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: 15-3028	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/30/2024 8:35 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/30/2024 Time: 8:35 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by REHABILITATION HOSPITAL OF INDIANA (15-3028) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	Marjorie Basey		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	Marjorie Basey			2
3	Signatory Title	CHIEF FINANCIAL OFFICER			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	22,984	-9,939	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
12.00	CMHC I	0		0		0	12.00
200.00	TOTAL	0	22,984	-9,939	0	0	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 8:35 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 4141 SHORE DRIVE	PO Box:			1.00
2.00	City: INDIANAPOLIS	State: IN	Zip Code: 46254	County: MARION	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	REHABILITATION HOSPITAL OF INDIANA	153028	26900	5	01/07/1992	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									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
17.10	Hospital-Based (CORF) I									17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2023	12/31/2023	20.00
21.00	Type of Control (see instructions)	4		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2024 8:35 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	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.	751	146	0	15	4,049		25.00

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 8:35 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 8:35 am

				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	2.99	0.000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

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					1.00	
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)					
68.00	For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?					68.00
			1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.		N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	71.00
	Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.		Y			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)		Y	N	0	76.00
					1.00	
	Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.				N	81.00
	TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.				N	87.00
				Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
				1.00	2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.			N	0	88.00
			Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge	
			1.00	2.00	3.00	
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.		0.00		0	89.00
				V	XIX	
				1.00	2.00	
	Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	97.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 8:35 am

		V	XIX	
		1.00	2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	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.	N	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.	N	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.	N	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.	N	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)			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)			107.00
107.01	If this facility is a REH (line 3, column 4, is "12"), is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no. (see instructions)			107.01
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2024 8:35 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	69,586	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	Y	N	123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H059	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: IU HEALTH	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 340 W 10TH STREET	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46202	143.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 8:35 am

						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					N	149.00
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)						
155.00	Hospital	N	N	N	N		155.00
156.00	Subprovider - IPF	N	N	N	N		156.00
157.00	Subprovider - IRF	N	N	N	N		157.00
158.00	SUBPROVIDER						158.00
159.00	SNF	N	N	N	N		159.00
160.00	HOME HEALTH AGENCY	N	N	N	N		160.00
161.00	CMHC		N	N	N		161.00
161.10	CORF		N	N	N		161.10
						1.00	
	Multicampus						
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00

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

				1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act				
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)				168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)				168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			0.00	169.00
			Beginning	Ending	
			1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)				170.00
			1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 5/30/2024 8:35 am

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

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

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

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	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.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	04/15/2024	Y	04/15/2024	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II Date/Time Prepared: 5/30/2024 8:35 am

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	Y	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.		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.	N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RHONDA	UTTER	41.00
42.00	Enter the employer/company name of the cost report preparer.	INDIANA UNIVERSITY HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317.556.3910	RUTTER@IUHEALTH.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-3028	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/30/2024 8:35 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I Date/Time Prepared: 5/30/2024 8:35 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	91	33,215	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)		91	33,215	0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		91	33,215	0.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC	99.00				0	25.00
25.10	CMHC - CORF	99.10				0	25.10
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)		91				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2024 8:35 am

	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)	5,231	751	18,813			1.00
2.00	HMO and other (see instructions)	4,299	4,210				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	5,231	751	18,813			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	5,231	751	18,813	2.99	275.21	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits	0	0	0			15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC	0	0	0	0.00	0.00	25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				2.99	275.21	27.00
28.00	Observation Bed Days		0	0			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2024 8:35 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	403	61	1,387	1.00
2.00	HMO and other (see instructions)			316	292		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	403	61	1,387	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC	0.00					25.00
25.10	CMHC - CORF	0.00					25.10
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

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/30/2024 8:35 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,478,307	1,478,307	0	1,478,307	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		625,600	625,600	0	625,600	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	413,034	5,854,853	6,267,887	-283	6,267,604	4.00
5.01	00591	ADMINISTRATIVE AND GENERAL	3,314,330	2,427,940	5,742,270	-163,398	5,578,872	5.01
5.02	00590	OTHER A&G - NON FOUNDATION	786,101	274,708	1,060,809	-1,410	1,059,399	5.02
7.00	00700	OPERATION OF PLANT	49,443	1,777,645	1,827,088	-1,816	1,825,272	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	103,084	103,084	0	103,084	8.00
9.00	00900	HOUSEKEEPING	390,678	168,536	559,214	-171	559,043	9.00
10.00	01000	DIETARY	62,466	1,393,869	1,456,335	-579,994	876,341	10.00
11.00	01100	CAFETERIA	0	0	0	579,917	579,917	11.00
13.00	01300	NURSING ADMINISTRATION	1,633,943	313,864	1,947,807	258,793	2,206,600	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	56,895	261,721	318,616	172,921	491,537	14.00
15.00	01500	PHARMACY	591,069	159,745	750,814	-5,740	745,074	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	412,233	108,594	520,827	0	520,827	16.00
17.00	01700	SOCIAL SERVICE	517,562	179,348	696,910	-888	696,022	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	243,374	243,374	0	243,374	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,102,500	2,671,169	9,773,669	-238,969	9,534,700	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	135,308	36,799	172,107	-2,586	169,521	54.00
60.00	06000	LABORATORY	0	432,316	432,316	236	432,552	60.00
65.00	06500	RESPIRATORY THERAPY	512,068	128,190	640,258	-76,409	563,849	65.00
66.00	06600	PHYSICAL THERAPY	1,694,172	458,035	2,152,207	609,486	2,761,693	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	-8,893	-8,893	8,893	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	2,111,844	311,039	2,422,883	-238,107	2,184,776	67.00
68.00	06800	SPEECH PATHOLOGY	914,490	112,448	1,026,938	309,878	1,336,816	68.00
68.01	06801	VISION	0	0	0	0	0	68.01
68.02	06802	FAC RESOURCE	35,329	15,345	50,674	-50,674	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	214,703	214,703	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,308,849	1,308,849	0	1,308,849	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	206,725	65,602	272,327	-22,242	250,085	90.00
90.01	09001	SLEEP CENTER	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	644,925	163,854	808,779	-808,779	0	99.10
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,585,115	21,065,941	42,651,056	-36,639	42,614,417	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	480,440	439,150	919,590	27,072	946,662	192.00
194.00	07950	FOUNDATION	203,613	81,513	285,126	10,350	295,476	194.00
194.01	07951	PUBLIC RELATIONS	127,182	66,222	193,404	-783	192,621	194.01
194.02	07952	ST. VINCENT - ARU	0	0	0	0	0	194.02
194.03	07953	MUNCIE - ARU	0	0	0	0	0	194.03
194.04	07954	RILEY - ARU	0	0	0	0	0	194.04
194.05	07955	RETAIL PHARMACY	221,663	1,265,132	1,486,795	0	1,486,795	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	22,618,013	22,917,958	45,535,971	0	45,535,971	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/30/2024 8:35 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	113,607	1,591,914		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	134,373	759,973		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-839	6,266,765		4.00
5.01	00591	ADMINISTRATIVE AND GENERAL	1,979,350	7,558,222		5.01
5.02	00590	OTHER A&G - NON FOUNDATION	0	1,059,399		5.02
7.00	00700	OPERATION OF PLANT	-32,469	1,792,803		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	103,084		8.00
9.00	00900	HOUSEKEEPING	0	559,043		9.00
10.00	01000	DIETARY	0	876,341		10.00
11.00	01100	CAFETERIA	-193,137	386,780		11.00
13.00	01300	NURSING ADMINISTRATION	-68	2,206,532		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	491,537		14.00
15.00	01500	PHARMACY	-29,303	715,771		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-60	520,767		16.00
17.00	01700	SOCIAL SERVICE	0	696,022		17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	243,374		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	9,534,700		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	169,521		54.00
60.00	06000	LABORATORY	-66,858	365,694		60.00
65.00	06500	RESPIRATORY THERAPY	0	563,849		65.00
66.00	06600	PHYSICAL THERAPY	-40,781	2,720,912		66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	-379	2,184,397		67.00
68.00	06800	SPEECH PATHOLOGY	0	1,336,816		68.00
68.01	06801	VISION	0	0		68.01
68.02	06802	FAC RESOURCE	0	0		68.02
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	214,703		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,308,849		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	250,085		90.00
90.01	09001	SLEEP CENTER	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
99.00	09900	CMHC	0	0		99.00
99.10	09910	CORF	0	0		99.10
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,863,436	44,477,853		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	946,662		192.00
194.00	07950	FOUNDATION	710,393	1,005,869		194.00
194.01	07951	PUBLIC RELATIONS	0	192,621		194.01
194.02	07952	ST. VINCENT - ARU	0	0		194.02
194.03	07953	MUNCIE - ARU	0	0		194.03
194.04	07954	RILEY - ARU	0	0		194.04
194.05	07955	RETAIL PHARMACY	0	1,486,795		194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	2,573,829	48,109,800		200.00

RECLASSIFICATIONS | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/30/2024 8:35 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	24,875	555,042		1.00
	0		24,875	555,042		
	B - NURSING ADMINISTRATION					
1.00	NURSING ADMINISTRATION	13.00	196,710	0		1.00
	0		196,710	0		
	C - NCR (CORF)					
1.00	PHYSICAL THERAPY	66.00	302,656	76,199		1.00
2.00	OCCUPATIONAL THERAPY	67.00	188,625	47,490		2.00
3.00	SPEECH PATHOLOGY	68.00	153,644	38,683		3.00
	0		644,925	162,372		
	D - MEDICAL SUPPLIES					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	241,039		1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	214,703		2.00
3.00	LABORATORY	60.00	0	236		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
	0		0	455,978		
	E - THERAPY ADMIN					
1.00	ADMINISTRATIVE AND GENERAL	5.01	17,745	2,526		1.00
2.00	NURSING ADMINISTRATION	13.00	59,056	8,408		2.00
3.00	PHYSICAL THERAPY	66.00	213,856	30,446		3.00
4.00	SPEECH PATHOLOGY	68.00	108,347	15,425		4.00
5.00	FOUNDATION	194.00	10,569	1,505		5.00
	0		409,573	58,310		
	F - RTOC ADMIN					
1.00	PHYSICIANS PRIVATE OFFICES	192.00	35,329	1,761		1.00
	0		35,329	1,761		
	G - OUTPT- CARMEL					
1.00	PHYSICAL THERAPY - CARMEL	66.01	0	8,893		1.00
	TOTALS		0	8,893		
	H - CLINICAL RES FACILITATION					
1.00	ADMINISTRATIVE AND GENERAL	5.01	0	13,068		1.00
	TOTALS		0	13,068		
500.00	Grand Total: Increases		1,311,412	1,255,424		500.00

RECLASSIFICATIONS | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/30/2024 8:35 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	24,875	555,042	0		1.00
	0		24,875	555,042			
	B - NURSING ADMINISTRATION						
1.00	ADMINISTRATIVE AND GENERAL	5.01	196,710	0	0		1.00
	0		196,710	0			
	C - NCR (CORF)						
1.00	CORF	99.10	644,925	162,372	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		644,925	162,372			
	D - MEDICAL SUPPLIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	283	0		1.00
2.00	ADMINISTRATIVE AND GENERAL	5.01	0	27	0		2.00
3.00	OTHER A&G - NON FOUNDATION	5.02	0	1,410	0		3.00
4.00	OPERATION OF PLANT	7.00	0	1,816	0		4.00
5.00	HOUSEKEEPING	9.00	0	171	0		5.00
6.00	DIETARY	10.00	0	77	0		6.00
7.00	NURSING ADMINISTRATION	13.00	0	5,381	0		7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	68,118	0		8.00
9.00	PHARMACY	15.00	0	5,740	0		9.00
10.00	SOCIAL SERVICE	17.00	0	888	0		10.00
11.00	ADULTS & PEDIATRICS	30.00	0	238,969	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,586	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	76,409	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	4,778	0		14.00
15.00	OCCUPATIONAL THERAPY	67.00	0	6,339	0		15.00
16.00	SPEECH PATHOLOGY	68.00	0	6,221	0		16.00
17.00	FAC RESOURCE	68.02	0	516	0		17.00
18.00	CLINIC	90.00	0	22,242	0		18.00
19.00	CORF	99.10	0	1,482	0		19.00
20.00	PHYSICIANS PRIVATE OFFICES	192.00	0	10,018	0		20.00
21.00	FOUNDATION	194.00	0	1,724	0		21.00
22.00	PUBLIC RELATIONS	194.01	0	783	0		22.00
	0		0	455,978			
	E - THERAPY ADMIN						
1.00	OCCUPATIONAL THERAPY	67.00	409,573	58,310	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	0		409,573	58,310			
	F - RTOC ADMIN						
1.00	FAC RESOURCE	68.02	35,329	1,761	0		1.00
	0		35,329	1,761			
	G - OUTPT- CARMEL						
1.00	PHYSICAL THERAPY	66.00	0	8,893	0		1.00
	TOTALS		0	8,893			
	H - CLINICAL RES FACILITATION						
1.00	FAC RESOURCE	68.02	0	13,068	0		1.00
	TOTALS		0	13,068			
500.00	Grand Total: Decreases		1,311,412	1,255,424			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 5/30/2024 8:35 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,506,638	0	0	0	0	1.00
2.00	Land Improvements	757,042	0	0	0	0	2.00
3.00	Buildings and Fixtures	33,498,105	123,659	0	123,659	0	3.00
4.00	Building Improvements	205,018	0	0	0	0	4.00
5.00	Fixed Equipment	2,523,031	12,396	0	12,396	0	5.00
6.00	Movable Equipment	15,995,533	344,028	0	344,028	26,784	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	55,485,367	480,083	0	480,083	26,784	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	55,485,367	480,083	0	480,083	26,784	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,506,638	0	1.00
2.00	Land Improvements	757,042	250,663	2.00
3.00	Buildings and Fixtures	33,621,764	13,878,995	3.00
4.00	Building Improvements	205,018	187,578	4.00
5.00	Fixed Equipment	2,535,427	1,789,083	5.00
6.00	Movable Equipment	16,312,777	12,002,716	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	55,938,666	28,109,035	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	55,938,666	28,109,035	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part II | Date/Time Prepared: 5/30/2024 8:35 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,260,024	0	156,481	61,802	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	612,109	0	0	3,880	0	2.00
3.00	Total (sum of lines 1-2)	1,872,133	0	156,481	65,682	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1,478,307	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	9,611	625,600	2.00
3.00	Total (sum of lines 1-2)	9,611	2,103,907	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part III Date/Time Prepared: 5/30/2024 8:35 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	39,625,889	0	39,625,889	0.708381	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	16,312,777	0	16,312,777	0.291619	0	2.00
3.00	Total (sum of lines 1-2)	55,938,666	0	55,938,666	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	1,380,961	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	746,482	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,127,443	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	153,345	61,802	0	-4,194	1,591,914	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,880	0	9,611	759,973	2.00
3.00	Total (sum of lines 1-2)	153,345	65,682	0	5,417	2,351,887	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/30/2024 8:35 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-3,136	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-18,118	OPERATION OF PLANT	7.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-14,351	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	0			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	2,239,917			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-193,137	CAFETERIA	11.00	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	B	0	CENTRAL SERVICES & SUPPLY	14.00	0	16.00
17.00	Sale of drugs to other than patients	B	-29,303	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-60	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		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISCELLANEOUS REVENUE	B	-834	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/30/2024 8:35 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MISCELLANEOUS REVENUE	B	-63,508	ADMINISTRATIVE AND GENERAL	5.01	0	33.01
33.02	MISCELLANEOUS REVENUE	B	-40,781	PHYSICAL THERAPY	66.00	0	33.02
33.03	RHI FOUNDATION	A	710,393	FOUNDATION	194.00	0	33.03
33.07	DONATIONS/CONTRIBUTIONS	A	-76	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.07
33.08	DONATIONS/CONTRIBUTIONS	A	-8,469	ADMINISTRATIVE AND GENERAL	5.01	0	33.08
33.09	ADVERTISING	A	-68	NURSING ADMINISTRATION	13.00	0	33.09
33.10	ADVERTISING	A	-379	OCCUPATIONAL THERAPY	67.00	0	33.10
33.11	TAXES	A	-138	ADMINISTRATIVE AND GENERAL	5.01	0	33.11
33.13	TAXES	A	71	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14	BOND ISSUANCE COST AMORTIZATION CARR	A	14,182	CAP REL COSTS-BLDG & FIXT	1.00	14	33.14
33.15	LATE FEES	A	-18,376	CAP REL COSTS-BLDG & FIXT	1.00	14	33.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		2,573,829				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: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 5/30/2024 8:35 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	ALLOCATION FROM HO REPORT	120,937	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	ALLOCATION FROM HO REPORT	134,373	0	2.00
3.00	5.01	ADMINISTRATIVE AND GENERAL	ALLOCATION FROM HO REPORT	2,051,465	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	ALLOCATION FROM RELATED PART	3,285	3,285	4.00
4.01	60.00	LABORATORY	ALLOCATION FROM RELATED PART	367,925	434,783	4.01
4.02	5.01	ADMINISTRATIVE AND GENERAL	RELATED PARTY FEES	653,117	653,117	4.02
4.03	54.00	RADIOLOGY-DIAGNOSTIC	RELATED PARTY FEES	4,079	4,079	4.03
4.04	66.00	PHYSICAL THERAPY	RELATED PARTY FEES	420	420	4.04
4.05	15.00	PHARMACY	RELATED PARTY FEES	400	400	4.05
4.06	192.00	PHYSICIANS PRIVATE OFFICES	RELATED PARTY FEES	259,453	259,453	4.06
4.07	7.00	OPERATION OF PLANT	RELATED PARTY FEES	437,153	437,153	4.07
4.08	4.00	EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY FEES	22,341	22,341	4.08
4.09	0.00			0	0	4.09
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			4,054,948	1,815,031	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		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	B		51.00	IU HEALTH	51.00	6.00
7.00	B		49.00	ST. VINCENT	49.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 5/30/2024 8:35 am

	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	120,937	9		1.00
2.00	134,373	9		2.00
3.00	2,051,465	0		3.00
4.00	0	0		4.00
4.01	-66,858	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
5.00	2,239,917			5.00

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

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

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

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

6.00	HOME OFFICE		6.00
7.00	MGMT COMPANY		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.

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/30/2024 8:35 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,591,914	1,591,914				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	759,973		759,973			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,266,765	17,154	8,189	6,292,108		4.00
5.01	00591	ADMINISTRATIVE AND GENERAL	7,558,222	35,883	17,130	888,453	8,499,688	5.01
5.02	00590	OTHER A&G - NON FOUNDATION	1,059,399	24,047	11,480	222,754	1,317,680	5.02
7.00	00700	OPERATION OF PLANT	1,792,803	356,442	170,164	14,010	2,333,419	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	103,084	0	0	0	103,084	8.00
9.00	00900	HOUSEKEEPING	559,043	14,538	6,940	110,704	691,225	9.00
10.00	01000	DIETARY	876,341	37,299	17,806	10,652	942,098	10.00
11.00	01100	CAFETERIA	386,780	24,683	11,783	7,049	430,295	11.00
13.00	01300	NURSING ADMINISTRATION	2,206,532	7,096	3,387	535,477	2,752,492	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	491,537	16,749	7,996	16,122	532,404	14.00
15.00	01500	PHARMACY	715,771	24,423	11,659	167,488	919,341	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	520,767	1,373	655	116,812	639,607	16.00
17.00	01700	SOCIAL SERVICE	696,022	4,668	2,228	146,659	849,577	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	243,374	6,677	3,187	0	253,238	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,534,700	650,755	310,671	2,012,593	12,508,719	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	169,521	5,145	2,456	38,342	215,464	54.00
60.00	06000	LABORATORY	365,694	7,847	3,746	0	377,287	60.00
65.00	06500	RESPIRATORY THERAPY	563,849	4,856	2,318	145,102	716,125	65.00
66.00	06600	PHYSICAL THERAPY	2,720,912	110,712	52,853	626,430	3,510,907	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	2,184,397	94,699	45,209	535,814	2,860,119	67.00
68.00	06800	SPEECH PATHOLOGY	1,336,816	54,149	25,851	333,374	1,750,190	68.00
68.01	06801	VISION	0	0	0	0	0	68.01
68.02	06802	FAC RESOURCE	0	0	0	0	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	214,703	0	0	0	214,703	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,308,849	0	0	0	1,308,849	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	250,085	51,952	24,802	58,579	385,418	90.00
90.01	09001	SLEEP CENTER	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	44,477,853	1,551,147	740,510	5,986,414	44,111,929	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	946,662	10,636	5,078	146,151	1,108,527	192.00
194.00	07950	FOUNDATION	1,005,869	21,619	10,321	60,692	1,098,501	194.00
194.01	07951	PUBLIC RELATIONS	192,621	8,512	4,064	36,039	241,236	194.01
194.02	07952	ST. VINCENT - ARU	0	0	0	0	0	194.02
194.03	07953	MUNCIE - ARU	0	0	0	0	0	194.03
194.04	07954	RILEY - ARU	0	0	0	0	0	194.04
194.05	07955	RETAIL PHARMACY	1,486,795	0	0	62,812	1,549,607	194.05
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	48,109,800	1,591,914	759,973	6,292,108	48,109,800	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/30/2024 8:35 am

		Cost Center Description	ADMINISTRATIVE AND GENERAL	Subtotal	OTHER A&G - NON FOUNDATION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5A.01	5.02	7.00	8.00	
		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	00591	ADMINISTRATIVE AND GENERAL	8,499,688					5.01
5.02	00590	OTHER A&G - NON FOUNDATION	282,753	1,600,433	1,600,433			5.02
7.00	00700	OPERATION OF PLANT	500,714	2,834,133	97,525	2,931,658		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	22,120	125,204	4,308	0	129,512	8.00
9.00	00900	HOUSEKEEPING	148,326	839,551	28,890	36,793	0	9.00
10.00	01000	DIETARY	202,159	1,144,257	39,375	94,396	0	10.00
11.00	01100	CAFETERIA	92,334	522,629	17,984	62,468	0	11.00
13.00	01300	NURSING ADMINISTRATION	590,641	3,343,133	115,041	17,958	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	114,245	646,649	22,252	42,389	0	14.00
15.00	01500	PHARMACY	197,276	1,116,617	38,424	61,809	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	137,249	776,856	26,732	3,474	0	16.00
17.00	01700	SOCIAL SERVICE	182,306	1,031,883	35,508	11,813	0	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	54,341	307,579	10,584	16,897	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,684,163	15,192,882	522,802	1,646,940	128,763	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	46,235	261,699	9,005	13,020	0	54.00
60.00	06000	LABORATORY	80,960	458,247	15,769	19,859	0	60.00
65.00	06500	RESPIRATORY THERAPY	153,669	869,794	29,930	12,289	0	65.00
66.00	06600	PHYSICAL THERAPY	753,384	4,264,291	146,739	280,190	352	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	613,736	3,473,855	119,539	239,666	219	67.00
68.00	06800	SPEECH PATHOLOGY	375,563	2,125,753	73,149	137,041	178	68.00
68.01	06801	VISION	0	0	0	0	0	68.01
68.02	06802	FAC RESOURCE	0	0	0	0	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	46,072	260,775	8,974	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	280,858	1,589,707	54,703	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	82,705	468,123	16,109	131,482	0	90.00
90.01	09001	SLEEP CENTER	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,641,809	43,254,050	1,433,342	2,828,484	129,512	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	237,872	1,346,399	46,331	26,918	0	192.00
194.00	07950	FOUNDATION	235,721	1,334,222	45,912	54,714	0	194.00
194.01	07951	PUBLIC RELATIONS	51,765	293,001	10,082	21,542	0	194.01
194.02	07952	ST. VINCENT - ARU	0	0	0	0	0	194.02
194.03	07953	MUNCIE - ARU	0	0	0	0	0	194.03
194.04	07954	RILEY - ARU	0	0	0	0	0	194.04
194.05	07955	RETAIL PHARMACY	332,521	1,882,128	64,766	0	0	194.05
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)	8,499,688	48,109,800	1,600,433	2,931,658	129,512	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/30/2024 8:35 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		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	00591	ADMINISTRATIVE AND GENERAL						5.01
5.02	00590	OTHER A&G - NON FOUNDATION						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	905,234					9.00
10.00	01000	DIETARY	29,518	1,307,546				10.00
11.00	01100	CAFETERIA	19,534	0	622,615			11.00
13.00	01300	NURSING ADMINISTRATION	5,615	0	76,570	3,558,317		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,255	0	4,361	0	728,906	14.00
15.00	01500	PHARMACY	19,328	0	25,017	300,573	9,313	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,086	0	18,553	222,914	0	16.00
17.00	01700	SOCIAL SERVICE	3,694	0	15,786	0	1,441	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	5,284	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	515,006	1,307,546	229,561	2,758,091	189,597	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,071	0	4,653	55,901	4,186	54.00
60.00	06000	LABORATORY	6,210	0	9,571	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,843	0	18,381	220,838	120,280	65.00
66.00	06600	PHYSICAL THERAPY	87,616	0	78,353	0	8,047	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	74,944	0	61,751	0	10,502	67.00
68.00	06800	SPEECH PATHOLOGY	42,853	0	39,694	0	10,666	68.00
68.01	06801	VISION	0	0	0	0	0	68.01
68.02	06802	FAC RESOURCE	0	0	0	0	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	348,340	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
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	41,115	0	10,183	0	5,377	90.00
90.01	09001	SLEEP CENTER	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	872,972	1,307,546	592,434	3,558,317	707,749	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	8,417	0	18,745	0	17,091	192.00
194.00	07950	FOUNDATION	17,109	0	5,606	0	2,797	194.00
194.01	07951	PUBLIC RELATIONS	6,736	0	5,830	0	1,269	194.01
194.02	07952	ST. VINCENT - ARU	0	0	0	0	0	194.02
194.03	07953	MUNCIE - ARU	0	0	0	0	0	194.03
194.04	07954	RILEY - ARU	0	0	0	0	0	194.04
194.05	07955	RETAIL PHARMACY	0	0	0	0	0	194.05
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)	905,234	1,307,546	622,615	3,558,317	728,906	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/30/2024 8:35 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	Subtotal	
			15.00	16.00	17.00	22.00	24.00	
		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	00591	ADMINISTRATIVE AND GENERAL						5.01
5.02	00590	OTHER A&G - NON FOUNDATION						5.02
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	1,571,081					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,049,615				16.00
17.00	01700	SOCIAL SERVICE	0	0	1,100,125			17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	340,344		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,049,615	1,100,125	340,344	24,981,272	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	352,535	54.00
60.00	06000	LABORATORY	0	0	0	0	509,656	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	1,275,355	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	4,865,588	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	3,980,476	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	2,429,334	68.00
68.01	06801	VISION	0	0	0	0	0	68.01
68.02	06802	FAC RESOURCE	0	0	0	0	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	618,089	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,571,081	0	0	0	3,215,491	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	672,389	90.00
90.01	09001	SLEEP CENTER	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,571,081	1,049,615	1,100,125	340,344	42,900,185	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	1,463,901	192.00
194.00	07950	FOUNDATION	0	0	0	0	1,460,360	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0	338,460	194.01
194.02	07952	ST. VINCENT - ARU	0	0	0	0	0	194.02
194.03	07953	MUNCIE - ARU	0	0	0	0	0	194.03
194.04	07954	RILEY - ARU	0	0	0	0	0	194.04
194.05	07955	RETAIL PHARMACY	0	0	0	0	1,946,894	194.05
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)	1,571,081	1,049,615	1,100,125	340,344	48,109,800	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/30/2024 8:35 am

		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-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00591	ADMINISTRATIVE AND GENERAL				5.01
5.02	00590	OTHER A&G - NON FOUNDATION				5.02
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
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-340,344	24,640,928		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	352,535		54.00
60.00	06000	LABORATORY	0	509,656		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,275,355		65.00
66.00	06600	PHYSICAL THERAPY	0	4,865,588		66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	3,980,476		67.00
68.00	06800	SPEECH PATHOLOGY	0	2,429,334		68.00
68.01	06801	VISION	0	0		68.01
68.02	06802	FAC RESOURCE	0	0		68.02
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	618,089		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,215,491		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	672,389		90.00
90.01	09001	SLEEP CENTER	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
99.00	09900	CMHC	0	0		99.00
99.10	09910	CORF	0	0		99.10
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-340,344	42,559,841		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	1,463,901		192.00
194.00	07950	FOUNDATION	0	1,460,360		194.00
194.01	07951	PUBLIC RELATIONS	0	338,460		194.01
194.02	07952	ST. VINCENT - ARU	0	0		194.02
194.03	07953	MUNCIE - ARU	0	0		194.03
194.04	07954	RILEY - ARU	0	0		194.04
194.05	07955	RETAIL PHARMACY	0	1,946,894		194.05
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)	-340,344	47,769,456		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/30/2024 8:35 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	17,154	8,189	25,343	25,343	4.00
5.01	00591	ADMINISTRATIVE AND GENERAL	0	35,883	17,130	53,013	3,577	5.01
5.02	00590	OTHER A&G - NON FOUNDATION	0	24,047	11,480	35,527	897	5.02
7.00	00700	OPERATION OF PLANT	0	356,442	170,164	526,606	56	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	14,538	6,940	21,478	446	9.00
10.00	01000	DIETARY	0	37,299	17,806	55,105	43	10.00
11.00	01100	CAFETERIA	0	24,683	11,783	36,466	28	11.00
13.00	01300	NURSING ADMINISTRATION	0	7,096	3,387	10,483	2,156	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	16,749	7,996	24,745	65	14.00
15.00	01500	PHARMACY	0	24,423	11,659	36,082	674	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,373	655	2,028	470	16.00
17.00	01700	SOCIAL SERVICE	0	4,668	2,228	6,896	591	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	6,677	3,187	9,864	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	650,755	310,671	961,426	8,114	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,145	2,456	7,601	154	54.00
60.00	06000	LABORATORY	0	7,847	3,746	11,593	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	4,856	2,318	7,174	584	65.00
66.00	06600	PHYSICAL THERAPY	0	110,712	52,853	163,565	2,522	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	94,699	45,209	139,908	2,158	67.00
68.00	06800	SPEECH PATHOLOGY	0	54,149	25,851	80,000	1,342	68.00
68.01	06801	VISION	0	0	0	0	0	68.01
68.02	06802	FAC RESOURCE	0	0	0	0	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	51,952	24,802	76,754	236	90.00
90.01	09001	SLEEP CENTER	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,551,147	740,510	2,291,657	24,113	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	10,636	5,078	15,714	588	192.00
194.00	07950	FOUNDATION	0	21,619	10,321	31,940	244	194.00
194.01	07951	PUBLIC RELATIONS	0	8,512	4,064	12,576	145	194.01
194.02	07952	ST. VINCENT - ARU	0	0	0	0	0	194.02
194.03	07953	MUNCIE - ARU	0	0	0	0	0	194.03
194.04	07954	RILEY - ARU	0	0	0	0	0	194.04
194.05	07955	RETAIL PHARMACY	0	0	0	0	253	194.05
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,591,914	759,973	2,351,887	25,343	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/30/2024 8:35 am

		Cost Center Description	ADMINISTRATIVE AND GENERAL	OTHER A&G - NON FOUNDATION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	8.00	9.00	
		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	00591	ADMINISTRATIVE AND GENERAL	56,590					5.01
5.02	00590	OTHER A&G - NON FOUNDATION	1,883	38,307				5.02
7.00	00700	OPERATION OF PLANT	3,334	2,335	532,331			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	147	103	0	250		8.00
9.00	00900	HOUSEKEEPING	988	692	6,681	0	30,285	9.00
10.00	01000	DIETARY	1,346	943	17,140	0	988	10.00
11.00	01100	CAFETERIA	615	431	11,343	0	654	11.00
13.00	01300	NURSING ADMINISTRATION	3,933	2,755	3,261	0	188	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	761	533	7,697	0	443	14.00
15.00	01500	PHARMACY	1,314	920	11,223	0	647	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	914	640	631	0	36	16.00
17.00	01700	SOCIAL SERVICE	1,214	850	2,145	0	124	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	362	253	3,068	0	177	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,863	12,502	299,052	249	17,228	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	308	216	2,364	0	136	54.00
60.00	06000	LABORATORY	539	378	3,606	0	208	60.00
65.00	06500	RESPIRATORY THERAPY	1,023	717	2,231	0	129	65.00
66.00	06600	PHYSICAL THERAPY	5,017	3,514	50,877	1	2,931	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	4,087	2,862	43,519	0	2,507	67.00
68.00	06800	SPEECH PATHOLOGY	2,501	1,752	24,884	0	1,434	68.00
68.01	06801	VISION	0	0	0	0	0	68.01
68.02	06802	FAC RESOURCE	0	0	0	0	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	307	215	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	1,870	1,310	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	551	386	23,874	0	1,376	90.00
90.01	09001	SLEEP CENTER	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	50,877	34,307	513,596	250	29,206	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	1,584	1,109	4,888	0	282	192.00
194.00	07950	FOUNDATION	1,570	1,099	9,935	0	572	194.00
194.01	07951	PUBLIC RELATIONS	345	241	3,912	0	225	194.01
194.02	07952	ST. VINCENT - ARU	0	0	0	0	0	194.02
194.03	07953	MUNCIE - ARU	0	0	0	0	0	194.03
194.04	07954	RILEY - ARU	0	0	0	0	0	194.04
194.05	07955	RETAIL PHARMACY	2,214	1,551	0	0	0	194.05
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)	56,590	38,307	532,331	250	30,285	202.00

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		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		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	00591	ADMINISTRATIVE AND GENERAL						5.01
5.02	00590	OTHER A&G - NON FOUNDATION						5.02
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	75,565					10.00
11.00	01100	CAFETERIA	0	49,537				11.00
13.00	01300	NURSING ADMINISTRATION	0	6,092	28,868			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	347	0	34,591		14.00
15.00	01500	PHARMACY	0	1,990	2,438	442	55,730	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,476	1,808	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,256	0	68	0	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	75,565	18,266	22,376	8,998	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	370	454	199	0	54.00
60.00	06000	LABORATORY	0	762	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,462	1,792	5,708	0	65.00
66.00	06600	PHYSICAL THERAPY	0	6,234	0	382	0	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	4,913	0	498	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,158	0	506	0	68.00
68.01	06801	VISION	0	0	0	0	0	68.01
68.02	06802	FAC RESOURCE	0	0	0	0	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	16,531	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	55,730	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	810	0	255	0	90.00
90.01	09001	SLEEP CENTER	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	75,565	47,136	28,868	33,587	55,730	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	1,491	0	811	0	192.00
194.00	07950	FOUNDATION	0	446	0	133	0	194.00
194.01	07951	PUBLIC RELATIONS	0	464	0	60	0	194.01
194.02	07952	ST. VINCENT - ARU	0	0	0	0	0	194.02
194.03	07953	MUNCIE - ARU	0	0	0	0	0	194.03
194.04	07954	RILEY - ARU	0	0	0	0	0	194.04
194.05	07955	RETAIL PHARMACY	0	0	0	0	0	194.05
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)	75,565	49,537	28,868	34,591	55,730	202.00

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		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	22.00	24.00	25.00	
		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	00591	ADMINISTRATIVE AND GENERAL						5.01
5.02	00590	OTHER A&G - NON FOUNDATION						5.02
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	8,003					16.00
17.00	01700	SOCIAL SERVICE	0	13,144				17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	13,724			22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,003	13,144		1,462,786	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		11,802	0	54.00
60.00	06000	LABORATORY	0	0		17,086	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0		20,820	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0		235,043	0	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0		0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0		200,452	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0		115,577	0	68.00
68.01	06801	VISION	0	0		0	0	68.01
68.02	06802	FAC RESOURCE	0	0		0	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0		0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		17,053	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		58,910	0	73.00
74.00	07400	RENAL DIALYSIS	0	0		0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0		104,242	0	90.00
90.01	09001	SLEEP CENTER	0	0		0	0	90.01
91.00	09100	EMERGENCY	0	0		0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0		0	0	99.00
99.10	09910	CORF	0	0		0	0	99.10
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,003	13,144	0	2,243,771	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0		26,467	0	192.00
194.00	07950	FOUNDATION	0	0		45,939	0	194.00
194.01	07951	PUBLIC RELATIONS	0	0		17,968	0	194.01
194.02	07952	ST. VINCENT - ARU	0	0		0	0	194.02
194.03	07953	MUNCIE - ARU	0	0		0	0	194.03
194.04	07954	RILEY - ARU	0	0		0	0	194.04
194.05	07955	RETAIL PHARMACY	0	0		4,018	0	194.05
200.00		Cross Foot Adjustments			13,724	13,724	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	8,003	13,144	13,724	2,351,887	0	202.00

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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-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00591	ADMINISTRATIVE AND GENERAL			5.01
5.02	00590	OTHER A&G - NON FOUNDATION			5.02
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
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV			22.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	1,462,786		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,802		54.00
60.00	06000	LABORATORY	17,086		60.00
65.00	06500	RESPIRATORY THERAPY	20,820		65.00
66.00	06600	PHYSICAL THERAPY	235,043		66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	200,452		67.00
68.00	06800	SPEECH PATHOLOGY	115,577		68.00
68.01	06801	VISION	0		68.01
68.02	06802	FAC RESOURCE	0		68.02
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,053		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	58,910		73.00
74.00	07400	RENAL DIALYSIS	0		74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		78.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	104,242		90.00
90.01	09001	SLEEP CENTER	0		90.01
91.00	09100	EMERGENCY	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
99.00	09900	CMHC	0		99.00
99.10	09910	CORF	0		99.10
102.00	10200	OPIOID TREATMENT PROGRAM	0		102.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,243,771		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	26,467		192.00
194.00	07950	FOUNDATION	45,939		194.00
194.01	07951	PUBLIC RELATIONS	17,968		194.01
194.02	07952	ST. VINCENT - ARU	0		194.02
194.03	07953	MUNCIE - ARU	0		194.03
194.04	07954	RILEY - ARU	0		194.04
194.05	07955	RETAIL PHARMACY	4,018		194.05
200.00		Cross Foot Adjustments	13,724		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	2,351,887		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/30/2024 8:35 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A.01	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	110,157					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		110,157				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,187	1,187	22,204,979			4.00
5.01	00591	ADMINISTRATIVE AND GENERAL	2,483	2,483	3,135,365	-8,499,688	39,610,112	5.01
5.02	00590	OTHER A&G - NON FOUNDATION	1,664	1,664	786,101	0	1,317,680	5.02
7.00	00700	OPERATION OF PLANT	24,665	24,665	49,443	0	2,333,419	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	103,084	8.00
9.00	00900	HOUSEKEEPING	1,006	1,006	390,678	0	691,225	9.00
10.00	01000	DIETARY	2,581	2,581	37,591	0	942,098	10.00
11.00	01100	CAFETERIA	1,708	1,708	24,875	0	430,295	11.00
13.00	01300	NURSING ADMINISTRATION	491	491	1,889,709	0	2,752,492	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,159	1,159	56,895	0	532,404	14.00
15.00	01500	PHARMACY	1,690	1,690	591,069	0	919,341	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	95	95	412,233	0	639,607	16.00
17.00	01700	SOCIAL SERVICE	323	323	517,562	0	849,577	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	462	462	0	0	253,238	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	45,031	45,031	7,102,500	0	12,508,719	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	356	356	135,308	0	215,464	54.00
60.00	06000	LABORATORY	543	543	0	0	377,287	60.00
65.00	06500	RESPIRATORY THERAPY	336	336	512,068	0	716,125	65.00
66.00	06600	PHYSICAL THERAPY	7,661	7,661	2,210,684	0	3,510,907	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	6,553	6,553	1,890,896	0	2,860,119	67.00
68.00	06800	SPEECH PATHOLOGY	3,747	3,747	1,176,481	0	1,750,190	68.00
68.01	06801	VISION	0	0	0	0	0	68.01
68.02	06802	FAC RESOURCE	0	0	0	0	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	214,703	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	1,308,849	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,595	3,595	206,725	0	385,418	90.00
90.01	09001	SLEEP CENTER	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	107,336	107,336	21,126,183	-8,499,688	35,612,241	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	736	736	515,769	0	1,108,527	192.00
194.00	07950	FOUNDATION	1,496	1,496	214,182	0	1,098,501	194.00
194.01	07951	PUBLIC RELATIONS	589	589	127,182	0	241,236	194.01
194.02	07952	ST. VINCENT - ARU	0	0	0	0	0	194.02
194.03	07953	MUNCIE - ARU	0	0	0	0	0	194.03
194.04	07954	RILEY - ARU	0	0	0	0	0	194.04
194.05	07955	RETAIL PHARMACY	0	0	221,663	0	1,549,607	194.05
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)	1,591,914	759,973	6,292,108		8,499,688	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.451319	6.898999	0.283365		0.214584	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			25,343		56,590	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001141		0.001429	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/30/2024 8:35 am

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A.01	5.01	
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/30/2024 8:35 am

		Cost Center Description	Reconciliation	OTHER A&G - NON FOUNDATION (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
			5A.02	5.02	7.00	8.00	9.00	
		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	00591	ADMINISTRATIVE AND GENERAL						5.01
5.02	00590	OTHER A&G - NON FOUNDATION	-1,600,433	46,509,367				5.02
7.00	00700	OPERATION OF PLANT	0	2,834,133	80,158			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	125,204	0	153,181		8.00
9.00	00900	HOUSEKEEPING	0	839,551	1,006	0	79,152	9.00
10.00	01000	DIETARY	0	1,144,257	2,581	0	2,581	10.00
11.00	01100	CAFETERIA	0	522,629	1,708	0	1,708	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,343,133	491	0	491	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	646,649	1,159	0	1,159	14.00
15.00	01500	PHARMACY	0	1,116,617	1,690	0	1,690	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	776,856	95	0	95	16.00
17.00	01700	SOCIAL SERVICE	0	1,031,883	323	0	323	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	307,579	462	0	462	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	15,192,882	45,031	152,295	45,031	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	261,699	356	0	356	54.00
60.00	06000	LABORATORY	0	458,247	543	0	543	60.00
65.00	06500	RESPIRATORY THERAPY	0	869,794	336	0	336	65.00
66.00	06600	PHYSICAL THERAPY	0	4,264,291	7,661	416	7,661	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	3,473,855	6,553	259	6,553	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,125,753	3,747	211	3,747	68.00
68.01	06801	VISION	0	0	0	0	0	68.01
68.02	06802	FAC RESOURCE	0	0	0	0	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	260,775	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,589,707	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	468,123	3,595	0	3,595	90.00
90.01	09001	SLEEP CENTER	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,600,433	41,653,617	77,337	153,181	76,331	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	1,346,399	736	0	736	192.00
194.00	07950	FOUNDATION	0	1,334,222	1,496	0	1,496	194.00
194.01	07951	PUBLIC RELATIONS	0	293,001	589	0	589	194.01
194.02	07952	ST. VINCENT - ARU	0	0	0	0	0	194.02
194.03	07953	MUNCIE - ARU	0	0	0	0	0	194.03
194.04	07954	RILEY - ARU	0	0	0	0	0	194.04
194.05	07955	RETAIL PHARMACY	0	1,882,128	0	0	0	194.05
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)		1,600,433	2,931,658	129,512	905,234	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.034411	36.573492	0.845483	11.436654	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		38,307	532,331	250	30,285	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000824	6.641021	0.001632	0.382618	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/30/2024 8:35 am

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (HOURS PAID)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		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	00591	ADMINISTRATIVE AND GENERAL						5.01
5.02	00590	OTHER A&G - NON FOUNDATION						5.02
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	56,439					10.00
11.00	01100	CAFETERIA	0	454,172				11.00
13.00	01300	NURSING ADMINISTRATION	0	55,855	216,040			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,181	0	449,268		14.00
15.00	01500	PHARMACY	0	18,249	18,249	5,740	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	13,534	13,534	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	11,515	0	888	0	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	56,439	167,455	167,455	116,860	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,394	3,394	2,580	0	54.00
60.00	06000	LABORATORY	0	6,982	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	13,408	13,408	74,136	0	65.00
66.00	06600	PHYSICAL THERAPY	0	57,155	0	4,960	0	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	45,045	0	6,473	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	28,955	0	6,574	0	68.00
68.01	06801	VISION	0	0	0	0	0	68.01
68.02	06802	FAC RESOURCE	0	0	0	0	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	214,703	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	100	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	7,428	0	3,314	0	90.00
90.01	09001	SLEEP CENTER	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	56,439	432,156	216,040	436,228	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	13,674	0	10,534	0	192.00
194.00	07950	FOUNDATION	0	4,089	0	1,724	0	194.00
194.01	07951	PUBLIC RELATIONS	0	4,253	0	782	0	194.01
194.02	07952	ST. VINCENT - ARU	0	0	0	0	0	194.02
194.03	07953	MUNCIE - ARU	0	0	0	0	0	194.03
194.04	07954	RILEY - ARU	0	0	0	0	0	194.04
194.05	07955	RETAIL PHARMACY	0	0	0	0	0	194.05
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)	1,307,546	622,615	3,558,317	728,906	1,571,081	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.167420	1.370879	16.470640	1.622430	15,710.810000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	75,565	49,537	28,868	34,591	55,730	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.338879	0.109071	0.133623	0.076994	557.300000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/30/2024 8:35 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (TOTAL PATI ENT DAYS)	SOCIAL SERVICE (TOTAL PATI ENT DAYS)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
			16.00	17.00	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	00591	ADMINISTRATIVE AND GENERAL					5.01
5.02	00590	OTHER A&G - NON FOUNDATION					5.02
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	100				16.00
17.00	01700	SOCIAL SERVICE	0	100			17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	100		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	100	100	100		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
68.01	06801	VISION	0	0	0		68.01
68.02	06802	FAC RESOURCE	0	0	0		68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	SLEEP CENTER	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
		OTHER REIMBURSABLE COST CENTERS					
99.00	09900	CMHC	0	0	0		99.00
99.10	09910	CORF	0	0	0		99.10
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	100	100		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0		192.00
194.00	07950	FOUNDATION	0	0	0		194.00
194.01	07951	PUBLIC RELATIONS	0	0	0		194.01
194.02	07952	ST. VINCENT - ARU	0	0	0		194.02
194.03	07953	MUNCIE - ARU	0	0	0		194.03
194.04	07954	RILEY - ARU	0	0	0		194.04
194.05	07955	RETAIL PHARMACY	0	0	0		194.05
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)	1,049,615	1,100,125	340,344		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10,496.150000	11,001.250000	3,403.440000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	8,003	13,144	13,724		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	80.030000	131.440000	137.240000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/30/2024 8:35 am

	Cost Center Description	MEDICAL RECORDS & LIBRARY (TOTAL PATIENT DAYS)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
		16.00	17.00	22.00		
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/30/2024 8:35 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,640,928		24,640,928	0	24,640,928	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0		0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	352,535		352,535	0	352,535	54.00
60.00	06000	LABORATORY	509,656		509,656	0	509,656	60.00
65.00	06500	RESPIRATORY THERAPY	1,275,355	0	1,275,355	0	1,275,355	65.00
66.00	06600	PHYSICAL THERAPY	4,865,588	0	4,865,588	0	4,865,588	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	3,980,476	0	3,980,476	0	3,980,476	67.00
68.00	06800	SPEECH PATHOLOGY	2,429,334	0	2,429,334	0	2,429,334	68.00
68.01	06801	VISION	0	0	0	0	0	68.01
68.02	06802	FAC RESOURCE	0	0	0	0	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	618,089		618,089	0	618,089	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,215,491		3,215,491	0	3,215,491	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	672,389		672,389	0	672,389	90.00
90.01	09001	SLEEP CENTER	0		0	0	0	90.01
91.00	09100	EMERGENCY	0		0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0		0		0	99.00
99.10	09910	CORF	0		0		0	99.10
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	42,559,841	0	42,559,841	0	42,559,841	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	42,559,841	0	42,559,841	0	42,559,841	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/30/2024 8:35 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	47,010,303		47,010,303			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0.000000	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,331,751	12,110	2,343,861	0.150408	0.000000	54.00
60.00	06000	LABORATORY	1,772,571	0	1,772,571	0.287524	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,387,692	204	3,387,896	0.376445	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	14,211,127	7,430,949	21,642,076	0.224821	0.000000	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0	0	0.000000	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	14,750,518	3,761,822	18,512,340	0.215017	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	7,696,343	2,889,342	10,585,685	0.229492	0.000000	68.00
68.01	06801	VISION	0	0	0	0.000000	0.000000	68.01
68.02	06802	FAC RESOURCE	0	0	0	0.000000	0.000000	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,149,777	84,456	2,234,233	0.276645	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,757,254	4,679,277	13,436,531	0.239310	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,939,905	1,939,905	0.346609	0.000000	90.00
90.01	09001	SLEEP CENTER	0	0	0	0.000000	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0			99.00
99.10	09910	CORF	0	0	0			99.10
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	102,067,336	20,798,065	122,865,401			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	102,067,336	20,798,065	122,865,401			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/30/2024 8:35 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150408	54.00
60.00	06000	LABORATORY	0.287524	60.00
65.00	06500	RESPIRATORY THERAPY	0.376445	65.00
66.00	06600	PHYSICAL THERAPY	0.224821	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.215017	67.00
68.00	06800	SPEECH PATHOLOGY	0.229492	68.00
68.01	06801	VISION	0.000000	68.01
68.02	06802	FAC RESOURCE	0.000000	68.02
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.276645	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.239310	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.346609	90.00
90.01	09001	SLEEP CENTER	0.000000	90.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
99.00	09900	CMHC		99.00
99.10	09910	CORF		99.10
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
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: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/30/2024 8:35 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,640,928		24,640,928	0	24,640,928	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0		0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	352,535		352,535	0	352,535	54.00
60.00	06000	LABORATORY	509,656		509,656	0	509,656	60.00
65.00	06500	RESPIRATORY THERAPY	1,275,355	0	1,275,355	0	1,275,355	65.00
66.00	06600	PHYSICAL THERAPY	4,865,588	0	4,865,588	0	4,865,588	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	3,980,476	0	3,980,476	0	3,980,476	67.00
68.00	06800	SPEECH PATHOLOGY	2,429,334	0	2,429,334	0	2,429,334	68.00
68.01	06801	VISION	0	0	0	0	0	68.01
68.02	06802	FAC RESOURCE	0	0	0	0	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	618,089		618,089	0	618,089	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,215,491		3,215,491	0	3,215,491	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	672,389		672,389	0	672,389	90.00
90.01	09001	SLEEP CENTER	0		0	0	0	90.01
91.00	09100	EMERGENCY	0		0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0		0		0	99.00
99.10	09910	CORF	0		0		0	99.10
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	42,559,841	0	42,559,841	0	42,559,841	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	42,559,841	0	42,559,841	0	42,559,841	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/30/2024 8:35 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	47,010,303		47,010,303			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0.000000	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,331,751	12,110	2,343,861	0.150408	0.000000	54.00
60.00	06000	LABORATORY	1,772,571	0	1,772,571	0.287524	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,387,692	204	3,387,896	0.376445	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	14,211,127	7,430,949	21,642,076	0.224821	0.000000	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0	0	0.000000	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	14,750,518	3,761,822	18,512,340	0.215017	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	7,696,343	2,889,342	10,585,685	0.229492	0.000000	68.00
68.01	06801	VISION	0	0	0	0.000000	0.000000	68.01
68.02	06802	FAC RESOURCE	0	0	0	0.000000	0.000000	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,149,777	84,456	2,234,233	0.276645	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,757,254	4,679,277	13,436,531	0.239310	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,939,905	1,939,905	0.346609	0.000000	90.00
90.01	09001	SLEEP CENTER	0	0	0	0.000000	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0			99.00
99.10	09910	CORF	0	0	0			99.10
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	102,067,336	20,798,065	122,865,401			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	102,067,336	20,798,065	122,865,401			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/30/2024 8:35 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150408	54.00
60.00	06000	LABORATORY	0.287524	60.00
65.00	06500	RESPIRATORY THERAPY	0.376445	65.00
66.00	06600	PHYSICAL THERAPY	0.224821	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.215017	67.00
68.00	06800	SPEECH PATHOLOGY	0.229492	68.00
68.01	06801	VISION	0.000000	68.01
68.02	06802	FAC RESOURCE	0.000000	68.02
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.276645	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.239310	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.346609	90.00
90.01	09001	SLEEP CENTER	0.000000	90.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
99.00	09900	CMHC		99.00
99.10	09910	CORF		99.10
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part II Date/Time Prepared: 5/30/2024 8:35 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	352,535	11,802	340,733	0	0	54.00
60.00	06000	LABORATORY	509,656	17,086	492,570	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,275,355	20,820	1,254,535	0	0	65.00
66.00	06600	PHYSICAL THERAPY	4,865,588	235,043	4,630,545	0	0	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	3,980,476	200,452	3,780,024	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,429,334	115,577	2,313,757	0	0	68.00
68.01	06801	VISION	0	0	0	0	0	68.01
68.02	06802	FAC RESOURCE	0	0	0	0	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	618,089	17,053	601,036	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	3,215,491	58,910	3,156,581	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	672,389	104,242	568,147	0	0	90.00
90.01	09001	SLEEP CENTER	0	0	0	0	0	90.01
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
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
200.00		Subtotal (sum of lines 50 thru 199)	17,918,913	780,985	17,137,928	0	0	200.00
201.00		Less Observation Beds	0	0	0	0	0	201.00
202.00		Total (line 200 minus line 201)	17,918,913	780,985	17,137,928	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part II Date/Time Prepared: 5/30/2024 8:35 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	352,535	2,343,861	0.150408		54.00
60.00	06000	LABORATORY	509,656	1,772,571	0.287524		60.00
65.00	06500	RESPIRATORY THERAPY	1,275,355	3,387,896	0.376445		65.00
66.00	06600	PHYSICAL THERAPY	4,865,588	21,642,076	0.224821		66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0	0.000000		66.01
67.00	06700	OCCUPATIONAL THERAPY	3,980,476	18,512,340	0.215017		67.00
68.00	06800	SPEECH PATHOLOGY	2,429,334	10,585,685	0.229492		68.00
68.01	06801	VISION	0	0	0.000000		68.01
68.02	06802	FAC RESOURCE	0	0	0.000000		68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	618,089	2,234,233	0.276645		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,215,491	13,436,531	0.239310		73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000		74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000		78.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	672,389	1,939,905	0.346609		90.00
90.01	09001	SLEEP CENTER	0	0	0.000000		90.01
91.00	09100	EMERGENCY	0	0	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS					
99.00	09900	CMHC	0	0	0.000000		99.00
99.10	09910	CORF	0	0	0.000000		99.10
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0.000000		102.00
200.00		Subtotal (sum of lines 50 thru 199)	17,918,913	75,855,098			200.00
201.00		Less Observation Beds	0	0			201.00
202.00		Total (line 200 minus line 201)	17,918,913	75,855,098			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part I Date/Time Prepared: 5/30/2024 8:35 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,462,786	0	1,462,786	18,813	77.75	30.00
200.00	Total (lines 30 through 199)	1,462,786		1,462,786	18,813		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	5,231	406,710	30.00
200.00	Total (lines 30 through 199)	5,231	406,710	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/30/2024 8:35 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0.000000	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,802	2,343,861	0.005035	766,311	3,858	54.00
60.00	06000	LABORATORY	17,086	1,772,571	0.009639	490,780	4,731	60.00
65.00	06500	RESPIRATORY THERAPY	20,820	3,387,896	0.006145	1,182,734	7,268	65.00
66.00	06600	PHYSICAL THERAPY	235,043	21,642,076	0.010860	3,810,394	41,381	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0	0.000000	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	200,452	18,512,340	0.010828	3,962,571	42,907	67.00
68.00	06800	SPEECH PATHOLOGY	115,577	10,585,685	0.010918	2,115,238	23,094	68.00
68.01	06801	VISION	0	0	0.000000	0	0	68.01
68.02	06802	FAC RESOURCE	0	0	0.000000	0	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,053	2,234,233	0.007633	666,271	5,086	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	58,910	13,436,531	0.004384	2,252,217	9,874	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	104,242	1,939,905	0.053736	0	0	90.00
90.01	09001	SLEEP CENTER	0	0	0.000000	0	0	90.01
91.00	09100	EMERGENCY	0	0	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	780,985	75,855,098		15,246,516	138,199	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part III Date/Time Prepared: 5/30/2024 8:35 am

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
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	18,813	0.00	5,231	30.00
200.00		Total (lines 30 through 199)		0	18,813		5,231	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
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/30/2024 8:35 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	VISION	0	0	0	0	0	68.01
68.02	06802	FAC RESOURCE	0	0	0	0	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SLEEP CENTER	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/30/2024 8:35 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	2,343,861	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	1,772,571	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,387,896	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	21,642,076	0.000000	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0	0	0	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	18,512,340	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	10,585,685	0.000000	68.00
68.01	06801	VISION	0	0	0	0	0.000000	68.01
68.02	06802	FAC RESOURCE	0	0	0	0	0.000000	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,234,233	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	13,436,531	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	1,939,905	0.000000	90.00
90.01	09001	SLEEP CENTER	0	0	0	0	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	75,855,098		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/30/2024 8:35 am

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	766,311	0	1,869	0	54.00
60.00	06000	LABORATORY	0.000000	490,780	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,182,734	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	3,810,394	0	0	0	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	3,962,571	0	2,440	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	2,115,238	0	0	0	68.00
68.01	06801	VISION	0.000000	0	0	0	0	68.01
68.02	06802	FAC RESOURCE	0.000000	0	0	0	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	666,271	0	18,886	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,252,217	0	1,860,335	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	492,366	0	90.00
90.01	09001	SLEEP CENTER	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		15,246,516	0	2,375,896	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/30/2024 8:35 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150408	1,869	0	0	281	54.00
60.00	06000	LABORATORY	0.287524	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.376445	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.224821	0	0	0	0	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.215017	2,440	0	0	525	67.00
68.00	06800	SPEECH PATHOLOGY	0.229492	0	0	0	0	68.00
68.01	06801	VISION	0.000000	0	0	0	0	68.01
68.02	06802	FAC RESOURCE	0.000000	0	0	0	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.276645	18,886	0	0	5,225	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	0.239310	1,860,335	0	0	445,197	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.346609	492,366	0	0	170,658	90.00
90.01	09001	SLEEP CENTER	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Subtotal (see instructions)		2,375,896	0	0	621,886	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		2,375,896	0	0	621,886	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/30/2024 8:35 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
68.01	06801	VISION	0	0		68.01
68.02	06802	FAC RESOURCE	0	0		68.02
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	SLEEP CENTER	0	0		90.01
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	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part I Date/Time Prepared: 5/30/2024 8:35 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,462,786	0	1,462,786	18,813	77.75	30.00
200.00	Total (lines 30 through 199)	1,462,786		1,462,786	18,813		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	751	58,390	30.00
200.00	Total (lines 30 through 199)	751	58,390	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/30/2024 8:35 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0.000000	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,802	2,343,861	0.005035	60,181	303	54.00
60.00	06000	LABORATORY	17,086	1,772,571	0.009639	57,499	554	60.00
65.00	06500	RESPIRATORY THERAPY	20,820	3,387,896	0.006145	113,129	695	65.00
66.00	06600	PHYSICAL THERAPY	235,043	21,642,076	0.010860	528,611	5,741	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0	0.000000	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	200,452	18,512,340	0.010828	548,450	5,939	67.00
68.00	06800	SPEECH PATHOLOGY	115,577	10,585,685	0.010918	280,774	3,065	68.00
68.01	06801	VISION	0	0	0.000000	0	0	68.01
68.02	06802	FAC RESOURCE	0	0	0.000000	0	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,053	2,234,233	0.007633	53,854	411	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	58,910	13,436,531	0.004384	296,564	1,300	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	104,242	1,939,905	0.053736	0	0	90.00
90.01	09001	SLEEP CENTER	0	0	0.000000	0	0	90.01
91.00	09100	EMERGENCY	0	0	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	780,985	75,855,098		1,939,062	18,008	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part III Date/Time Prepared: 5/30/2024 8:35 am

Title XIX | 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
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	18,813	0.00	751	30.00
200.00		Total (lines 30 through 199)		0	18,813		751	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
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/30/2024 8:35 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	VISION	0	0	0	0	0	68.01
68.02	06802	FAC RESOURCE	0	0	0	0	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SLEEP CENTER	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/30/2024 8:35 am

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	2,343,861	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	1,772,571	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,387,896	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	21,642,076	0.000000	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0	0	0	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	18,512,340	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	10,585,685	0.000000	68.00
68.01	06801	VISION	0	0	0	0	0.000000	68.01
68.02	06802	FAC RESOURCE	0	0	0	0	0.000000	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,234,233	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	13,436,531	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	1,939,905	0.000000	90.00
90.01	09001	SLEEP CENTER	0	0	0	0	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	75,855,098		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/30/2024 8:35 am

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	60,181	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	57,499	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	113,129	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	528,611	0	0	0	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	548,450	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	280,774	0	0	0	68.00
68.01	06801	VISION	0.000000	0	0	0	0	68.01
68.02	06802	FAC RESOURCE	0.000000	0	0	0	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	53,854	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	296,564	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	SLEEP CENTER	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,939,062	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/30/2024 8:35 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150408	0	865	0	0	54.00
60.00	06000	LABORATORY	0.287524	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.376445	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.224821	0	407,829	0	0	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.215017	0	267,650	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.229492	0	207,579	0	0	68.00
68.01	06801	VISION	0.000000	0	0	0	0	68.01
68.02	06802	FAC RESOURCE	0.000000	0	0	0	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.276645	0	4,886	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	0.239310	0	84,919	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.346609	0	168,033	0	0	90.00
90.01	09001	SLEEP CENTER	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	1,141,761	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	1,141,761	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/30/2024 8:35 am

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	130	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	91,689	0		66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	57,549	0		67.00
68.00	06800	SPEECH PATHOLOGY	47,638	0		68.00
68.01	06801	VISION	0	0		68.01
68.02	06802	FAC RESOURCE	0	0		68.02
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,352	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,322	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	58,242	0		90.00
90.01	09001	SLEEP CENTER	0	0		90.01
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)	276,922	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	276,922	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/30/2024 8:35 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	18,813	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	18,813	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)	18,813	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)	5,231	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	266.32	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)	24,640,928	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)	24,640,928	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)	24,640,928	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)	1,309.78	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	6,851,459	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)	6,851,459	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/30/2024 8:35 am

Title XVIII | Hospital | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	3,619,010	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)	10,470,469	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)	406,710	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	138,199	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	544,909	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	9,925,560	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
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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/30/2024 8:35 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,462,786	24,640,928	0.059364	0	0	90.00
91.00	Nursing Program cost	0	24,640,928	0.000000	0	0	91.00
92.00	Allied health cost	0	24,640,928	0.000000	0	0	92.00
93.00	All other Medical Education	0	24,640,928	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/30/2024 8:35 am

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	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)	18,813	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	18,813	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)	18,813	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)	751	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	266.32	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)	24,640,928	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)	24,640,928	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)	24,640,928	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)	1,309.78	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	983,645	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)	983,645	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/30/2024 8:35 am

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	455,244	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)	1,438,889	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)	58,390	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	18,008	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	76,398	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,362,491	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
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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/30/2024 8:35 am

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	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,462,786	24,640,928	0.059364	0	0	90.00
91.00	Nursing Program cost	0	24,640,928	0.000000	0	0	91.00
92.00	Allied health cost	0	24,640,928	0.000000	0	0	92.00
93.00	All other Medical Education	0	24,640,928	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/30/2024 8:35 am

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		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		12,485,556		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150408	766,311	115,259	54.00
60.00	06000	LABORATORY	0.287524	490,780	141,111	60.00
65.00	06500	RESPIRATORY THERAPY	0.376445	1,182,734	445,234	65.00
66.00	06600	PHYSICAL THERAPY	0.224821	3,810,394	856,657	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0.000000	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.215017	3,962,571	852,020	67.00
68.00	06800	SPEECH PATHOLOGY	0.229492	2,115,238	485,430	68.00
68.01	06801	VISION	0.000000	0	0	68.01
68.02	06802	FAC RESOURCE	0.000000	0	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.276645	666,271	184,321	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.239310	2,252,217	538,978	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.346609	0	0	90.00
90.01	09001	SLEEP CENTER	0.000000	0	0	90.01
91.00	09100	EMERGENCY	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		15,246,516	3,619,010	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)		15,246,516		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/30/2024 8:35 am

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		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		1,759,439		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150408	60,181	9,052	54.00
60.00	06000	LABORATORY	0.287524	57,499	16,532	60.00
65.00	06500	RESPIRATORY THERAPY	0.376445	113,129	42,587	65.00
66.00	06600	PHYSICAL THERAPY	0.224821	528,611	118,843	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0.000000	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.215017	548,450	117,926	67.00
68.00	06800	SPEECH PATHOLOGY	0.229492	280,774	64,435	68.00
68.01	06801	VISION	0.000000	0	0	68.01
68.02	06802	FAC RESOURCE	0.000000	0	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.276645	53,854	14,898	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.239310	296,564	70,971	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.346609	0	0	90.00
90.01	09001	SLEEP CENTER	0.000000	0	0	90.01
91.00	09100	EMERGENCY	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,939,062	455,244	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)		1,939,062		202.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/30/2024 8:35 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	0	0		0	0	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	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	0	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	-2,017,266	2,017,266	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	0	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	0	0	0	0	0	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	0	0	0	0	0	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	0	0	0	0	0	16.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/30/2024 8:35 am

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		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	0	0	0	0	0	17.00
17.01	Net organ aquisition 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	0	0	0	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	0	0	0	0	0	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	0	0	0	0	0	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	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	0	0	0	0	0	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/30/2024 8:35 am

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		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	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	0		0	0	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	5,260,966	2,017,266	7,278,232	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	0	0	0	0	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	0	0	0	0	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	0	0	0	0	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			0	0	0	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/30/2024 8:35 am

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	0	0	0	0	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	0	0	0	0	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	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	0	0	0	0	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	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part B Date/Time Prepared: 5/30/2024 8:35 am

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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	621,886	2.00
3.00	OPPS or REH payments	535,951	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	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)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	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)	0	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)	535,951	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)	111,318	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)	424,633	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount (see instructions)		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	424,633	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	424,633	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)	68,636	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	44,613	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	68,636	36.00
37.00	Subtotal (see instructions)	469,246	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	469,246	40.00
40.01	Sequestration adjustment (see instructions)	9,385	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	469,800	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-9,939	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	8,244	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-3028	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/30/2024 8:35 am
	Title XVIII	Hospital	PPS

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/30/2024 8:35 am

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		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		9,480,797		436,300	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0	08/30/2023	33,500	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		33,500	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)		9,480,797		469,800	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		22,984		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		9,939	6.02
7.00	Total Medicare program liability (see instructions)		9,503,781		459,861	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-3028	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part III Date/Time Prepared: 5/30/2024 8:35 am
	Title XVIII	Hospital	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	8,991,471	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0374	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	784,056	3.00
4.00	Outlier Payments	93,880	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.34	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	2.99	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.34	9.00
10.00	Average Daily Census (see instructions)	51.542466	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.006705	11.00
12.00	Teaching Adjustment (see instructions)	60,288	12.00
13.00	Total PPS Payment (see instructions)	9,929,695	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	9,929,695	17.00
18.00	Primary payer payments	44,305	18.00
19.00	Subtotal (line 17 less line 18).	9,885,390	19.00
20.00	Deductibles	52,712	20.00
21.00	Subtotal (line 19 minus line 20)	9,832,678	21.00
22.00	Coinsurance	166,800	22.00
23.00	Subtotal (line 21 minus line 22)	9,665,878	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	49,013	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	31,858	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	49,013	26.00
27.00	Subtotal (sum of lines 23 and 25)	9,697,736	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.98	Recovery of accelerated depreciation.	0	31.98
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	9,697,736	32.00
32.01	Sequestration adjustment (see instructions)	193,955	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	9,480,797	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	22,984	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	334,223	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	93,880	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)	0.006705	99.01

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

Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-4 | Date/Time Prepared: 5/30/2024 8:35 am

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				1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
1.01	FTE cap adjustment under §131 of the CAA 2021 (see instructions)			0.00	1.01
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
2.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)			0.00	2.26
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
3.02	Adjustment (increase or decrease) to the hospital's rural track FTE limitation(s) for rural track programs with a rural track Medicare GME affiliation agreement in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)			0.00	3.02
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
4.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)			0.00	4.21
5.00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lines 2.26 through 2.49, minus lines 3 and 3.01, plus or minus line 3.02, plus or minus line 4, plus lines 4.01 through 4.27			0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			2.99	6.00
7.00	Enter the lesser of line 5 or line 6			0.00	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	2.70	2.70	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6. For cost reporting periods beginning on or after October 1, 2022, or if Worksheet S-2, Part I, line 68, is "Y", see instructions.	0.00	0.00	0.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.00	0.00		17.00
18.00	Per resident amount	103,607.15	103,607.15		18.00
18.01	Per resident amount under §131 of the CAA 2021	0.00	0.00		18.01
19.00	Approved amount for resident costs	0	0	0	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)			2.99	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)			0	25.00

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

Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-4 | Date/Time Prepared: 5/30/2024 8:35 am

Title XVIII | Hospital | PPS

		Inpatient Part A	Managed Care	Total	
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	5,231	4,299		26.00
27.00	Total Inpatient Days (see instructions)	18,813	18,813		27.00
28.00	Ratio of inpatient days to total inpatient days	0.278052	0.228512		28.00
29.00	Program direct GME amount	0	0	0	29.00
29.01	Percent reduction for MA DGME		3.27		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		0	0	30.00
31.00	Net Program direct GME amount			0	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)			0	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)			10,470,469	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)			44,305	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			10,426,164	41.00
	Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)			621,886	42.00
43.00	Primary payer payments (see instructions)			0	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			621,886	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			11,048,050	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.943711	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.056289	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)			0	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			0	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			0	50.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-3028	Period: From 01/01/2023 To 12/31/2023	Worksheet E-5 Date/Time Prepared: 5/30/2024 8:35 am
	Title XVIII		PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR		
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. 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: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G | Date/Time Prepared: 5/30/2024 8:35 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	2,802,438	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	16,430,239	0	0	0	4.00
5.00	Other receivable	836,710	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-11,281,121	0	0	0	6.00
7.00	Inventory	516,750	0	0	0	7.00
8.00	Prepaid expenses	889,344	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)	10,194,360	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,506,638	0	0	0	12.00
13.00	Land improvements	757,042	0	0	0	13.00
14.00	Accumulated depreciation	-427,471	0	0	0	14.00
15.00	Buildings	33,661,545	0	0	0	15.00
16.00	Accumulated depreciation	-17,030,086	0	0	0	16.00
17.00	Leasehold improvements	205,018	0	0	0	17.00
18.00	Accumulated depreciation	-194,263	0	0	0	18.00
19.00	Fixed equipment	3,580,974	0	0	0	19.00
20.00	Accumulated depreciation	-2,167,770	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	16,206,945	0	0	0	23.00
24.00	Accumulated depreciation	-14,629,071	0	0	0	24.00
25.00	Minor equipment depreciable	105,832	0	0	0	25.00
26.00	Accumulated depreciation	-105,832	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)	22,469,501	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	965,144	0	0	0	33.00
34.00	Other assets	135,547	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,100,691	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	33,764,552	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,169,141	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,762,697	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,053,665	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	813,917	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,799,420	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	7,001,882	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)	7,001,882	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	15,801,302	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	17,963,250				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	17,963,250	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	33,764,552	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 5/30/2024 8:35 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		16,702,844		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,260,406				2.00
3.00	Total (sum of line 1 and line 2)		17,963,250		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)		17,963,250		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		17,963,250		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-3028 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/30/2024 8:35 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	47,010,303		47,010,303	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	47,010,303		47,010,303	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	47,010,303		47,010,303	17.00
18.00	Ancillary services	55,057,033	18,858,160	73,915,193	18.00
19.00	Outpatient services	197,757	2,743,044	2,940,801	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC		0	0	24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	102,265,093	21,601,204	123,866,297	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		45,535,971		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		45,535,971		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-3028	Period: From 01/01/2023 To 12/31/2023	Worksheet G-3 Date/Time Prepared: 5/30/2024 8:35 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	123,866,297	1.00
2.00	Less contractual allowances and discounts on patients' accounts	79,352,887	2.00
3.00	Net patient revenues (line 1 minus line 2)	44,513,410	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	45,535,971	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,022,561	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	2,282,967	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	2,282,967	25.00
26.00	Total (line 5 plus line 25)	1,260,406	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)	1,260,406	29.00