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: 15-0048	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/31/2024 2:00 pm

PART I - COST REPORT STATUS

Provider use only
1. [X] Electronically prepared cost report — Date: 5/31/2024 Time: 2:00 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by REID HOSPITAL & HEALTH CARE SERVICES (15-0048) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	-552,775	-987,066	0	3,371,152	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	54,069	13		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	-498,706	-987,053	0	3,371,152	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: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 2:00 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1401 CHESTER BOULEVARD	PO Box:			1.00
2.00	City: RICHMOND	State: IN	Zip Code: 47374	County: WAYNE	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	REID HOSPITAL & HEALTH CARE SERVICES	150048	99915	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	REHAB UNIT	15T048	99915	5	01/01/2003	N	P	O	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	HOSPICE	151524	99915		11/03/1993				14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2023	12/31/2023	20.00
21.00	Type of Control (see instructions)	2		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 2:00 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,007	363	206	218	7,738	120	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	40	0	21	642		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	1		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.	01/01/2023	12/31/2023	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

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

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	Y	Y		60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1	60.01

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

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

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during 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

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

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

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

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	FAMILY MED	1350	0.00	14.32	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2024 2:00 pm

Line	Description	1.00	Line
	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

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

Line	Description	1.00	Line
	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

Line	Description	Approved for Permanent Adjustment (Y/N) 1.00	Number of Approved Permanent Adjustments 2.00	Line
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

Line	Description	Wkst. A Line No. 1.00	Effective Date 2.00	Approved Permanent Adjustment Amount Per Discharge 3.00	Line
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

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

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	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.	Y	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.06	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		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: REID HOME OFFICE	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 1100 REID PARKWAY	PO Box:		142.00
143.00	City: RICHMOND	State: IN	Zip Code: 47374	143.00

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

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

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

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

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

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

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

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

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

		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	04/20/2023	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/02/2024	Y	04/02/2024	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II Date/Time Prepared: 5/31/2024 2:00 pm

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	Y	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	Y	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	Y	33.00
	Provider-Based Physicians		
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	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.	N	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.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KERRY	BEJARANO	41.00
42.00	Enter the employer/company name of the cost report preparer.	FORVIS		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	3173834000	KERRY.BEJARANO@FORVIS.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II Date/Time Prepared: 5/31/2024 2:00 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2024 2:00 pm

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	153	55,845	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)		153	55,845	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	30	10,950	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		183	66,795	0.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	20	7,300		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		203				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: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2024 2:00 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	12,825	772	32,888			1.00
2.00	HMO and other (see instructions)	8,574	8,525				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	757	703				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)	12,825	772	32,888			7.00
8.00	INTENSIVE CARE UNIT	1,550	156	4,214			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		79	1,274			13.00
14.00	Total (see instructions)	14,375	1,007	38,376	17.93	1,245.80	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	1,691	0	3,964	0.00	22.75	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	1,053	27	1,211	0.00	26.32	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				17.93	1,294.87	27.00
28.00	Observation Bed Days		390	10,256			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			429			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	120	161			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: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2024 2:00 pm

	Component	Full Time Equivalents Nonpaid Workers	Discharges 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	4,106	274	10,457	1.00
2.00	HMO and other (see instructions)			2,037	2,323		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				49		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	4,106	274	10,457	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	138	0	276	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	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	101,153,220	0	101,153,220	2,730,630.63	37.04	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	1,803,728	1,803,728	37,285.65	48.38	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		5,465,794	333,125	5,798,919	169,159.95	34.28	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		11,450,239	0	11,450,239	182,143.90	62.86	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		459,288	0	459,288	3,083.75	148.94	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		39,003,421	0	39,003,421	1,059,195.66	36.82	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		30,837,175	0	30,837,175			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		1,910,333	0	1,910,333			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		421,069	0	421,069			25.00
25.50	Home office wage-related (core)		5,686,569	0	5,686,569			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part II Date/Time Prepared: 5/31/2024 2:00 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	106,548	0	106,548	3,214.96	33.14	26.00
27.00	Administrative & General	5.00	2,897,097	295,984	3,193,081	109,528.35	29.15	27.00
28.00	Administrative & General under contract (see inst.)		6,263,854	0	6,263,854	88,691.25	70.63	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	3,425,600	-2,256,865	1,168,735	56,300.26	20.76	34.00
35.00	Dietary under contract (see instructions)		392,148	0	392,148	5,556.00	70.58	35.00
36.00	Cafeteria	11.00	0	2,256,865	2,256,865	108,717.65	20.76	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	0	383,496	383,496	2,080.00	184.37	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	4,857,435	0	4,857,435	126,350.78	38.44	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	4,261,295	0	4,261,295	100,465.87	42.42	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part III Date/Time Prepared: 5/31/2024 2:00 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		107,809,222	-1,803,728	106,005,494	2,787,592.23	38.03	1.00
2.00	Excluded area salaries (see instructions)		5,465,794	333,125	5,798,919	169,159.95	34.28	2.00
3.00	Subtotal salaries (line 1 minus line 2)		102,343,428	-2,136,853	100,206,575	2,618,432.28	38.27	3.00
4.00	Subtotal other wages & related costs (see inst.)		50,912,948	0	50,912,948	1,244,423.31	40.91	4.00
5.00	Subtotal wage-related costs (see inst.)		36,523,744	0	36,523,744	0.00	36.45	5.00
6.00	Total (sum of lines 3 thru 5)		189,780,120	-2,136,853	187,643,267	3,862,855.59	48.58	6.00
7.00	Total overhead cost (see instructions)		22,203,977	679,480	22,883,457	600,905.12	38.08	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part IV Date/Time Prepared: 5/31/2024 2:00 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	233,361	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	4,133,619	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	18,775,281	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	74,664	9.00
10.00	Dental, Hearing and Vision Plan	652,574	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	150,508	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	375,877	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	816,676	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	7,697,284	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	258,734	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	33,168,578	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part V Date/Time Prepared: 5/31/2024 2:00 pm

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

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA	Provider CCN: 15-0048 Hospice CCN: 15-1524	Period: From 01/01/2023 To 12/31/2023	Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 5/31/2024 2:00 pm
		Hospice I	

		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
1.00	Hospice Continuous Home Care							1.00
2.00	Hospice Routine Home Care							2.00
3.00	Hospice Inpatient Respite Care							3.00
4.00	Hospice General Inpatient Care							4.00
5.00	Total Hospice Days							5.00
	Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
6.00	Number of patients receiving hospice care							6.00
7.00	Total number of unduplicated Continuous Care hours billable to Medicare							7.00
8.00	Average Length of Stay (line 5 / line 6)							8.00
9.00	Unduplicated census count							9.00

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	17,341	369	2,167	19,877	11.00
12.00	Hospice Inpatient Respite Care	169	0	36	205	12.00
13.00	Hospice General Inpatient Care	884	27	95	1,006	13.00
14.00	Total Hospice Days	18,394	396	2,298	21,088	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 5/31/2024 2:00 pm

		1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.270221	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	88,520,329	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	263,689,250	6.00
7.00	Medicaid cost (line 1 times line 6)	71,254,373	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	5,967,862	8,646,409	14,614,271	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,612,642	8,646,409	10,259,051	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (see instructions)	1,612,642	8,646,409	10,259,051	23.00

		1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
25.01	Charges for insured patients' liability (see instructions)	0	25.01
26.00	Bad debt amount (see instructions)	12,361,935	26.00
27.00	Medicare reimbursable bad debts (see instructions)	937,488	27.00
27.01	Medicare allowable bad debts (see instructions)	1,442,289	27.01
28.00	Non-Medicare bad debt amount (see instructions)	10,919,646	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	3,455,519	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	13,714,570	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	13,714,570	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-10 Parts I & II | Date/Time Prepared: 5/31/2024 2:00 pm

				1.00	
	PART II - HOSPITAL DATA				
	Uncompensated and Indigent Care Cost-to-Charge Ratio				
1.00	Cost to charge ratio (see instructions)			0.264927	1.00
	Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid				2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?				4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid				5.00
6.00	Medicaid charges				6.00
7.00	Medicaid cost (line 1 times line 6)				7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)				8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP				9.00
10.00	Stand-alone CHIP charges				10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)				11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)				12.00
	Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)				13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)				14.00
15.00	State or local indigent care program cost (line 1 times line 14)				15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)				16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care				17.00
18.00	Government grants, appropriations or transfers for support of hospital operations				18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)				19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	5,967,862	8,646,409	14,614,271	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,581,048	8,646,409	10,227,457	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (see instructions)	1,581,048	8,646,409	10,227,457	23.00
				1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
25.01	Charges for insured patients' liability (see instructions)			0	25.01
26.00	Bad debt amount (see instructions)			12,361,935	26.00
27.00	Medicare reimbursable bad debts (see instructions)			935,726	27.00
27.01	Medicare allowable bad debts (see instructions)			1,439,578	27.01
28.00	Non-Medicare bad debt amount (see instructions)			10,922,357	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)			3,397,479	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)			13,624,936	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			13,624,936	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/31/2024 2:00 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	19,723,079	19,723,079	1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE		0	0	11,112,825	11,112,825	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	106,548	21,408	127,956	-1,816	126,140	4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	0	0	5.01
5.02	00550	DATA PROCESSING	0	0	0	0	0	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	0	0	0	0	5.03
5.04	00570	ADMITTING	77,081	1,705,650	1,782,731	0	1,782,731	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	106,709	106,709	-21,569	85,140	5.05
5.06	00590	OTHER A&G	2,820,016	27,037,006	29,857,022	413	29,857,435	5.06
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	0	9.00
10.00	01000	DIETARY	3,425,600	4,375,715	7,801,315	-5,139,952	2,661,363	10.00
11.00	01100	CAFETERIA	0	0	0	5,139,179	5,139,179	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	383,496	383,496	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	4,857,435	44,894,167	49,751,602	-6,822	49,744,780	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	3,962,065	602,637	4,564,702	0	4,564,702	17.00
17.01	01701	INSERVICE EDUCATION	299,230	1,708,350	2,007,580	0	2,007,580	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	1,886,075	1,886,075	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	1,932,026	692,514	2,624,540	-1,886,075	738,465	22.00
23.00	02300	PARAMED ED PRGM	191,622	21,409	213,031	0	213,031	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,980,440	14,726,073	42,706,513	-435,897	42,270,616	30.00
31.00	03100	INTENSIVE CARE UNIT	4,571,700	2,581,027	7,152,727	0	7,152,727	31.00
41.00	04100	SUBPROVIDER - IRF	1,871,963	416,605	2,288,568	0	2,288,568	41.00
43.00	04300	NURSERY	458,695	133,793	592,488	0	592,488	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,067,913	54,833,587	56,901,500	-17,661,891	39,239,609	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	630,813	258,532	889,345	-1,652	887,693	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,015,620	13,558,483	22,574,103	-55,676	22,518,427	54.00
59.00	05900	CARDIAC CATHETERIZATION	2,128,470	13,918,287	16,046,757	-9,496,513	6,550,244	59.00
60.00	06000	LABORATORY	5,417,333	9,330,556	14,747,889	-45,755	14,702,134	60.00
65.00	06500	RESPIRATORY THERAPY	1,902,445	855,110	2,757,555	-963	2,756,592	65.00
66.00	06600	PHYSICAL THERAPY	9,190,229	3,150,364	12,340,593	-260,795	12,079,798	66.00
69.00	06900	ELECTROCARDIOLOGY	1,591,460	1,268,413	2,859,873	0	2,859,873	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	516,954	142,552	659,506	-646	658,860	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	27,179,455	27,179,455	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	95,503	714,646	810,149	0	810,149	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	551,658	82,057	633,715	-64	633,651	76.97
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						
91.00	09100	EMERGENCY	9,691,492	5,596,986	15,288,478	-1,008,159	14,280,319	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	FAMILY PRACTICE	2,076,529	481,592	2,558,121	-59,984	2,498,137	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	320,171	526,492	846,663	0	846,663	96.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		9,836,425	9,836,425	-9,836,425	0	113.00
116.00	11600	HOSPICE	1,659,327	1,358,584	3,017,911	396,675	3,414,586	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	99,410,338	214,935,729	314,346,067	19,900,543	334,246,610	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	12,707,680	12,707,680	-7,714,568	4,993,112	192.00
194.00	07950	RENTAL SPACE	0	14,763,310	14,763,310	-8,794,187	5,969,123	194.00
194.01	07951	FOUNDATION	268,804	123,207	392,011	0	392,011	194.01
194.02	07952	RETAIL SERVICES	179,031	34,872	213,903	0	213,903	194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	0	4,113,743	4,113,743	-2,868,140	1,245,603	194.05
194.06	07956	VACANT SPACE	0	721,570	721,570	-518,179	203,391	194.06
194.07	07957	HOME OFFICE	0	0	0	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08
194.09	07959	REID HEALTH PAVILION - RES	1,295,047	206,788	1,501,835	-5,469	1,496,366	194.09

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES	Provider CCN: 15-0048	Period: From 01/01/2023 To 12/31/2023	Worksheet A Date/Time Prepared: 5/31/2024 2:00 pm

	Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
200.00	TOTAL (SUM OF LINES 118 through 199)	101,153,220	247,606,899	348,760,119	0	348,760,119	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/31/2024 2:00 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	-4,328,837	15,394,242	1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE	0	11,112,825	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	19,975,686	20,101,826	4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	5.01
5.02	00550	DATA PROCESSING	22,438,447	22,438,447	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	0	5.03
5.04	00570	ADMITTING	-10	1,782,721	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	85,140	5.05
5.06	00590	OTHER A&G	10,813,819	40,671,254	5.06
7.00	00700	OPERATION OF PLANT	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	9.00
10.00	01000	DIETARY	-399	2,660,964	10.00
11.00	01100	CAFETERIA	-4,097,816	1,041,363	11.00
13.00	01300	NURSING ADMINISTRATION	0	383,496	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	-741,710	49,003,070	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	4,564,702	17.00
17.01	01701	INSERVICE EDUCATION	-602,391	1,405,189	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	1,886,075	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	-976	737,489	22.00
23.00	02300	PARAMED ED PRGM	-54,281	158,750	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-7,087,889	35,182,727	30.00
31.00	03100	INTENSIVE CARE UNIT	0	7,152,727	31.00
41.00	04100	SUBPROVIDER - IRF	-151,660	2,136,908	41.00
43.00	04300	NURSERY	-762	591,726	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-12,375,983	26,863,626	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-148	887,545	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,489,960	21,028,467	54.00
59.00	05900	CARDIAC CATHETERIZATION	-1,010	6,549,234	59.00
60.00	06000	LABORATORY	-488,357	14,213,777	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,756,592	65.00
66.00	06600	PHYSICAL THERAPY	-147,011	11,932,787	66.00
69.00	06900	ELECTROCARDIOLOGY	-20,244	2,839,629	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-2,052	656,808	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	27,179,455	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	810,149	74.00
76.00	03950	ANCILLARY - OTHER	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	-5,780	627,871	76.97
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			
91.00	09100	EMERGENCY	-2,601,075	11,679,244	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.00	04040	FAMILY PRACTICE	-34,559	2,463,578	93.00
		OTHER REIMBURSABLE COST CENTERS			
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	-493,290	353,373	96.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	-6,196	3,408,390	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,495,556	352,742,166	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,993,112	192.00
194.00	07950	RENTAL SPACE	0	5,969,123	194.00
194.01	07951	FOUNDATION	0	392,011	194.01
194.02	07952	RETAIL SERVICES	0	213,903	194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	0	1,245,603	194.05
194.06	07956	VACANT SPACE	0	203,391	194.06
194.07	07957	HOME OFFICE	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	194.08
194.09	07959	REID HEALTH PAVILION - RES	0	1,496,366	194.09
200.00		TOTAL (SUM OF LINES 118 through 199)	18,495,556	367,255,675	200.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAPITAL EXPENSE RECLASS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	9,571,584	1.00
2.00	NEW CAP BLDG & FIXT - OFFSITE	1.01	0	10,655,555	2.00
3.00	CAP REL COSTS-BLDG & FIXT	1.00	0	98,084	3.00
4.00	NEW CAP BLDG & FIXT - OFFSITE	1.01	0	457,270	4.00
5.00	CAP REL COSTS-BLDG & FIXT	1.00	0	216,986	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
	0		0	20,999,479	
	B - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	2,256,865	2,882,314	1.00
	0		2,256,865	2,882,314	
	C - NURSING VP RECLASS				
1.00	NURSING ADMINISTRATION	13.00	383,496	0	1.00
	0		383,496	0	
	D - OCCUPATIONAL MEDICINE RECLASS				
1.00	OTHER A&G	5.06	679,480	321,410	1.00
	0		679,480	321,410	
	E - IMPLANTABLE DEVICES RECLASS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	27,179,455	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	0		0	27,179,455	
	F - INTEREST RECLASS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	9,836,425	1.00
	0		0	9,836,425	
	G - INTERN AND RESIDENT				
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	1,803,728	82,347	1.00
	0		1,803,728	82,347	
	H - HOSPICE				
1.00	HOSPICE	116.00	333,125	65,350	1.00
	0		333,125	65,350	
500.00	Grand Total: Increases		5,456,694	61,366,780	500.00

RECLASSIFICATIONS | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/31/2024 2:00 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - CAPITAL EXPENSE RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,816	9	1.00
2.00	DATA PROCESSING	5.02	0	0	9	2.00
3.00	PURCHASING RECEIVING AND STORES	5.03	0	0	13	3.00
4.00	ADMITTING	5.04	0	0	13	4.00
5.00	CASHIERING/ACCOUNTS RECEIVABLE	5.05	0	21,569	10	5.00
6.00	OTHER A&G	5.06	0	616,981	0	6.00
7.00	OPERATION OF PLANT	7.00	0	0	0	7.00
8.00	DIETARY	10.00	0	773	0	8.00
9.00	PHARMACY	15.00	0	6,822	0	9.00
10.00	MEDICAL RECORDS & LIBRARY	16.00	0	0	0	10.00
11.00	ADULTS & PEDIATRICS	30.00	0	37,422	0	11.00
12.00	OPERATING ROOM	50.00	0	17,911	0	12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	18,366	0	13.00
14.00	LABORATORY	60.00	0	45,755	0	14.00
15.00	RESPIRATORY THERAPY	65.00	0	963	0	15.00
16.00	PHYSICAL THERAPY	66.00	0	260,795	0	16.00
17.00	ELECTROCARDIOLOGY	69.00	0	0	0	17.00
18.00	ELECTROENCEPHALOGRAPHY	70.00	0	646	0	18.00
19.00	CARDIAC REHABILITATION	76.97	0	64	0	19.00
20.00	EMERGENCY	91.00	0	7,269	0	20.00
21.00	FAMILY PRACTICE	93.00	0	59,984	0	21.00
22.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	0	0	22.00
23.00	HOSPICE	116.00	0	1,800	0	23.00
24.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	7,714,568	0	24.00
25.00	RENTAL SPACE	194.00	0	8,794,187	0	25.00
26.00	FOUNDATION	194.01	0	0	0	26.00
27.00	CONNERSVILLE LOCATION	194.05	0	2,868,140	0	27.00
28.00	VACANT SPACE	194.06	0	518,179	0	28.00
29.00	REID HEALTH PAVILION - RES	194.09	0	5,469	0	29.00
	0		0	20,999,479		
	B - CAFETERIA RECLASS					
1.00	DIETARY	10.00	2,256,865	2,882,314	0	1.00
	0		2,256,865	2,882,314		
	C - NURSING VP RECLASS					
1.00	OTHER A&G	5.06	383,496	0	0	1.00
	0		383,496	0		
	D - OCCUPATIONAL MEDICINE RECLASS					
1.00	EMERGENCY	91.00	679,480	321,410	0	1.00
	0		679,480	321,410		
	E - IMPLANTABLE DEVICES RECLASS					
1.00	OPERATING ROOM	50.00	0	17,643,980	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	0	1,652	0	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	37,310	0	3.00
4.00	CARDIAC CATHETERIZATION	59.00	0	9,496,513	0	4.00
	0		0	27,179,455		
	F - INTEREST RECLASS					
1.00	INTEREST EXPENSE	113.00	0	9,836,425	11	1.00
	0		0	9,836,425		
	G - INTERN AND RESIDENT					
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	1,803,728	82,347	0	1.00
	0		1,803,728	82,347		
	H - HOSPICE					
1.00	ADULTS & PEDIATRICS	30.00	333,125	65,350	0	1.00
	0		333,125	65,350		
500.00	Grand Total: Decreases		5,456,694	61,366,780		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I Date/Time Prepared: 5/31/2024 2:00 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	18,717,396	0	0	0	234,987	1.00
2.00	Land Improvements	10,883,356	0	0	0	534,441	2.00
3.00	Buildings and Fixtures	344,604,749	12,096,845	0	12,096,845	0	3.00
4.00	Building Improvements	13,645,110	0	0	0	0	4.00
5.00	Fixed Equipment	2,237,098	0	0	0	27,739	5.00
6.00	Movable Equipment	220,799,729	9,887,802	0	9,887,802	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	610,887,438	21,984,647	0	21,984,647	797,167	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	610,887,438	21,984,647	0	21,984,647	797,167	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	18,482,409	0	1.00
2.00	Land Improvements	10,348,915	0	2.00
3.00	Buildings and Fixtures	356,701,594	0	3.00
4.00	Building Improvements	13,645,110	0	4.00
5.00	Fixed Equipment	2,209,359	0	5.00
6.00	Movable Equipment	230,687,531	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	632,074,918	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	632,074,918	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0048

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

Worksheet A-7 Part II

Date/Time Prepared: 5/31/2024 2:00 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	NEW CAP BLDG & FIXT - OFFSITE	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0	1.00
1.01	NEW CAP BLDG & FIXT - OFFSITE	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part III | Date/Time Prepared: 5/31/2024 2:00 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	401,387,387	0	401,387,387	0.635031	0	1.00
1.01	NEW CAP BLDG & FIXT - OFFSITE	230,687,531	0	230,687,531	0.364969	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	632,074,918	0	632,074,918	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	15,079,172	216,986	1.00
1.01	NEW CAP BLDG & FIXT - OFFSITE	0	0	0	10,655,555	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	25,734,727	216,986	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	98,084	0	15,394,242	1.00
1.01	NEW CAP BLDG & FIXT - OFFSITE	0	0	457,270	0	11,112,825	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	555,354	0	26,507,067	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/31/2024 2:00 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - NEW CAP BLDG & FIXT - OFFSITE (chapter 2)		0	NEW CAP BLDG & FIXT - OFFSITE	1.01	0	1.01
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)	B	0	PURCHASING RECEIVING AND STORES	5.03	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-16,932,529			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	84,604,621			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-4,097,816	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	PURCHASING RECEIVING AND STORES	5.03	0	16.00
17.00	Sale of drugs to other than patients	B	-736,048	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	0	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	0	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		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
26.01	Depreciation - NEW CAP BLDG & FIXT - OFFSITE		0	NEW CAP BLDG & FIXT - OFFSITE	1.01	0	26.01
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

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/31/2024 2:00 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISCELLANEOUS INCOME	B	-50,449	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	MISCELLANEOUS INCOME	B	-10	ADMITTING	5.04	0	33.01
33.02	MISCELLANEOUS INCOME	B	-37,754	OTHER A&G	5.06	0	33.02
33.03	MISCELLANEOUS INCOME	B	-42,050	INSERVICE EDUCATION	17.01	0	33.03
33.04	MISCELLANEOUS INCOME	B	-54,281	PARAMED ED PRGM	23.00	0	33.04
33.05	MISCELLANEOUS INCOME	B	-5,792	ADULTS & PEDIATRICS	30.00	0	33.05
33.06	MISCELLANEOUS INCOME	B	0	NURSERY	43.00	0	33.06
33.07	MISCELLANEOUS INCOME	B	-11,704	OPERATING ROOM	50.00	0	33.07
33.08	MISCELLANEOUS INCOME	B	-225,394	RADIOLOGY-DIAGNOSTIC	54.00	0	33.08
33.09	MISCELLANEOUS INCOME	B	-29,066	LABORATORY	60.00	0	33.09
33.10	MISCELLANEOUS INCOME	B	-119,506	PHYSICAL THERAPY	66.00	0	33.10
33.11	MISCELLANEOUS INCOME	B	-46,633	EMERGENCY	91.00	0	33.11
33.12	MISCELLANEOUS INCOME	B	-15	FAMILY PRACTICE	93.00	0	33.12
33.13	MISCELLANEOUS INCOME	B	-491,154	DURABLE MEDICAL EQUIP-RENTED	96.00	0	33.13
33.14	INTEREST INCOME	B	-4,283,763	CAP REL COSTS-BLDG & FIXT	1.00	11	33.14
33.15	UNNECESSARY BORROWING	A	-5,552,662	CAP REL COSTS-BLDG & FIXT	1.00	11	33.15
33.16	SELF INSURANCE ADJUSTMENT	A	-8,903,833	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.16
33.17	MARKETING/ADVERTISING	A	-69,713	OTHER A&G	5.06	0	33.17
33.18	MARKETING/ADVERTISING	A	-260	DIETARY	10.00	0	33.18
33.19	MARKETING/ADVERTISING	A	-1,155	INSERVICE EDUCATION	17.01	0	33.19
33.20	MARKETING/ADVERTISING	A	-963	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	33.20
33.21	MARKETING/ADVERTISING	A	-3,128	ADULTS & PEDIATRICS	30.00	0	33.21
33.22	MARKETING/ADVERTISING	A	-4,468	SUBPROVIDER - IRF	41.00	0	33.22
33.23	MARKETING/ADVERTISING	A	-762	NURSERY	43.00	0	33.23
33.24	MARKETING/ADVERTISING	A	-386	OPERATING ROOM	50.00	0	33.24
33.25	MARKETING/ADVERTISING	A	-1,010	CARDIAC CATHETERIZATION	59.00	0	33.25
33.26	MARKETING/ADVERTISING	A	-18,865	PHYSICAL THERAPY	66.00	0	33.26
33.27	MARKETING/ADVERTISING	A	-2,052	ELECTROENCEPHALOGRAPHY	70.00	0	33.27
33.28	MARKETING/ADVERTISING	A	-5,749	CARDIAC REHABILITATION	76.97	0	33.28
33.29	MARKETING/ADVERTISING	A	-34,544	FAMILY PRACTICE	93.00	0	33.29
33.30	MARKETING/ADVERTISING	A	-2,136	DURABLE MEDICAL EQUIP-RENTED	96.00	0	33.30
33.31	MARKETING/ADVERTISING	A	-6,121	HOSPICE	116.00	0	33.31
33.32	NON-ALLOWABLE EXPENSES	A	-773,478	OTHER A&G	5.06	0	33.32
33.33	NON-ALLOWABLE EXPENSES	A	-139	DIETARY	10.00	0	33.33
33.34	NON-ALLOWABLE EXPENSES	A	-456,403	INSERVICE EDUCATION	17.01	0	33.34
33.35	NON-ALLOWABLE EXPENSES	A	-13	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	33.35
33.36	NON-ALLOWABLE EXPENSES	A	-705	ADULTS & PEDIATRICS	30.00	0	33.36
33.37	NON-ALLOWABLE EXPENSES	A	-388	OPERATING ROOM	50.00	0	33.37
33.38	NON-ALLOWABLE EXPENSES	A	-148	DELIVERY ROOM & LABOR ROOM	52.00	0	33.38
33.39	NON-ALLOWABLE EXPENSES	A	-147	RADIOLOGY-DIAGNOSTIC	54.00	0	33.39
33.40	NON-ALLOWABLE EXPENSES	A	-8,640	PHYSICAL THERAPY	66.00	0	33.40
33.41	NON-ALLOWABLE EXPENSES	A	-31	CARDIAC REHABILITATION	76.97	0	33.41
33.42	NON-ALLOWABLE EXPENSES	A	-3,710	EMERGENCY	91.00	0	33.42
33.43	NON-ALLOWABLE EXPENSES	A	-75	HOSPICE	116.00	0	33.43
33.44	HAF EXPENSE	A	-22,323,215	OTHER A&G	5.06	0	33.44
33.45	BOND REFUNDING - 2015 BONDS	A	-401,531	OTHER A&G	5.06	0	33.45
33.46	BOND REFUNDING - 2016 BONDS	A	-7,737	OTHER A&G	5.06	0	33.46
33.47	OCC MED - EMPLOYEE COST	A	-82,341	OTHER A&G	5.06	0	33.47
33.48	OCC MED - EMPLOYEE COST	A	-266,787	LABORATORY	60.00	0	33.48
33.49	OCC MED - EMPLOYEE COST	A	-6,144	RADIOLOGY-DIAGNOSTIC	54.00	0	33.49
33.50	OCC MED - EMPLOYEE COST	A	-5,662	PHARMACY	15.00	0	33.50
33.51	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.51

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/31/2024 2:00 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.52	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.52
33.53	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.53
33.54	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.54
33.55	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.55
33.56	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.56
33.57	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.57
33.58	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.58
33.59	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.59
33.60	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.60
33.61	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.61
33.62	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.62
33.63	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.63
33.64	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.64
33.65	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.65
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		18,495,556				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: 15-0048	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8-1 Date/Time Prepared: 5/31/2024 2:00 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	50.00	OPERATING ROOM	REID OUTPATIENT SURGERY	26,256,664	33,064,601	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL	5,507,588	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	BENEFITS & HR	28,929,968	0	3.00
4.00	5.02	DATA PROCESSING	INFORMATION SYSTEMS	22,438,447	0	4.00
4.01	5.06	OTHER A&G	A&G	34,536,555	0	4.01
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			117,669,222	33,064,601	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.

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	A	REID O/P SURGER	55.00		0.00	6.00
7.00	B		0.00	REID HOME OFFIC	100.00	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: 15-0048	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8-1 Date/Time Prepared: 5/31/2024 2:00 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:		
1.00	-6,807,937	0	1.00
2.00	5,507,588	9	2.00
3.00	28,929,968	0	3.00
4.00	22,438,447	0	4.00
4.01	34,536,555	0	4.01
5.00	84,604,621		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		6.00
7.00	HOME OFFICE	7.00
8.00		8.00
9.00		9.00
10.00		10.00
100.00		100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 5/31/2024 2:00 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.06	OTHER A&G	26,967	26,967	0	179,000	0	1.00
2.00	17.01	INSERVICE EDUCATION	102,783	102,783	0	179,000	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	7,078,264	7,078,264	0	179,000	0	3.00
4.00	41.00	SUBPROVIDER - IRF	147,192	147,192	0	179,000	0	4.00
5.00	50.00	OPERATING ROOM	5,555,568	5,555,568	0	246,400	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	1,258,275	1,258,275	0	260,300	0	6.00
7.00	60.00	LABORATORY	192,504	192,504	0	260,300	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	20,244	20,244	0	179,000	0	8.00
9.00	91.00	EMERGENCY	2,550,732	2,550,732	0	179,000	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			16,932,529	16,932,529	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.06	OTHER A&G	0	0	0	0	0	1.00
2.00	17.01	INSERVICE EDUCATION	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	0	0	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.06	OTHER A&G	0	0	0	26,967		1.00
2.00	17.01	INSERVICE EDUCATION	0	0	0	102,783		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	7,078,264		3.00
4.00	41.00	SUBPROVIDER - IRF	0	0	0	147,192		4.00
5.00	50.00	OPERATING ROOM	0	0	0	5,555,568		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,258,275		6.00
7.00	60.00	LABORATORY	0	0	0	192,504		7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	20,244		8.00
9.00	91.00	EMERGENCY	0	0	0	2,550,732		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	16,932,529		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/31/2024 2:00 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	NEW CAP BLDG & FIXT - OFFSITE	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	15,394,242	15,394,242				1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE	11,112,825	0	11,112,825			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0			0		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	20,101,826	0	19,365	0	20,121,191	4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	0	0	5.01
5.02	00550	DATA PROCESSING	22,438,447	0	0	0	0	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	243,316	0	0	0	5.03
5.04	00570	ADMITTING	1,782,721	12,672	91,208	0	15,349	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	85,140	0	378,580	0	0	5.05
5.06	00590	OTHER A&G	40,671,254	105,105	33,114	0	620,483	5.06
7.00	00700	OPERATION OF PLANT	0	301,821	75,426	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	0	9.00
10.00	01000	DIETARY	2,660,964	502,212	0	0	232,728	10.00
11.00	01100	CAFETERIA	1,041,363	263,696	0	0	449,405	11.00
13.00	01300	NURSING ADMINISTRATION	383,496	53,622	0	0	76,365	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	49,003,070	270,745	0	0	967,251	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	228,552	0	0	16.00
17.00	01700	SOCIAL SERVICE	4,564,702	34,039	0	0	788,958	17.00
17.01	01701	INSERVICE EDUCATION	1,405,189	285,501	0	0	59,585	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,886,075	0	0	0	359,173	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	737,489	0	0	0	25,548	22.00
23.00	02300	PARAMED ED PRGM	158,750	29,101	129,744	0	38,157	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,182,727	3,612,033	0	0	5,505,325	30.00
31.00	03100	INTENSIVE CARE UNIT	7,152,727	673,420	0	0	910,353	31.00
41.00	04100	SUBPROVIDER - IRF	2,136,908	490,912	0	0	372,760	41.00
43.00	04300	NURSERY	591,726	73,535	0	0	91,339	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,863,626	1,252,431	633,758	0	411,779	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	887,545	228,094	0	0	125,613	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,028,467	1,918,390	77,459	0	1,795,262	54.00
59.00	05900	CARDIAC CATHETERIZATION	6,549,234	372,449	0	0	423,838	59.00
60.00	06000	LABORATORY	14,213,777	798,026	0	0	1,078,743	60.00
65.00	06500	RESPIRATORY THERAPY	2,756,592	45,174	0	0	378,830	65.00
66.00	06600	PHYSICAL THERAPY	11,932,787	221,730	2,048,592	0	1,830,032	66.00
69.00	06900	ELECTROCARDIOLOGY	2,839,629	214,188	0	0	316,904	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	656,808	0	188,419	0	102,940	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,179,455	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	810,149	40,868	0	0	19,017	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	627,871	224,501	0	0	109,851	76.97
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						
91.00	09100	EMERGENCY	11,679,244	849,235	0	0	1,794,544	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	FAMILY PRACTICE	2,463,578	0	41,005	0	413,495	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	353,373	48,658	139,039	0	63,755	96.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	3,408,390	12,206	0	0	396,753	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	352,742,166	13,177,680	4,084,261	0	19,774,135	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,993,112	0	5,236,845	0	0	192.00
194.00	07950	RENTAL SPACE	5,969,123	0	945,482	0	0	194.00
194.01	07951	FOUNDATION	392,011	5,650	0	0	53,526	194.01
194.02	07952	RETAIL SERVICES	213,903	64,182	0	0	35,650	194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	15,104	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	1,245,603	0	0	0	0	194.05
194.06	07956	VACANT SPACE	203,391	1,940,634	831,133	0	0	194.06

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/31/2024 2:00 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	NEW CAP BLDG & FIXT - OFFSITE	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	1.01	2.00	4.00	
194.07	07957	HOME OFFICE	0	0	0	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08
194.09	07959	REID HEALTH PAVILION - RES	1,496,366	206,096	0	0	257,880	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	367,255,675	15,394,242	11,112,825	0	20,121,191	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/31/2024 2:00 pm

		Cost Center Description	NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	0					5.01
5.02	00550	DATA PROCESSING	0	22,438,447				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	28,260	271,576			5.03
5.04	00570	ADMITTING	0	226,080	183	2,128,213		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	463,720	5.05
5.06	00590	OTHER A&G	0	4,069,443	2,438	0	0	5.06
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	28,260	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	84,780	0	0	0	9.00
10.00	01000	DIETARY	0	664,110	4,030	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	141,300	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	904,320	35,008	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	409,770	784	0	0	17.00
17.01	01701	INSERVICE EDUCATION	0	579,330	332	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	508,680	63	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	197,820	50	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,723,861	43,468	150,367	32,791	30.00
31.00	03100	INTENSIVE CARE UNIT	0	310,860	12,153	16,887	3,683	31.00
41.00	04100	SUBPROVIDER - IRF	0	240,210	2,157	8,158	1,779	41.00
43.00	04300	NURSERY	0	0	2,279	2,372	517	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,953,171	39,259	357,402	77,941	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	268,470	4,062	12,998	2,835	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,119,501	35,592	364,671	79,133	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	324,990	22,230	224,966	49,060	59.00
60.00	06000	LABORATORY	0	1,158,660	5,899	213,089	46,470	60.00
65.00	06500	RESPIRATORY THERAPY	0	169,560	12,488	45,900	10,010	65.00
66.00	06600	PHYSICAL THERAPY	0	2,190,151	2,744	52,949	11,547	66.00
69.00	06900	ELECTROCARDIOLOGY	0	565,200	1,532	60,569	13,209	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	254,340	1,068	11,776	2,568	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	76,923	16,775	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	296,748	64,714	73.00
74.00	07400	RENAL DIALYSIS	0	56,520	314	2,080	454	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	84,780	453	4,077	889	76.97
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						
91.00	09100	EMERGENCY	0	1,271,700	24,834	200,359	43,693	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	FAMILY PRACTICE	0	211,950	3,309	15,129	3,299	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	197,820	4,770	896	195	96.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	367,380	8,163	9,897	2,158	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	22,311,277	269,662	2,128,213	463,720	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	RENTAL SPACE	0	0	170	0	0	194.00
194.01	07951	FOUNDATION	0	70,650	276	0	0	194.01
194.02	07952	RETAIL SERVICES	0	42,390	171	0	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	0	0	764	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
194.07	07957	HOME OFFICE	0	0	0	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08
194.09	07959	REID HEALTH PAVILION - RES	0	14,130	533	0	0	194.09
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/31/2024 2:00 pm

	Cost Center Description	NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	
		5.01	5.02	5.03	5.04	5.05	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	22,438,447	271,576	2,128,213	463,720	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/31/2024 2:00 pm

		Cost Center Description	Subtotal	OTHER A&G	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5A.05	5.06	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G	45,501,837	45,501,837				5.06
7.00	00700	OPERATION OF PLANT	377,247	53,350	430,597			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	28,260	3,996	0	32,256		8.00
9.00	00900	HOUSEKEEPING	84,780	11,989	0	0	96,769	9.00
10.00	01000	DIETARY	4,064,044	574,729	11,503	0	2,747	10.00
11.00	01100	CAFETERIA	1,754,464	248,113	6,040	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	654,783	92,598	1,228	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	51,180,394	7,237,885	6,056	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	228,552	32,321	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	5,798,253	819,977	275	0	481	17.00
17.01	01701	INSERVICE EDUCATION	2,329,937	329,495	5,857	0	421	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	2,245,248	317,518	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	1,271,780	179,853	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	553,622	78,292	1,764	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	46,250,572	6,540,663	83,428	12,673	48,385	30.00
31.00	03100	INTENSIVE CARE UNIT	9,080,083	1,284,087	15,425	2,350	5,280	31.00
41.00	04100	SUBPROVIDER - IRF	3,252,884	460,016	11,244	1,045	0	41.00
43.00	04300	NURSERY	761,768	107,728	1,684	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	32,589,367	4,608,723	25,522	2,589	15,253	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,529,617	216,315	5,225	1,533	1,571	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,418,475	3,877,466	33,850	3,294	2,707	54.00
59.00	05900	CARDIAC CATHETERIZATION	7,966,767	1,126,644	2,886	1,556	1,036	59.00
60.00	06000	LABORATORY	17,514,664	2,476,889	12,687	20	2,025	60.00
65.00	06500	RESPIRATORY THERAPY	3,418,554	483,445	750	0	334	65.00
66.00	06600	PHYSICAL THERAPY	18,290,532	2,586,610	30,294	287	789	66.00
69.00	06900	ELECTROCARDIOLOGY	4,011,231	567,260	350	0	902	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,217,919	172,236	3,393	131	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,273,153	3,856,915	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	361,462	51,117	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	929,402	131,434	936	0	762	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,052,422	148,831	2,301	0	267	76.97
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						
91.00	09100	EMERGENCY	15,863,609	2,243,400	19,452	4,597	5,661	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
93.00	04040	FAMILY PRACTICE	3,151,765	445,716	0	1,015	1,343	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	808,506	114,337	2,357	0	67	96.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	4,204,947	594,655	0	0	3,556	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	343,020,900	42,074,603	284,507	31,090	93,587	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	10,229,957	1,446,700	67,960	1,063	535	192.00
194.00	07950	RENTAL SPACE	6,914,775	977,874	14,400	0	0	194.00
194.01	07951	FOUNDATION	522,113	73,836	129	0	0	194.01
194.02	07952	RETAIL SERVICES	356,296	50,387	430	0	67	194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	15,104	2,136	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	1,246,367	176,259	0	0	0	194.05
194.06	07956	VACANT SPACE	2,975,158	420,741	58,450	0	0	194.06
194.07	07957	HOME OFFICE	0	0	0	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08
194.09	07959	REID HEALTH PAVILION - RES	1,975,005	279,301	4,721	103	2,580	194.09
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/31/2024 2:00 pm

	Cost Center Description	Subtotal	OTHER A&G	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5A.05	5.06	7.00	8.00	9.00	
202.00	TOTAL (sum lines 118 through 201)	367,255,675	45,501,837	430,597	32,256	96,769	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/31/2024 2:00 pm

		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
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	4,653,023					10.00
11.00	01100	CAFETERIA	0	2,008,617				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,703	750,312			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0		14.00
15.00	01500	PHARMACY	0	103,467	0	0	58,527,802	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	77,662	0	0	0	17.00
17.01	01701	INSERVICE EDUCATION	0	4,608	0	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	30,533	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	4,415	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	4,045	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,726,407	558,245	348,844	0	8,483	30.00
31.00	03100	INTENSIVE CARE UNIT	477,471	84,911	53,060	0	646	31.00
41.00	04100	SUBPROVIDER - IRF	449,145	38,755	24,218	0	22	41.00
43.00	04300	NURSERY	0	7,322	4,576	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	50,001	31,245	0	188,356	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	10,979	6,861	0	2,800	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	188,982	118,094	0	1,208,430	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	43,927	27,450	0	4,999	59.00
60.00	06000	LABORATORY	0	154,329	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	39,343	24,585	0	220	65.00
66.00	06600	PHYSICAL THERAPY	0	205,590	0	0	12	66.00
69.00	06900	ELECTROCARDIOLOGY	0	35,273	0	0	331,347	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	14,798	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	56,397,443	73.00
74.00	07400	RENAL DIALYSIS	0	1,588	992	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	15,582	9,737	0	7	76.97
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						
91.00	09100	EMERGENCY	0	161,066	100,650	0	165,362	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	FAMILY PRACTICE	0	62,876	0	0	17,255	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	12,894	0	0	3,902	96.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	44,835	0	0	167,939	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,653,023	1,957,729	750,312	0	58,497,223	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	RENTAL SPACE	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	6,513	0	0	0	194.01
194.02	07952	RETAIL SERVICES	0	6,171	0	0	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	0	0	0	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
194.07	07957	HOME OFFICE	0	0	0	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08
194.09	07959	REID HEALTH PAVILION - RES	0	38,204	0	0	30,579	194.09
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/31/2024 2:00 pm

	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	4,653,023	2,008,617	750,312	0	58,527,802	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/31/2024 2:00 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INSERVICE EDUCATION	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	
			16.00	17.00	17.01	21.00	22.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	260,873					16.00
17.00	01700	SOCIAL SERVICE	0	6,696,648				17.00
17.01	01701	INSERVICE EDUCATION	0	0	2,670,318			17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	2,593,299		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0		1,456,048	22.00
23.00	02300	PARAMED ED PRGM	0	0	5,527			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,412	4,421,591	796,214	2,159,338	1,212,392	30.00
31.00	03100	INTENSIVE CARE UNIT	2,068	538,524	118,286	134,678	75,617	31.00
41.00	04100	SUBPROVIDER - IRF	999	0	53,414	0	0	41.00
43.00	04300	NURSERY	290	0	10,126	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	43,763	0	204,500	86,792	48,731	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,592	168,871	15,209	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	44,927	0	274,657	11,971	6,722	54.00
59.00	05900	CARDIAC CATHETERIZATION	27,547	0	60,031	0	0	59.00
60.00	06000	LABORATORY	26,093	0	215,756	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	5,620	0	55,512	0	0	65.00
66.00	06600	PHYSICAL THERAPY	6,484	0	296,926	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	7,417	0	48,694	100,260	56,293	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,442	0	20,172	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,419	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	36,337	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	255	0	2,219	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	499	0	21,382	0	0	76.97
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						
91.00	09100	EMERGENCY	24,534	1,567,662	247,425	100,260	56,293	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	FAMILY PRACTICE	1,853	0	85,971	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	110	0	17,590	0	0	96.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,212	0	47,363			116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	260,873	6,696,648	2,596,974	2,593,299	1,456,048	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	RENTAL SPACE	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	8,916	0	0	194.01
194.02	07952	RETAIL SERVICES	0	0	8,674	0	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	0	0	0	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
194.07	07957	HOME OFFICE	0	0	0	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/31/2024 2:00 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INSERVICE EDUCATION	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	
			16.00	17.00	17.01	21.00	22.00	
194.09	07959	REID HEALTH PAVILION - RES	0	0	55,754	0	0	194.09
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)	260,873	6,696,648	2,670,318	2,593,299	1,456,048	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/31/2024 2:00 pm

		Cost Center Description	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
17.01	01701	INSERVICE EDUCATION						17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV						22.00
23.00	02300	PARAMED ED PRGM	643,250					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	66,185,647	-3,371,730	62,813,917		30.00
31.00	03100	INTENSIVE CARE UNIT	0	11,872,486	-210,295	11,662,191		31.00
41.00	04100	SUBPROVIDER - IRF	0	4,291,742	0	4,291,742		41.00
43.00	04300	NURSERY	0	893,494	0	893,494		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	37,894,842	-135,523	37,759,319		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,960,573	0	1,960,573		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	643,250	33,832,825	-18,693	33,814,132		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	9,262,843	0	9,262,843		59.00
60.00	06000	LABORATORY	0	20,402,463	0	20,402,463		60.00
65.00	06500	RESPIRATORY THERAPY	0	4,028,363	0	4,028,363		65.00
66.00	06600	PHYSICAL THERAPY	0	21,417,524	0	21,417,524		66.00
69.00	06900	ELECTROCARDIOLOGY	0	5,159,027	-156,553	5,002,474		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,430,091	0	1,430,091		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	31,139,487	0	31,139,487		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	56,846,359	0	56,846,359		73.00
74.00	07400	RENAL DIALYSIS	0	1,067,588	0	1,067,588		74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	1,251,028	0	1,251,028		76.97
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						
91.00	09100	EMERGENCY	0	20,559,971	-156,553	20,403,418		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
93.00	04040	FAMILY PRACTICE	0	3,767,794	0	3,767,794		93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	959,763	0	959,763		96.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	5,064,507	0	5,064,507		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	643,250	339,288,417	-4,049,347	335,239,070		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	11,746,215	0	11,746,215		192.00
194.00	07950	RENTAL SPACE	0	7,907,049	0	7,907,049		194.00
194.01	07951	FOUNDATION	0	611,507	0	611,507		194.01
194.02	07952	RETAIL SERVICES	0	422,025	0	422,025		194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	0		194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	17,240	0	17,240		194.04
194.05	07955	CONNERSVILLE LOCATION	0	1,422,626	0	1,422,626		194.05
194.06	07956	VACANT SPACE	0	3,454,349	0	3,454,349		194.06
194.07	07957	HOME OFFICE	0	0	0	0		194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0		194.08

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/31/2024 2:00 pm

		Cost Center Description	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.00	24.00	25.00	26.00		
194.09	07959	REID HEALTH PAVILION - RES	0	2,386,247	0	2,386,247		194.09
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	643,250	367,255,675	-4,049,347	363,206,328		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/31/2024 2:00 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	NEW CAP BLDG & FIXT - OFFSITE	MVBLE EQUIP	Subtotal	
			0	1.00	1.01	2.00	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	19,365	0	19,365	4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	0	0	5.01
5.02	00550	DATA PROCESSING	0	0	0	0	0	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	243,316	0	0	243,316	5.03
5.04	00570	ADMITTING	0	12,672	91,208	0	103,880	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	378,580	0	378,580	5.05
5.06	00590	OTHER A&G	0	105,105	33,114	0	138,219	5.06
7.00	00700	OPERATION OF PLANT	0	301,821	75,426	0	377,247	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	0	9.00
10.00	01000	DIETARY	0	502,212	0	0	502,212	10.00
11.00	01100	CAFETERIA	0	263,696	0	0	263,696	11.00
13.00	01300	NURSING ADMINISTRATION	0	53,622	0	0	53,622	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	270,745	0	0	270,745	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	228,552	0	228,552	16.00
17.00	01700	SOCIAL SERVICE	0	34,039	0	0	34,039	17.00
17.01	01701	INSERVICE EDUCATION	0	285,501	0	0	285,501	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	29,101	129,744	0	158,845	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	3,612,033	0	0	3,612,033	30.00
31.00	03100	INTENSIVE CARE UNIT	0	673,420	0	0	673,420	31.00
41.00	04100	SUBPROVIDER - IRF	0	490,912	0	0	490,912	41.00
43.00	04300	NURSERY	0	73,535	0	0	73,535	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,252,431	633,758	0	1,886,189	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	228,094	0	0	228,094	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,918,390	77,459	0	1,995,849	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	372,449	0	0	372,449	59.00
60.00	06000	LABORATORY	0	798,026	0	0	798,026	60.00
65.00	06500	RESPIRATORY THERAPY	0	45,174	0	0	45,174	65.00
66.00	06600	PHYSICAL THERAPY	0	221,730	2,048,592	0	2,270,322	66.00
69.00	06900	ELECTROCARDIOLOGY	0	214,188	0	0	214,188	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	188,419	0	188,419	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	40,868	0	0	40,868	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	224,501	0	0	224,501	76.97
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						
91.00	09100	EMERGENCY	0	849,235	0	0	849,235	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.00	04040	FAMILY PRACTICE	0	0	41,005	0	41,005	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	48,658	139,039	0	187,697	96.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	12,206	0	0	12,206	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	13,177,680	4,084,261	0	17,261,941	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	5,236,845	0	5,236,845	192.00
194.00	07950	RENTAL SPACE	0	0	945,482	0	945,482	194.00
194.01	07951	FOUNDATION	0	5,650	0	0	5,650	194.01
194.02	07952	RETAIL SERVICES	0	64,182	0	0	64,182	194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	15,104	0	15,104	194.04
194.05	07955	CONNERSVILLE LOCATION	0	0	0	0	0	194.05
194.06	07956	VACANT SPACE	0	1,940,634	831,133	0	2,771,767	194.06
194.07	07957	HOME OFFICE	0	0	0	0	0	194.07

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/31/2024 2:00 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	NEW CAP BLDG & FIXT - OFFSITE	MVBLE EQUIP	Subtotal	
			0	1.00	1.01	2.00	2A	
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08
194.09	07959	REID HEALTH PAVILION - RES	0	206,096	0	0	206,096	194.09
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	15,394,242	11,112,825	0	26,507,067	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/31/2024 2:00 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	
			4.00	5.01	5.02	5.03	5.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	19,365					4.00
5.01	00540	NONPATIENT TELEPHONES	0	0				5.01
5.02	00550	DATA PROCESSING	0	0	0			5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	0	0	243,316		5.03
5.04	00570	ADMITTING	15	0	0	164	104,059	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.05
5.06	00590	OTHER A&G	598	0	0	2,184	0	5.06
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	0	9.00
10.00	01000	DIETARY	224	0	0	3,611	0	10.00
11.00	01100	CAFETERIA	433	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	74	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	933	0	0	31,365	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	761	0	0	703	0	17.00
17.01	01701	INSERVICE EDUCATION	57	0	0	298	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	346	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	25	0	0	57	0	22.00
23.00	02300	PARAMED ED PRGM	37	0	0	45	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,272	0	0	38,946	7,365	30.00
31.00	03100	INTENSIVE CARE UNIT	878	0	0	10,888	827	31.00
41.00	04100	SUBPROVIDER - IRF	359	0	0	1,932	400	41.00
43.00	04300	NURSERY	88	0	0	2,042	116	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	397	0	0	35,174	17,505	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	121	0	0	3,639	637	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,731	0	0	31,888	17,679	54.00
59.00	05900	CARDIAC CATHETERIZATION	409	0	0	19,917	11,019	59.00
60.00	06000	LABORATORY	1,040	0	0	5,285	10,437	60.00
65.00	06500	RESPIRATORY THERAPY	365	0	0	11,188	2,248	65.00
66.00	06600	PHYSICAL THERAPY	1,765	0	0	2,459	2,593	66.00
69.00	06900	ELECTROCARDIOLOGY	306	0	0	1,372	2,967	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	99	0	0	957	577	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,768	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	14,535	73.00
74.00	07400	RENAL DIALYSIS	18	0	0	281	102	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	106	0	0	406	200	76.97
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						
91.00	09100	EMERGENCY	1,730	0	0	22,250	9,814	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	FAMILY PRACTICE	399	0	0	2,964	741	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	61	0	0	4,274	44	96.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	383	0	0	7,313	485	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,030	0	0	241,602	104,059	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	RENTAL SPACE	0	0	0	152	0	194.00
194.01	07951	FOUNDATION	52	0	0	247	0	194.01
194.02	07952	RETAIL SERVICES	34	0	0	153	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	0	0	0	684	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
194.07	07957	HOME OFFICE	0	0	0	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08
194.09	07959	REID HEALTH PAVILION - RES	249	0	0	478	0	194.09
200.00		Cross Foot Adjustments						200.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/31/2024 2:00 pm

	Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	
		4.00	5.01	5.02	5.03	5.04	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	19,365	0	0	243,316	104,059	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/31/2024 2:00 pm

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE	OTHER A&G	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.05	5.06	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	378,580					5.05
5.06	00590	OTHER A&G	0	141,001				5.06
7.00	00700	OPERATION OF PLANT	0	165	377,412			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	12	0	12		8.00
9.00	00900	HOUSEKEEPING	0	37	0	0	37	9.00
10.00	01000	DIETARY	0	1,780	10,082	0	1	10.00
11.00	01100	CAFETERIA	0	768	5,294	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	287	1,077	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	22,492	5,308	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	100	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	2,540	241	0	0	17.00
17.01	01701	INSERVICE EDUCATION	0	1,021	5,133	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	983	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	557	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	242	1,546	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,742	20,258	73,125	5	20	30.00
31.00	03100	INTENSIVE CARE UNIT	3,003	3,977	13,520	1	2	31.00
41.00	04100	SUBPROVIDER - IRF	1,451	1,425	9,856	0	0	41.00
43.00	04300	NURSERY	422	334	1,476	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	63,561	14,274	22,370	1	6	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,312	670	4,579	1	1	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	64,948	12,009	29,669	1	1	54.00
59.00	05900	CARDIAC CATHETERIZATION	40,008	3,489	2,529	1	0	59.00
60.00	06000	LABORATORY	37,896	7,671	11,120	0	1	60.00
65.00	06500	RESPIRATORY THERAPY	8,163	1,497	657	0	0	65.00
66.00	06600	PHYSICAL THERAPY	9,417	8,011	26,552	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	10,772	1,757	307	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,094	533	2,974	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,680	11,946	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	52,774	158	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	370	407	820	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	725	461	2,016	0	0	76.97
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						
91.00	09100	EMERGENCY	35,632	6,948	17,049	2	2	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	FAMILY PRACTICE	2,691	1,380	0	0	1	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	159	354	2,066	0	0	96.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,760	1,842	0	0	1	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	378,580	130,385	249,366	12	36	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,481	59,566	0	0	192.00
194.00	07950	RENTAL SPACE	0	3,029	12,621	0	0	194.00
194.01	07951	FOUNDATION	0	229	113	0	0	194.01
194.02	07952	RETAIL SERVICES	0	156	377	0	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	7	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	0	546	0	0	0	194.05
194.06	07956	VACANT SPACE	0	1,303	51,231	0	0	194.06
194.07	07957	HOME OFFICE	0	0	0	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08
194.09	07959	REID HEALTH PAVILION - RES	0	865	4,138	0	1	194.09
200.00		Cross Foot Adjustments						200.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/31/2024 2:00 pm

	Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE	OTHER A&G	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.05	5.06	7.00	8.00	9.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	378,580	141,001	377,412	12	37	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/31/2024 2:00 pm

		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
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	517,910					10.00
11.00	01100	CAFETERIA	0	270,191				11.00
13.00	01300	NURSING ADMINISTRATION	0	229	55,289			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0		14.00
15.00	01500	PHARMACY	0	13,918	0	0	344,761	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	10,447	0	0	0	17.00
17.01	01701	INSERVICE EDUCATION	0	620	0	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	4,107	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	594	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	544	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	414,772	75,092	25,705	0	50	30.00
31.00	03100	INTENSIVE CARE UNIT	53,145	11,422	3,910	0	4	31.00
41.00	04100	SUBPROVIDER - IRF	49,993	5,213	1,785	0	0	41.00
43.00	04300	NURSERY	0	985	337	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	6,726	2,302	0	1,110	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,477	506	0	16	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	25,421	8,702	0	7,119	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	5,909	2,023	0	29	59.00
60.00	06000	LABORATORY	0	20,760	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,292	1,812	0	1	65.00
66.00	06600	PHYSICAL THERAPY	0	27,655	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	4,745	0	0	1,952	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,991	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	332,212	73.00
74.00	07400	RENAL DIALYSIS	0	214	73	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	2,096	717	0	0	76.97
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						
91.00	09100	EMERGENCY	0	21,666	7,417	0	974	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	FAMILY PRACTICE	0	8,458	0	0	102	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	1,734	0	0	23	96.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	6,031	0	0	989	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	517,910	263,346	55,289	0	344,581	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	RENTAL SPACE	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	876	0	0	0	194.01
194.02	07952	RETAIL SERVICES	0	830	0	0	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	0	0	0	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
194.07	07957	HOME OFFICE	0	0	0	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08
194.09	07959	REID HEALTH PAVILION - RES	0	5,139	0	0	180	194.09
200.00		Cross Foot Adjustments						200.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/31/2024 2:00 pm

	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	517,910	270,191	55,289	0	344,761	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/31/2024 2:00 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INSERVICE EDUCATION	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	
			16.00	17.00	17.01	21.00	22.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	228,652					16.00
17.00	01700	SOCIAL SERVICE	0	48,731				17.00
17.01	01701	INSERVICE EDUCATION	0	0	292,630			17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	5,436		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0		1,233	22.00
23.00	02300	PARAMED ED PRGM	0	0	606			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,133	32,175	87,253			30.00
31.00	03100	INTENSIVE CARE UNIT	1,812	3,919	12,963			31.00
41.00	04100	SUBPROVIDER - IRF	875	0	5,853			41.00
43.00	04300	NURSERY	255	0	1,110			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	38,345	0	22,410			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,395	1,229	1,667			52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	39,444	0	30,099			54.00
59.00	05900	CARDIAC CATHETERIZATION	24,136	0	6,579			59.00
60.00	06000	LABORATORY	22,862	0	23,644			60.00
65.00	06500	RESPIRATORY THERAPY	4,925	0	6,083			65.00
66.00	06600	PHYSICAL THERAPY	5,681	0	32,539			66.00
69.00	06900	ELECTROCARDIOLOGY	6,498	0	5,336			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,263	0	2,211			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,253	0	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,838	0	0			73.00
74.00	07400	RENAL DIALYSIS	223	0	243			74.00
76.00	03950	ANCILLARY - OTHER	0	0	0			76.00
76.97	07697	CARDIAC REHABILITATION	437	0	2,343			76.97
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						
91.00	09100	EMERGENCY	21,496	11,408	27,114			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	FAMILY PRACTICE	1,623	0	9,421			93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	96	0	1,928			96.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,062	0	5,190			116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	228,652	48,731	284,592	0	0	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	RENTAL SPACE	0	0	0			194.00
194.01	07951	FOUNDATION	0	0	977			194.01
194.02	07952	RETAIL SERVICES	0	0	951			194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0			194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	0			194.04
194.05	07955	CONNERSVILLE LOCATION	0	0	0			194.05
194.06	07956	VACANT SPACE	0	0	0			194.06
194.07	07957	HOME OFFICE	0	0	0			194.07
194.08	07958	CAMBRIDGE RHC	0	0	0			194.08

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/31/2024 2:00 pm

						INTERNS & RESIDENTS		
		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INSERVICE EDUCATION	SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	
			16.00	17.00	17.01	21.00	22.00	
194.09	07959	REID HEALTH PAVILION - RES	0	0	6,110			194.09
200.00		Cross Foot Adjustments				5,436	1,233	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	228,652	48,731	292,630	5,436	1,233	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/31/2024 2:00 pm

		Cost Center Description	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
17.01	01701	INSERVICE EDUCATION						17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV						22.00
23.00	02300	PARAMED ED PRGM	161,865					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		4,434,946	0	4,434,946		30.00
31.00	03100	INTENSIVE CARE UNIT		793,691	0	793,691		31.00
41.00	04100	SUBPROVIDER - IRF		570,054	0	570,054		41.00
43.00	04300	NURSERY		80,700	0	80,700		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		2,110,370	0	2,110,370		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		246,344	0	246,344		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		2,264,560	0	2,264,560		54.00
59.00	05900	CARDIAC CATHETERIZATION		488,497	0	488,497		59.00
60.00	06000	LABORATORY		938,742	0	938,742		60.00
65.00	06500	RESPIRATORY THERAPY		87,405	0	87,405		65.00
66.00	06600	PHYSICAL THERAPY		2,386,994	0	2,386,994		66.00
69.00	06900	ELECTROCARDIOLOGY		250,200	0	250,200		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		201,118	0	201,118		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		37,647	0	37,647		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		431,517	0	431,517		73.00
74.00	07400	RENAL DIALYSIS		43,619	0	43,619		74.00
76.00	03950	ANCILLARY - OTHER		0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION		234,008	0	234,008		76.97
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						
91.00	09100	EMERGENCY		1,032,737	0	1,032,737		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
93.00	04040	FAMILY PRACTICE		68,785	0	68,785		93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED		198,436	0	198,436		96.00
102.00	10200	OPIOID TREATMENT PROGRAM		0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE		37,262	0	37,262		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	16,937,632	0	16,937,632		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		5,300,892	0	5,300,892		192.00
194.00	07950	RENTAL SPACE		961,284	0	961,284		194.00
194.01	07951	FOUNDATION		8,144	0	8,144		194.01
194.02	07952	RETAIL SERVICES		66,683	0	66,683		194.02
194.03	07953	REID CONTRACTED SERVICES		0	0	0		194.03
194.04	07954	REID PHYSICIAN ASSOC.		15,111	0	15,111		194.04
194.05	07955	CONNERSVILLE LOCATION		1,230	0	1,230		194.05
194.06	07956	VACANT SPACE		2,824,301	0	2,824,301		194.06
194.07	07957	HOME OFFICE		0	0	0		194.07
194.08	07958	CAMBRIDGE RHC		0	0	0		194.08

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/31/2024 2:00 pm

		Cost Center Description	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.00	24.00	25.00	26.00		
194.09	07959	REID HEALTH PAVILION - RES		223,256	0	223,256		194.09
200.00		Cross Foot Adjustments	161,865	168,534	0	168,534		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	161,865	26,507,067	0	26,507,067		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 2:00 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	NEW CAP BLDG & FIXT - OFFSITE (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (PHONES)	
			1.00	1.01	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	561,254					1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE	0	229,548				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			0			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	400	0	101,046,672		4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	0	0	5.01
5.02	00550	DATA PROCESSING	0	0	0	0	0	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	8,871	0	0	0	0	5.03
5.04	00570	ADMITTING	462	1,884	0	77,081	0	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	7,820	0	0	0	5.05
5.06	00590	OTHER A&G	3,832	684	0	3,116,000	0	5.06
7.00	00700	OPERATION OF PLANT	11,004	1,558	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	0	9.00
10.00	01000	DIETARY	18,310	0	0	1,168,735	0	10.00
11.00	01100	CAFETERIA	9,614	0	0	2,256,865	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,955	0	0	383,496	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	9,871	0	0	4,857,435	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,721	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,241	0	0	3,962,065	0	17.00
17.01	01701	INSERVICE EDUCATION	10,409	0	0	299,230	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	1,803,728	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	128,298	0	22.00
23.00	02300	PARAMED ED PRGM	1,061	2,680	0	191,622	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	131,690	0	0	27,647,315	0	30.00
31.00	03100	INTENSIVE CARE UNIT	24,552	0	0	4,571,700	0	31.00
41.00	04100	SUBPROVIDER - IRF	17,898	0	0	1,871,963	0	41.00
43.00	04300	NURSERY	2,681	0	0	458,695	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,662	13,091	0	2,067,913	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,316	0	0	630,813	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	69,942	1,600	0	9,015,620	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	13,579	0	0	2,128,470	0	59.00
60.00	06000	LABORATORY	29,095	0	0	5,417,333	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,647	0	0	1,902,445	0	65.00
66.00	06600	PHYSICAL THERAPY	8,084	42,316	0	9,190,229	0	66.00
69.00	06900	ELECTROCARDIOLOGY	7,809	0	0	1,591,460	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,892	0	516,954	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,490	0	0	95,503	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	8,185	0	0	551,658	0	76.97
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						
91.00	09100	EMERGENCY	30,962	0	0	9,012,012	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	FAMILY PRACTICE	0	847	0	2,076,529	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,774	2,872	0	320,171	0	96.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	445	0	0	1,992,452	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	480,441	84,365	0	99,303,790	0	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	108,173	0	0	0	192.00
194.00	07950	RENTAL SPACE	0	19,530	0	0	0	194.00
194.01	07951	FOUNDATION	206	0	0	268,804	0	194.01
194.02	07952	RETAIL SERVICES	2,340	0	0	179,031	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	312	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	0	0	0	0	0	194.05
194.06	07956	VACANT SPACE	70,753	17,168	0	0	0	194.06

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 2:00 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	NEW CAP BLDG & FIXT - OFFSITE (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (PHONES)	
			1.00	1.01	2.00	4.00	5.01	
194.07	07957	HOME OFFICE	0	0	0	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08
194.09	07959	REID HEALTH PAVILION - RES	7,514	0	0	1,295,047	0	194.09
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)	15,394,242	11,112,825	0	20,121,191	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.428298	48.411770	0.000000	0.199128	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				19,365	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000192	0.000000	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: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 2:00 pm

		Cost Center Description	DATA PROCESSING (TERMINALS)	PURCHASING RECEIVING AND STORES (SUPPLY EXPENSE)	ADMITTING (TOTAL REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (TOTAL REVENUE)	Reconciliation	
			5.02	5.03	5.04	5.05	5A.06	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	1,588					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	2	8,639,971				5.03
5.04	00570	ADMITTING	16	5,809	1,240,611,068			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	1,240,611,068		5.05
5.06	00590	OTHER A&G	288	77,557	0	0	-45,501,837	5.06
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	6	0	0	0	0	9.00
10.00	01000	DIETARY	47	128,221	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	10	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	64	1,113,740	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	29	24,954	0	0	0	17.00
17.01	01701	INSERVICE EDUCATION	41	10,571	0	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	36	2,015	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	14	1,596	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	122	1,383,027	87,677,508	87,677,508	0	30.00
31.00	03100	INTENSIVE CARE UNIT	22	386,627	9,846,705	9,846,705	0	31.00
41.00	04100	SUBPROVIDER - IRF	17	68,609	4,756,800	4,756,800	0	41.00
43.00	04300	NURSERY	0	72,515	1,383,248	1,383,248	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	209	1,248,984	208,397,587	208,397,587	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	19	129,220	7,579,241	7,579,241	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	150	1,132,322	212,306,018	212,306,018	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	23	707,212	131,175,384	131,175,384	0	59.00
60.00	06000	LABORATORY	82	187,664	124,250,263	124,250,263	0	60.00
65.00	06500	RESPIRATORY THERAPY	12	397,286	26,763,730	26,763,730	0	65.00
66.00	06600	PHYSICAL THERAPY	155	87,310	30,873,908	30,873,908	0	66.00
69.00	06900	ELECTROCARDIOLOGY	40	48,727	35,317,387	35,317,387	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	18	33,969	6,866,598	6,866,598	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	44,853,298	44,853,298	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	173,030,975	173,030,975	0	73.00
74.00	07400	RENAL DIALYSIS	4	9,978	1,212,998	1,212,998	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	6	14,424	2,377,007	2,377,007	0	76.97
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						
91.00	09100	EMERGENCY	90	790,059	116,827,391	116,827,391	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	FAMILY PRACTICE	15	105,261	8,821,675	8,821,675	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	14	151,756	522,352	522,352	0	96.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	26	259,680	5,770,995	5,770,995	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,579	8,579,093	1,240,611,068	1,240,611,068	-45,501,837	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	RENTAL SPACE	0	5,415	0	0	0	194.00
194.01	07951	FOUNDATION	5	8,769	0	0	0	194.01
194.02	07952	RETAIL SERVICES	3	5,432	0	0	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	0	24,294	0	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
194.07	07957	HOME OFFICE	0	0	0	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 Date/Time Prepared: 5/31/2024 2:00 pm

		Cost Center Description	DATA PROCESSING (TERMINALS)	PURCHASING RECEIVING AND STORES (SUPPLY EXPENSE)	ADMITTING (TOTAL REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (TOTAL REVENUE)	Reconciliation	
			5.02	5.03	5.04	5.05	5A.06	
194.09	07959	REID HEALTH PAVILION - RES	1	16,968	0	0	0	194.09
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)	22,438,447	271,576	2,128,213	463,720		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14,130.004408	0.031433	0.001715	0.000374		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	243,316	104,059	378,580		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.028162	0.000084	0.000305		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: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 2:00 pm

		Cost Center Description	OTHER A&G (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			5.06	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G	321,753,838					5.06
7.00	00700	OPERATION OF PLANT	377,247	685,390				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	28,260	0	2,204,591			8.00
9.00	00900	HOUSEKEEPING	84,780	0	0	14,478		9.00
10.00	01000	DIETARY	4,064,044	18,310	0	411	41,066	10.00
11.00	01100	CAFETERIA	1,754,464	9,614	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	654,783	1,955	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	51,180,394	9,640	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	228,552	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	5,798,253	438	0	72	0	17.00
17.01	01701	INSERVICE EDUCATION	2,329,937	9,322	0	63	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	2,245,248	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	1,271,780	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	553,622	2,807	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	46,250,572	132,796	866,179	7,239	32,888	30.00
31.00	03100	INTENSIVE CARE UNIT	9,080,083	24,552	160,625	790	4,214	31.00
41.00	04100	SUBPROVIDER - IRF	3,252,884	17,898	71,414	0	3,964	41.00
43.00	04300	NURSERY	761,768	2,681	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	32,589,367	40,624	176,964	2,282	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,529,617	8,316	104,779	235	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,418,475	53,880	225,143	405	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	7,966,767	4,593	106,323	155	0	59.00
60.00	06000	LABORATORY	17,514,664	20,194	1,351	303	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,418,554	1,194	0	50	0	65.00
66.00	06600	PHYSICAL THERAPY	18,290,532	48,220	19,622	118	0	66.00
69.00	06900	ELECTROCARDIOLOGY	4,011,231	557	0	135	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,217,919	5,400	8,937	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,273,153	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	361,462	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	929,402	1,490	0	114	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,052,422	3,662	0	40	0	76.97
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						
91.00	09100	EMERGENCY	15,863,609	30,962	314,178	847	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	FAMILY PRACTICE	3,151,765	0	69,361	201	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	808,506	3,752	0	10	0	96.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	4,204,947	0	0	532	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	297,519,063	452,857	2,124,876	14,002	41,066	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	10,229,957	108,173	72,642	80	0	192.00
194.00	07950	RENTAL SPACE	6,914,775	22,920	0	0	0	194.00
194.01	07951	FOUNDATION	522,113	206	0	0	0	194.01
194.02	07952	RETAIL SERVICES	356,296	684	0	10	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	15,104	0	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	1,246,367	0	0	0	0	194.05
194.06	07956	VACANT SPACE	2,975,158	93,036	0	0	0	194.06
194.07	07957	HOME OFFICE	0	0	0	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08
194.09	07959	REID HEALTH PAVILION - RES	1,975,005	7,514	7,073	386	0	194.09

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 2:00 pm

		Cost Center Description	OTHER A&G (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			5.06	7.00	8.00	9.00	10.00	
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	45,501,837	430,597	32,256	96,769	4,653,023	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.141418	0.628251	0.014631	6.683865	113.305971	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	141,001	377,412	12	37	517,910	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000438	0.550653	0.000005	0.002556	12.611650	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: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 2:00 pm

		Cost Center Description	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (MED SUPPLIES)	PHARMACY (DRUGS)	MEDICAL RECORDS & LIBRARY (TOTAL REVENUE)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	2,452,869					11.00
13.00	01300	NURSING ADMINISTRATION	2,080	1,466,263				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0			14.00
15.00	01500	PHARMACY	126,351	0	0	43,390,651		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	1,240,611,068	16.00
17.00	01700	SOCIAL SERVICE	94,839	0	0	0	0	17.00
17.01	01701	INSERVICE EDUCATION	5,627	0	0	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	37,286	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	5,391	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	4,940	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	681,714	681,714	0	6,289	87,677,508	30.00
31.00	03100	INTENSIVE CARE UNIT	103,691	103,691	0	479	9,846,705	31.00
41.00	04100	SUBPROVIDER - IRF	47,326	47,326	0	16	4,756,800	41.00
43.00	04300	NURSERY	8,942	8,942	0	0	1,383,248	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	61,060	61,060	0	139,641	208,397,587	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,407	13,407	0	2,076	7,579,241	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	230,780	230,780	0	895,892	212,306,018	54.00
59.00	05900	CARDIAC CATHETERIZATION	53,642	53,642	0	3,706	131,175,384	59.00
60.00	06000	LABORATORY	188,462	0	0	0	124,250,263	60.00
65.00	06500	RESPIRATORY THERAPY	48,044	48,044	0	163	26,763,730	65.00
66.00	06600	PHYSICAL THERAPY	251,061	0	0	9	30,873,908	66.00
69.00	06900	ELECTROCARDIOLOGY	43,075	0	0	245,650	35,317,387	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	18,071	0	0	0	6,866,598	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	44,853,298	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	41,811,271	173,030,975	73.00
74.00	07400	RENAL DIALYSIS	1,939	1,939	0	0	1,212,998	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	19,028	19,028	0	5	2,377,007	76.97
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						
91.00	09100	EMERGENCY	196,690	196,690	0	122,594	116,827,391	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	FAMILY PRACTICE	76,783	0	0	12,792	8,821,675	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	15,746	0	0	2,893	522,352	96.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	54,751	0	0	124,505	5,770,995	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,390,726	1,466,263	0	43,367,981	1,240,611,068	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	RENTAL SPACE	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	7,953	0	0	0	0	194.01
194.02	07952	RETAIL SERVICES	7,536	0	0	0	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	0	0	0	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
194.07	07957	HOME OFFICE	0	0	0	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 2:00 pm

		Cost Center Description	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (MED SUPPLIES)	PHARMACY (DRUGS)	MEDICAL RECORDS & LIBRARY (TOTAL REVENUE)	
			11.00	13.00	14.00	15.00	16.00	
194.09	07959	REID HEALTH PAVILION - RES	46,654	0	0	22,670	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,008,617	750,312	0	58,527,802	260,873	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.818885	0.511717	0.000000	1.348857	0.000210	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	270,191	55,289	0	344,761	228,652	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.110153	0.037707	0.000000	0.007946	0.000184	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: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 2:00 pm

		Cost Center Description	SOCIAL SERVICE (TIME SPENT)	INSERVICE EDUCATION (IN HOUSE ED)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	PARAMED ED PRGM (TIME SPENT)	
			17.00	17.01	21.00	22.00	23.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	76,178					17.00
17.01	01701	INSERVICE EDUCATION	0	66,190				17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	1,733			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		1,733		22.00
23.00	02300	PARAMED ED PRGM	0	137			100	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	50,298	19,736	1,443	1,443	0	30.00
31.00	03100	INTENSIVE CARE UNIT	6,126	2,932	90	90	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	1,324	0	0	0	41.00
43.00	04300	NURSERY	0	251	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,069	58	58	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,921	377	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,808	8	8	100	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,488	0	0	0	59.00
60.00	06000	LABORATORY	0	5,348	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,376	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	7,360	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,207	67	67	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	500	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	55	0	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	530	0	0	0	76.97
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						
91.00	09100	EMERGENCY	17,833	6,133	67	67	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	FAMILY PRACTICE	0	2,131	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	436	0	0	0	96.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	1,174			0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	76,178	64,372	1,733	1,733	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	0	0	0	0	192.00
194.00	07950	RENTAL SPACE	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	221	0	0	0	194.01
194.02	07952	RETAIL SERVICES	0	215	0	0	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	0	0	0	194.04
194.05	07955	CONNERSVILLE LOCATION	0	0	0	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06

		Cost Center Description	SOCIAL SERVICE (TIME SPENT)	INSERVICE EDUCATION (IN HOUSE ED)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	PARAMED ED PRGM (TIME SPENT)	
			17.00	17.01	21.00	22.00	23.00	
194.07	07957	HOME OFFICE	0	0	0	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	0	0	194.08
194.09	07959	REID HEALTH PAVILION - RES	0	1,382	0	0	0	194.09
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)	6,696,648	2,670,318	2,593,299	1,456,048	643,250	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	87.907900	40.343224	1,496.421812	840.189267	6,432.500000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	48,731	292,630	5,436	1,233	161,865	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.639699	4.421061	3.136757	0.711483	1,618.650000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I | Date/Time Prepared: 5/31/2024 2:00 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	62,813,917		62,813,917	0	62,813,917	30.00
31.00	03100	INTENSIVE CARE UNIT	11,662,191		11,662,191	0	11,662,191	31.00
41.00	04100	SUBPROVIDER - IRF	4,291,742		4,291,742	0	4,291,742	41.00
43.00	04300	NURSERY	893,494		893,494	0	893,494	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	37,759,319		37,759,319	0	37,759,319	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,960,573		1,960,573	0	1,960,573	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	33,814,132		33,814,132	0	33,814,132	54.00
59.00	05900	CARDIAC CATHETERIZATION	9,262,843		9,262,843	0	9,262,843	59.00
60.00	06000	LABORATORY	20,402,463		20,402,463	0	20,402,463	60.00
65.00	06500	RESPIRATORY THERAPY	4,028,363	0	4,028,363	0	4,028,363	65.00
66.00	06600	PHYSICAL THERAPY	21,417,524	0	21,417,524	0	21,417,524	66.00
69.00	06900	ELECTROCARDIOLOGY	5,002,474		5,002,474	0	5,002,474	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,430,091		1,430,091	0	1,430,091	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	31,139,487		31,139,487	0	31,139,487	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	56,846,359		56,846,359	0	56,846,359	73.00
74.00	07400	RENAL DIALYSIS	1,067,588		1,067,588	0	1,067,588	74.00
76.00	03950	ANCILLARY - OTHER	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,251,028		1,251,028	0	1,251,028	76.97
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						
91.00	09100	EMERGENCY	20,403,418		20,403,418	0	20,403,418	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	14,931,813		14,931,813		14,931,813	92.00
93.00	04040	FAMILY PRACTICE	3,767,794		3,767,794	0	3,767,794	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	959,763		959,763	0	959,763	96.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	5,064,507		5,064,507		5,064,507	116.00
200.00		Subtotal (see instructions)	350,170,883	0	350,170,883	0	350,170,883	200.00
201.00		Less Observation Beds	14,931,813		14,931,813		14,931,813	201.00
202.00		Total (see instructions)	335,239,070	0	335,239,070	0	335,239,070	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/31/2024 2:00 pm

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		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	62,096,413		62,096,413			30.00
31.00	03100	INTENSIVE CARE UNIT	9,846,705		9,846,705			31.00
41.00	04100	SUBPROVIDER - IRF	4,756,800		4,756,800			41.00
43.00	04300	NURSERY	1,383,248		1,383,248			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	50,654,042	157,743,545	208,397,587	0.181189	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,665,273	913,968	7,579,241	0.258677	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	43,400,962	168,905,056	212,306,018	0.159271	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	50,487,749	80,687,635	131,175,384	0.070614	0.000000	59.00
60.00	06000	LABORATORY	41,046,395	83,203,868	124,250,263	0.164205	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	20,845,926	5,917,804	26,763,730	0.150516	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	8,796,674	22,077,234	30,873,908	0.693710	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	7,250,149	28,067,238	35,317,387	0.141643	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	6,042	6,860,556	6,866,598	0.208268	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,999,080	25,854,218	44,853,298	0.694252	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	59,069,337	113,961,638	173,030,975	0.328533	0.000000	73.00
74.00	07400	RENAL DIALYSIS	942,387	270,611	1,212,998	0.880123	0.000000	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	821	2,376,186	2,377,007	0.526304	0.000000	76.97
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						
91.00	09100	EMERGENCY	31,008,612	85,818,779	116,827,391	0.174646	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	7,795,903	17,785,192	25,581,095	0.583705	0.000000	92.00
93.00	04040	FAMILY PRACTICE	25,974	8,795,701	8,821,675	0.427106	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	522,352	522,352	1.837387	0.000000	96.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,235,428	4,535,567	5,770,995			116.00
200.00		Subtotal (see instructions)	426,313,920	814,297,148	1,240,611,068			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	426,313,920	814,297,148	1,240,611,068			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/31/2024 2:00 pm

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.181189	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.258677	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.159271	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.070614	59.00
60.00	06000	LABORATORY	0.164205	60.00
65.00	06500	RESPIRATORY THERAPY	0.150516	65.00
66.00	06600	PHYSICAL THERAPY	0.693710	66.00
69.00	06900	ELECTROCARDIOLOGY	0.141643	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.208268	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.694252	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.328533	73.00
74.00	07400	RENAL DIALYSIS	0.880123	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0.526304	76.97
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		
91.00	09100	EMERGENCY	0.174646	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.583705	92.00
93.00	04040	FAMILY PRACTICE	0.427106	93.00
		OTHER REIMBURSABLE COST CENTERS		
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.837387	96.00
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
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: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I | Date/Time Prepared: 5/31/2024 2:00 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	62,813,917		62,813,917	0	62,813,917	30.00
31.00	03100	INTENSIVE CARE UNIT	11,662,191		11,662,191	0	11,662,191	31.00
41.00	04100	SUBPROVIDER - IRF	4,291,742		4,291,742	0	4,291,742	41.00
43.00	04300	NURSERY	893,494		893,494	0	893,494	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	37,759,319		37,759,319	0	37,759,319	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,960,573		1,960,573	0	1,960,573	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	33,814,132		33,814,132	0	33,814,132	54.00
59.00	05900	CARDIAC CATHETERIZATION	9,262,843		9,262,843	0	9,262,843	59.00
60.00	06000	LABORATORY	20,402,463		20,402,463	0	20,402,463	60.00
65.00	06500	RESPIRATORY THERAPY	4,028,363	0	4,028,363	0	4,028,363	65.00
66.00	06600	PHYSICAL THERAPY	21,417,524	0	21,417,524	0	21,417,524	66.00
69.00	06900	ELECTROCARDIOLOGY	5,002,474		5,002,474	0	5,002,474	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,430,091		1,430,091	0	1,430,091	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	31,139,487		31,139,487	0	31,139,487	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	56,846,359		56,846,359	0	56,846,359	73.00
74.00	07400	RENAL DIALYSIS	1,067,588		1,067,588	0	1,067,588	74.00
76.00	03950	ANCILLARY - OTHER	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,251,028		1,251,028	0	1,251,028	76.97
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						
91.00	09100	EMERGENCY	20,403,418		20,403,418	0	20,403,418	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	14,931,813		14,931,813		14,931,813	92.00
93.00	04040	FAMILY PRACTICE	3,767,794		3,767,794	0	3,767,794	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	959,763		959,763	0	959,763	96.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	5,064,507		5,064,507		5,064,507	116.00
200.00		Subtotal (see instructions)	350,170,883	0	350,170,883	0	350,170,883	200.00
201.00		Less Observation Beds	14,931,813		14,931,813		14,931,813	201.00
202.00		Total (see instructions)	335,239,070	0	335,239,070	0	335,239,070	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I | Date/Time Prepared: 5/31/2024 2:00 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	62,096,413		62,096,413			30.00
31.00	03100	INTENSIVE CARE UNIT	9,846,705		9,846,705			31.00
41.00	04100	SUBPROVIDER - IRF	4,756,800		4,756,800			41.00
43.00	04300	NURSERY	1,383,248		1,383,248			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	50,654,042	157,743,545	208,397,587	0.181189	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,665,273	913,968	7,579,241	0.258677	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	43,400,962	168,905,056	212,306,018	0.159271	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	50,487,749	80,687,635	131,175,384	0.070614	0.000000	59.00
60.00	06000	LABORATORY	41,046,395	83,203,868	124,250,263	0.164205	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	20,845,926	5,917,804	26,763,730	0.150516	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	8,796,674	22,077,234	30,873,908	0.693710	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	7,250,149	28,067,238	35,317,387	0.141643	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	6,042	6,860,556	6,866,598	0.208268	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,999,080	25,854,218	44,853,298	0.694252	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	59,069,337	113,961,638	173,030,975	0.328533	0.000000	73.00
74.00	07400	RENAL DIALYSIS	942,387	270,611	1,212,998	0.880123	0.000000	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	821	2,376,186	2,377,007	0.526304	0.000000	76.97
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						
91.00	09100	EMERGENCY	31,008,612	85,818,779	116,827,391	0.174646	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	7,795,903	17,785,192	25,581,095	0.583705	0.000000	92.00
93.00	04040	FAMILY PRACTICE	25,974	8,795,701	8,821,675	0.427106	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	522,352	522,352	1.837387	0.000000	96.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,235,428	4,535,567	5,770,995			116.00
200.00		Subtotal (see instructions)	426,313,920	814,297,148	1,240,611,068			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	426,313,920	814,297,148	1,240,611,068			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/31/2024 2:00 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
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		
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
93.00	04040	FAMILY PRACTICE	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS		
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	96.00
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part I | Date/Time Prepared: 5/31/2024 2:00 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	4,434,946	0	4,434,946	43,144	102.79	30.00
31.00	INTENSIVE CARE UNIT	793,691		793,691	4,214	188.35	31.00
41.00	SUBPROVIDER - IRF	570,054	0	570,054	3,964	143.81	41.00
43.00	NURSERY	80,700		80,700	1,274	63.34	43.00
200.00	Total (lines 30 through 199)	5,879,391		5,879,391	52,596		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	12,825	1,318,282	30.00
31.00	INTENSIVE CARE UNIT	1,550	291,943	31.00
41.00	SUBPROVIDER - IRF	1,691	243,183	41.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	16,066	1,853,408	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/31/2024 2:00 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,110,370	208,397,587	0.010127	21,599,779	218,741	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	246,344	7,579,241	0.032502	14,676	477	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,264,560	212,306,018	0.010666	18,042,621	192,443	54.00
59.00	05900	CARDIAC CATHETERIZATION	488,497	131,175,384	0.003724	23,195,202	86,379	59.00
60.00	06000	LABORATORY	938,742	124,250,263	0.007555	15,904,852	120,161	60.00
65.00	06500	RESPIRATORY THERAPY	87,405	26,763,730	0.003266	8,297,919	27,101	65.00
66.00	06600	PHYSICAL THERAPY	2,386,994	30,873,908	0.077314	2,358,594	182,352	66.00
69.00	06900	ELECTROCARDIOLOGY	250,200	35,317,387	0.007084	2,585,505	18,316	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	201,118	6,866,598	0.029289	5,838	171	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	37,647	44,853,298	0.000839	10,203,509	8,561	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	431,517	173,030,975	0.002494	22,629,139	56,437	73.00
74.00	07400	RENAL DIALYSIS	43,619	1,212,998	0.035960	414,240	14,896	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	234,008	2,377,007	0.098446	190	19	76.97
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						
91.00	09100	EMERGENCY	1,032,737	116,827,391	0.008840	12,664,650	111,956	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,054,261	25,581,095	0.041213	3,277,741	135,086	92.00
93.00	04040	FAMILY PRACTICE	68,785	8,821,675	0.007797	24,452	191	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	198,436	522,352	0.379889	0	0	96.00
200.00		Total (lines 50 through 199)	12,075,240	1,156,756,907		141,218,907	1,173,287	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part III Date/Time Prepared: 5/31/2024 2:00 pm

Title XVIII | Hospital | PPS

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	43,144	0.00	12,825	30.00
31.00	03100	INTENSIVE CARE UNIT		0	4,214	0.00	1,550	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	3,964	0.00	1,691	41.00
43.00	04300	NURSERY		0	1,274	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	52,596		16,066	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/31/2024 2:00 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	643,250	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
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						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)	0	0	0	0	643,250	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/31/2024 2:00 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	208,397,587	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	7,579,241	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	643,250	643,250	212,306,018	0.003030	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	131,175,384	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	124,250,263	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	26,763,730	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	30,873,908	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	35,317,387	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	6,866,598	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	44,853,298	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	173,030,975	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,212,998	0.000000	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	2,377,007	0.000000	76.97
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						
91.00	09100	EMERGENCY	0	0	0	116,827,391	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	25,581,095	0.000000	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	8,821,675	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	522,352	0.000000	96.00
200.00		Total (lines 50 through 199)	0	643,250	643,250	1,156,756,907		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0048	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/31/2024 2:00 pm
	Title XVIII	Hospital	PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	21,599,779	0	40,755,144	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	14,676	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.003030	18,042,621	54,669	41,209,530	124,865	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	23,195,202	0	28,110,609	0	59.00
60.00	06000	LABORATORY	0.000000	15,904,852	0	8,491,026	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	8,297,919	0	1,191,871	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	2,358,594	0	117,537	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	2,585,505	0	9,455,262	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	5,838	0	1,434,861	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	10,203,509	0	7,585,388	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	22,629,139	0	36,989,483	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	414,240	0	58,391	0	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	190	0	736,075	0	76.97
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						
91.00	09100	EMERGENCY	0.000000	12,664,650	0	14,993,989	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	3,277,741	0	1,484,129	0	92.00
93.00	04040	FAMILY PRACTICE	0.000000	24,452	0	2,803,438	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		141,218,907	54,669	195,416,733	124,865	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/31/2024 2:00 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.181189	40,755,144	0	0	7,384,384	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.258677	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.159271	41,209,530	0	0	6,563,483	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.070614	28,110,609	0	0	1,985,003	59.00
60.00	06000	LABORATORY	0.164205	8,491,026	0	0	1,394,269	60.00
65.00	06500	RESPIRATORY THERAPY	0.150516	1,191,871	0	0	179,396	65.00
66.00	06600	PHYSICAL THERAPY	0.693710	117,537	0	0	81,537	66.00
69.00	06900	ELECTROCARDIOLOGY	0.141643	9,455,262	0	0	1,339,272	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.208268	1,434,861	0	0	298,836	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.694252	7,585,388	0	0	5,266,171	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.328533	36,989,483	13,407	0	12,152,266	73.00
74.00	07400	RENAL DIALYSIS	0.880123	58,391	0	0	51,391	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.526304	736,075	0	0	387,399	76.97
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						
91.00	09100	EMERGENCY	0.174646	14,993,989	0	0	2,618,640	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.583705	1,484,129	0	0	866,294	92.00
93.00	04040	FAMILY PRACTICE	0.427106	2,803,438	0	0	1,197,365	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.837387	0	0	0	0	96.00
200.00		Subtotal (see instructions)		195,416,733	13,407	0	41,765,706	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		195,416,733	13,407	0	41,765,706	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/31/2024 2:00 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,405	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
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			
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS			
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00		Subtotal (see instructions)	4,405	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	4,405	0	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0048 | Component CCN: 15-T048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II | Date/Time Prepared: 5/31/2024 2:00 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,110,370	208,397,587	0.010127	65,385	662	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	246,344	7,579,241	0.032502	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,264,560	212,306,018	0.010666	107,826	1,150	54.00
59.00	05900	CARDIAC CATHETERIZATION	488,497	131,175,384	0.003724	2,657	10	59.00
60.00	06000	LABORATORY	938,742	124,250,263	0.007555	286,532	2,165	60.00
65.00	06500	RESPIRATORY THERAPY	87,405	26,763,730	0.003266	249,745	816	65.00
66.00	06600	PHYSICAL THERAPY	2,386,994	30,873,908	0.077314	1,559,089	120,539	66.00
69.00	06900	ELECTROCARDIOLOGY	250,200	35,317,387	0.007084	1,870	13	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	201,118	6,866,598	0.029289	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	37,647	44,853,298	0.000839	657	1	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	431,517	173,030,975	0.002494	539,205	1,345	73.00
74.00	07400	RENAL DIALYSIS	43,619	1,212,998	0.035960	22,820	821	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	234,008	2,377,007	0.098446	0	0	76.97
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						
91.00	09100	EMERGENCY	1,032,737	116,827,391	0.008840	10,996	97	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	25,581,095	0.000000	0	0	92.00
93.00	04040	FAMILY PRACTICE	68,785	8,821,675	0.007797	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	198,436	522,352	0.379889	0	0	96.00
200.00		Total (lines 50 through 199)	11,020,979	1,156,756,907		2,846,782	127,619	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0048 | Component CCN: 15-T048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/31/2024 2:00 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	643,250	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
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						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)	0	0	0	0	643,250	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0048 | Component CCN: 15-T048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/31/2024 2:00 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	208,397,587	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	7,579,241	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	643,250	643,250	212,306,018	0.003030	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	131,175,384	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	124,250,263	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	26,763,730	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	30,873,908	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	35,317,387	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	6,866,598	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	44,853,298	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	173,030,975	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,212,998	0.000000	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	2,377,007	0.000000	76.97
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						
91.00	09100	EMERGENCY	0	0	0	116,827,391	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	25,581,095	0.000000	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	8,821,675	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	522,352	0.000000	96.00
200.00		Total (lines 50 through 199)	0	643,250	643,250	1,156,756,907		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/31/2024 2:00 pm
	Title XVIII	Subprovider - IRF	PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	65,385	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.003030	107,826	327	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	2,657	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	286,532	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	249,745	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,559,089	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,870	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	657	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	539,205	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	22,820	0	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
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						
91.00	09100	EMERGENCY	0.000000	10,996	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	0	80	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		2,846,782	327	80	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0048 | Component CCN: 15-T048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V | Date/Time Prepared: 5/31/2024 2:00 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.181189	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.258677	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.159271	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.070614	0	0	0	0	59.00
60.00	06000	LABORATORY	0.164205	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.150516	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.693710	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.141643	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.208268	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.694252	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.328533	0	0	110	0	73.00
74.00	07400	RENAL DIALYSIS	0.880123	0	0	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.526304	0	0	0	0	76.97
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						
91.00	09100	EMERGENCY	0.174646	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.583705	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.427106	80	0	0	34	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.837387	0	0	0	0	96.00
200.00		Subtotal (see instructions)		80	0	110	34	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		80	0	110	34	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0048 | Component CCN: 15-T048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V | Date/Time Prepared: 5/31/2024 2:00 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	36	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
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			
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS			
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00		Subtotal (see instructions)	0	36	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	36	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/31/2024 2:00 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.181189	0	2,211,096	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.258677	0	68,586	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.159271	0	3,575,301	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.070614	0	936,817	0	0	59.00
60.00	06000	LABORATORY	0.164205	0	1,957,008	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.150516	0	181,602	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.693710	0	831,922	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.141643	0	361,898	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.208268	0	59,559	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.694252	0	288,723	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.328533	0	3,004,263	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.880123	0	8,205	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.526304	0	12,350	0	0	76.97
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						
91.00	09100	EMERGENCY	0.174646	0	3,320,299	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.583705	0	640,243	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.427106	0	122,183	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.837387	0	0	0	0	96.00
200.00		Subtotal (see instructions)		0	17,580,055	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	17,580,055	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/31/2024 2:00 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	400,626	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	17,742	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	569,442	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	66,152	0	59.00
60.00	06000	LABORATORY	321,350	0	60.00
65.00	06500	RESPIRATORY THERAPY	27,334	0	65.00
66.00	06600	PHYSICAL THERAPY	577,113	0	66.00
69.00	06900	ELECTROCARDIOLOGY	51,260	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	12,404	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	200,447	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	987,000	0	73.00
74.00	07400	RENAL DIALYSIS	7,221	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	6,500	0	76.97
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			
91.00	09100	EMERGENCY	579,877	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	373,713	0	92.00
93.00	04040	FAMILY PRACTICE	52,185	0	93.00
		OTHER REIMBURSABLE COST CENTERS			
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00		Subtotal (see instructions)	4,250,366	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	4,250,366	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 2:00 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	43,144	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	43,144	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)	32,888	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)	12,825	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	62,813,917	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)	62,813,917	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)	62,813,917	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)	1,455.91	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	18,672,046	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)	18,672,046	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 Date/Time Prepared: 5/31/2024 2:00 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	11,662,191	4,214	2,767.49	1,550	4,289,610	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)	33,311,667	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)	56,273,323	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	1,610,225	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,227,956	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,838,181	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	53,435,142	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)	10,256	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,455.91	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0048	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/31/2024 2:00 pm
	Title XVIII	Hospital	PPS

	Cost Center Description	1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	14,931,813	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	4,434,946	62,813,917	0.070605	14,931,813	1,054,261	90.00
91.00	Nursing Program cost	0	62,813,917	0.000000	14,931,813	0	91.00
92.00	Allied health cost	0	62,813,917	0.000000	14,931,813	0	92.00
93.00	All other Medical Education	0	62,813,917	0.000000	14,931,813	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0048 | Component CCN: 15-T048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 2:00 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,964	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,964	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,964	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,691	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,291,742	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,291,742	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,291,742	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)	1,082.68	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,830,812	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,830,812	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0048 | Component CCN: 15-T048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 2:00 pm

Title XVIII | Subprovider - IRF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,395,278	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)	3,226,090	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)	243,183	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	127,946	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	371,129	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,854,961	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/31/2024 2:00 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	570,054	4,291,742	0.132826	0	0	90.00
91.00	Nursing Program cost	0	4,291,742	0.000000	0	0	91.00
92.00	Allied health cost	0	4,291,742	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,291,742	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 2:00 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	43,144	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	43,144	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)	32,888	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)	772	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)	1,274	15.00
16.00	Nursery days (title V or XIX only)	79	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	62,813,917	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)	62,813,917	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)	62,813,917	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)	1,455.91	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,123,963	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,123,963	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 2:00 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	893,494	1,274	701.33	79	55,405	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	11,662,191	4,214	2,767.49	156	431,728	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)	1,760,056	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)	3,371,152	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	10,256	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,455.91	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0048	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/31/2024 2:00 pm
	Title XIX	Hospital	Cost

	Cost Center Description	1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	14,931,813	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	4,434,946	62,813,917	0.070605	14,931,813	1,054,261	90.00
91.00	Nursing Program cost	0	62,813,917	0.000000	14,931,813	0	91.00
92.00	Allied health cost	0	62,813,917	0.000000	14,931,813	0	92.00
93.00	All other Medical Education	0	62,813,917	0.000000	14,931,813	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/31/2024 2:00 pm
	Title XIX	Subprovider - IRF	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,964	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,964	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,964	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)	0	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)	1,274	15.00
16.00	Nursery days (title V or XIX only)	79	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,291,742	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,291,742	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,291,742	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)	1,082.68	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	0	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)	0	41.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/31/2024 2:00 pm
	Title XIX	Subprovider - IRF	Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
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)	0	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)	0	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/31/2024 2:00 pm
	Title XIX	Subprovider - IRF	Cost

	Cost Center Description	1.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	570,054	4,291,742	0.132826	0	0	90.00
91.00	Nursing Program cost	0	4,291,742	0.000000	0	0	91.00
92.00	Allied health cost	0	4,291,742	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,291,742	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0048	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 5/31/2024 2:00 pm
	Title XVIII	Hospital	PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		22,812,678		30.00
31.00	03100	INTENSIVE CARE UNIT		3,205,077		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.181189	21,599,779	3,913,642	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.258677	14,676	3,796	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.159271	18,042,621	2,873,666	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.070614	23,195,202	1,637,906	59.00
60.00	06000	LABORATORY	0.164205	15,904,852	2,611,656	60.00
65.00	06500	RESPIRATORY THERAPY	0.150516	8,297,919	1,248,970	65.00
66.00	06600	PHYSICAL THERAPY	0.693710	2,358,594	1,636,180	66.00
69.00	06900	ELECTROCARDIOLOGY	0.141643	2,585,505	366,219	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.208268	5,838	1,216	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.694252	10,203,509	7,083,807	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.328533	22,629,139	7,434,419	73.00
74.00	07400	RENAL DIALYSIS	0.880123	414,240	364,582	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.526304	190	100	76.97
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				
91.00	09100	EMERGENCY	0.174646	12,664,650	2,211,830	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.583705	3,277,741	1,913,234	92.00
93.00	04040	FAMILY PRACTICE	0.427106	24,452	10,444	93.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.837387	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		141,218,907	33,311,667	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)		141,218,907		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0048 | Component CCN: 15-T048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/31/2024 2:00 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
41.00	04100	SUBPROVIDER - IRF		2,025,542		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.181189	65,385	11,847	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.258677	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.159271	107,826	17,174	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.070614	2,657	188	59.00
60.00	06000	LABORATORY	0.164205	286,532	47,050	60.00
65.00	06500	RESPIRATORY THERAPY	0.150516	249,745	37,591	65.00
66.00	06600	PHYSICAL THERAPY	0.693710	1,559,089	1,081,556	66.00
69.00	06900	ELECTROCARDIOLOGY	0.141643	1,870	265	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.208268	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.694252	657	456	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.328533	539,205	177,147	73.00
74.00	07400	RENAL DIALYSIS	0.880123	22,820	20,084	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.526304	0	0	76.97
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				
91.00	09100	EMERGENCY	0.174646	10,996	1,920	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.583705	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.427106	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.837387	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,846,782	1,395,278	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)		2,846,782		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/31/2024 2:00 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,897,277		30.00
31.00	03100	INTENSIVE CARE UNIT		453,089		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		180,899		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.181189	828,715	150,154	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.258677	377,135	97,556	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.159271	1,113,842	177,403	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.070614	372,076	26,274	59.00
60.00	06000	LABORATORY	0.164205	1,342,987	220,525	60.00
65.00	06500	RESPIRATORY THERAPY	0.150516	715,716	107,727	65.00
66.00	06600	PHYSICAL THERAPY	0.693710	174,278	120,898	66.00
69.00	06900	ELECTROCARDIOLOGY	0.141643	165,074	23,382	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.208268	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.694252	115,329	80,067	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.328533	1,732,102	569,053	73.00
74.00	07400	RENAL DIALYSIS	0.880123	40,453	35,604	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.526304	0	0	76.97
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				
91.00	09100	EMERGENCY	0.174646	866,972	151,413	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.583705	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.427106	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.837387	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		7,844,679	1,760,056	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		7,844,679		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 5/31/2024 2:00 pm
	Title XIX	Subprovider - IRF	Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
41.00	04100	SUBPROVIDER - IRF		93,070		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.181189	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.258677	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.159271	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.070614	0	0	59.00
60.00	06000	LABORATORY	0.164205	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.150516	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.693710	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.141643	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.208268	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.694252	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.328533	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.880123	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.526304	0	0	76.97
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				
91.00	09100	EMERGENCY	0.174646	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.583705	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.427106	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.837387	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/31/2024 2:00 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	32,162,983	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	10,954,796	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	243,862	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	68,221	2.04
3.00	Managed Care Simulated Payments	22,735,373	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	154.90	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	17.91	5.00
5.01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)	0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)	0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	17.91	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	14.32	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	14.32	12.00
13.00	Total allowable FTE count for the prior year.	16.37	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	16.44	14.00
15.00	Sum of lines 12 through 14 divided by 3.	15.71	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	15.71	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.101420	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.100184	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.100184	21.00
22.00	IME payment adjustment (see instructions)	2,294,944	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	1,210,090	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	-3.59	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	2,294,944	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	1,210,090	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	5.26	30.00
31.00	Percentage of Medicaid patient days (see instructions)	24.77	31.00
32.00	Sum of lines 30 and 31	30.03	32.00
33.00	Allowable disproportionate share percentage (see instructions)	13.99	33.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/31/2024 2:00 pm
	Title XVIII	Hospital	PPS

Line	Description		1.00	
34.00	Disproportionate share adjustment (see instructions)		1,508,044	34.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Payment Adjustment			
35.00	Total uncompensated care amount (see instructions)	6,874,403,459	5,938,006,757	35.00
35.01	Factor 3 (see instructions)	0.000172527	0.000182113	35.01
35.02	Hospital UCP, including supplemental UCP (see instructions)	1,186,020	1,081,388	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	887,078	271,824	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	1,158,902		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	48,391,752		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	57,165,776		48.00

Line	Description	Amount 1.00	
49.00	Total payment for inpatient operating costs (see instructions)	58,375,866	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	3,431,204	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	573,339	52.00
53.00	Nursing and Allied Health Managed Care payment	57,038	53.00
54.00	Special add-on payments for new technologies	70,751	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
55.01	Cellular therapy acquisition cost (see instructions)	0	55.01
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	54,669	58.00
59.00	Total (sum of amounts on lines 49 through 58)	62,562,867	59.00
60.00	Primary payer payments	22,173	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	62,540,694	61.00
62.00	Deductibles billed to program beneficiaries	4,642,512	62.00
63.00	Coinsurance billed to program beneficiaries	36,000	63.00
64.00	Allowable bad debts (see instructions)	451,318	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	293,357	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	162,125	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	58,155,539	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)	0	70.75
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	-75,275	70.93
70.94	HRR adjustment amount (see instructions)	-360,276	70.94
70.95	Recovery of accelerated depreciation	0	70.95

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	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3	0	0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		57,719,988	71.00
71.01	Sequestration adjustment (see instructions)		1,154,400	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		57,118,363	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-552,775	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/31/2024 2:00 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,405	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	41,640,841	2.00
3.00	OPPS or REH payments	48,999,085	3.00
4.00	Outlier payment (see instructions)	24,264	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	124,865	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,405	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	13,407	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)	13,407	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)	13,407	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	9,002	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)	4,405	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)	49,148,214	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)	8,334,899	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)	40,817,720	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	402,573	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)	41,220,293	30.00
31.00	Primary payer payments	10,479	31.00
32.00	Subtotal (line 30 minus line 31)	41,209,814	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)	988,260	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	642,369	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	594,247	36.00
37.00	Subtotal (see instructions)	41,852,183	37.00
38.00	MSP-LCC reconciliation amount from PS&R	163	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)	41,852,020	40.00
40.01	Sequestration adjustment (see instructions)	837,040	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	42,002,046	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)	-987,066	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/31/2024 2:00 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	36	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	34	2.00
3.00	OPPS or REH payments	38	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)	36	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	110	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)	110	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)	110	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	74	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)	36	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)	38	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	74	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)	74	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	74	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	74	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)	74	40.00
40.01	Sequestration adjustment (see instructions)	1	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	60	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)	13	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00

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	Title XVIII	Subprovider - IRF	PPS

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CCN: 15-0048	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part I Date/Time Prepared: 5/31/2024 2:00 pm
	Title XVIII	Hospital	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		56,961,263		41,403,946	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	09/20/2023	216,000	09/20/2023	598,100	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	06/07/2023	58,900		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)		157,100		598,100	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)		57,118,363		42,002,046	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		552,775		987,066	6.02
7.00	Total Medicare program liability (see instructions)		56,565,588		41,014,980	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0048 | Component CCN: 15-T048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/31/2024 2:00 pm

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,305,197		60	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,305,197		60	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		54,069		13	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,359,266		73	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0048	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/31/2024 2:00 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part III Date/Time Prepared: 5/31/2024 2:00 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	3,261,187	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0218	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	193,715	3.00
4.00	Outlier Payments	11,243	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	10.860274	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	3,466,145	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)	3,466,145	17.00
18.00	Primary payer payments	3,656	18.00
19.00	Subtotal (line 17 less line 18).	3,462,489	19.00
20.00	Deductibles	23,956	20.00
21.00	Subtotal (line 19 minus line 20)	3,438,533	21.00
22.00	Coinsurance	12,800	22.00
23.00	Subtotal (line 21 minus line 22)	3,425,733	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	2,711	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	1,762	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	3,427,495	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)	327	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)	3,427,822	32.00
32.01	Sequestration adjustment (see instructions)	68,556	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	3,305,197	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)	54,069	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	11,243	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)		
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0.000000	99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0.000000	99.01

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-3 Part VII Date/Time Prepared: 5/31/2024 2:00 pm

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	3,371,152		1.00
2.00	Medical and other services		4,250,366	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	3,371,152	4,250,366	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	3,371,152	4,250,366	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	7,844,679	17,580,055	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	7,844,679	17,580,055	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	7,844,679	17,580,055	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	4,473,527	13,329,689	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	3,371,152	4,250,366	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	3,371,152	4,250,366	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	3,371,152	4,250,366	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	3,371,152	4,250,366	36.00
37.00	ZERO OUT MEDICAID	0	-4,250,366	37.00
38.00	Subtotal (line 36 ± line 37)	3,371,152	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	3,371,152	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	3,371,152	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/31/2024 2:00 pm
	Title XIX	Subprovider - IRF	Cost

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

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-4 | Date/Time Prepared: 5/31/2024 2:00 pm

Title XVIII | Hospital | PPS

		1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT		
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.	0.00	1.00
1.01	FTE cap adjustment under §131 of the CAA 2021 (see instructions)	17.91	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	17.91	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)	14.32	6.00
7.00	Enter the lesser of line 5 or line 6	14.32	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.	14.32	0.00	14.32	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.	14.32	0.00	14.32	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	14.32	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	15.99	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	15.85	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	15.39	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	15.39	0.00		17.00
18.00	Per resident amount	104,184.87	104,184.87		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	1,603,405	0	1,603,405	19.00

		1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)	0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)	0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)	0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)	0.00	23.00
24.00	Multiply line 22 time line 23	0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)	1,603,405	25.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 15-0048	Period: From 01/01/2023 To 12/31/2023	Worksheet E-4 Date/Time Prepared: 5/31/2024 2:00 pm
	Title XVIII	Hospital	PPS

		Inpatient Part A	Managed Care	Total	
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	16,066	9,331		26.00
27.00	Total Inpatient Days (see instructions)	41,227	41,227		27.00
28.00	Ratio of inpatient days to total inpatient days	0.389696	0.226332		28.00
29.00	Program direct GME amount	624,841	362,902	987,743	29.00
29.01	Percent reduction for MA DGME		3.26		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		11,831	11,831	30.00
31.00	Net Program direct GME amount			975,912	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)	1,212,998	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)	59,499,413	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)	25,829	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	59,473,584	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	41,770,181	42.00
43.00	Primary payer payments (see instructions)	10,479	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	41,759,702	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	101,233,286	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.587490	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.412510	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	975,912	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	573,339	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	402,573	50.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0048	Period: From 01/01/2023 To 12/31/2023	Worksheet E-5 Date/Time Prepared: 5/31/2024 2:00 pm
	Title XVIII		PPS

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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)	Provider CCN: 15-0048	Period: From 01/01/2023 To 12/31/2023	Worksheet G Date/Time Prepared: 5/31/2024 2:00 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	43,758,436	0	0	0	1.00
2.00	Temporary investments	494,565,726	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	148,532,554	0	0	0	4.00
5.00	Other receivable	668,977,494	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-84,545,425	0	0	0	6.00
7.00	Inventory	8,788,493	0	0	0	7.00
8.00	Prepaid expenses	10,266,686	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	100	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	1,290,344,064	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	18,482,409	0	0	0	12.00
13.00	Land improvements	10,348,915	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	356,701,594	0	0	0	15.00
16.00	Accumulated depreciation	-222,057,944	0	0	0	16.00
17.00	Leasehold improvements	13,645,110	0	0	0	17.00
18.00	Accumulated depreciation	-10,063,115	0	0	0	18.00
19.00	Fixed equipment	2,209,359	0	0	0	19.00
20.00	Accumulated depreciation	-2,038,211	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	230,687,531	0	0	0	23.00
24.00	Accumulated depreciation	-183,411,422	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	214,504,226	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	75,206,126	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	75,206,126	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	1,580,054,416	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	22,722,030	0	0	0	37.00
38.00	Salaries, wages, and fees payable	16,516,575	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	14,931,476	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	4,414,367				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	58,584,448	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	326,560,789	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	2,875,444	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	329,436,233	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	388,020,681	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	1,192,033,735				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)	1,192,033,735	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	1,580,054,416	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 Date/Time Prepared: 5/31/2024 2:00 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		1,134,239,734		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		216,438,187				2.00
3.00	Total (sum of line 1 and line 2)		1,350,677,921		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)		1,350,677,921		0		11.00
12.00	AMOUNTS INCLUDED ON HO COST REPORT	161,904,753		0		0	12.00
13.00	AMOUNTS INCLUDED ON HO COST REPORT	-3,260,567		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)		158,644,186		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		1,192,033,735		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	AMOUNTS INCLUDED ON HO COST REPORT		0		12.00
13.00	AMOUNTS INCLUDED ON HO COST REPORT		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: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/31/2024 2:00 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	89,438,597		89,438,597	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	4,771,521		4,771,521	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)	94,210,118		94,210,118	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	11,578,304		11,578,304	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)	11,578,304		11,578,304	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	105,788,422		105,788,422	17.00
18.00	Ancillary services	310,958,137	720,810,542	1,031,768,679	18.00
19.00	Outpatient services	30,473,477	96,190,945	126,664,422	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	5,816,649	5,816,649	26.00
27.00	OTHER PATIENT REVENUE	4,829,205	2,406,526	7,235,731	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	452,049,241	825,224,662	1,277,273,903	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		348,760,119		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)		348,760,119		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-3 | Date/Time Prepared: 5/31/2024 2:00 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,277,273,903	1.00
2.00	Less contractual allowances and discounts on patients' accounts	786,999,158	2.00
3.00	Net patient revenues (line 1 minus line 2)	490,274,745	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	348,760,119	4.00
5.00	Net income from service to patients (line 3 minus line 4)	141,514,626	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	1,039,527	6.00
7.00	Income from investments	59,824,340	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	4,055,041	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	577	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	54,781	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	10,058	21.00
22.00	Rental of hospital space	8,243,401	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	1,695,836	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	74,923,561	25.00
26.00	Total (line 5 plus line 25)	216,438,187	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)	216,438,187	29.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0048 | Hospice CCN: 15-1524 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O | Date/Time Prepared: 5/31/2024 2:00 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		1,800	1,800	-1,800	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		8,567	8,567	0	8,567	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	106,961	106,961	25,484	132,445	3.00
4.00	ADMINISTRATIVE & GENERAL*	520,718	64,757	585,475	12,862	598,337	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	2,432	2,432	0	2,432	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	105,496	105,496	0	105,496	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	124,505	124,505	0	124,505	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	0	27.00
28.00	REGISTERED NURSE**	908,348	0	908,348	249,834	1,158,182	28.00
29.00	LPN/LVN**	114,267	0	114,267	11,186	125,453	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING**	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	115,994	0	115,994	59,243	175,237	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	252,975	252,975	39,866	292,841	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	691,091	691,091	0	691,091	46.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	1,659,327	1,358,584	3,017,911	396,675	3,414,586	100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0048 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O
Hospice CCN: 15-1524 | Date/Time Prepared: 5/31/2024 2:00 pm

Hospice I

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT*	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	8,567	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	132,445	3.00
4.00	ADMINISTRATIVE & GENERAL*	-6,196	592,141	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	6.00
7.00	HOUSEKEEPING*	0	0	7.00
8.00	DIETARY*	0	2,432	8.00
9.00	NURSING ADMINISTRATION*	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	105,496	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	13.00
14.00	PHARMACY*	0	124,505	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED**	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	0	26.00
27.00	NURSE PRACTITIONER**	0	0	27.00
28.00	REGISTERED NURSE**	0	1,158,182	28.00
29.00	LPN/LVN**	0	125,453	29.00
30.00	PHYSICAL THERAPY**	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	0	33.00
34.00	SPIRITUAL COUNSELING**	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	175,237	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	39.00
40.00	IMAGING SERVICES**	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	292,841	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	691,091	46.00
	NONREIMBURSABLE COST CENTERS			
60.00	BEREAVEMENT PROGRAM *	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	61.00
62.00	FUNDRAISING*	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	66.00
67.00	ADVERTISING*	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	68.00
69.00	THRIFT STORE*	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	71.00
100.00	TOTAL	-6,196	3,408,390	100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE

Provider CCN: 15-0048 | Hospice CCN: 15-1524 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O-2 | Date/Time Prepared: 5/31/2024 2:00 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	908,348	0	908,348	0	908,348	28.00
29.00	LPN/LVN	114,267	0	114,267	0	114,267	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	115,994	0	115,994	0	115,994	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	252,975	252,975	0	252,975	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	691,091	691,091	0	691,091	46.00
100.00	TOTAL *	1,138,609	944,066	2,082,675	0	2,082,675	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED			25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	908,348	28.00
29.00	LPN/LVN	0	114,267	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	115,994	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	252,975	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	691,091	46.00
100.00	TOTAL *	0	2,082,675	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT RESPITE CARE	Provider CCN: 15-0048 Hospice CCN: 15-1524	Period: From 01/01/2023 To 12/31/2023	Worksheet O-3 Date/Time Prepared: 5/31/2024 2:00 pm
		Hospice I	

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	0	0	0	42,297	42,297	28.00
29.00	LPN/LVN	0	0	0	1,894	1,894	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	10,030	10,030	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	6,749	6,749	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	0	0	0	60,970	60,970	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	42,297	28.00
29.00	LPN/LVN	0	1,894	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	10,030	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	6,749	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	60,970	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL INPATIENT CARE

Provider CCN: 15-0048 | Hospice CCN: 15-1524 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O-4 | Date/Time Prepared: 5/31/2024 2:00 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	0	0	0	207,537	207,537	28.00
29.00	LPN/LVN	0	0	0	9,292	9,292	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	49,213	49,213	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	33,117	33,117	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	0	0	0	299,159	299,159	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	207,537	28.00
29.00	LPN/LVN	0	9,292	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	49,213	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	33,117	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	299,159	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 53.

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET EXPENSES FOR ALLOCATION

Provider CCN: 15-0048 | Hospice CCN: 15-1524 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O-5 | Date/Time Prepared: 5/31/2024 2:00 pm

Hospice I

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	12,206	12,206	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	8,567	0	8,567	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	132,445	396,753	529,198	3.00
4.00	ADMINISTRATIVE & GENERAL	592,141	1,027,088	1,619,229	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	3,556	3,556	7.00
8.00	DIETARY	2,432	0	2,432	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	10.00
11.00	MEDICAL RECORDS	0	1,212	1,212	11.00
12.00	STAFF TRANSPORTATION	105,496		105,496	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0	13.00
14.00	PHARMACY	124,505	167,939	292,444	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		47,363	47,363	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	2,082,675		2,082,675	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	60,970		60,970	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	299,159		299,159	53.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	3,408,390	1,656,117	5,064,507	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0048 | Hospice CCN: 15-1524 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O-6 Part I | Date/Time Prepared: 5/31/2024 2:00 pm

Hospice I

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	12,206	12,206				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	8,567		8,567			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	529,198	0	4,283	533,481		3.00
4.00	ADMINISTRATIVE & GENERAL	1,619,229	12,206	0	140,064	1,771,499	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	3,556	0	0	0	3,556	7.00
8.00	DIETARY	2,432	0	0	0	2,432	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS	1,212	0	0	0	1,212	11.00
12.00	STAFF TRANSPORTATION	105,496	0	0	0	105,496	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	292,444	0	0	0	292,444	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		47,363	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	2,082,675			298,883	2,381,558	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	60,970	0	722	16,005	77,697	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	299,159	0	3,562	78,529	381,250	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	5,064,507	12,206	8,567	533,481	5,064,507	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0048 | Hospice CCN: 15-1524

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

Worksheet O-6 Part I | Date/Time Prepared: 5/31/2024 2:00 pm

Hospice I

	Descriptions	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	1,771,499					4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	1,913	0		5,469		7.00
8.00	DIETARY	1,308	0		0	3,740	8.00
9.00	NURSING ADMINISTRATION	0	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0		0		10.00
11.00	MEDICAL RECORDS	652	0		0		11.00
12.00	STAFF TRANSPORTATION	56,752	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14.00	PHARMACY	157,323	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00	OTHER GENERAL SERVICE	0	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	25,479	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	1,281,178					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	41,798	0	0	922	633	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	205,096	0	0	4,547	3,107	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61.00
62.00	FUNDRAISING	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00	THRIFT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	1,771,499	0	0	5,469	3,740	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Hospice CCN: 15-1524 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O-6 Part I | Date/Time Prepared: 5/31/2024 2:00 pm

Hospice I

	Descriptions	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	0					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0				10.00
11.00	MEDICAL RECORDS	0		1,864			11.00
12.00	STAFF TRANSPORTATION	0			162,248		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	162,248	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	1,757	0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	18	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	89	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	0	1,864	162,248	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0048 | Hospice CCN: 15-1524 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O-6 Part I | Date/Time Prepared: 5/31/2024 2:00 pm

Hospice I

	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	449,767					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				72,842		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		162,248	50.00
51.00	HOSPICE ROUTINE HOME CARE	423,939	0	0		4,088,432	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	4,372	0	0	12,331	137,771	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	21,456	0	0	60,511	676,056	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	449,767	0	0	72,842	5,064,507	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS

Provider CCN: 15-0048 | Hospice CCN: 15-1524 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O-6 Part II | Date/Time Prepared: 5/31/2024 2:00 pm

Hospice I

	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	445					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		890				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	445	2,032,318			3.00
4.00	ADMINISTRATIVE & GENERAL	445	0	533,580	-1,771,499	3,293,008	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	3,556	7.00
8.00	DIETARY	0	0	0	0	2,432	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	0	1,212	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	105,496	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	292,444	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	47,363	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			1,138,609	0	2,381,558	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	75	60,970	0	77,697	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	370	299,159	0	381,250	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	12,206	8,567	533,481		1,771,499	100.00
101.00	UNIT COST MULTIPLIER	27.429213	9.625843	0.262499		0.537958	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS

Provider CCN: 15-0048
Hospice CCN: 15-1524

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

Worksheet O-6 Part II
Date/Time Prepared: 5/31/2024 2:00 pm

Hospice I

	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	445					5.00
6.00	LAUNDRY & LINEN SERVICE	0	445				6.00
7.00	HOUSEKEEPING	0		445			7.00
8.00	DIETARY	0		0	1,211		8.00
9.00	NURSING ADMINISTRATION	0		0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	75	75	75	205	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	370	370	370	1,006	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	5,469	3,740	0	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	12.289888	3.088357	0.000000	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS

Provider CCN: 15-0048 | Hospice CCN: 15-1524 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O-6 Part II | Date/Time Prepared: 5/31/2024 2:00 pm

Hospice I

	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	21,088					10.00
11.00	MEDICAL RECORDS		21,088				11.00
12.00	STAFF TRANSPORTATION			1,000			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	21,088	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	1,000	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	19,877	19,877	0	0	19,877	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	205	205	0	0	205	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1,006	1,006	0	0	1,006	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	1,864	162,248	0	449,767	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.088392	162.248000	0.000000	21.328101	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS

Provider CCN: 15-0048 | Hospice CCN: 15-1524 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O-6 Part II | Date/Time Prepared: 5/31/2024 2:00 pm

Hospice I

	Cost Center Descriptions	PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)		
		15.00	16.00	17.00		
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	21,088				15.00
16.00	OTHER GENERAL SERVICE		1,211			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			1,211		17.00
	LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	19,877	0			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	205	205	205		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1,006	1,006	1,006		53.00
	NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	72,842		100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	60.150289		101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

Provider CCN: 15-0048 | Hospice CCN: 15-1524 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O-7 | Date/Time Prepared: 5/31/2024 2:00 pm

Hospice I

	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records) HCHC	HRHC	HIRC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.693710	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00					2.00
3.00	SPEECH PATHOLOGY	68.00					3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.328533	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00	1.837387	0	0	0	5.00
6.00	LABORATORY	60.00	0.164205	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0.000000	0	0	0	7.00
8.00	FAMILY PRACTICE	93.00	0.427106	0	0	0	8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	ANCILLARY - OTHER	76.00	0.000000	0	0	0	10.00
10.97	CARDIAC REHABILITATION	76.97	0.526304	0	0	0	10.97
11.00	Totals (sum of lines 1-11)						11.00

	Cost Center Descriptions	Charges by LOC (from Provider Records) HGIP	Shared Service Costs by LOC HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY						2.00
3.00	SPEECH PATHOLOGY						3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	7.00
8.00	FAMILY PRACTICE	0	0	0	0	0	8.00
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.00	ANCILLARY - OTHER	0	0	0	0	0	10.00
10.97	CARDIAC REHABILITATION	0	0	0	0	0	10.97
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-0048 | Hospice CCN: 15-1524 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O-8 | Date/Time Prepared: 5/31/2024 2:00 pm

Hospice I

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			162,248	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			4,088,432	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			19,877	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			205.69	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	17,341	369		9.00
10.00	Program cost (line 8 times line 9)	3,566,870	75,900		10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)			137,771	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			205	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			672.05	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	169	0		14.00
15.00	Program cost (line 13 times line 14)	113,576	0		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			676,056	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			1,006	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			672.02	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	884	27		19.00
20.00	Program cost (line 18 times line 19)	594,066	18,145		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			5,064,507	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			21,088	22.00
23.00	Average cost per diem (line 21 divided by line 22)			240.16	23.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0048	Period: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III Date/Time Prepared: 5/31/2024 2:00 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	3,265,246	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	22,940	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	103.27	3.00
4.00	Number of interns & residents (see instructions)	15.71	4.00
5.00	Indirect medical education percentage (see instructions)	4.38	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	143,018	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	3,431,204	12.00

		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00

		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00