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: 15-0153	Period: From 07/01/2022 To 06/30/2023	Worksheet S Parts I-III Date/Time Prepared: 11/20/2023 11:34 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 11/20/2023 Time: 11:34 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. VINCENT HEART CENTER (15-0153) for the cost reporting period beginning 07/01/2022 and ending 06/30/2023 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	Ronald Frick		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Ronald Frick			2
3	Signatory Title	SENIOR DIRECTOR - FINANCE			3
4	Date	11/20/2023 11:34:00 AM			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	42,858	37,237	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	42,858	37,237	0	0	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/20/2023 11:34 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 10580 N MERIDIAN ST	PO Box:			1.00
2.00	City: INDIANAPOLIS	State: IN	Zip Code: 46290	County: HAMILTON	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	ST. VINCENT HEART CENTER	150153	26900	1	12/05/2002	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
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)	07/01/2022	06/30/2023	20.00
21.00	Type of Control (see instructions)	4		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/20/2023 11:34 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	263	0	0	0	1,265	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			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.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				58.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0153	Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part I Date/Time Prepared: 11/20/2023 11:34 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/20/2023 11:34 am

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 11/20/2023 11:34 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	825,410	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.			123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15HO46	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: ST. VINCENT HEALTH	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 250 W. 96TH STREET	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46260	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.			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

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

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

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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0		171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 11/20/2023 11:34 am

			Y/N	Date	
			1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE				
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	09/19/2023	Y	09/19/2023	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 11/20/2023 11:34 am

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	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.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JILL	HILL	41.00
42.00	Enter the employer/company name of the cost report preparer.	ASCENSION HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	NA	JILL.HILL1@ASCENSION.ORG	43.00

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		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.	MANAGER, NET REVENUE MANAGEMENT		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: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I Date/Time Prepared: 11/20/2023 11:34 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	107	39,055	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)		107	39,055	0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		107	39,055	0.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	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)		107				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: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 11/20/2023 11:34 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	7,923	263	22,252			1.00
2.00	HMO and other (see instructions)	6,626	1,265				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	7,923	263	22,252			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)	7,923	263	22,252	0.00	317.72	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			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)				0.00	317.72	27.00
28.00	Observation Bed Days		0	1,678			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			119			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 11/20/2023 11:34 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,548	66	4,315	1.00
2.00	HMO and other (see instructions)			1,140	215		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,548	66	4,315	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						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

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part II Date/Time Prepared: 11/20/2023 11:34 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	30,799,936	-167,589	30,632,347	661,015.78	46.34	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		115,122	0	115,122	2,080.00	55.35	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		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)		0	0	0	0.00	0.00	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,653,994	0	1,653,994	16,699.54	99.04	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		142,122	0	142,122	711.97	199.62	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		7,783,248	0	7,783,248	146,496.84	53.13	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)		8,789,426	0	8,789,426			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		0	0	0			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)		32,976	0	32,976			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		2,485,962	0	2,485,962			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: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part II Date/Time Prepared: 11/20/2023 11:34 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	692,250	-685,546	6,704	147.30	45.51	26.00
27.00	Administrative & General	5.00	942,515	15,423	957,938	32,514.94	29.46	27.00
28.00	Administrative & General under contract (see inst.)		730,776	0	730,776	4,339.24	168.41	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	672,233	8,504	680,737	18,598.88	36.60	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1,058,862	0	1,058,862	37,594.09	28.17	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		509,879	0	509,879	14,829.88	34.38	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,840,279	29,045	1,869,324	39,993.30	46.74	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	2,006,772	52,427	2,059,199	36,488.99	56.43	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	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part III Date/Time Prepared: 11/20/2023 11:34 am

		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)		32,984,331	-167,589	32,816,742	715,698.99	45.85	1.00
2.00	Excluded area salaries (see instructions)		0	0	0	0.00	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)		32,984,331	-167,589	32,816,742	715,698.99	45.85	3.00
4.00	Subtotal other wages & related costs (see inst.)		9,579,364	0	9,579,364	163,908.35	58.44	4.00
5.00	Subtotal wage-related costs (see inst.)		11,275,388	0	11,275,388	0.00	34.36	5.00
6.00	Total (sum of lines 3 thru 5)		53,839,083	-167,589	53,671,494	879,607.34	61.02	6.00
7.00	Total overhead cost (see instructions)		8,453,566	-580,147	7,873,419	184,506.62	42.67	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part IV | Date/Time Prepared: 11/20/2023 11:34 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,216,122	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	164,462	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)	3,756,977	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	1,182,740	9.00
10.00	Dental, Hearing and Vision Plan	83,085	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	21,951	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)	193,644	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	2,041	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	2,192,698	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	5,396	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	3,286	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	8,822,402	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: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part V Date/Time Prepared: 11/20/2023 11:34 am

	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	1,653,994	8,822,402	1.00
2.00	Hospital	1,653,994	8,822,402	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-10 | Date/Time Prepared: 11/20/2023 11:34 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.178482	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	5,093,439	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	50,821,340	6.00
7.00	Medicaid cost (line 1 times line 6)	9,070,694	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	3,977,255	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	3,977,255	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	3,860,569	696,489	4,557,058	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	689,042	696,489	1,385,531	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 (line 21 minus line 22)	689,042	696,489	1,385,531	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	3,630,682	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	80,483	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	123,821	27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,506,861	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	669,250	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,054,781	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,032,036	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A | Date/Time Prepared: 11/20/2023 11:34 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,113,853	1,113,853	-70,656	1,043,197	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,570,099	2,570,099	70,656	2,640,755	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	692,250	4,889,930	5,582,180	-517,957	5,064,223	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	942,515	21,690,950	22,633,465	15,423	22,648,888	5.00
7.00	00700	OPERATION OF PLANT	672,233	4,572,581	5,244,814	8,504	5,253,318	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	301,643	301,643	0	301,643	8.00
9.00	00900	HOUSEKEEPING	0	1,131,710	1,131,710	0	1,131,710	9.00
10.00	01000	DIETARY	0	2,143,423	2,143,423	-1,432,604	710,819	10.00
11.00	01100	CAFETERIA	0	0	0	1,432,604	1,432,604	11.00
13.00	01300	NURSING ADMINISTRATION	1,840,279	481,594	2,321,873	29,045	2,350,918	13.00
15.00	01500	PHARMACY	2,006,772	138,933	2,145,705	52,427	2,198,132	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	225	225	0	225	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,818,042	7,673,572	23,491,614	257,634	23,749,248	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,893,211	3,987,842	5,881,053	42,337	5,923,390	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,308,295	1,324,228	2,632,523	14,382	2,646,905	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,515,686	-130,593	2,385,093	35,510	2,420,603	59.00
60.00	06000	LABORATORY	0	4,065,518	4,065,518	0	4,065,518	60.00
65.00	06500	RESPIRATORY THERAPY	1,436,517	386,617	1,823,134	36,310	1,859,444	65.00
66.00	06600	PHYSICAL THERAPY	212,894	570,352	783,246	2,719	785,965	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,984,017	4,984,017	0	4,984,017	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	33,454,232	33,454,232	0	33,454,232	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,602,251	4,602,251	0	4,602,251	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,461,242	1,390,751	2,851,993	23,666	2,875,659	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,799,936	101,343,728	132,143,664	0	132,143,664	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	0	0	0	0	0	193.01
200.00		TOTAL (SUM OF LINES 118 through 199)	30,799,936	101,343,728	132,143,664	0	132,143,664	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A | Date/Time Prepared: 11/20/2023 11:34 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-52,244	990,953		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	34,152	2,674,907		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	578,773	5,642,996		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,793,063	33,441,951		5.00
7.00	00700	OPERATION OF PLANT	0	5,253,318		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	301,643		8.00
9.00	00900	HOUSEKEEPING	0	1,131,710		9.00
10.00	01000	DIETARY	0	710,819		10.00
11.00	01100	CAFETERIA	-452,056	980,548		11.00
13.00	01300	NURSING ADMINISTRATION	-98,163	2,252,755		13.00
15.00	01500	PHARMACY	0	2,198,132		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,838	-2,613		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-11,006	23,738,242		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-148,378	5,775,012		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-53,587	2,593,318		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,420,603		59.00
60.00	06000	LABORATORY	0	4,065,518		60.00
65.00	06500	RESPIRATORY THERAPY	-820	1,858,624		65.00
66.00	06600	PHYSICAL THERAPY	0	785,965		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,984,017		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	33,454,232		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,602,251		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-1,175,910	1,699,749		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,410,986	141,554,650		118.00
		NONREIMBURSABLE COST CENTERS				
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	MARKETING	0	0		193.01
200.00		TOTAL (SUM OF LINES 118 through 199)	9,410,986	141,554,650		200.00

RECLASSIFICATIONS | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 11/20/2023 11:34 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAPITAL				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	70,656	1.00
	0		0	70,656	
	B - CAFETERIA				
1.00	CAFETERIA	11.00	0	1,432,604	1.00
	0		0	1,432,604	
	C - SALARY PTO ACCRUAL RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	167,589	1.00
	0		0	167,589	
	D - STARP RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	10,435	0	1.00
2.00	OPERATION OF PLANT	7.00	7,390	0	2.00
3.00	NURSING ADMINISTRATION	13.00	20,230	0	3.00
4.00	PHARMACY	15.00	22,060	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	173,884	0	5.00
6.00	OPERATING ROOM	50.00	20,812	0	6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	14,382	0	7.00
8.00	CARDIAC CATHETERIZATION	59.00	27,654	0	8.00
9.00	RESPIRATORY THERAPY	65.00	15,791	0	9.00
10.00	PHYSICAL THERAPY	66.00	2,340	0	10.00
11.00	EMERGENCY	91.00	16,063	0	11.00
	0		331,041	0	
	E - PTO PAY-OUT RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	4,988	0	1.00
2.00	OPERATION OF PLANT	7.00	1,114	0	2.00
3.00	NURSING ADMINISTRATION	13.00	8,815	0	3.00
4.00	PHARMACY	15.00	30,367	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	83,750	0	5.00
6.00	OPERATING ROOM	50.00	21,525	0	6.00
7.00	CARDIAC CATHETERIZATION	59.00	7,856	0	7.00
8.00	RESPIRATORY THERAPY	65.00	20,519	0	8.00
9.00	PHYSICAL THERAPY	66.00	379	0	9.00
10.00	EMERGENCY	91.00	7,603	0	10.00
	TOTALS		186,916	0	
500.00	Grand Total: Increases		517,957	1,670,849	500.00

RECLASSIFICATIONS | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 11/20/2023 11:34 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAPITAL						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	70,656	11		1.00
	0		0	70,656			
	B - CAFETERIA						
1.00	DIETARY	10.00	0	1,432,604	0		1.00
	0		0	1,432,604			
	C - SALARY PTO ACCRUAL RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	167,589	0	0		1.00
	0		167,589	0			
	D - STARP RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	331,041	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
	0		331,041	0			
	E - PTO PAY-OUT RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	186,916	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
	TOTALS		186,916	0			
500.00	Grand Total: Decreases		685,546	1,503,260			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part I | Date/Time Prepared: 11/20/2023 11:34 am

		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	0	0	0	0	0	1.00
2.00	Land Improvements	379,058	84,099	0	84,099	0	2.00
3.00	Buildings and Fixtures	44,889,488	443,001	0	443,001	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	1,520,827	6,691	0	6,691	0	5.00
6.00	Movable Equipment	29,339,404	615,005	0	615,005	1,063,690	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	76,128,777	1,148,796	0	1,148,796	1,063,690	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	76,128,777	1,148,796	0	1,148,796	1,063,690	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	463,157	0	2.00
3.00	Buildings and Fixtures	45,332,489	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	1,527,518	0	5.00
6.00	Movable Equipment	28,890,719	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	76,213,883	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	76,213,883	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part II | Date/Time Prepared: 11/20/2023 11:34 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	928,764	0	0	0	185,089	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,313,063	208,428	0	0	48,608	2.00
3.00	Total (sum of lines 1-2)	3,241,827	208,428	0	0	233,697	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1,113,853	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,570,099	2.00
3.00	Total (sum of lines 1-2)	0	3,683,952	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part III Date/Time Prepared: 11/20/2023 11:34 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	47,323,164	0	47,323,164	0.620926	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	28,890,719	0	28,890,719	0.379074	0	2.00
3.00	Total (sum of lines 1-2)	76,213,883	0	76,213,883	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	876,520	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,347,215	208,428	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,223,735	208,428	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	-70,656	0	185,089	0	990,953	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	70,656	0	48,608	0	2,674,907	2.00
3.00	Total (sum of lines 1-2)	0	0	233,697	0	3,665,860	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8 | Date/Time Prepared: 11/20/2023 11:34 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-57,245	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		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	-1,377,804			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	18,243,618			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-452,056	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		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-2,838	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	-6,391	ADMINISTRATIVE & GENERAL	5.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** 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	ENTERTAINMENT - ADULTS & PEDS	A	-587	ADULTS & PEDIATRICS	30.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8 | Date/Time Prepared: 11/20/2023 11:34 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MISC INCOME	B	-6,300	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	ENTERTAINMENT - OPER ROOM	A	-71	OPERATING ROOM	50.00	0	33.02
33.03	PROMOTIONAL ITEMS - ADULTS & PEDS	A	-10,419	ADULTS & PEDIATRICS	30.00	0	33.03
33.04	LOBBYING DUES	A	-1,488	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	PROMOTIONAL ITEMS - RESP THERAPY	A	-820	RESPIRATORY THERAPY	65.00	0	33.05
33.06	PROVIDER TAX ADJUSTMENT	A	-6,893,384	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	PATIENT INTEREST INCOME	B	-5,137	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	REALIZED GAIN/LOSS	B	175,810	CAP REL COSTS-BLDG & FIXT	1.00	9	33.08
33.09	UNREALIZED GAIN ON INVESTMENTS	B	-228,054	CAP REL COSTS-BLDG & FIXT	1.00	9	33.09
33.10	LOSS ON SALE DISPOSAL PPE	B	34,152	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.10
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		9,410,986				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: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 11/20/2023 11:34 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE - BENEFITS	4,581,228	4,002,455	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - CAPITAL	1,528,935	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - INTEREST	57,245	0	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - OTHER	18,166,328	0	3.01
4.00	5.00	ADMINISTRATIVE & GENERAL	ST. VINCENT HEALTH CHARGEBAC	-12,156	-12,156	4.00
4.01	15.00	PHARMACY	ST. VINCENT HEALTH CHARGEBAC	-15,000	-15,000	4.01
4.02	54.00	RADIOLOGY-DIAGNOSTIC	ST. VINCENT HEALTH CHARGEBAC	216,714	216,714	4.02
4.03	59.00	CARDIAC CATHETERIZATION	ST. VINCENT HEALTH CHARGEBAC	1,560	1,560	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	TRG ADMIN FEES - SUPPLIES	-1,775,593	0	4.04
4.05	13.00	NURSING ADMINISTRATION	TRG ADMIN FEES - CONTRACTED	-98,163	0	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	TRG ADMIN FEES - OTHER	-213,907	0	4.06
5.00	0		0	22,437,191	4,193,573	5.00

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

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

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

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

6.00	B		0.00	ASCENSION	100.00	6.00
7.00	B		0.00	ST. VINCENT HEA	74.08	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: 15-0153	Period: From 07/01/2022 To 06/30/2023	Worksheet A-8-1 Date/Time Prepared: 11/20/2023 11:34 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	578,773	0		1.00
2.00	1,528,935	0		2.00
3.00	57,245	0		3.00
3.01	18,166,328	0		3.01
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	-1,775,593	0		4.04
4.05	-98,163	0		4.05
4.06	-213,907	0		4.06
5.00	18,243,618			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	HEALTH SVCS		6.00
7.00	HEALTH MGMT		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: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-2 | Date/Time Prepared: 11/20/2023 11:34 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	50.00	OPERATING ROOM	148,307	148,307	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	112,281	30,877	81,404	271,900	449	2.00
3.00	91.00	EMERGENCY	1,175,910	1,175,910	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,436,498	1,355,094	81,404		449	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	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	58,694	2,935	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			58,694	2,935	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	50.00	OPERATING ROOM	0	0	0	148,307		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	58,694	22,710	53,587		2.00
3.00	91.00	EMERGENCY	0	0	0	1,175,910		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	58,694	22,710	1,377,804		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I Date/Time Prepared: 11/20/2023 11:34 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	990,953	990,953				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,674,907		2,674,907			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,642,996	3,469	9,364	5,655,829		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	33,441,951	69,577	187,810	176,908	33,876,246	5.00
7.00	00700	OPERATION OF PLANT	5,253,318	175,412	473,495	125,716	6,027,941	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	301,643	13,190	35,604	0	350,437	8.00
9.00	00900	HOUSEKEEPING	1,131,710	28,017	75,628	0	1,235,355	9.00
10.00	01000	DIETARY	710,819	14,070	37,980	0	762,869	10.00
11.00	01100	CAFETERIA	980,548	28,361	76,555	0	1,085,464	11.00
13.00	01300	NURSING ADMINISTRATION	2,252,755	22,083	59,609	345,219	2,679,666	13.00
15.00	01500	PHARMACY	2,198,132	22,505	60,750	380,285	2,661,672	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,613	22,972	62,009	0	82,368	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,738,242	345,340	932,184	2,968,798	27,984,564	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,775,012	97,101	262,107	357,449	6,491,669	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,593,318	19,450	52,502	244,267	2,909,537	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,420,603	55,207	149,022	471,145	3,095,977	59.00
60.00	06000	LABORATORY	4,065,518	12,538	33,845	0	4,111,901	60.00
65.00	06500	RESPIRATORY THERAPY	1,858,624	32,059	86,537	271,996	2,249,216	65.00
66.00	06600	PHYSICAL THERAPY	785,965	0	0	39,819	825,784	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,984,017	0	0	0	4,984,017	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	33,454,232	0	0	0	33,454,232	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,602,251	0	0	0	4,602,251	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,699,749	29,602	79,906	274,227	2,083,484	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	141,554,650	990,953	2,674,907	5,655,829	141,554,650	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	0	0	0	0	0	193.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	141,554,650	990,953	2,674,907	5,655,829	141,554,650	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I Date/Time Prepared: 11/20/2023 11:34 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	33,876,246					5.00
7.00	00700	OPERATION OF PLANT	1,896,426	7,924,367				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	110,250	140,770	601,457			8.00
9.00	00900	HOUSEKEEPING	388,650	299,019	0	1,923,024		9.00
10.00	01000	DIETARY	240,003	150,167	0	38,583	1,191,622	10.00
11.00	01100	CAFETERIA	341,493	302,683	0	77,769	0	11.00
13.00	01300	NURSING ADMINISTRATION	843,039	235,681	0	60,554	0	13.00
15.00	01500	PHARMACY	837,378	240,192	0	61,713	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	25,913	245,173	0	62,993	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,804,112	3,685,671	601,457	946,963	1,182,262	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,042,318	1,036,322	0	266,264	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	915,358	207,584	0	53,335	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	974,013	589,204	0	151,385	0	59.00
60.00	06000	LABORATORY	1,293,629	133,816	0	34,382	0	60.00
65.00	06500	RESPIRATORY THERAPY	707,617	342,152	0	87,910	246	65.00
66.00	06600	PHYSICAL THERAPY	259,797	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,568,002	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,524,875	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,447,896	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	655,477	315,933	0	81,173	9,114	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,876,246	7,924,367	601,457	1,923,024	1,191,622	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	0	0	0	0	0	193.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	33,876,246	7,924,367	601,457	1,923,024	1,191,622	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I Date/Time Prepared: 11/20/2023 11:34 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			11.00	13.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,807,409					11.00
13.00	01300	NURSING ADMINISTRATION	118,545	3,937,485				13.00
15.00	01500	PHARMACY	108,159	1,132	3,910,246			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	416,447		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,036,465	3,096,483	0	81,673	47,419,650	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	116,044	318,329	0	47,511	10,318,457	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	81,769	38,120	0	9,129	4,214,832	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	144,671	258,489	0	115,174	5,328,913	59.00
60.00	06000	LABORATORY	0	0	0	35,911	5,609,639	60.00
65.00	06500	RESPIRATORY THERAPY	98,268	0	0	10,024	3,495,433	65.00
66.00	06600	PHYSICAL THERAPY	19,531	21,711	0	1,357	1,128,180	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	44,104	6,596,123	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	41,460	44,020,567	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,910,246	21,952	9,982,345	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	83,957	203,221	0	8,152	3,440,511	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,807,409	3,937,485	3,910,246	416,447	141,554,650	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	0	0	0	0	0	193.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,807,409	3,937,485	3,910,246	416,447	141,554,650	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I Date/Time Prepared: 11/20/2023 11:34 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	47,419,650		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	10,318,457		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,214,832		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	5,328,913		59.00
60.00	06000	LABORATORY	0	5,609,639		60.00
65.00	06500	RESPIRATORY THERAPY	0	3,495,433		65.00
66.00	06600	PHYSICAL THERAPY	0	1,128,180		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,596,123		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	44,020,567		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,982,345		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	3,440,511		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	141,554,650		118.00
		NONREIMBURSABLE COST CENTERS				
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	MARKETING	0	0		193.01
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	141,554,650		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II Date/Time Prepared: 11/20/2023 11:34 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,469	9,364	12,833	12,833	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,528,935	69,577	187,810	1,786,322	401	5.00
7.00	00700	OPERATION OF PLANT	0	175,412	473,495	648,907	285	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	13,190	35,604	48,794	0	8.00
9.00	00900	HOUSEKEEPING	0	28,017	75,628	103,645	0	9.00
10.00	01000	DIETARY	0	14,070	37,980	52,050	0	10.00
11.00	01100	CAFETERIA	0	28,361	76,555	104,916	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	22,083	59,609	81,692	783	13.00
15.00	01500	PHARMACY	0	22,505	60,750	83,255	863	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	22,972	62,009	84,981	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	345,340	932,184	1,277,524	6,738	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	97,101	262,107	359,208	811	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,450	52,502	71,952	554	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	55,207	149,022	204,229	1,069	59.00
60.00	06000	LABORATORY	0	12,538	33,845	46,383	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	32,059	86,537	118,596	617	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	90	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	29,602	79,906	109,508	622	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,528,935	990,953	2,674,907	5,194,795	12,833	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	0	0	0	0	0	193.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,528,935	990,953	2,674,907	5,194,795	12,833	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II Date/Time Prepared: 11/20/2023 11:34 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,786,723					5.00
7.00	00700	OPERATION OF PLANT	100,022	749,214				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,815	13,309	67,918			8.00
9.00	00900	HOUSEKEEPING	20,498	28,271	0	152,414		9.00
10.00	01000	DIETARY	12,658	14,198	0	3,058	81,964	10.00
11.00	01100	CAFETERIA	18,011	28,617	0	6,164	0	11.00
13.00	01300	NURSING ADMINISTRATION	44,464	22,283	0	4,799	0	13.00
15.00	01500	PHARMACY	44,165	22,709	0	4,891	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,367	23,180	0	4,993	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	464,348	348,463	67,918	75,055	81,320	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	107,716	97,980	0	21,103	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	48,278	19,626	0	4,227	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	51,372	55,707	0	11,998	0	59.00
60.00	06000	LABORATORY	68,229	12,652	0	2,725	0	60.00
65.00	06500	RESPIRATORY THERAPY	37,321	32,349	0	6,967	17	65.00
66.00	06600	PHYSICAL THERAPY	13,702	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	82,700	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	555,121	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	76,365	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	34,571	29,870	0	6,434	627	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,786,723	749,214	67,918	152,414	81,964	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	0	0	0	0	0	193.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,786,723	749,214	67,918	152,414	81,964	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II Date/Time Prepared: 11/20/2023 11:34 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			11.00	13.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	157,708					11.00
13.00	01300	NURSING ADMINISTRATION	10,344	164,365				13.00
15.00	01500	PHARMACY	9,438	47	165,368			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	113,807		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	90,438	129,260	0	22,246	2,563,310	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,126	13,288	0	12,941	623,173	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,135	1,591	0	2,487	155,850	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	12,623	10,790	0	31,747	379,535	59.00
60.00	06000	LABORATORY	0	0	0	9,781	139,770	60.00
65.00	06500	RESPIRATORY THERAPY	8,574	0	0	2,730	207,171	65.00
66.00	06600	PHYSICAL THERAPY	1,704	906	0	370	16,772	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	12,013	94,713	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11,293	566,414	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	165,368	5,979	247,712	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	7,326	8,483	0	2,220	199,661	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	157,708	164,365	165,368	113,807	5,194,081	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	0	0	0	0	0	193.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	714	714	201.00
202.00		TOTAL (sum lines 118 through 201)	157,708	164,365	165,368	114,521	5,194,795	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II | Date/Time Prepared: 11/20/2023 11:34 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,563,310		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	623,173		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	155,850		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	379,535		59.00
60.00	06000	LABORATORY	0	139,770		60.00
65.00	06500	RESPIRATORY THERAPY	0	207,171		65.00
66.00	06600	PHYSICAL THERAPY	0	16,772		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	94,713		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	566,414		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	247,712		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	199,661		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	5,194,081		118.00
		NONREIMBURSABLE COST CENTERS				
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	MARKETING	0	0		193.01
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	714		201.00
202.00		TOTAL (sum lines 118 through 201)	0	5,194,795		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/20/2023 11:34 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	112,545					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		112,545				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	394	394	30,625,643			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,902	7,902	957,938	-33,876,246	107,678,404	5.00
7.00	00700	OPERATION OF PLANT	19,922	19,922	680,737	0	6,027,941	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,498	1,498	0	0	350,437	8.00
9.00	00900	HOUSEKEEPING	3,182	3,182	0	0	1,235,355	9.00
10.00	01000	DIETARY	1,598	1,598	0	0	762,869	10.00
11.00	01100	CAFETERIA	3,221	3,221	0	0	1,085,464	11.00
13.00	01300	NURSING ADMINISTRATION	2,508	2,508	1,869,324	0	2,679,666	13.00
15.00	01500	PHARMACY	2,556	2,556	2,059,199	0	2,661,672	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,609	2,609	0	0	82,368	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	39,221	39,221	16,075,676	0	27,984,564	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,028	11,028	1,935,548	0	6,491,669	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,209	2,209	1,322,677	0	2,909,537	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,270	6,270	2,551,196	0	3,095,977	59.00
60.00	06000	LABORATORY	1,424	1,424	0	0	4,111,901	60.00
65.00	06500	RESPIRATORY THERAPY	3,641	3,641	1,472,827	0	2,249,216	65.00
66.00	06600	PHYSICAL THERAPY	0	0	215,613	0	825,784	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	4,984,017	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	33,454,232	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	4,602,251	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,362	3,362	1,484,908	0	2,083,484	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	112,545	112,545	30,625,643	-33,876,246	107,678,404	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	0	0	0	0	0	193.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	990,953	2,674,907	5,655,829		33,876,246	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.804949	23.767444	0.184676		0.314606	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			12,833		1,786,723	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000419		0.016593	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: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/20/2023 11:34 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	84,327					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,498	22,252				8.00
9.00	00900	HOUSEKEEPING	3,182	0	79,647			9.00
10.00	01000	DIETARY	1,598	0	1,598	82,501		10.00
11.00	01100	CAFETERIA	3,221	0	3,221	0	609,756	11.00
13.00	01300	NURSING ADMINISTRATION	2,508	0	2,508	0	39,993	13.00
15.00	01500	PHARMACY	2,556	0	2,556	0	36,489	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,609	0	2,609	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	39,221	22,252	39,221	81,853	349,667	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,028	0	11,028	0	39,149	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,209	0	2,209	0	27,586	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,270	0	6,270	0	48,807	59.00
60.00	06000	LABORATORY	1,424	0	1,424	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,641	0	3,641	17	33,152	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	6,589	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,362	0	3,362	631	28,324	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	84,327	22,252	79,647	82,501	609,756	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	0	0	0	0	0	193.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	7,924,367	601,457	1,923,024	1,191,622	1,807,409	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	93.971883	27.029346	24.144337	14.443728	2.964151	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	749,214	67,918	152,414	81,964	157,708	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	8.884628	3.052220	1.913619	0.993491	0.258641	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: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/20/2023 11:34 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION	431,451				13.00
15.00	01500	PHARMACY	124	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	793,102,706		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	339,298	0	155,567,928		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	34,881	0	90,497,756		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,177	0	17,388,940		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	28,324	0	219,247,137		59.00
60.00	06000	LABORATORY	0	0	68,401,651		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	19,092,497		65.00
66.00	06600	PHYSICAL THERAPY	2,379	0	2,585,360		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	84,008,207		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	78,972,379		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	41,814,015		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	22,268	0	15,526,836		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	431,451	100	793,102,706		118.00
		NONREIMBURSABLE COST CENTERS					
193.00	19300	NONPAID WORKERS	0	0	0		193.00
193.01	19301	MARKETING	0	0	0		193.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,937,485	3,910,246	416,447		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.126146	39,102.460000	0.000525		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	164,365	165,368	114,521		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.380959	1,653.680000	0.000143		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/20/2023 11:34 am

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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	47,419,650		47,419,650	0	47,419,650	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,318,457		10,318,457	0	10,318,457	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,214,832		4,214,832	22,710	4,237,542	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,328,913		5,328,913	0	5,328,913	59.00
60.00	06000	LABORATORY	5,609,639		5,609,639	0	5,609,639	60.00
65.00	06500	RESPIRATORY THERAPY	3,495,433	0	3,495,433	0	3,495,433	65.00
66.00	06600	PHYSICAL THERAPY	1,128,180	0	1,128,180	0	1,128,180	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,596,123		6,596,123	0	6,596,123	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	44,020,567		44,020,567	0	44,020,567	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,982,345		9,982,345	0	9,982,345	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,440,511		3,440,511	0	3,440,511	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,325,125		3,325,125		3,325,125	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	144,879,775	0	144,879,775	22,710	144,902,485	200.00
201.00		Less Observation Beds	3,325,125		3,325,125		3,325,125	201.00
202.00		Total (see instructions)	141,554,650	0	141,554,650	22,710	141,577,360	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/20/2023 11:34 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	143,292,137		143,292,137			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	87,975,891	2,521,865	90,497,756	0.114019	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,682,561	9,706,379	17,388,940	0.242386	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	96,387,920	122,859,217	219,247,137	0.024306	0.000000	59.00
60.00	06000	LABORATORY	59,441,661	8,959,990	68,401,651	0.082010	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	15,615,391	3,477,106	19,092,497	0.183079	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,562,932	22,428	2,585,360	0.436372	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	74,988,584	9,019,623	84,008,207	0.078518	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	52,035,273	26,937,106	78,972,379	0.557417	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	37,769,784	4,044,231	41,814,015	0.238732	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,783,889	10,742,947	15,526,836	0.221585	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,971,509	9,304,282	12,275,791	0.270868	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	585,507,532	207,595,174	793,102,706			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	585,507,532	207,595,174	793,102,706			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/20/2023 11:34 am

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		Cost Center Description	PPS Inpatient Ratio		
			11.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS			30.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.114019		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.243692		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.024306		59.00
60.00	06000	LABORATORY	0.082010		60.00
65.00	06500	RESPIRATORY THERAPY	0.183079		65.00
66.00	06600	PHYSICAL THERAPY	0.436372		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.078518		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.557417		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.238732		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000		77.00
	OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.221585		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.270868		92.00
	OTHER REIMBURSABLE COST CENTERS				
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/20/2023 11:34 am

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	47,419,650		47,419,650	0	47,419,650	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,318,457		10,318,457	0	10,318,457	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,214,832		4,214,832	22,710	4,237,542	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,328,913		5,328,913	0	5,328,913	59.00
60.00	06000	LABORATORY	5,609,639		5,609,639	0	5,609,639	60.00
65.00	06500	RESPIRATORY THERAPY	3,495,433	0	3,495,433	0	3,495,433	65.00
66.00	06600	PHYSICAL THERAPY	1,128,180	0	1,128,180	0	1,128,180	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,596,123		6,596,123	0	6,596,123	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	44,020,567		44,020,567	0	44,020,567	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,982,345		9,982,345	0	9,982,345	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,440,511		3,440,511	0	3,440,511	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,325,125		3,325,125		3,325,125	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	144,879,775	0	144,879,775	22,710	144,902,485	200.00
201.00		Less Observation Beds	3,325,125		3,325,125		3,325,125	201.00
202.00		Total (see instructions)	141,554,650	0	141,554,650	22,710	141,577,360	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/20/2023 11:34 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	143,292,137		143,292,137			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	87,975,891	2,521,865	90,497,756	0.114019	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,682,561	9,706,379	17,388,940	0.242386	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	96,387,920	122,859,217	219,247,137	0.024306	0.000000	59.00
60.00	06000	LABORATORY	59,441,661	8,959,990	68,401,651	0.082010	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	15,615,391	3,477,106	19,092,497	0.183079	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,562,932	22,428	2,585,360	0.436372	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	74,988,584	9,019,623	84,008,207	0.078518	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	52,035,273	26,937,106	78,972,379	0.557417	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	37,769,784	4,044,231	41,814,015	0.238732	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,783,889	10,742,947	15,526,836	0.221585	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,971,509	9,304,282	12,275,791	0.270868	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	585,507,532	207,595,174	793,102,706			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	585,507,532	207,595,174	793,102,706			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/20/2023 11:34 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS			30.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000		77.00
	OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
	OTHER REIMBURSABLE COST CENTERS				
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part I Date/Time Prepared: 11/20/2023 11:34 am

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	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	2,563,310	0	2,563,310	23,930	107.12	30.00
200.00	Total (lines 30 through 199)	2,563,310		2,563,310	23,930		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	7,923	848,712	30.00
200.00	Total (lines 30 through 199)	7,923	848,712	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part II Date/Time Prepared: 11/20/2023 11:34 am

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		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	623,173	90,497,756	0.006886	32,734,424	225,409	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	155,850	17,388,940	0.008963	5,359,894	48,041	54.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	379,535	219,247,137	0.001731	29,726,247	51,456	59.00
60.00	06000	LABORATORY	139,770	68,401,651	0.002043	20,919,096	42,738	60.00
65.00	06500	RESPIRATORY THERAPY	207,171	19,092,497	0.010851	4,943,097	53,638	65.00
66.00	06600	PHYSICAL THERAPY	16,772	2,585,360	0.006487	935,556	6,069	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	94,713	84,008,207	0.001127	29,464,420	33,206	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	566,414	78,972,379	0.007172	22,173,738	159,030	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	247,712	41,814,015	0.005924	12,926,181	76,575	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	199,661	15,526,836	0.012859	1,912,799	24,597	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	179,743	12,275,791	0.014642	1,213,217	17,764	92.00
200.00		Total (lines 50 through 199)	2,810,514	649,810,569		162,308,669	738,523	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part III Date/Time Prepared: 11/20/2023 11:34 am

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		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	23,930	0.00	7,923	30.00
200.00		Total (lines 30 through 199)		0	23,930		7,923	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	30.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 11/20/2023 11:34 am

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		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 11/20/2023 11:34 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	90,497,756	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	17,388,940	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	219,247,137	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	68,401,651	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	19,092,497	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,585,360	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	84,008,207	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	78,972,379	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	41,814,015	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	15,526,836	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	12,275,791	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	649,810,569		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 11/20/2023 11:34 am

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	32,734,424	0	780,566	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	5,359,894	0	4,771,172	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	29,726,247	0	44,488,727	0	59.00
60.00	06000	LABORATORY	0.000000	20,919,096	0	2,774,222	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	4,943,097	0	20,223	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	935,556	0	566	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	29,464,420	0	4,672,508	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	22,173,738	0	9,187,865	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	12,926,181	0	2,546,055	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	1,912,799	0	3,785,904	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	1,213,217	0	2,087,724	0	92.00
200.00		Total (lines 50 through 199)		162,308,669	0	75,115,532	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 11/20/2023 11:34 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.114019	780,566	0	0	88,999	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.242386	4,771,172	0	0	1,156,465	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.024306	44,488,727	0	0	1,081,343	59.00
60.00	06000	LABORATORY	0.082010	2,774,222	0	0	227,514	60.00
65.00	06500	RESPIRATORY THERAPY	0.183079	20,223	0	0	3,702	65.00
66.00	06600	PHYSICAL THERAPY	0.436372	566	0	0	247	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.078518	4,672,508	0	0	366,876	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.557417	9,187,865	0	0	5,121,472	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.238732	2,546,055	0	6,731	607,825	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.221585	3,785,904	0	0	838,900	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.270868	2,087,724	0	0	565,498	92.00
200.00		Subtotal (see instructions)		75,115,532	0	6,731	10,058,841	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		75,115,532	0	6,731	10,058,841	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 11/20/2023 11:34 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,607		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
	OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	1,607		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	1,607		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 11/20/2023 11:34 am

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	0.114019	0	4,840	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.242386	0	22,971	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.024306	0	338,447	0	0	59.00
60.00	06000	LABORATORY	0.082010	0	15,612	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.183079	0	16,380	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.436372	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.078518	0	15,465	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.557417	0	46,185	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.238732	0	12,165	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.221585	0	19,085	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.270868	0	19,122	0	0	92.00
200.00		Subtotal (see instructions)		0	510,272	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	510,272	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 11/20/2023 11:34 am

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	552	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,568	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	8,226	0		59.00
60.00	06000	LABORATORY	1,280	0		60.00
65.00	06500	RESPIRATORY THERAPY	2,999	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,214	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,744	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,904	0		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
	OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	4,229	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,180	0		92.00
200.00		Subtotal (see instructions)	57,896	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	57,896	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/20/2023 11:34 am

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	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	23,930	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	23,930	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)	22,252	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	7,923	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)	47,419,650	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)	47,419,650	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)	47,419,650	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)	1,981.60	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	15,700,217	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	15,700,217	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/20/2023 11:34 am

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	27,301,706	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)	43,001,923	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)	848,712	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	738,523	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,587,235	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	41,414,688	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)	1,678	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,981.60	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,325,125	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/20/2023 11:34 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,563,310	47,419,650	0.054056	3,325,125	179,743	90.00
91.00	Nursing Program cost	0	47,419,650	0.000000	3,325,125	0	91.00
92.00	Allied health cost	0	47,419,650	0.000000	3,325,125	0	92.00
93.00	All other Medical Education	0	47,419,650	0.000000	3,325,125	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/20/2023 11:34 am

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)	23,930	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	23,930	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)	22,252	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)	263	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)	47,419,650	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)	47,419,650	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)	47,419,650	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)	1,981.60	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	521,161	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)	521,161	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/20/2023 11:34 am

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	474,364	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)	995,525	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)	1,678	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,981.60	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,325,125	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/20/2023 11:34 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,563,310	47,419,650	0.054056	3,325,125	179,743	90.00
91.00	Nursing Program cost	0	47,419,650	0.000000	3,325,125	0	91.00
92.00	Allied health cost	0	47,419,650	0.000000	3,325,125	0	92.00
93.00	All other Medical Education	0	47,419,650	0.000000	3,325,125	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 11/20/2023 11:34 am

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		46,875,749		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.114019	32,734,424	3,732,346	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.243692	5,359,894	1,306,163	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.024306	29,726,247	722,526	59.00
60.00	06000	LABORATORY	0.082010	20,919,096	1,715,575	60.00
65.00	06500	RESPIRATORY THERAPY	0.183079	4,943,097	904,977	65.00
66.00	06600	PHYSICAL THERAPY	0.436372	935,556	408,250	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.078518	29,464,420	2,313,487	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.557417	22,173,738	12,360,019	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.238732	12,926,181	3,085,893	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.221585	1,912,799	423,848	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.270868	1,213,217	328,622	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		162,308,669	27,301,706	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)		162,308,669		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 11/20/2023 11:34 am

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		1,181,177		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.114019	449,515	51,253	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.242386	74,323	18,015	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.024306	1,749,281	42,518	59.00
60.00	06000	LABORATORY	0.082010	423,277	34,713	60.00
65.00	06500	RESPIRATORY THERAPY	0.183079	61,411	11,243	65.00
66.00	06600	PHYSICAL THERAPY	0.436372	9,351	4,081	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.078518	482,445	37,881	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.557417	334,773	186,608	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.238732	282,335	67,402	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.221585	93,192	20,650	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.270868	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,959,903	474,364	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)		3,959,903		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0153	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part A Date/Time Prepared: 11/20/2023 11:34 am
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		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)	9,026,019	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	25,757,340	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)	281,588	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	639,053	2.04
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	102.40	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
5.01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)	0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)	0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	1.29	30.00
31.00	Percentage of Medicaid patient days (see instructions)	6.83	31.00
32.00	Sum of lines 30 and 31	8.12	32.00
33.00	Allowable disproportionate share percentage (see instructions)	0.00	33.00
34.00	Disproportionate share adjustment (see instructions)	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0153	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part A Date/Time Prepared: 11/20/2023 11:34 am
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		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Payment Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital UCP, including supplemental UCP (If line 34 is zero, enter zero on this line) (see instructions)	0	0	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	0	0	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	0		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)	0		40.00

		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	35,704,000		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	35,704,000	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	2,714,236	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).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	55,786	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
55.01	Cellular therapy acquisition cost (see instructions)	0	55.01
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	38,474,022	59.00
60.00	Primary payer payments	7,623	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	38,466,399	61.00
62.00	Deductibles billed to program beneficiaries	1,900,720	62.00
63.00	Coinsurance billed to program beneficiaries	17,435	63.00
64.00	Allowable bad debts (see instructions)	65,945	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	42,864	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	14,016	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	36,591,108	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	780	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)	0	70.93
70.94	HRR adjustment amount (see instructions)	0	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0153	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part A Date/Time Prepared: 11/20/2023 11:34 am
	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)		36,590,328	71.00
71.01	Sequestration adjustment (see instructions)		731,807	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		35,815,663	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)		42,858	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

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/20/2023 11:34 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	9,026,019	0	9,026,019		9,026,019	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	25,757,340	0		25,757,340	25,757,340	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	281,588	0	281,588		281,588	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	639,053	0		639,053	639,053	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	0	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	35,704,000	0	9,307,607	26,396,393	35,704,000	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	35,704,000	0	9,307,607	26,396,393	35,704,000	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,714,236	0	714,407	1,999,829	2,714,236	16.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/20/2023 11:34 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	55,786	0	11,209	44,577	55,786	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	780	0	780	0	780	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	10,034,003	28,440,799	38,474,802	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	2,643,412	0	693,730	1,949,682	2,643,412	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	27,208	0	9,230	17,978	27,208	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0165	0.0165	0.0165	0.0165		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	43,616	0	11,447	32,169	43,616	25.00
26.00	Total prospective capital payments (see instructions)	12.00	2,714,236	0	714,407	1,999,829	2,714,236	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/20/2023 11:34 am

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	9,026,019	9,026,019		9,026,019	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	25,757,340		25,757,340	25,757,340	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	281,588	281,588		281,588	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	639,053		639,053	639,053	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	35,704,000	9,307,607	26,396,393	35,704,000	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	35,704,000	9,307,607	26,396,393	35,704,000	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,714,236	714,407	1,999,829	2,714,236	16.00
17.00	Special add-on payments for new technologies	54.00	55,786	11,209	44,577	55,786	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	780	780	0	780	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			10,034,003	28,440,799	38,474,802	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/20/2023 11:34 am

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	2,643,412	693,730	1,949,682	2,643,412	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	27,208	9,230	17,978	27,208	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0165	0.0165	0.0165		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	43,616	11,447	32,169	43,616	25.00
26.00	Total prospective capital payments (see instructions)	12.00	2,714,236	714,407	1,999,829	2,714,236	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	0	0	0	0	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0153	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 11/20/2023 11:34 am
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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,607	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	10,058,841	2.00
3.00	OPPS or REH payments	11,087,200	3.00
4.00	Outlier payment (see instructions)	41,545	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	1,607	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	6,731	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)	6,731	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)	6,731	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	5,124	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)	1,607	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	11,128,745	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)	1,775,430	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	9,354,922	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	9,354,922	30.00
31.00	Primary payer payments	194	31.00
32.00	Subtotal (line 30 minus line 31)	9,354,728	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)	57,876	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	37,619	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	32,005	36.00
37.00	Subtotal (see instructions)	9,392,347	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)	9,392,347	40.00
40.01	Sequestration adjustment (see instructions)	187,847	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	9,167,263	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)	37,237	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
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0153	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 11/20/2023 11:34 am
	Title XVIII	Hospital	PPS

		1.00	
	MEDICARE PART B ANCILLARY COSTS		
200.00	Part B Combined Billed Days	0	200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 11/20/2023 11:34 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		35,815,663		9,167,263	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)		35,815,663		9,167,263	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		42,858		37,237	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		35,858,521		9,204,500	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: 15-0153	Period: From 07/01/2022 To 06/30/2023	Worksheet E-1 Part II Date/Time Prepared: 11/20/2023 11:34 am
	Title XVIII	Hospital	PPS

			1.00
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days (see instructions)		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days (see instructions)		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE 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: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-3 Part VII | Date/Time Prepared: 11/20/2023 11:34 am

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	995,525		1.00
2.00	Medical and other services		57,896	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	995,525	57,896	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)	995,525	57,896	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	3,959,903	510,272	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)	3,959,903	510,272	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)	3,959,903	510,272	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	2,964,378	452,376	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)	995,525	57,896	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)	995,525	57,896	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)	995,525	57,896	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)	995,525	57,896	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	995,525	57,896	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)	995,525	57,896	40.00
41.00	Interim payments	995,525	57,896	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

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0153	Period: From 07/01/2022 To 06/30/2023	Worksheet E-5 Date/Time Prepared: 11/20/2023 11:34 am
	Title XVIII		PPS

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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G | Date/Time Prepared: 11/20/2023 11:34 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	37,491,870	0	0	0	1.00
2.00	Temporary investments	8,448,784	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	63,860,623	0	0	0	4.00
5.00	Other receivable	47,166	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-35,370,316	0	0	0	6.00
7.00	Inventory	3,143,203	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	3,022	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	77,624,352	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	463,157	0	0	0	13.00
14.00	Accumulated depreciation	-174,371	0	0	0	14.00
15.00	Buildings	41,510,169	0	0	0	15.00
16.00	Accumulated depreciation	-36,705,569	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	5,349,839	0	0	0	19.00
20.00	Accumulated depreciation	-2,542,832	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	28,933,767	0	0	0	23.00
24.00	Accumulated depreciation	-22,541,242	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)	14,292,918	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	1,630,476	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,630,476	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	93,547,746	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	22,508,144	0	0	0	37.00
38.00	Salaries, wages, and fees payable	618	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	209,165	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	22,717,927	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	94,606	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	94,606	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	22,812,533	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	70,735,213				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)	70,735,213	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	93,547,746	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-1 | Date/Time Prepared: 11/20/2023 11:34 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		65,232,505		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		45,332,544				2.00
3.00	Total (sum of line 1 and line 2)		110,565,049		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)		110,565,049		0		11.00
12.00	TRANSFER TO AFFILIATES	41,494,985		0		0	12.00
13.00	NONCONTROLLING INTEREST	-1,665,149		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)		39,829,836		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		70,735,213		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	TRANSFER TO AFFILIATES		0				12.00
13.00	NONCONTROLLING INTEREST		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: 15-0153 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/20/2023 11:34 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	143,292,137		143,292,137	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	143,292,137		143,292,137	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	143,292,137		143,292,137	17.00
18.00	Ancillary services	434,459,997	187,547,945	622,007,942	18.00
19.00	Outpatient services	7,755,398	20,047,229	27,802,627	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	585,507,532	207,595,174	793,102,706	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		132,143,664		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)		132,143,664		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0153	Period: From 07/01/2022 To 06/30/2023	Worksheet G-3 Date/Time Prepared: 11/20/2023 11:34 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	793,102,706	1.00
2.00	Less contractual allowances and discounts on patients' accounts	597,757,117	2.00
3.00	Net patient revenues (line 1 minus line 2)	195,345,589	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	132,143,664	4.00
5.00	Net income from service to patients (line 3 minus line 4)	63,201,925	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	-18,511,847	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	452,056	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	2,838	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	6,391	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC REVENUE	8,613	24.00
24.01	CONTRACT SERVICES REVENUE	122,784	24.01
24.02	OTHER MISC REVENUE	44,647	24.02
24.03	SEMINARS TUITION REVENUE	0	24.03
24.04	INCOME FROM UNCONSOLIDATED ENTITIES	0	24.04
24.05	OTHER NONOPERATING	0	24.05
24.06	PATIENT INTEREST	5,137	24.06
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	-17,869,381	25.00
26.00	Total (line 5 plus line 25)	45,332,544	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)	45,332,544	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0153	Period: From 07/01/2022 To 06/30/2023	Worksheet L Parts I-III Date/Time Prepared: 11/20/2023 11:34 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	2,643,412	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	27,208	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)	61.29	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	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)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	1.29	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	6.83	8.00
9.00	Sum of lines 7 and 8	8.12	9.00
10.00	Allowable disproportionate share percentage (see instructions)	1.65	10.00
11.00	Disproportionate share adjustment (see instructions)	43,616	11.00
12.00	Total prospective capital payments (see instructions)	2,714,236	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