IRF	0		0	0	0
42.00 04200	SUBPROVIDER	0		0	0	0
43.00 04300	NURSERY	742,049		742,049	0	742,049
44.00 04400	SKILLED NURSING FACILITY	0		0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	14,733,908		14,733,908	0	14,733,908
51.00 05100	RECOVERY ROOM	2,099,567		2,099,567	0	2,099,567
52.00 05200	DELIVERY ROOM & LABOR ROOM	3,240,454		3,240,454	0	3,240,454
54.00 05400	RADIOLOGY-DIAGNOSTIC	12,880,079		12,880,079	0	12,880,079
59.00 05900	CARDIAC CATHETERIZATION	4,011,747		4,011,747	0	4,011,747
60.00 06000	LABORATORY	7,859,585		7,859,585	0	7,859,585
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	1,105,468		1,105,468	0	1,105,468
64.00 06400	INTRAVENOUS THERAPY	1,574,231		1,574,231	0	1,574,231
65.00 06500	RESPIRATORY THERAPY	3,872,605	0	3,872,605	0	3,872,605
66.00 06600	PHYSICAL THERAPY	999,190	0	999,190	0	999,190
69.00 06900	ELECTROCARDIOLOGY	1,288,450		1,288,450	0	1,288,450
70.00 07000	ELECTROENCEPHALOGRAPHY	265,952		265,952	0	265,952
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,266,613		9,266,613	0	9,266,613
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	9,822,306		9,822,306	0	9,822,306
73.00 07300	DRUGS CHARGED TO PATIENTS	9,658,530		9,658,530	0	9,658,530
74.00 07400	RENAL DIALYSIS	383,661		383,661	0	383,661
76.00 03950	ANCILLARY	0		0	0	0
76.01 03951	PARTIAL HOSPITALIZATION	1,379,947		1,379,947	0	1,379,947
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	12,047,040		12,047,040	0	12,047,040
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	2,828,096		2,828,096	0	2,828,096
OTHER REIMBURSABLE COST CENTERS						
102.00 10200	OPIOID TREATMENT PROGRAM	0		0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	140,343,635	0	140,343,635	0	140,343,635
201.00	Less Observation Beds	2,828,096		2,828,096	0	2,828,096
202.00	Total (see instructions)	137,515,539	0	137,515,539	0	137,515,539

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0009

Period:

From

08/01/2022

To

07/31/2023

Worksheet C

Part I

Date/Time Prepared:

12/29/2023 12:01 pm

Cost Center Description	Title XIX			Hospital	Cost
	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	52,982,328		52,982,328	
31.00 03100	INTENSIVE CARE UNIT	5,979,592		5,979,592	
32.00 03200	CORONARY CARE UNIT	0		0	
32.01 02060	NEONATAL INTENSIVE CARE UNIT	1,774,359		1,774,359	
40.00 04000	SUBPROVIDER - IPF	3,568,893		3,568,893	
41.00 04100	SUBPROVIDER - IRF	0		0	
42.00 04200	SUBPROVIDER	0		0	
43.00 04300	NURSERY	2,542,267		2,542,267	
44.00 04400	SKILLED NURSING FACILITY	0		0	
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	19,552,415	78,882,241	98,434,656	0.149682
51.00 05100	RECOVERY ROOM	1,587,673	7,005,517	8,593,190	0.244329
52.00 05200	DELIVERY ROOM & LABOR ROOM	2,641,040	334,285	2,975,325	1.089109
54.00 05400	RADIOLOGY-DIAGNOSTIC	28,749,613	86,771,227	115,520,840	0.111496
59.00 05900	CARDIAC CATHETERIZATION	10,072,599	8,679,695	18,752,294	0.213934
60.00 06000	LABORATORY	44,673,687	40,952,659	85,626,346	0.091789
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	9,070,370	6,579,144	15,649,514	0.070639
64.00 06400	INTRAVENOUS THERAPY	2,239,456	3,224,420	5,463,876	0.288116
65.00 06500	RESPIRATORY THERAPY	26,770,879	14,129,861	40,900,740	0.094683
66.00 06600	PHYSICAL THERAPY	3,180,693	838,648	4,019,341	0.248595
69.00 06900	ELECTROCARDIOLOGY	6,615,757	9,971,488	16,587,245	0.077677
70.00 07000	ELECTROENCEPHALOGRAPHY	612,651	3,714,991	4,327,642	0.061454
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	28,625,163	30,814,632	59,439,795	0.155899
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	9,529,351	15,387,722	24,917,073	0.394200
73.00 07300	DRUGS CHARGED TO PATIENTS	28,538,247	36,764,990	65,303,237	0.147903
74.00 07400	RENAL DIALYSIS	373,029	0	373,029	1.028502
76.00 03950	ANCILLARY	0	0	0	0.000000
76.01 03951	PARTIAL HOSPITALIZATION	8,859	3,432,201	3,441,060	0.401024
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000
OUTPATIENT SERVICE COST CENTERS					
91.00 09100	EMERGENCY	21,693,290	41,718,819	63,412,109	0.189980
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	4,229,365	9,245,291	13,474,656	0.209883
OTHER REIMBURSABLE COST CENTERS					
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0	
SPECIAL PURPOSE COST CENTERS					
113.00 11300	INTEREST EXPENSE				
200.00	Subtotal (see instructions)	315,611,576	398,447,831	714,059,407	
201.00	Less Observation Beds				
202.00	Total (see instructions)	315,611,576	398,447,831	714,059,407	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet C
Part I
Date/Time Prepared:
12/29/2023 12:01 pm

			Title XIX	Hospital	Cost
Cost Center Description		PPS Inpatient Ratio			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
32.00	03200 CORONARY CARE UNIT				32.00
32.01	02060 NEONATAL INTENSIVE CARE UNIT				32.01
40.00	04000 SUBPROVIDER - IPF				40.00
41.00	04100 SUBPROVIDER - IRF				41.00
42.00	04200 SUBPROVIDER				42.00
43.00	04300 NURSERY				43.00
44.00	04400 SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.149682			50.00
51.00	05100 RECOVERY ROOM	0.244329			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.089109			52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.111496			54.00
59.00	05900 CARDIAC CATHETERIZATION	0.213934			59.00
60.00	06000 LABORATORY	0.091789			60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.070639			63.00
64.00	06400 INTRAVENOUS THERAPY	0.288116			64.00
65.00	06500 RESPIRATORY THERAPY	0.094683			65.00
66.00	06600 PHYSICAL THERAPY	0.248595			66.00
69.00	06900 ELECTROCARDIOLOGY	0.077677			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.061454			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.155899			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.394200			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.147903			73.00
74.00	07400 RENAL DIALYSIS	1.028502			74.00
76.00	03950 ANCILLARY	0.000000			76.00
76.01	03951 PARTIAL HOSPITALIZATION	0.401024			76.01
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000			77.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.189980			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.209883			92.00
OTHER REIMBURSABLE COST CENTERS					
102.00	10200 OPIOID TREATMENT PROGRAM				102.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet D
Part I
Date/Time Prepared:
12/29/2023 12:01 pm

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	Hospital		PPS
						1.00	2.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	2,845,590	0	2,845,590	27,071	105.12	30.00	
31.00	INTENSIVE CARE UNIT	309,158		309,158	4,437	69.68	31.00	
32.00	CORONARY CARE UNIT	0		0	0	0.00	32.00	
32.01	NEONATAL INTENSIVE CARE UNIT	13,186		13,186	706	18.68	32.01	
40.00	SUBPROVIDER - IPF	488,616	0	488,616	1,838	265.84	40.00	
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00	
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00	
43.00	NURSERY	12,616		12,616	2,085	6.05	43.00	
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00	
200.00	Total (lines 30 through 199)	3,669,166		3,669,166	36,137		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	7,237	760,753					30.00
31.00	INTENSIVE CARE UNIT	465	32,401					31.00
32.00	CORONARY CARE UNIT	0	0					32.00
32.01	NEONATAL INTENSIVE CARE UNIT	0	0					32.01
40.00	SUBPROVIDER - IPF	734	195,127					40.00
41.00	SUBPROVIDER - IRF	0	0					41.00
42.00	SUBPROVIDER	0	0					42.00
43.00	NURSERY	0	0					43.00
44.00	SKILLED NURSING FACILITY	0	0					44.00
200.00	Total (lines 30 through 199)	8,436	988,281					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet D
Part II
Date/Time Prepared:
12/29/2023 12:01 pm

Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Title XVIII		Hospital	Capital Costs (column 3 x column 4)	PPS
		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	1,336,484	98,434,656	0.013577	6,150,355	83,503
51.00 05100	RECOVERY ROOM	35,763	8,593,190	0.004162	453,839	1,889
52.00 05200	DELIVERY ROOM & LABOR ROOM	457,642	2,975,325	0.153812	6,904	1,062
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,018,401	115,520,840	0.008816	9,514,398	83,879
59.00 05900	CARDIAC CATHETERIZATION	239,304	18,752,294	0.012761	2,767,935	35,322
60.00 06000	LABORATORY	518,173	85,626,346	0.006052	10,795,285	65,333
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	29,518	15,649,514	0.001886	2,712,028	5,115
64.00 06400	INTRAVENOUS THERAPY	29,058	5,463,876	0.005318	296,203	1,575
65.00 06500	RESPIRATORY THERAPY	90,621	40,900,740	0.002216	8,466,420	18,762
66.00 06600	PHYSICAL THERAPY	15,585	4,019,341	0.003878	1,193,433	4,628
69.00 06900	ELECTROCARDIOLOGY	133,362	16,587,245	0.008040	2,196,301	17,658
70.00 07000	ELECTROENCEPHALOGRAPHY	24,199	4,327,642	0.005592	206,212	1,153
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	300,305	59,439,795	0.005052	7,584,118	38,315
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	148,936	24,917,073	0.005977	3,618,899	21,630
73.00 07300	DRUGS CHARGED TO PATIENTS	274,277	65,303,237	0.004200	7,931,686	33,313
74.00 07400	RENAL DIALYSIS	4,695	373,029	0.012586	120,294	1,514
76.00 03950	ANCILLARY	0	0	0.000000	0	0
76.01 03951	PARTIAL HOSPITALIZATION	19,224	3,441,060	0.005587	3,036	17
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	813,642	63,412,109	0.012831	5,783,444	74,207
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	246,814	13,474,656	0.018317	1,152,316	21,107
200.00	Total (lines 50 through 199)	5,736,003	647,211,968		70,953,106	509,982
						200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet D
Part III
Date/Time Prepared:
12/29/2023 12:01 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
32.00	03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
32.01	02060 NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	32.01
40.00	04000 SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300 NURSERY	0	0	0	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
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	27,071	0.00	7,237	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	4,437	0.00	465	31.00
32.00	03200 CORONARY CARE UNIT	0	0	0	0.00	0	32.00
32.01	02060 NEONATAL INTENSIVE CARE UNIT	0	0	706	0.00	0	32.01
40.00	04000 SUBPROVIDER - IPF	0	0	1,838	0.00	734	40.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0.00	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0.00	0	42.00
43.00	04300 NURSERY	0	0	2,085	0.00	0	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0.00	0	44.00
200.00	Total (lines 30 through 199)	0	0	36,137		8,436	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
32.00	03200 CORONARY CARE UNIT	0					32.00
32.01	02060 NEONATAL INTENSIVE CARE UNIT	0					32.01
40.00	04000 SUBPROVIDER - IPF	0					40.00
41.00	04100 SUBPROVIDER - IRF	0					41.00
42.00	04200 SUBPROVIDER	0					42.00
43.00	04300 NURSERY	0					43.00
44.00	04400 SKILLED NURSING FACILITY	0					44.00
200.00	Total (lines 30 through 199)	0					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet D
Part IV
Date/Time Prepared:
12/29/2023 12:01 pm

Cost Center Description	Title XVIII		Hospital		Allied Health
	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	
	1.00	2A	2.00	3A	3.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0	0	0	0	0 50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00 06000 LABORATORY	0	0	0	0	0 60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0 63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0 66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0 69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO 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	71,306 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 03951 PARTIAL HOSPITALIZATION	0	0	0	0	0 76.01
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0 77.00
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	0	0 92.00
200.00 Total (lines 50 through 199)	0	0	0	0	71,306 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet D
Part IV
Date/Time Prepared:
12/29/2023 12:01 pm

Cost Center Description	All Other Medical Education Cost	Title XVIII		Hospital	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	PPS
		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)		
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	0	98,434,656	0.000000
51.00 05100	RECOVERY ROOM	0	0	0	8,593,190	0.000000
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,975,325	0.000000
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	115,520,840	0.000000
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	18,752,294	0.000000
60.00 06000	LABORATORY	0	0	0	85,626,346	0.000000
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	15,649,514	0.000000
64.00 06400	INTRAVENOUS THERAPY	0	0	0	5,463,876	0.000000
65.00 06500	RESPIRATORY THERAPY	0	0	0	40,900,740	0.000000
66.00 06600	PHYSICAL THERAPY	0	0	0	4,019,341	0.000000
69.00 06900	ELECTROCARDIOLOGY	0	0	0	16,587,245	0.000000
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	4,327,642	0.000000
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	59,439,795	0.000000
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	24,917,073	0.000000
73.00 07300	DRUGS CHARGED TO PATIENTS	0	71,306	71,306	65,303,237	0.001092
74.00 07400	RENAL DIALYSIS	0	0	0	373,029	0.000000
76.00 03950	ANCILLARY	0	0	0	0	0.000000
76.01 03951	PARTIAL HOSPITALIZATION	0	0	0	3,441,060	0.000000
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	0	0	0	63,412,109	0.000000
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	13,474,656	0.000000
200.00	Total (lines 50 through 199)	0	71,306	71,306	647,211,968	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet D
Part IV
Date/Time Prepared:
12/29/2023 12:01 pm

Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Title XVIII		Hospital	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PPS
		Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges		
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0.000000	6,150,355	0	16,615,779	0 50.00
51.00 05100	RECOVERY ROOM	0.000000	453,839	0	1,170,939	0 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0.000000	6,904	0	1,328	0 52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0.000000	9,514,398	0	18,816,261	0 54.00
59.00 05900	CARDIAC CATHETERIZATION	0.000000	2,767,935	0	2,621,910	0 59.00
60.00 06000	LABORATORY	0.000000	10,795,285	0	4,354,417	0 60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	2,712,028	0	1,018,888	0 63.00
64.00 06400	INTRAVENOUS THERAPY	0.000000	296,203	0	852,879	0 64.00
65.00 06500	RESPIRATORY THERAPY	0.000000	8,466,420	0	3,360,987	0 65.00
66.00 06600	PHYSICAL THERAPY	0.000000	1,193,433	0	174,001	0 66.00
69.00 06900	ELECTROCARDIOLOGY	0.000000	2,196,301	0	2,813,532	0 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0.000000	206,212	0	683,686	0 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	7,584,118	0	6,132,554	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	3,618,899	0	5,258,098	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0.001092	7,931,686	8,661	9,630,598	10,517 73.00
74.00 07400	RENAL DIALYSIS	0.000000	120,294	0	0	0 74.00
76.00 03950	ANCILLARY	0.000000	0	0	0	0 76.00
76.01 03951	PARTIAL HOSPITALIZATION	0.000000	3,036	0	454,971	0 76.01
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0 77.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	0.000000	5,783,444	0	5,436,815	0 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,152,316	0	1,307,642	0 92.00
200.00	Total (lines 50 through 199)		70,953,106	8,661	80,705,285	10,517 200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet D
Part V
Date/Time Prepared:
12/29/2023 12:01 pm

Title XVIII

Hospital

PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs PPS Services (see inst.)
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	0.149682	16,615,779	0	0 2,487,083 50.00
51.00 05100	RECOVERY ROOM	0.244329	1,170,939	0	0 286,094 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1.089109	1,328	0	0 1,446 52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0.111496	18,816,261	0	0 2,097,938 54.00
59.00 05900	CARDIAC CATHETERIZATION	0.213934	2,621,910	0	0 560,916 59.00
60.00 06000	LABORATORY	0.091789	4,354,417	0	0 399,688 60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0.070639	1,018,888	0	0 71,973 63.00
64.00 06400	INTRAVENOUS THERAPY	0.288116	852,879	0	0 245,728 64.00
65.00 06500	RESPIRATORY THERAPY	0.094683	3,360,987	0	0 318,228 65.00
66.00 06600	PHYSICAL THERAPY	0.248595	174,001	0	0 43,256 66.00
69.00 06900	ELECTROCARDIOLOGY	0.077677	2,813,532	0	0 218,547 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0.061454	683,686	0	0 42,015 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.155899	6,132,554	0	0 956,059 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0.394200	5,258,098	0	0 2,072,742 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0.147903	9,630,598	0	5,496 1,424,394 73.00
74.00 07400	RENAL DIALYSIS	1.028502	0	0	0 0 74.00
76.00 03950	ANCILLARY	0.000000	0	0	0 0 76.00
76.01 03951	PARTIAL HOSPITALIZATION	0.401024	454,971	0	0 182,454 76.01
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0 0 77.00
OUTPATIENT SERVICE COST CENTERS					
91.00 09100	EMERGENCY	0.189980	5,436,815	0	0 1,032,886 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0.209883	1,307,642	0	0 274,452 92.00
200.00	Subtotal (see instructions)		80,705,285	0	5,496 12,715,899 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0 201.00
202.00	Net Charges (line 200 - line 201)		80,705,285	0	5,496 12,715,899 202.00

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
51.00 05100 RECOVERY ROOM	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
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	813	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
76.00 03950 ANCILLARY	0	0	76.00
76.01 03951 PARTIAL HOSPITALIZATION	0	0	76.01
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	77.00
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	813	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 - line 201)	0	813	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0009

Period:

From 08/01/2022

Worksheet D

Part II

Date/Time Prepared:

12/29/2023 12:01 pm

Component CCN: 15-S009

To 07/31/2023

Title XVIII

PPS

Subprovider -

IPF

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,336,484	98,434,656	0.013577	1,576	21	50.00
51.00	05100 RECOVERY ROOM	35,763	8,593,190	0.004162	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	457,642	2,975,325	0.153812	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,018,401	115,520,840	0.008816	104,412	920	54.00
59.00	05900 CARDIAC CATHETERIZATION	239,304	18,752,294	0.012761	0	0	59.00
60.00	06000 LABORATORY	518,173	85,626,346	0.006052	533,603	3,229	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	29,518	15,649,514	0.001886	58,108	110	63.00
64.00	06400 INTRAVENOUS THERAPY	29,058	5,463,876	0.005318	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	90,621	40,900,740	0.002216	108,103	240	65.00
66.00	06600 PHYSICAL THERAPY	15,585	4,019,341	0.003878	46,101	179	66.00
69.00	06900 ELECTROCARDIOLOGY	133,362	16,587,245	0.008040	3,209	26	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	24,199	4,327,642	0.005592	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	300,305	59,439,795	0.005052	29,909	151	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	148,936	24,917,073	0.005977	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	274,277	65,303,237	0.004200	236,514	993	73.00
74.00	07400 RENAL DIALYSIS	4,695	373,029	0.012586	0	0	74.00
76.00	03950 ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03951 PARTIAL HOSPITALIZATION	19,224	3,441,060	0.005587	0	0	76.01
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	813,642	63,412,109	0.012831	141,463	1,815	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	13,474,656	0.000000	0	0	92.00
200.00	Total (lines 50 through 199)	5,489,189	647,211,968		1,262,998	7,684	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTSProvider CCN: 15-0009
Component CCN: 15-S009Period:
From 08/01/2022
To 07/31/2023Worksheet D
Part IV
Date/Time Prepared:
12/29/2023 12:01 pm

Title XVIII

Subprovider -

PPS
IPF

Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM		0	0	0	0	0 50.00
51.00 05100 RECOVERY ROOM		0	0	0	0	0 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0	0	0	0	0 52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC		0	0	0	0	0 54.00
59.00 05900 CARDIAC CATHETERIZATION		0	0	0	0	0 59.00
60.00 06000 LABORATORY		0	0	0	0	0 60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0	0	0	0	0 63.00
64.00 06400 INTRAVENOUS THERAPY		0	0	0	0	0 64.00
65.00 06500 RESPIRATORY THERAPY		0	0	0	0	0 65.00
66.00 06600 PHYSICAL THERAPY		0	0	0	0	0 66.00
69.00 06900 ELECTROCARDIOLOGY		0	0	0	0	0 69.00
70.00 07000 ELECTROENCEPHALOGRAPHY		0	0	0	0	0 70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO 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	71,306 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 03951 PARTIAL HOSPITALIZATION		0	0	0	0	0 76.01
77.00 07700 ALLOGENEIC HSCT ACQUISITION		0	0	0	0	0 77.00
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	0	0 92.00
200.00 Total (lines 50 through 199)		0	0	0	0	71,306 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet D
Part IV
Date/Time Prepared:
12/29/2023 12:01 pm

Title XVIII

Subprovider -
IPF

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		
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	0	98,434,656	0.000000
51.00 05100	RECOVERY ROOM	0	0	0	8,593,190	0.000000
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,975,325	0.000000
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	115,520,840	0.000000
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	18,752,294	0.000000
60.00 06000	LABORATORY	0	0	0	85,626,346	0.000000
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	15,649,514	0.000000
64.00 06400	INTRAVENOUS THERAPY	0	0	0	5,463,876	0.000000
65.00 06500	RESPIRATORY THERAPY	0	0	0	40,900,740	0.000000
66.00 06600	PHYSICAL THERAPY	0	0	0	4,019,341	0.000000
69.00 06900	ELECTROCARDIOLOGY	0	0	0	16,587,245	0.000000
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	4,327,642	0.000000
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	59,439,795	0.000000
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	24,917,073	0.000000
73.00 07300	DRUGS CHARGED TO PATIENTS	0	71,306	71,306	65,303,237	0.001092
74.00 07400	RENAL DIALYSIS	0	0	0	373,029	0.000000
76.00 03950	ANCILLARY	0	0	0	0	0.000000
76.01 03951	PARTIAL HOSPITALIZATION	0	0	0	3,441,060	0.000000
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	0	0	0	63,412,109	0.000000
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	13,474,656	0.000000
200.00	Total (lines 50 through 199)	0	71,306	71,306	647,211,968	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTSProvider CCN: 15-0009
Component CCN: 15-S009Period:
From 08/01/2022
To 07/31/2023Worksheet D
Part IV
Date/Time Prepared:
12/29/2023 12:01 pm

			Title XVIII		Subprovider - IPF	PPS	
Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	1,576	0	0	0 50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	104,412	0	0	0 54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0 59.00
60.00	06000	LABORATORY	0.000000	533,603	0	0	0 60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	58,108	0	0	0 63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	108,103	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0.000000	46,101	0	0	0 66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	3,209	0	0	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	29,909	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.001092	236,514	258	0	0 73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0 74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0 76.00
76.01	03951	PARTIAL HOSPITALIZATION	0.000000	0	0	0	0 76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0 77.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.000000	141,463	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0 92.00
200.00		Total (lines 50 through 199)		1,262,998	258	0	0 200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet D
Part V
Date/Time Prepared:
12/29/2023 12:01 pm

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Title XIX		Hospital	Cost	
		PPS Reimbursed Services (see inst.)	Charges	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	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	0.149682	0	866,157	0	0 50.00
51.00 05100	RECOVERY ROOM	0.244329	0	102,248	0	0 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1.089109	0	12,331	0	0 52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0.111496	0	1,530,092	0	0 54.00
59.00 05900	CARDIAC CATHETERIZATION	0.213934	0	53,763	0	0 59.00
60.00 06000	LABORATORY	0.091789	0	1,004,694	0	0 60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0.070639	0	166,998	0	0 63.00
64.00 06400	INTRAVENOUS THERAPY	0.288116	0	22,383	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	0.094683	0	238,037	0	0 65.00
66.00 06600	PHYSICAL THERAPY	0.248595	0	9,475	0	0 66.00
69.00 06900	ELECTROCARDIOLOGY	0.077677	0	91,516	0	0 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0.061454	0	7,771	0	0 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.155899	0	385,250	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0.394200	0	94,954	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0.147903	0	371,875	0	0 73.00
74.00 07400	RENAL DIALYSIS	1.028502	0	0	0	0 74.00
76.00 03950	ANCILLARY	0.000000	0	0	0	0 76.00
76.01 03951	PARTIAL HOSPITALIZATION	0.401024	0	27,825	0	0 76.01
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0 77.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	0.189980	0	1,694,450	0	0 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0.209883	0	204,010	0	0 92.00
200.00	Subtotal (see instructions)		0	6,883,829	0	0 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0 201.00
202.00	Net Charges (line 200 - line 201)		0	6,883,829	0	0 202.00

Cost Center Description	Costs		Title XIX	Hospital	Cost
	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	129,648	0			50.00
51.00 05100 RECOVERY ROOM	24,982	0			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	13,430	0			52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	170,599	0			54.00
59.00 05900 CARDIAC CATHETERIZATION	11,502	0			59.00
60.00 06000 LABORATORY	92,220	0			60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	11,797	0			63.00
64.00 06400 INTRAVENOUS THERAPY	6,449	0			64.00
65.00 06500 RESPIRATORY THERAPY	22,538	0			65.00
66.00 06600 PHYSICAL THERAPY	2,355	0			66.00
69.00 06900 ELECTROCARDIOLOGY	7,109	0			69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	478	0			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	60,060	0			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	37,431	0			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	55,001	0			73.00
74.00 07400 RENAL DIALYSIS	0	0			74.00
76.00 03950 ANCILLARY	0	0			76.00
76.01 03951 PARTIAL HOSPITALIZATION	11,158	0			76.01
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0			77.00
OUTPATIENT SERVICE COST CENTERS					
91.00 09100 EMERGENCY	321,912	0			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	42,818	0			92.00
200.00	Subtotal (see instructions)	1,021,487	0		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00	Net Charges (line 200 - line 201)	1,021,487	0		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0009

Period:

From 08/01/2022

Worksheet D

Part II

Date/Time Prepared:

12/29/2023 12:01 pm

Component CCN: 15-S009

To 07/31/2023

PPS

Title XIX

Subprovider -

IPF

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,336,484	98,434,656	0.013577	0	0	50.00
51.00	05100 RECOVERY ROOM	35,763	8,593,190	0.004162	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	457,642	2,975,325	0.153812	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,018,401	115,520,840	0.008816	4,221	37	54.00
59.00	05900 CARDIAC CATHETERIZATION	239,304	18,752,294	0.012761	0	0	59.00
60.00	06000 LABORATORY	518,173	85,626,346	0.006052	28,430	172	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	29,518	15,649,514	0.001886	3,588	7	63.00
64.00	06400 INTRAVENOUS THERAPY	29,058	5,463,876	0.005318	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	90,621	40,900,740	0.002216	10,276	23	65.00
66.00	06600 PHYSICAL THERAPY	15,585	4,019,341	0.003878	8,978	35	66.00
69.00	06900 ELECTROCARDIOLOGY	133,362	16,587,245	0.008040	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	24,199	4,327,642	0.005592	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	300,305	59,439,795	0.005052	1,471	7	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	148,936	24,917,073	0.005977	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	274,277	65,303,237	0.004200	25,253	106	73.00
74.00	07400 RENAL DIALYSIS	4,695	373,029	0.012586	0	0	74.00
76.00	03950 ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03951 PARTIAL HOSPITALIZATION	19,224	3,441,060	0.005587	0	0	76.01
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	813,642	63,412,109	0.012831	12,513	161	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	13,474,656	0.000000	0	0	92.00
200.00	Total (lines 50 through 199)	5,489,189	647,211,968		94,730	548	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTSProvider CCN: 15-0009
Component CCN: 15-S009Period:
From 08/01/2022
To 07/31/2023Worksheet D
Part IV
Date/Time Prepared:
12/29/2023 12:01 pm

Title XIX

Subprovider -

PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM		0	0	0	0	0 50.00
51.00 05100 RECOVERY ROOM		0	0	0	0	0 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0	0	0	0	0 52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC		0	0	0	0	0 54.00
59.00 05900 CARDIAC CATHETERIZATION		0	0	0	0	0 59.00
60.00 06000 LABORATORY		0	0	0	0	0 60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0	0	0	0	0 63.00
64.00 06400 INTRAVENOUS THERAPY		0	0	0	0	0 64.00
65.00 06500 RESPIRATORY THERAPY		0	0	0	0	0 65.00
66.00 06600 PHYSICAL THERAPY		0	0	0	0	0 66.00
69.00 06900 ELECTROCARDIOLOGY		0	0	0	0	0 69.00
70.00 07000 ELECTROENCEPHALOGRAPHY		0	0	0	0	0 70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO 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	71,306 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 03951 PARTIAL HOSPITALIZATION		0	0	0	0	0 76.01
77.00 07700 ALLOGENEIC HSCT ACQUISITION		0	0	0	0	0 77.00
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	0	0 92.00
200.00 Total (lines 50 through 199)		0	0	0	0	71,306 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet D
Part IV
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Subprovider -
IPF

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		
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	0	98,434,656	0.000000
51.00 05100	RECOVERY ROOM	0	0	0	8,593,190	0.000000
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,975,325	0.000000
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	115,520,840	0.000000
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	18,752,294	0.000000
60.00 06000	LABORATORY	0	0	0	85,626,346	0.000000
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	15,649,514	0.000000
64.00 06400	INTRAVENOUS THERAPY	0	0	0	5,463,876	0.000000
65.00 06500	RESPIRATORY THERAPY	0	0	0	40,900,740	0.000000
66.00 06600	PHYSICAL THERAPY	0	0	0	4,019,341	0.000000
69.00 06900	ELECTROCARDIOLOGY	0	0	0	16,587,245	0.000000
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	4,327,642	0.000000
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	59,439,795	0.000000
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	24,917,073	0.000000
73.00 07300	DRUGS CHARGED TO PATIENTS	0	71,306	71,306	65,303,237	0.001092
74.00 07400	RENAL DIALYSIS	0	0	0	373,029	0.000000
76.00 03950	ANCILLARY	0	0	0	0	0.000000
76.01 03951	PARTIAL HOSPITALIZATION	0	0	0	3,441,060	0.000000
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	0	0	0	63,412,109	0.000000
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	13,474,656	0.000000
200.00	Total (lines 50 through 199)	0	71,306	71,306	647,211,968	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTSProvider CCN: 15-0009
Component CCN: 15-S009Period:
From 08/01/2022
To 07/31/2023Worksheet D
Part IV
Date/Time Prepared:
12/29/2023 12:01 pm

Title XIX

Subprovider -
IPF

PPS

Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	4,221	0	0	0	54.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	28,430	0	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	3,588	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	10,276	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	8,978	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,471	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.001092	25,253	28	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950 ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951 PARTIAL HOSPITALIZATION	0.000000	0	0	0	0	76.01
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0.000000	12,513	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00	Total (lines 50 through 199)		94,730	28	0	0	200.00

PART I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	27,071	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	27,071	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.	22,539	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,184	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)	7,237	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)	32,606,076	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)	32,606,076	27.00

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	52,982,328	28.00
29.00	Private room charges (excluding swing-bed charges)	48,892,231	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	4,090,097	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.615414	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	2,169.23	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1,872.76	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	296.47	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	182.45	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	4,112,241	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	28,493,835	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)	1,204.47	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	8,716,749	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)	8,716,749	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet D-1
Date/Time Prepared:
12/29/2023 12:01 pm

Cost Center Description		Title XVIII				Hospital		PPS
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT	3,529,162	4,437	795.39	465	369,856	43.00	
44.00	CORONARY CARE UNIT	0	0	0.00	0	0	0	44.00
44.01	NEONATAL INTENSIVE CARE UNIT	887,479	706	1,257.05	0	0	0	44.01
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)					10,488,938	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)					19,575,543	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)					793,154	50.00	
51.00	Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					518,643	51.00	
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,311,797	52.00	
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					18,263,746	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)					2,348	87.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,204.47	88.00	

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COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023

Worksheet D-1

Date/Time Prepared:
12/29/2023 12:01 pm

Title XVIII

Hospital

PPS

Cost Center Description

1.00

2,828,096 89.00

89.00 observation bed cost (line 87 x line 88) (see instructions)

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	2,845,590	32,606,076	0.087272	2,828,096	246,814	90.00
91.00 Nursing Program cost	0	32,606,076	0.000000	2,828,096	0	91.00
92.00 Allied health cost	0	32,606,076	0.000000	2,828,096	0	92.00
93.00 All other Medical Education	0	32,606,076	0.000000	2,828,096	0	93.00

Cost Center Description		1.00	
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,838	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,838	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,838	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)	734	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)		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)	3,261,440	0
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	22.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	23.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	24.00
26.00	Total swing-bed cost (see instructions)	0	25.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,261,440	0
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	26.00
29.00	Private room charges (excluding swing-bed charges)	0	27.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	28.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	29.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	30.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	31.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	0.00	32.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	33.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0.00	34.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,261,440	0
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)	1,774.45	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,302,446	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,302,446	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0009

Worksheet D-1

Component CCN: 15-S009

Period:

From 08/01/2022

To 07/31/2023

Date/Time Prepared:

12/29/2023 12:01 pm

Title XVIII

Subprovider -

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	
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
44.00	CORONARY CARE UNIT	0	0	0.00	0	0	44.00
44.01	NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	44.01
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)					153,426	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					1,455,872	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)					195,127	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					7,942	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					203,069	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,252,803	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

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COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet D-1
Date/Time Prepared:
12/29/2023 12:01 pm
PPSTitle XVIII
Subprovider -
IPF

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	488,616	3,261,440	0.149816	0	0	90.00
91.00	Nursing Program cost	0	3,261,440	0.000000	0	0	91.00
92.00	Allied health cost	0	3,261,440	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,261,440	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet D-1
Date/Time Prepared:
12/29/2023 12:01 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)	27,071	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	27,071	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)	24,723	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)	928	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)	2,085	15.00
16.00	Nursery days (title V or XIX only)	149	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)	32,606,076	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)	32,606,076	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)	32,606,076	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)	1,204.47	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,117,748	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,117,748	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet D-1
Date/Time Prepared:
12/29/2023 12:01 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)	
42.00	NURSERY (title V & XIX only)	742,049	2,085	355.90	149	53,029	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,529,162	4,437	795.39	170	135,216	43.00
44.00	CORONARY CARE UNIT	0	0	0.00	0	0	44.00
44.01	NEONATAL INTENSIVE CARE UNIT	887,479	706	1,257.05	66	82,965	44.01
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)					1,407,221	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)					2,796,179	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)					2,348	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,204.47	88.00

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COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023

Worksheet D-1

Date/Time Prepared:
12/29/2023 12:01 pm

Title XIX

Hospital

Cost

Cost Center Description

1.00

2,828,096 89.00

89.00 observation bed cost (line 87 x line 88) (see instructions)

Cost Center Description

Cost

Routine Cost
(from line 21)column 1 ÷
column 2Total
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	2,845,590	32,606,076	0.087272	2,828,096	246,814	90.00
91.00	Nursing Program cost	0	32,606,076	0.000000	2,828,096	0	91.00
92.00	Allied health cost	0	32,606,076	0.000000	2,828,096	0	92.00
93.00	All other Medical Education	0	32,606,076	0.000000	2,828,096	0	93.00

PART I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,838	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,838	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,838	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)	50	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)	2,085	15.00
16.00	Nursery days (title V or XIX only)	149	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)	3,261,440	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)	3,261,440	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)	3,261,440	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)	1,774.45	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	88,723	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)	88,723	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0009

Worksheet D-1

Component CCN: 15-S009

Period:

From 08/01/2022

To 07/31/2023

Date/Time Prepared:

12/29/2023 12:01 pm

PPS

Title XIX

Subprovider -

IPF

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)	
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
44.00	CORONARY CARE UNIT	0	0	0.00	0	0	44.00
44.01	NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	44.01
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)					12,880	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)					101,603	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)					576	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					576	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					101,027	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

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COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0009

Worksheet D-1

Component CCN: 15-S009

Period:

From 08/01/2022

To 07/31/2023

Date/Time Prepared:

12/29/2023 12:01 pm

PPS

Title XIX
Subprovider -
IPF

Cost Center Description					1.00	
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)	88.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00	0	88.00
89.00 observation bed cost (line 87 x line 88) (see instructions)				0	0	89.00
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	0	3,261,440	0.000000	0	0	90.00
91.00 Nursing Program cost	0	3,261,440	0.000000	0	0	91.00
92.00 Allied health cost	0	3,261,440	0.000000	0	0	92.00
93.00 All other Medical Education	0	3,261,440	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0009	Period: From 08/01/2022 To 07/31/2023	Worksheet D-3
		Title XVIII		Hospital
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		14,308,480	30.00
31.00	03100 INTENSIVE CARE UNIT		1,702,563	31.00
32.00	03200 CORONARY CARE UNIT		0	32.00
32.01	02060 NEONATAL INTENSIVE CARE UNIT		0	32.01
40.00	04000 SUBPROVIDER - IPF		0	40.00
41.00	04100 SUBPROVIDER - IRF		0	41.00
42.00	04200 SUBPROVIDER		0	42.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.149682	6,150,355	50.00
51.00	05100 RECOVERY ROOM	0.244329	453,839	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.089109	6,904	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.111496	9,514,398	54.00
59.00	05900 CARDIAC CATHETERIZATION	0.213934	2,767,935	59.00
60.00	06000 LABORATORY	0.091789	10,795,285	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.070639	2,712,028	63.00
64.00	06400 INTRAVENOUS THERAPY	0.288116	296,203	64.00
65.00	06500 RESPIRATORY THERAPY	0.094683	8,466,420	65.00
66.00	06600 PHYSICAL THERAPY	0.248595	1,193,433	66.00
69.00	06900 ELECTROCARDIOLOGY	0.077677	2,196,301	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.061454	206,212	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.155899	7,584,118	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.394200	3,618,899	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.147903	7,931,686	73.00
74.00	07400 RENAL DIALYSIS	1.028502	120,294	74.00
76.00	03950 ANCILLARY	0.000000	0	76.00
76.01	03951 PARTIAL HOSPITALIZATION	0.401024	3,036	76.01
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	77.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0.189980	5,783,444	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.209883	1,152,316	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		70,953,106	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)		70,953,106	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0009 Component CCN: 15-S009	Period: From 08/01/2022 To 07/31/2023	Worksheet D-3 Date/Time Prepared: 12/29/2023 12:01 pm		
		Title XVIII	Subprovider - IPF	PPS		
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)		
			1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00	
31.00	03100 INTENSIVE CARE UNIT				31.00	
32.00	03200 CORONARY CARE UNIT				32.00	
32.01	02060 NEONATAL INTENSIVE CARE UNIT				32.01	
40.00	04000 SUBPROVIDER - IPF			1,301,411	40.00	
41.00	04100 SUBPROVIDER - IRF				41.00	
42.00	04200 SUBPROVIDER				42.00	
43.00	04300 NURSERY				43.00	
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.149682	1,576	236	50.00	
51.00	05100 RECOVERY ROOM	0.244329	0	0	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.089109	0	0	52.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.111496	104,412	11,642	54.00	
59.00	05900 CARDIAC CATHETERIZATION	0.213934	0	0	59.00	
60.00	06000 LABORATORY	0.091789	533,603	48,979	60.00	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.070639	58,108	4,105	63.00	
64.00	06400 INTRAVENOUS THERAPY	0.288116	0	0	64.00	
65.00	06500 RESPIRATORY THERAPY	0.094683	108,103	10,236	65.00	
66.00	06600 PHYSICAL THERAPY	0.248595	46,101	11,460	66.00	
69.00	06900 ELECTROCARDIOLOGY	0.077677	3,209	249	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY	0.061454	0	0	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.155899	29,909	4,663	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.394200	0	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0.147903	236,514	34,981	73.00	
74.00	07400 RENAL DIALYSIS	1.028502	0	0	74.00	
76.00	03950 ANCILLARY	0.000000	0	0	76.00	
76.01	03951 PARTIAL HOSPITALIZATION	0.401024	0	0	76.01	
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00	
	OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.189980	141,463	26,875	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.209883	0	0	92.00	
200.00	Total (sum of lines 50 through 94 and 96 through 98)			1,262,998	153,426	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)			0	201.00	201.00
202.00	Net charges (line 200 minus line 201)			1,262,998	202.00	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0009	Period: From 08/01/2022 To 07/31/2023	Worksheet D-3
		Title XIX		Hospital
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00
INPATIENT ROUTINE SERVICE COST CENTERS				3.00
30.00	03000 ADULTS & PEDIATRICS		2,034,492	30.00
31.00	03100 INTENSIVE CARE UNIT		243,144	31.00
32.00	03200 CORONARY CARE UNIT		0	32.00
32.01	02060 NEONATAL INTENSIVE CARE UNIT		0	32.01
40.00	04000 SUBPROVIDER - IPF		0	40.00
41.00	04100 SUBPROVIDER - IRF		0	41.00
42.00	04200 SUBPROVIDER		0	42.00
43.00	04300 NURSERY		368,538	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.149682	578,879	50.00
51.00	05100 RECOVERY ROOM	0.244329	64,923	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.089109	124,640	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.111496	1,074,807	54.00
59.00	05900 CARDIAC CATHETERIZATION	0.213934	331,902	59.00
60.00	06000 LABORATORY	0.091789	1,900,935	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.070639	320,511	63.00
64.00	06400 INTRAVENOUS THERAPY	0.288116	59,601	64.00
65.00	06500 RESPIRATORY THERAPY	0.094683	999,714	65.00
66.00	06600 PHYSICAL THERAPY	0.248595	71,618	66.00
69.00	06900 ELECTROCARDIOLOGY	0.077677	211,878	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.061454	16,522	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.155899	1,059,252	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.394200	232,404	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.147903	953,564	73.00
74.00	07400 RENAL DIALYSIS	1.028502	18,450	74.00
76.00	03950 ANCILLARY	0.000000	0	76.00
76.01	03951 PARTIAL HOSPITALIZATION	0.401024	0	76.01
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	77.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0.189980	997,881	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.209883	131,271	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		9,148,752	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)		9,148,752	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0009 Component CCN: 15-S009	Period: From 08/01/2022 To 07/31/2023	Worksheet D-3 Date/Time Prepared: 12/29/2023 12:01 pm
		Title XIX	Subprovider - IPF	PPS
Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
	1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
32.00 03200 CORONARY CARE UNIT				32.00
32.01 02060 NEONATAL INTENSIVE CARE UNIT				32.01
40.00 04000 SUBPROVIDER - IPF			107,380	40.00
41.00 04100 SUBPROVIDER - IRF				41.00
42.00 04200 SUBPROVIDER				42.00
43.00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0.149682	0	0	50.00
51.00 05100 RECOVERY ROOM	0.244329	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1.089109	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.111496	4,221	471	54.00
59.00 05900 CARDIAC CATHETERIZATION	0.213934	0	0	59.00
60.00 06000 LABORATORY	0.091789	28,430	2,610	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.070639	3,588	253	63.00
64.00 06400 INTRAVENOUS THERAPY	0.288116	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0.094683	10,276	973	65.00
66.00 06600 PHYSICAL THERAPY	0.248595	8,978	2,232	66.00
69.00 06900 ELECTROCARDIOLOGY	0.077677	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.061454	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.155899	1,471	229	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.394200	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.147903	25,253	3,735	73.00
74.00 07400 RENAL DIALYSIS	1.028502	0	0	74.00
76.00 03950 ANCILLARY	0.000000	0	0	76.00
76.01 03951 PARTIAL HOSPITALIZATION	0.401024	0	0	76.01
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
OUTPATIENT SERVICE COST CENTERS				
91.00 09100 EMERGENCY	0.189980	12,513	2,377	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.209883	0	0	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)		94,730	12,880	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00 Net charges (line 200 minus line 201)		94,730	12,880	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet E
Part A
Date/Time Prepared:
12/29/2023 12:01 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)		2,915,689	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		13,840,103	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)		0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		45,829	2.04
3.00	Managed Care Simulated Payments		14,693,259	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		146.40	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)		4.49	5.00
5.01	FTE cap adjustment for qualifying hospitals under §131 of the CAA 2021 (see instructions)		0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)		0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.86	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)		3.63	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.03	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)		0.03	12.00
13.00	Total allowable FTE count for the prior year.		0.68	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.		0.71	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.47	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.47	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.003210	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.004675	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.003210	21.00
22.00	IME payment adjustment (see instructions)		29,390	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		25,772	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)		-3.60	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)		29,390	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		25,772	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		6.93	30.00
31.00	Percentage of Medicaid patient days (see instructions)		32.84	31.00
32.00	Sum of lines 30 and 31		39.77	32.00
33.00	Allowable disproportionate share percentage (see instructions)		22.03	33.00
34.00	Disproportionate share adjustment (see instructions)		922,826	34.00

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CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet E
Part A
Date/Time Prepared:
12/29/2023 12:01 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)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital UCP, including supplemental UCP (If line 34 is zero, enter zero on this line) (see instructions)	1,061,065	943,614	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	177,328	785,914	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	963,242		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
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0	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	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)	18,717,079		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)	18,742,851	49.00	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,351,582	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).	18,430	52.00	
53.00	Nursing and Allied Health Managed Care payment	0	53.00	
54.00	Special add-on payments for new technologies	46,096	54.00	
54.01	Islet isolation add-on payment	0	54.01	
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00	
55.01	Cellular therapy acquisition cost (see instructions)	0	55.01	
56.00	Cost of physicians' services in a teaching hospital (see instructions)	0	56.00	
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00	
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	8,661	58.00	
59.00	Total (sum of amounts on lines 49 through 58)	20,167,620	59.00	
60.00	Primary payer payments	94,741	60.00	
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	20,072,879	61.00	
62.00	Deductibles billed to program beneficiaries	2,099,845	62.00	
63.00	Coinsurance billed to program beneficiaries	33,505	63.00	
64.00	Allowable bad debts (see instructions)	207,910	64.00	
65.00	Adjusted reimbursable bad debts (see instructions)	135,142	65.00	
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	50,410	66.00	
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	18,074,671	67.00	
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00	
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)	0	69.00	
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00	
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50	
70.75	N95 respirator payment adjustment amount (see instructions)	0	70.75	
70.87	Demonstration payment adjustment amount before sequestration	0	70.87	
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88	
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)	0	70.89	
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90	
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91	
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92	
70.93	HVBP payment adjustment amount (see instructions)	0	70.93	
70.94	HRR adjustment amount (see instructions)	-179,558	70.94	
70.95	Recovery of accelerated depreciation	0	70.95	

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet E
Part A
Date/Time Prepared:
12/29/2023 12:01 pm

	Title XVIII	Hospital		PPS
		FFY (yyyy)	Amount	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	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)		34,586	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		17,860,527	71.00
71.01	Sequestration adjustment (see instructions)		357,211	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		16,991,222	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		512,094	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		453,443	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
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0009

Period:

From 08/01/2022

To 07/31/2023

Worksheet E

Part A Exhibit 4

Date/Time Prepared:

12/29/2023 12:01 pm

		Title XVIII		Hospital		PPS	
W/S E, Part A Line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	5.00	1.00
		0	2.00	3.00			
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,915,689	0	2,915,689	2,915,689	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	13,840,103	0	13,840,103	13,840,103	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	1.04
2.00	outlier payments for discharges (see instructions)	2.00					2.00
2.01	outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	0	0	2.02
2.03	outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	45,829	0	45,829	45,829	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	14,693,259	0	14,693,259	14,693,259	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, Line 21 (see instructions)	21.00	0.003210	0.003210	0.003210	0.003210	5.00
6.00	IME payment adjustment (see instructions)	22.00	29,390	0	5,114	24,276	29,390
6.01	IME payment adjustment for managed care (see instructions)	22.01	25,772	0	0	25,772	25,772
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	29,390	0	5,114	24,276	29,390
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	25,772	0	0	25,772	25,772
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.2203	0.2203	0.2203	0.2203	10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	922,826	0	160,582	762,244	922,826
11.01	Uncompensated care payments	36.00	963,242	0	177,328	785,914	963,242
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	18,717,079	0	3,258,713	15,458,366	18,717,079
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	18,742,851	0	3,258,713	15,484,138	18,742,851
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,351,582	0	0	1,351,582	1,351,582

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0009

Period:

From 08/01/2022

To 07/31/2023

Worksheet E

Part A Exhibit 4

Date/Time Prepared:

12/29/2023 12:01 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	special add-on payments for new technologies	54.00	46,096	0	0	46,096	46,096	17.00
17.01	Net organ acquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	3,258,713	16,881,816	20,140,529	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,242,173	0	0	1,242,173	1,242,173	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	3,328	0	0	3,328	3,328	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0016	0.0016	0.0016	0.0016	0.0016	22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	1,987	0	0	1,987	1,987	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0838	0.0838	0.0838	0.0838	0.0838	24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	104,094	0	0	104,094	104,094	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,351,582	0	0	1,351,582	1,351,582	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0	0	0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

		Title XVIII		Hospital		PPS
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00
1.00	DRG amounts other than outlier payments	1.00				1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,915,689	2,915,689		2,915,689
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	13,840,103		13,840,103	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00				2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0		0
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	45,829		45,829	45,829
3.00	Operating outlier reconciliation	2.01	0	0	0	0
4.00	Managed care simulated payments	3.00	14,693,259	2,352,428	12,340,831	14,693,259
Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.003210	0.003210	0.003210	5.00
6.00	IME payment adjustment (see instructions)	22.00	29,390	5,114	24,276	29,390
6.01	IME payment adjustment for managed care (see instructions)	22.01	25,772	4,126	21,646	25,772
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	29,390	5,114	24,276	29,390
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	25,772	4,126	21,646	25,772
Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.2203	0.2203	0.2203	10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	922,826	160,582	762,244	922,826
11.01	Uncompensated care payments	36.00	963,242	177,328	785,914	963,242
Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0
13.00	Subtotal (see instructions)	47.00	18,717,079	3,258,713	15,458,366	18,717,079
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	18,742,851	3,262,839	15,480,012	18,742,851
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,351,582	233,776	1,117,806	1,351,582
17.00	Special add-on payments for new technologies	54.00	46,096	0	46,096	46,096
17.01	Net organ acquisition cost	68.00	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	18.00
19.00	SUBTOTAL			3,496,615	16,643,914	20,140,529
						19.00

		Title XVIII		Hospital		Worksheet E Part A Exhibit 5 Date/Time Prepared: 12/29/2023 12:01 pm
		Wkst. L, line	(Amt. from Wkst. L)			
		0	1.00	2.00	3.00	
20.00	Capital DRG other than outlier	1.00	1,242,173	215,382	1,026,791	1,242,173 20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0 20.01
21.00	Capital DRG outlier payments	2.00	3,328	0	3,328	3,328 21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0 21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0016	0.0016	0.0016	22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	1,987	345	1,642	1,987 23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0838	0.0838	0.0838	24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	104,094	18,049	86,045	104,094 25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,351,582	233,776	1,117,806	1,351,582 26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)			
		0	1.00	2.00	3.00	4.00
27.00						27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0 28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0 29.00
30.00	HVBP payment adjustment (see instructions)	70.93	0	0	0	0 30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0 30.01
31.00	HRR adjustment (see instructions)	70.94	-179,558	-37,971	-141,587	-179,558 31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0 31.01
						(Amt. to Wkst. E, Pt. A)
		0	1.00	2.00	3.00	4.00
32.00	HAC Reduction Program adjustment (see instructions)	70.99		34,586	0	34,586 32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y			100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet E
Part B
Date/Time Prepared:
12/29/2023 12:01 pm

		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		813	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		12,705,382	2.00
3.00	OPPS or REH payments		11,217,390	3.00
4.00	outlier payment (see instructions)		9,816	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 from Wkst. D, Pt. IV, col. 13, line 200		10,517	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		813	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		5,496	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)		5,496	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		5,496	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		4,683	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)		813	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)		11,237,723	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)		2,080,803	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)		9,157,733	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		11,189	28.00
28.50	REH facility payment amount			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)		9,168,922	30.00
31.00	Primary payer payments		5,938	31.00
32.00	Subtotal (line 30 minus line 31)		9,162,984	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)		165,608	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		107,645	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		101,146	36.00
37.00	Subtotal (see instructions)		9,270,629	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-33	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)		9,270,662	40.00
40.01	Sequestration adjustment (see instructions)		185,413	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			41.00
41.01	Interim payments-PARHM		9,087,084	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)		-1,835	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		80	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
94.00	Total (sum of lines 91 and 93)		0	94.00

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Health Financial Systems

CALCULATION OF REIMBURSEMENT SETTLEMENT

CLARK MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023

Worksheet E
Part B
Date/Time Prepared:
12/29/2023 12:01 pm

Title XVIII

Hospital

PPS

1.00

MEDICARE PART B ANCILLARY COSTS

200.00 Part B Combined Billed Days

0200.00

		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			16,991,222	9,087,084
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
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
3.02				0	0
3.03				0	0
3.04				0	0
3.05				0	0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM			0	0
3.51				0	0
3.52				0	0
3.53				0	0
3.54				0	0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0
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)		16,991,222		9,087,084
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
5.02				0	0
5.03				0	0
Provider to Program					
5.50	TENTATIVE TO PROGRAM			0	0
5.51				0	0
5.52				0	0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER		512,094		0
6.02	SETTLEMENT TO PROGRAM		0		1,835
7.00	Total Medicare program liability (see instructions)		17,503,316		9,085,249
				Contractor Number	NPR Date (Mo/Day/Yr)
8.00 Name of Contractor				0	1.00
					2.00
					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0009

Worksheet E-1

Component CCN: 15-S009

Part I

From 08/01/2022

Date/Time Prepared:

To 07/31/2023

12/29/2023 12:01 pm

Title XVIII

Subprovider -

PPS

IPF

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
1.00	Total interim payments paid to provider	1.00	2.00	3.00	4.00	
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		657,807	0	0	1.00
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)					2.00
	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)		657,807		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		2,356		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		660,163		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
8.00	Name of Contractor		0	1.00	2.00	8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet E-1
Part II
Date/Time Prepared:
12/29/2023 12:01 pm

Title XVIII

Hospital

PPS

1.00

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS**HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION**

1.00	Total hospital discharges as defined in AARA §4102 from wkst. S-3, Pt. I col. 15 line 14	1.00
2.00	Medicare days (see instructions)	2.00
3.00	Medicare HMO days from wkst. S-3, Pt. I, col. 6. line 2	3.00
4.00	Total inpatient days (see instructions)	4.00
5.00	Total hospital charges from wkst C, Pt. I, col. 8 line 200	5.00
6.00	Total hospital charity care charges from wkst. S-10, col. 3 line 20	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology wkst. S-2, Pt. I line 168	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	8.00
9.00	Sequestration adjustment amount (see instructions)	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	10.00

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30.00	Initial/interim HIT payment adjustment (see instructions)	30.00
31.00	Other Adjustment (specify)	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0009

Worksheet E-3

Component CCN: 15-S009

Part II

Period: From 08/01/2022

Date/Time Prepared:

To 07/31/2023

12/29/2023 12:01 pm

Title XVIII

Subprovider -

PPS

IPF

1.00

PART II - MEDICARE PART A SERVICES - IPF PPS

1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	707,615	1.00
2.00	Net IPF PPS Outlier Payments	30,123	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	5.035616	9.00
10.00	Teaching Adjustment Factor $\{(1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of .5150 - 1}\}$.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	737,738	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)	0	14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	737,738	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	737,738	18.00
19.00	Deductibles	66,496	19.00
20.00	Subtotal (line 18 minus line 19)	671,242	20.00
21.00	Coinsurance	0	21.00
22.00	Subtotal (line 20 minus line 21)	671,242	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	3,286	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	2,136	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	673,378	26.00
27.00	Direct graduate medical education payments (see instructions)	0	27.00
28.00	other pass through costs (see instructions)	258	28.00
29.00	outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.98	Recovery of accelerated depreciation.	0	30.98
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	673,636	31.00
31.01	Sequestration adjustment (see instructions)	13,473	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	657,807	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	2,356	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00

TO BE COMPLETED BY CONTRACTOR

50.00	Original outlier amount from Worksheet E-3, Part II, line 2	30,123	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: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet E-3
Part VII
Date/Time Prepared:
12/29/2023 12:01 pm

	Title XIX	Hospital	Cost	
		Inpatient	Outpatient	
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	2,796,179	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)	2,796,179	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)	2,796,179	7.00	
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	2,646,174	8.00	
9.00	Ancillary service charges	9,148,752	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)	11,794,926	12.00	
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	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	14.00	
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	15.00	
16.00	Total customary charges (see instructions)	11,794,926	16.00	
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	8,998,747	17.00	
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	18.00	
19.00	Interns and Residents (see instructions)	0	19.00	
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	20.00	
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	2,796,179	21.00	
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	22.00	
23.00	Outlier payments	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	26.00	
27.00	Subtotal (sum of lines 22 through 26)	0	27.00	
28.00	Customary charges (title V or XIX PPS covered services only)	0	28.00	
29.00	Titles V or XIX (sum of lines 21 and 27)	2,796,179	29.00	
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	30.00	
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	2,796,179	31.00	
32.00	Deductibles	0	32.00	
33.00	Coinsurance	0	33.00	
34.00	Allowable bad debts (see instructions)	0	34.00	
35.00	Utilization review	0	35.00	
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	2,796,179	36.00	
37.00	NO SETTLEMENT ADJUSTMENT	1,425,213	37.00	
38.00	Subtotal (line 36 ± line 37)	4,221,392	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)	4,221,392	40.00	
41.00	Interim payments	4,285,654	41.00	
42.00	Balance due provider/program (line 40 minus line 41)	-64,262	42.00	
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	43.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet E-3
Part VII
Date/Time Prepared:
12/29/2023 12:01 pm

Title XIX

Subprovider -

IPF

PPS

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	0	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)	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)	0	7.00

COMPUTATION OF LESSER OF COST OR CHARGES

8.00	Routine service charges	107,380	8.00
9.00	Ancillary service charges	94,730	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)	202,110	12.00

CUSTOMARY CHARGES

13.00	Amount actually collected from patients liable for payment for services on a charge basis	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	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000
16.00	Total customary charges (see instructions)	202,110	0
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	202,110	0
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	18.00
19.00	Interns and Residents (see instructions)	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	21.00

PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.

22.00	Other than outlier payments	0	22.00
23.00	Outlier payments	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	28	0
27.00	Subtotal (sum of lines 22 through 26)	28	0
28.00	Customary charges (title V or XIX PPS covered services only)	0	0
29.00	Titles V or XIX (sum of lines 21 and 27)	28	0

COMPUTATION OF REIMBURSEMENT SETTLEMENT

30.00	Excess of reasonable cost (from line 18)	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	28	0
32.00	Deductibles	0	32.00
33.00	Coinsurance	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Utilization review	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	28	0
37.00	NO SETTLEMENT ADJUSTMENT	5,472	0
38.00	Subtotal (line 36 ± line 37)	5,500	0
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)	5,500	0
41.00	Interim payments	5,500	0
42.00	Balance due provider/program (line 40 minus line 41)	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	43.00

		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.		4.49	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		0.86	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 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		3.63	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)		0.03	6.00
7.00	Enter the lesser of line 5 or line 6		0.03	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.	0.03	0.00	0.03 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.	0.03	0.00	0.03 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	0.03	0.00	11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.68	0.00	12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.71	0.00	13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.47	0.00	14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00	15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00	15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00	16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00	16.01
17.00	Adjusted rolling average FTE count	0.47	0.00	17.00
18.00	Per resident amount	119,923.37	119,923.37	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	56,364	0	56,364 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)		56,364	25.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet E-4
Date/Time Prepared:
12/29/2023 12:01 pm

		Title XVIII		Hospital	Total	PPS
		Inpatient Part A	Managed Care Prior to 1/1	Managed Care On or after 1/1		
		1.00	2.00	2.01	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)	8,436	3,471	5,057		26.00
27.00	Total Inpatient Days (see instructions)	31,752	31,752	31,752		27.00
28.00	Ratio of inpatient days to total inpatient days	0.265684	0.109316	0.159266		28.00
29.00	Program direct GME amount	14,975	6,161	8,977	30,113	29.00
29.01	Percent reduction for MA DGME		3.26	3.26		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		201	293	494	30.00
31.00	Net Program direct GME amount				29,619	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)				373,029	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)				21,031,415	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)				94,741	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)				20,936,674	41.00
	Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)				12,716,712	42.00
43.00	Primary payer payments (see instructions)				5,938	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)				12,710,774	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)				33,647,448	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)				0.622237	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)				0.377763	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)				29,619	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)				18,430	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)				11,189	50.00

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: 15-0009

Period:
From 08/01/2022
To 07/31/2023

Worksheet G
Date/Time Prepared:
12/29/2023 12:01 pm

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund		
				1.00	2.00	3.00
CURRENT ASSETS						
1.00	Cash on hand in banks	281,617	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	22,399,693	0	0	0	4.00
5.00	Other receivable	71,969	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	4,155,648	0	0	0	7.00
8.00	Prepaid expenses	2,807,739	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	29,716,666	0	0	0	11.00
FIXED ASSETS						
12.00	Land	3,019,787	0	0	0	12.00
13.00	Land improvements	528,800	0	0	0	13.00
14.00	Accumulated depreciation	-380,823	0	0	0	14.00
15.00	Buildings	26,518,164	0	0	0	15.00
16.00	Accumulated depreciation	-5,057,235	0	0	0	16.00
17.00	Leasehold improvements	6,412,756	0	0	0	17.00
18.00	Accumulated depreciation	-1,309,612	0	0	0	18.00
19.00	Fixed equipment	9,370,587	0	0	0	19.00
20.00	Accumulated depreciation	-1,847,983	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	15,560,336	0	0	0	23.00
24.00	Accumulated depreciation	-9,437,338	0	0	0	24.00
25.00	Minor equipment depreciable	15,174,682	0	0	0	25.00
26.00	Accumulated depreciation	-9,014,952	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)	49,537,169	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	27,635,831	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	27,635,831	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	106,889,666	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	7,861,277	0	0	0	37.00
38.00	Salaries, wages, and fees payable	5,552,967	0	0	0	38.00
39.00	Payroll taxes payable	2,204,649	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	3,161,435	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	18,780,328	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	61,472,172	0	0	0	46.00
47.00	Notes payable	8,322,076	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	69,794,248	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	88,574,576	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	18,315,090	0	0	0	52.00
53.00	Specific purpose fund		0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted			0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted			0	0	55.00
56.00	Governing body created - endowment fund balance			0	0	56.00
57.00	Plant fund balance - invested in plant			0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion			0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	18,315,090	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	106,889,666	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet G-1
Date/Time Prepared:
12/29/2023 12:01 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		48,211,880		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-23,609,227		0	2.00
3.00	Total (sum of line 1 and line 2)		24,602,653		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)		24,602,653		0	11.00
12.00	IMPUTED INCOME TAX	6,275,871		0	0	12.00
13.00	RETAINED EARNINGS	11,591		0	0	13.00
14.00	ROUNDING	101		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)		6,287,563		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		18,315,090		0	19.00
		Endowment Fund	Plant Fund			
			6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)	0		0	0	2.00
3.00	Total (sum of line 1 and line 2)	0		0	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	0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	0	11.00
12.00	IMPUTED INCOME TAX		0		0	12.00
13.00	RETAINED EARNINGS		0		0	13.00
14.00	ROUNDING		0		0	14.00
15.00			0		0	15.00
16.00			0		0	16.00
17.00			0		0	17.00
18.00	Total deductions (sum of lines 12-17)	0		0	0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet G-2
Parts I & II
Date/Time Prepared:
12/29/2023 12:01 pm

Cost Center Description	Inpatient	Outpatient	Total
	1.00	2.00	3.00
PART I - PATIENT REVENUES			
General Inpatient Routine Services			
1.00 Hospital	52,979,393		52,979,393
2.00 SUBPROVIDER - IPF	3,568,893		3,568,893
3.00 SUBPROVIDER - IRF	0		0
4.00 SUBPROVIDER	0		0
5.00 Swing bed - SNF	0		0
6.00 Swing bed - NF	0		0
7.00 SKILLED NURSING FACILITY	0		0
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)	56,548,286		56,548,286
Intensive Care Type Inpatient Hospital Services			
11.00 INTENSIVE CARE UNIT	5,979,592		5,979,592
12.00 CORONARY CARE UNIT	0		0
12.01 NEONATAL INTENSIVE CARE UNIT	1,774,359		1,774,359
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)	7,753,951		7,753,951
17.00 Total inpatient routine care services (sum of lines 10 and 16)	64,302,237		64,302,237
18.00 Ancillary services	218,551,244	351,221,364	569,772,608
19.00 Outpatient services	28,001,811	49,440,478	77,442,289
20.00 RURAL HEALTH CLINIC	0	0	0
21.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0
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 NURSERY	2,542,267	0	2,542,267
27.01 PRIVATE PHYSICIAN OFFICE	0	43,030,422	43,030,422
28.00 Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	313,397,559	443,692,264	757,089,823
PART II - OPERATING EXPENSES			
29.00 Operating expenses (per wkst. A, column 3, line 200)		198,883,935	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 IMPUTED INCOME TAX	6,275,871		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)		6,275,871	42.00
43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to wkst. G-3, line 4)		192,608,064	43.00

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	757,089,823	1.00
2.00	Less contractual allowances and discounts on patients' accounts	589,504,103	2.00
3.00	Net patient revenues (line 1 minus line 2)	167,585,720	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	192,608,064	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-25,022,344	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	6,543	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	436,437	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	154	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	388,545	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	581,438	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	1,413,117	25.00
26.00	Total (line 5 plus line 25)	-23,609,227	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)	-23,609,227	29.00

CALCULATION OF CAPITAL PAYMENT

Provider CCN: 15-0009

Period:
From 08/01/2022
To 07/31/2023Worksheet L
Parts I-III
Date/Time Prepared:
12/29/2023 12:01 pm

	Title XVIII	Hospital	PPS
		1.00	
PART I - FULLY PROSPECTIVE METHOD			
CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier	1,242,173	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	3,328	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)	82.21	3.00
4.00	Number of interns & residents (see instructions)	0.47	4.00
5.00	Indirect medical education percentage (see instructions)	0.16	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)	1,987	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (worksheet E, part A line 30) (see instructions)	6.93	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	32.84	8.00
9.00	Sum of lines 7 and 8	39.77	9.00
10.00	Allowable disproportionate share percentage (see instructions)	8.38	10.00
11.00	Disproportionate share adjustment (see instructions)	104,094	11.00
12.00	Total prospective capital payments (see instructions)	1,351,582	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