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: 15-0046	Period: From 09/01/2022 To 08/31/2023	Worksheet S Parts I-III Date/Time Prepared: 1/29/2024 8:15 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 1/29/2024 Time: 8:15 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 TERRE HAUTE REGIONAL HOSPITAL (15-0046) for the cost reporting period beginning 09/01/2022 and ending 08/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	Korenna Power		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	Korenna Power			2
3	Signatory Title	CFO TERRE HAUTE REGIONAL HOSPITAL			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	523,203	18,531	0	0	1.00
2.00	SUBPROVIDER - IPF	0	7,764	-59		0	2.00
3.00	SUBPROVIDER - IRF	0	-28,564	-96		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	502,403	18,376	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: 15-0046	Period: From 09/01/2022 To 08/31/2023	Worksheet S-2 Part I Date/Time Prepared: 1/29/2024 8:15 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 3901 HOSPITAL LANE	PO Box:			1.00
2.00	City: TERRE HAUTE	State: IN	Zip Code: 47802	County: VIGO	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	TERRE HAUTE REGIONAL HOSPITAL	150046	45460	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	TERRE HAUTE PSYCHIATRIC UNIT	15S046	45460	4	09/01/1991	N	P	O	4.00
5.00	Subprovider - IRF	TERRE HAUTE REHAB UNIT	15T046	45460	5	09/01/2006	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									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)	09/01/2022	08/31/2023	20.00
21.00	Type of Control (see instructions)	4		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N		22.00
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y		22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period 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: 15-0046	Period: From 09/01/2022 To 08/31/2023	Worksheet S-2 Part I Date/Time Prepared: 1/29/2024 8:15 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.	684	221	16	31	2,896	54	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.	83	5	0	0	229		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.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0046	Period: From 09/01/2022 To 08/31/2023	Worksheet S-2 Part I Date/Time Prepared: 1/29/2024 8:15 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

		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

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

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

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

		Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
		1.00	2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.		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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0046	Period: From 09/01/2022 To 08/31/2023	Worksheet S-2 Part I Date/Time Prepared: 1/29/2024 8:15 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	191,604	0	643,767	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.	Y	Y	123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	44H070	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: HOSPITAL CORP. OF AMERICA	Contractor's Name: PALMETTO	Contractor's Number: 10001	141.00
142.00	Street: ONE PARK PLAZA	PO Box:		142.00
143.00	City: NASHVILLE	State: TN	Zip Code: 37203	143.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0046	Period: From 09/01/2022 To 08/31/2023	Worksheet S-2 Part I Date/Time Prepared: 1/29/2024 8:15 am

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

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

		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)	N	168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

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

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

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

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

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?	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)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	12/04/2023	Y	12/04/2023	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

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	Y	12/31/2022	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.	JAMES	WELLS	41.00
42.00	Enter the employer/company name of the cost report preparer.	HCA		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-372-6585	JAMES.WELLS2@HCAHEALTHCARE.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0046	Period: From 09/01/2022 To 08/31/2023	Worksheet S-2 Part II Date/Time Prepared: 1/29/2024 8:15 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REPORTING MANAGER REIMBURSEMENT		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: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet S-3 Part I Date/Time Prepared: 1/29/2024 8:15 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	117	42,705	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)		117	42,705	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	18	6,570	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	NEONATAL INTENSIVE CARE UNIT	35.00	6	2,190	0.00	0	12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		141	51,465	0.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF	40.00	19	6,935		0	16.00
17.00	SUBPROVIDER - IRF	41.00	12	4,380		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		172				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: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 1/29/2024 8:15 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)	4,206	952	12,927			1.00
2.00	HMO and other (see instructions)	4,340	2,896				2.00
3.00	HMO IPF Subprovider	552	0				3.00
4.00	HMO IRF Subprovider	199	229				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)	4,206	952	12,927			7.00
8.00	INTENSIVE CARE UNIT	1,155	0	3,069			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	NEONATAL INTENSIVE CARE UNIT	0	0	165			12.00
13.00	NURSERY		0	318			13.00
14.00	Total (see instructions)	5,361	952	16,479	0.00	378.78	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF	378	3,292	5,083	0.00	26.84	16.00
17.00	SUBPROVIDER - IRF	1,230	88	2,111	0.00	14.07	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)			76			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	419.69	27.00
28.00	Observation Bed Days		192	844			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	54	74			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			11			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: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 1/29/2024 8:15 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	1,232	192	3,854	1.00
2.00	HMO and other (see instructions)			895	817		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				15		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	NEONATAL INTENSIVE CARE UNIT						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,232	192	3,854	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF	0.00	0	56	608	933	16.00
17.00	SUBPROVIDER - IRF	0.00	0	102	6	171	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	30,765,478	0	30,765,478	872,958.00	35.24	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	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)		3,918,783	0	3,918,783	127,264.00	30.79	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		0	0	0	0.00	0.00	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		256,121	0	256,121	1,570.00	163.13	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		10,435,183	0	10,435,183	213,549.80	48.87	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)		6,967,485	0	6,967,485			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		1,017,256	0	1,017,256			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		1,802,034	0	1,802,034			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: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet S-3 Part II Date/Time Prepared: 1/29/2024 8:15 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	107,557	0	107,557	2,913.00	36.92	26.00
27.00	Administrative & General	5.00	3,599,364	-209,233	3,390,131	89,412.00	37.92	27.00
28.00	Administrative & General under contract (see inst.)		46,786	0	46,786	65.00	719.78	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	556,878	0	556,878	21,680.00	25.69	30.00
31.00	Laundry & Linen Service	8.00	6,009	0	6,009	197.00	30.50	31.00
32.00	Housekeeping	9.00	1,034,411	0	1,034,411	56,497.00	18.31	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		992,675	0	992,675	37,852.00	26.23	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	492,596	209,233	701,829	9,834.00	71.37	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	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: 15-0046	Period: From 09/01/2022 To 08/31/2023	Worksheet S-3 Part III Date/Time Prepared: 1/29/2024 8:15 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)		31,804,939	0	31,804,939	910,875.00	34.92	1.00
2.00	Excluded area salaries (see instructions)		3,918,783	0	3,918,783	127,264.00	30.79	2.00
3.00	Subtotal salaries (line 1 minus line 2)		27,886,156	0	27,886,156	783,611.00	35.59	3.00
4.00	Subtotal other wages & related costs (see inst.)		10,691,304	0	10,691,304	215,119.80	49.70	4.00
5.00	Subtotal wage-related costs (see inst.)		8,769,519	0	8,769,519	0.00	31.45	5.00
6.00	Total (sum of lines 3 thru 5)		47,346,979	0	47,346,979	998,730.80	47.41	6.00
7.00	Total overhead cost (see instructions)		6,836,276	0	6,836,276	218,450.00	31.29	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0046	Period: From 09/01/2022 To 08/31/2023	Worksheet S-3 Part IV Date/Time Prepared: 1/29/2024 8:15 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,013,879	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	49,830	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	3,972,227	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	-10,611	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	35,027	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)	328,020	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	-4,561	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	1,995,645	17.00
18.00	Medicare Taxes - Employers Portion Only	465,794	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	62,147	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	77,344	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	7,984,741	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: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet S-3 Part V | Date/Time Prepared: 1/29/2024 8:15 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	0	7,984,741	1.00
2.00	Hospital	0	6,967,485	2.00
3.00	SUBPROVIDER - IPF	0	435,088	3.00
4.00	SUBPROVIDER - IRF	0	266,796	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I	0	0	17.00
18.00	Other	0	315,372	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet S-10 | Date/Time Prepared: 1/29/2024 8:15 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)	0.129277	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	20,333,710	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	196,484,867	6.00
7.00	Medicaid cost (line 1 times line 6)	25,400,974	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)	5,067,264	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)	5,067,264	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)	21,654,613	740,724	22,395,337	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,799,443	740,724	3,540,167	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)	2,799,443	740,724	3,540,167	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)	3,624,828	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	161,416	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	248,333	27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,376,495	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	523,420	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	4,063,587	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	9,130,851	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet A | Date/Time Prepared: 1/29/2024 8:15 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		3,106,924	3,106,924	71,485	3,178,409	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,913,579	2,913,579	329,286	3,242,865	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	107,557	5,934,124	6,041,681	130,412	6,172,093	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,599,364	1,391,443	4,990,807	-559,184	4,431,623	5.00
7.00	00700	OPERATION OF PLANT	556,878	3,360,347	3,917,225	-4,130	3,913,095	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,009	420,448	426,457	0	426,457	8.00
9.00	00900	HOUSEKEEPING	1,034,411	459,284	1,493,695	0	1,493,695	9.00
10.00	01000	DIETARY	0	2,044,992	2,044,992	-593,230	1,451,762	10.00
11.00	01100	CAFETERIA	0	0	0	592,621	592,621	11.00
13.00	01300	NURSING ADMINISTRATION	492,596	750,057	1,242,653	233,817	1,476,470	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	742,222	742,222	0	742,222	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,287,666	3,296,082	7,583,748	302,952	7,886,700	30.00
31.00	03100	INTENSIVE CARE UNIT	2,127,392	1,017,636	3,145,028	-20,192	3,124,836	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	417,528	275,181	692,709	-377	692,332	35.00
40.00	04000	SUBPROVIDER - IPF	1,676,091	507,570	2,183,661	-280	2,183,381	40.00
41.00	04100	SUBPROVIDER - IRF	1,027,782	409,252	1,437,034	-141,915	1,295,119	41.00
43.00	04300	NURSERY	120,677	38,267	158,944	-15	158,929	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,862,843	6,847,577	9,710,420	-136,498	9,573,922	50.00
51.00	05100	RECOVERY ROOM	204,335	31,932	236,267	-80	236,187	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	980,093	119,274	1,099,367	-20	1,099,347	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	668,461	342,052	1,010,513	-15,226	995,287	54.00
54.01	03630	ULTRA SOUND	156,816	44,275	201,091	-19,503	181,588	54.01
54.02	03440	MAMMOGRAPHY	78,488	18,022	96,510	0	96,510	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	557,901	522,180	1,080,081	-18,242	1,061,839	55.00
56.00	05600	RADIOISOTOPE	41,853	548,679	590,532	-1,197	589,335	56.00
57.00	05700	CT SCAN	392,193	153,325	545,518	-4,819	540,699	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	146,049	88,973	235,022	0	235,022	58.00
59.00	05900	CARDIAC CATHETERIZATION	500,234	401,788	902,022	-18,826	883,196	59.00
60.00	06000	LABORATORY	1,033,513	1,702,797	2,736,310	-55,630	2,680,680	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	58,055	490,964	549,019	1,253,514	1,802,533	62.00
65.00	06500	RESPIRATORY THERAPY	640,428	744,277	1,384,705	-66,034	1,318,671	65.00
66.00	06600	PHYSICAL THERAPY	975,625	166,784	1,142,409	0	1,142,409	66.00
69.00	06900	ELECTROCARDIOLOGY	408,720	84,106	492,826	0	492,826	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	18,262	7,802	26,064	0	26,064	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	189,156	3,559,665	3,748,821	229,833	3,978,654	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,374,182	2,374,182	114	2,374,296	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,130,211	13,445,391	14,575,602	-1,021,096	13,554,506	73.00
74.00	07400	RENAL DIALYSIS	670	537,101	537,771	-460	537,311	74.00
76.00	03950	LITHOTRIPSY	0	69,400	69,400	0	69,400	76.00
76.01	03330	ENDOSCOPY	241,027	304,438	545,465	-8,023	537,442	76.01
76.02	03040	PRISION CLINIC	196,016	25,361	221,377	-92	221,285	76.02
76.03	03050	WOUND CARE	81,228	651,030	732,258	-2,335	729,923	76.03
76.04	03060	OPIC	448,535	83,192	531,727	0	531,727	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,085,905	5,119,413	7,205,318	-456,461	6,748,857	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)	29,550,568	65,151,388	94,701,956	169	94,702,125	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	22	22	0	22	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	774,390	152,710	927,100	-169	926,931	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0	0	0	0	194.01
194.02	07952	SITTERS	440,520	35,123	475,643	0	475,643	194.02
194.03	07953	UNLICENSED STAFF	0	0	0	0	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	30,765,478	65,339,243	96,104,721	0	96,104,721	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet A | Date/Time Prepared: 1/29/2024 8:15 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	331,854	3,510,263	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-50,336	3,192,529	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	175,297	6,347,390	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	25,302,268	29,733,891	5.00
7.00	00700	OPERATION OF PLANT	52,308	3,965,403	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	426,457	8.00
9.00	00900	HOUSEKEEPING	0	1,493,695	9.00
10.00	01000	DIETARY	0	1,451,762	10.00
11.00	01100	CAFETERIA	-209,256	383,365	11.00
13.00	01300	NURSING ADMINISTRATION	1,089	1,477,559	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	28,515	770,737	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-1,739,868	6,146,832	30.00
31.00	03100	INTENSIVE CARE UNIT	-19,893	3,104,943	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	-224,272	468,060	35.00
40.00	04000	SUBPROVIDER - IPF	-117,971	2,065,410	40.00
41.00	04100	SUBPROVIDER - IRF	-48,171	1,246,948	41.00
43.00	04300	NURSERY	-17	158,912	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-4,861,984	4,711,938	50.00
51.00	05100	RECOVERY ROOM	0	236,187	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-440	1,098,907	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-4,325	990,962	54.00
54.01	03630	ULTRA SOUND	-9	181,579	54.01
54.02	03440	MAMMOGRAPHY	-23	96,487	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,061,839	55.00
56.00	05600	RADIOISOTOPE	-1,763	587,572	56.00
57.00	05700	CT SCAN	-1,282	539,417	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-45	234,977	58.00
59.00	05900	CARDIAC CATHETERIZATION	-6,615	876,581	59.00
60.00	06000	LABORATORY	0	2,680,680	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,802,533	62.00
65.00	06500	RESPIRATORY THERAPY	-104,281	1,214,390	65.00
66.00	06600	PHYSICAL THERAPY	-31,068	1,111,341	66.00
69.00	06900	ELECTROCARDIOLOGY	-11,548	481,278	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	26,064	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,978,654	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,374,296	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,554,506	73.00
74.00	07400	RENAL DIALYSIS	-20,877	516,434	74.00
76.00	03950	LITHOTRIPSY	0	69,400	76.00
76.01	03330	ENDOSCOPY	-153,800	383,642	76.01
76.02	03040	PRISION CLINIC	0	221,285	76.02
76.03	03050	WOUND CARE	-11,376	718,547	76.03
76.04	03060	OPIC	-30,747	500,980	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	-3,677,085	3,071,772	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)	14,564,279	109,266,404	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	22	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	0	926,931	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0	194.01
194.02	07952	SITTERS	0	475,643	194.02
194.03	07953	UNLICENSED STAFF	0	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	14,564,279	110,669,000	200.00

RECLASSIFICATIONS | Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet A-6 | Date/Time Prepared: 1/29/2024 8:15 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - LEASES				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	323,682	1.00
2.00	RESPIRATORY THERAPY	65.00	0	6,913	2.00
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	52,504	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
	0		0	383,099	
	B - PROPERTY INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	77,089	1.00
	0		0	77,089	
	C - EXECUTIVE COMP.				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	126,189	1.00
2.00	NURSING ADMINISTRATION	13.00	192,360	13,327	2.00
	0		192,360	139,516	
	D - CAFETERIA				
1.00	CAFETERIA	11.00	0	592,621	1.00
	0		0	592,621	
	E - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	400,959	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
	0		0	400,959	
	F - DRUG				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	187,573	1.00
2.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	0	1,253,514	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
	0		0	1,441,087	
	G - IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	210,008	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	210,008	
	H - ER BEDHOLD				
1.00	ADULTS & PEDIATRICS	30.00	229,150	159,265	1.00
2.00	INTENSIVE CARE UNIT	31.00	28,351	19,705	2.00
	0		257,501	178,970	

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	I - EQUIPMENT PROPERTY TAX				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	5,604	1.00
	0		0	5,604	
	J - LOST CHARGES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	19,538	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	19,538	
	K - CNO CONTRACT SALARY				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4,223	1.00
2.00	NURSING ADMINISTRATION	13.00	16,873	47,580	2.00
	TOTALS		16,873	51,803	
500.00	Grand Total: Increases		466,734	3,500,294	500.00

RECLASSIFICATIONS | Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet A-6 | Date/Time Prepared: 1/29/2024 8:15 am

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - LEASES					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	81,543	10	1.00
2.00	OPERATION OF PLANT	7.00	0	4,130	0	2.00
3.00	DIETARY	10.00	0	609	0	3.00
4.00	NURSING ADMINISTRATION	13.00	0	36,323	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	0	84,603	0	5.00
6.00	INTENSIVE CARE UNIT	31.00	0	62,639	0	6.00
7.00	SUBPROVIDER - IPF	40.00	0	267	0	7.00
8.00	OPERATING ROOM	50.00	0	25,175	0	8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	9,153	0	9.00
10.00	ULTRA SOUND	54.01	0	19,503	0	10.00
11.00	RADIOLOGY-THERAPEUTIC	55.00	0	40	0	11.00
12.00	LABORATORY	60.00	0	54,453	0	12.00
13.00	EMERGENCY	91.00	0	4,492	0	13.00
14.00	OCCUPATIONAL MEDICINE	194.00	0	169	0	14.00
	0		0	383,099		
	B - PROPERTY INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	77,089	12	1.00
	0		0	77,089		
	C - EXECUTIVE COMP.					
1.00	ADMINISTRATIVE & GENERAL	5.00	192,360	139,516	0	1.00
2.00		0.00	0	0	0	2.00
	0		192,360	139,516		
	D - CAFETERIA					
1.00	DIETARY	10.00	0	592,621	0	1.00
	0		0	592,621		
	E - MEDICAL SUPPLIES					
1.00	ADULTS & PEDIATRICS	30.00	0	860	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	0	4,905	0	2.00
3.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	377	0	3.00
4.00	SUBPROVIDER - IPF	40.00	0	13	0	4.00
5.00	SUBPROVIDER - IRF	41.00	0	141	0	5.00
6.00	NURSERY	43.00	0	15	0	6.00
7.00	OPERATING ROOM	50.00	0	63,230	0	7.00
8.00	RECOVERY ROOM	51.00	0	80	0	8.00
9.00	DELIVERY ROOM & LABOR ROOM	52.00	0	20	0	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,015	0	10.00
11.00	RADIOISOTOPE	56.00	0	1,197	0	11.00
12.00	CT SCAN	57.00	0	4,596	0	12.00
13.00	CARDIAC CATHETERIZATION	59.00	0	2,769	0	13.00
14.00	LABORATORY	60.00	0	1,177	0	14.00
15.00	RESPIRATORY THERAPY	65.00	0	72,603	0	15.00
16.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	209,894	0	16.00
17.00	DRUGS CHARGED TO PATIENTS	73.00	0	7,659	0	17.00
18.00	RENAL DIALYSIS	74.00	0	460	0	18.00
19.00	ENDOSCOPY	76.01	0	8,023	0	19.00
20.00	PRISION CLINIC	76.02	0	92	0	20.00
21.00	WOUND CARE	76.03	0	2,335	0	21.00
22.00	EMERGENCY	91.00	0	15,498	0	22.00
	0		0	400,959		
	F - DRUG					
1.00	INTENSIVE CARE UNIT	31.00	0	704	0	1.00
2.00	SUBPROVIDER - IRF	41.00	0	141,774	0	2.00
3.00	OPERATING ROOM	50.00	0	36,293	0	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,058	0	4.00
5.00	CT SCAN	57.00	0	223	0	5.00
6.00	CARDIAC CATHETERIZATION	59.00	0	947	0	6.00
7.00	RESPIRATORY THERAPY	65.00	0	344	0	7.00
8.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	6,230	0	8.00
9.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,253,514	0	9.00
	0		0	1,441,087		
	G - IMPLANTABLE DEVICES					
1.00	OPERATING ROOM	50.00		7,372	0	1.00
2.00	RADIOLOGY-THERAPEUTIC	55.00		18,202	0	2.00
3.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00		184,434	0	3.00
	0		0	210,008		
	H - ER BEDHOLD					
1.00	EMERGENCY	91.00	257,501	178,970	0	1.00
2.00		0.00	0	0	0	2.00
	0		257,501	178,970		

RECLASSIFICATIONS

Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet A-6 | Date/Time Prepared: 1/29/2024 8:15 am

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	I - EQUIPMENT PROPERTY TAX					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,604	13	1.00
	0		0	5,604		
	J - LOST CHARGES					
1.00	OPERATING ROOM	50.00	0	4,428	0	1.00
2.00	CARDIAC CATHETERIZATION	59.00	0	15,110	0	2.00
	TOTALS		0	19,538		
	K - CNO CONTRACT SALARY					
1.00	ADMINISTRATIVE & GENERAL	5.00	16,873	51,803	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		16,873	51,803		
500.00	Grand Total: Decreases		466,734	3,500,294		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 1/29/2024 8:15 am

		Beginning Balances	Acquisitions Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,262,718	0	0	0	0	1.00
2.00	Land Improvements	3,238,473	0	0	0	0	2.00
3.00	Buildings and Fixtures	38,638,215	30,039	0	30,039	0	3.00
4.00	Building Improvements	9,572,776	15,168	0	15,168	0	4.00
5.00	Fixed Equipment	31,608,284	3,512,258	0	3,512,258	0	5.00
6.00	Movable Equipment	54,195,962	1,773,105	0	1,773,105	326,454	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	138,516,428	5,330,570	0	5,330,570	326,454	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	138,516,428	5,330,570	0	5,330,570	326,454	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,262,718	0	1.00
2.00	Land Improvements	3,238,473	0	2.00
3.00	Buildings and Fixtures	38,668,254	0	3.00
4.00	Building Improvements	9,587,944	0	4.00
5.00	Fixed Equipment	35,120,542	0	5.00
6.00	Movable Equipment	55,642,613	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	143,520,544	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	143,520,544	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS	Provider CCN: 15-0046	Period: From 09/01/2022 To 08/31/2023	Worksheet A-7 Part II Date/Time Prepared: 1/29/2024 8:15 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	2,457,739	4,607	1,377	0	643,201	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,781,448	132,131	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,239,187	136,738	1,377	0	643,201	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	3,106,924	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,913,579	2.00
3.00	Total (sum of lines 1-2)	0	6,020,503	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet A-7 Part III | Date/Time Prepared: 1/29/2024 8:15 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	87,877,931	0	87,877,931	0.612302	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	55,642,613	0	55,642,613	0.387698	0	2.00
3.00	Total (sum of lines 1-2)	143,520,544	0	143,520,544	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,789,593	4,607	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,731,112	455,813	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,520,705	460,420	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,377	77,089	637,597	0	3,510,263	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	5,604	0	3,192,529	2.00
3.00	Total (sum of lines 1-2)	1,377	77,089	643,201	0	6,702,792	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet A-8 | Date/Time Prepared: 1/29/2024 8:15 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)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		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	-10,799,149			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	26,111,430			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-193,965	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		0		0.00	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	-15,291	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-36,485	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-49,753	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)	B	-91,937	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	INTEREST INCOME	B	-22,521	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet A-8 | Date/Time Prepared: 1/29/2024 8:15 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	OTHER REVENUE	B	-58,344	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	UNCLAIMED PROPERTY	B	-548	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	PATIENT TELEPHONES	A	-12,267	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.03
33.04	PATIENT TELEPHONES	A	-66,102	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	PATIENT TELEVISIONS	A	-583	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.05
33.06	PATIENT TELEVISIONS	A	-56,437	OPERATION OF PLANT	7.00	0	33.06
33.07	PATIENT TELEVISIONS	A	-217	RADIOLOGY-DIAGNOSTIC	54.00	0	33.07
33.08	CONSULTING SERVICES	A	-50,419	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	ADMIN TRAVEL	A	-5,513	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	ADMIN MEALS	A	-28,016	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	EMERGENCY NON-ALLOWABLE	A	-30,117	EMERGENCY	91.00	0	33.11
33.12	NON-PATIENT GIFTS	A	-19,312	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	NON-PATIENT GIFTS	A	-903	SUBPROVIDER - IPF	40.00	0	33.13
33.14	ALCOHOL	A	-244	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	COUNTRY CLUB DUES	A	-6,853	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	BHU NON-ALLOWABLE	A	-85	SUBPROVIDER - IPF	40.00	0	33.16
33.17	ADMIN NON-ALLOWABLE	A	-27,326	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	CONTRIBUTIONS	A	-5,050	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	MED STAFF NON-ALLOWABLE	A	-91,374	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	PUBLIC RELATIONS - DEPT. 920	A	-4,440	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21	PHYSICIAN RECRUIT - DEPT. 950	A	-29,855	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22	SALES - DEPT. 965	A	-316	ADMINISTRATIVE & GENERAL	5.00	0	33.22
33.23	LEGAL FEES	A	-1,270	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24	LOBBYING DUES	A	-13,181	ADMINISTRATIVE & GENERAL	5.00	0	33.24
33.25	MOB ACCOUNTING	A	-1,440	ADMINISTRATIVE & GENERAL	5.00	0	33.25
33.26	MOB ACCOUNTING	A	-378	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.26
33.27	USEFUL LIFE ADJUSTMENT	A	172,540	CAP REL COSTS-BLDG & FIXT	1.00	9	33.27
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		14,564,279				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: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 1/29/2024 8:15 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	5.00	ADMINISTRATIVE & GENERAL	HPG	103,833	213,168	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	IT&S	1,708,529	1,963,626	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE COST	1,821,754	3,940,371	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE DIRECT COMP.	202,216	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	SSC	2,132,700	2,026,242	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	SUPPLY CHAIN	1,542,677	1,525,495	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	PARALLON WORKFORCE SOLUTIONS	260,713	271,322	4.03
4.04	7.00	OPERATION OF PLANT	PARALLON WORKFORCE SOLUTIONS	138,324	143,953	4.04
4.05	13.00	NURSING ADMINISTRATION	PARALLON WORKFORCE SOLUTIONS	30,936	32,195	4.05
4.06	30.00	ADULTS & PEDIATRICS	PARALLON WORKFORCE SOLUTIONS	736,530	766,500	4.06
4.07	31.00	INTENSIVE CARE UNIT	PARALLON WORKFORCE SOLUTIONS	488,879	508,772	4.07
4.08	35.00	NEONATAL INTENSIVE CARE UNIT	PARALLON WORKFORCE SOLUTIONS	37,965	39,509	4.08
4.09	40.00	SUBPROVIDER - IPF	PARALLON WORKFORCE SOLUTIONS	39,314	40,914	4.09
4.10	41.00	SUBPROVIDER - IRF	PARALLON WORKFORCE SOLUTIONS	124,219	129,273	4.10
4.11	43.00	NURSERY	PARALLON WORKFORCE SOLUTIONS	439	456	4.11
4.12	50.00	OPERATING ROOM	PARALLON WORKFORCE SOLUTIONS	221,115	230,111	4.12
4.13	52.00	DELIVERY ROOM & LABOR ROOM	PARALLON WORKFORCE SOLUTIONS	10,827	11,267	4.13
4.14	54.00	RADIOLOGY-DIAGNOSTIC	PARALLON WORKFORCE SOLUTIONS	100,956	105,064	4.14
4.15	54.01	ULTRA SOUND	PARALLON WORKFORCE SOLUTIONS	216	225	4.15
4.16	54.02	MAMMOGRAPHY	PARALLON WORKFORCE SOLUTIONS	577	600	4.16
4.17	56.00	RADIOISOTOPE	PARALLON WORKFORCE SOLUTIONS	43,331	45,094	4.17
4.18	57.00	CT SCAN	PARALLON WORKFORCE SOLUTIONS	31,497	32,779	4.18
4.19	58.00	MAGNETIC RESONANCE IMAGING (	PARALLON WORKFORCE SOLUTIONS	1,095	1,140	4.19
4.20	59.00	CARDIAC CATHETERIZATION	PARALLON WORKFORCE SOLUTIONS	162,561	169,176	4.20
4.21	65.00	RESPIRATORY THERAPY	PARALLON WORKFORCE SOLUTIONS	375,524	390,805	4.21
4.22	74.00	RENAL DIALYSIS	PARALLON WORKFORCE SOLUTIONS	513,037	533,914	4.22
4.23	91.00	EMERGENCY	PARALLON WORKFORCE SOLUTIONS	898,281	934,832	4.23
4.24	5.00	ADMINISTRATIVE & GENERAL	PARALLON WORKFORCE SOLUTIONS	-1,090	-4,412	4.24
4.25	5.00	ADMINISTRATIVE & GENERAL	PARALLON WORKFORCE SOLUTIONS	75,976	70,694	4.25
4.26	5.00	ADMINISTRATIVE & GENERAL	PARALLON WORKFORCE SOLUTIONS	69,559	68,407	4.26
4.27	5.00	ADMINISTRATIVE & GENERAL	PARALLON MARK-UP	0	947,409	4.27
4.28	5.00	ADMINISTRATIVE & GENERAL	PARALLON PAYROLL	20,673	24,986	4.28
4.29	5.00	ADMINISTRATIVE & GENERAL	CAPITAL DIVISION IT&S	932,281	912,865	4.29
4.30	16.00	MEDICAL RECORDS & LIBRARY	HIM	588,810	558,840	4.30
4.31	16.00	MEDICAL RECORDS & LIBRARY	HIM ABSTRACTING	128,516	130,278	4.31
4.32	5.00	ADMINISTRATIVE & GENERAL	REVENUE INTEGRITY	1,349	1,349	4.32
4.33	5.00	ADMINISTRATIVE & GENERAL	CREDENTIALING	59,491	58,708	4.33
4.34	40.00	SUBPROVIDER - IPF	BEHAVIORAL HEALTH	161,101	157,088	4.34
4.35	5.00	ADMINISTRATIVE & GENERAL	CREDENTIAL IT&S FEES	7,384	7,370	4.35
4.36	5.00	ADMINISTRATIVE & GENERAL	CLINICAL IT FEES	74,835	72,125	4.36
4.37	5.00	ADMINISTRATIVE & GENERAL	PATIENT ACCTING FEES	293,904	282,620	4.37
4.38	5.00	ADMINISTRATIVE & GENERAL	CASE MGMT ALLOCATION	98,849	124,357	4.38
4.39	4.00	EMPLOYEE BENEFITS DEPARTMENT	HCA HR SERVICES	608,183	608,183	4.39
4.40	4.00	EMPLOYEE BENEFITS DEPARTMENT	MY HEALTH DIRECT ALLOC	0	13,880	4.40
4.41	13.00	NURSING ADMINISTRATION	CLINICAL EDUCATION	568,620	566,272	4.41
4.42	16.00	MEDICAL RECORDS & LIBRARY	CANCER REGISTRY-SARAH CANN	28,607	28,258	4.42
4.43	16.00	MEDICAL RECORDS & LIBRARY	CANCER REGISTRY-SARAH CANN	24,446	24,488	4.43
4.44	5.00	ADMINISTRATIVE & GENERAL	TRANSFER CTR ALLOCATION	311,894	312,551	4.44
4.45	5.00	ADMINISTRATIVE & GENERAL	URS ALLOCATION	66,895	62,613	4.45
4.46	5.00	ADMINISTRATIVE & GENERAL	CDI MS-DRGRECON TEAM ALLOC	0	23,939	4.46
4.47	5.00	ADMINISTRATIVE & GENERAL	SUPPORT SERVICES ALLOCATION	14,684	13,513	4.47
4.48	7.00	OPERATION OF PLANT	FACILITIES MGMT ALLOCATION	30,826	21,509	4.48
4.49	41.00	SUBPROVIDER - IRF	IRF ALLOCATION	145,787	141,774	4.49
4.50	60.00	LABORATORY	LAB SERVICES-DEPT 736	182,975	182,975	4.50
4.51	5.00	ADMINISTRATIVE & GENERAL	CALL CENTER	0	50,536	4.51
4.52	5.00	ADMINISTRATIVE & GENERAL	PHYSICIAN RECRUITING	0	46,512	4.52
4.53	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE	425,504	643,767	4.53
4.54	5.00	ADMINISTRATIVE & GENERAL	GENERAL LIABILITY INSURANCE	0	20,356	4.54
4.55	5.00	ADMINISTRATIVE & GENERAL	PHYSICIAN SALES	0	126,784	4.55
4.56	5.00	ADMINISTRATIVE & GENERAL	RICHMOND FSC	7,700	8,692	4.56
4.57	4.00	EMPLOYEE BENEFITS DEPARTMENT	RESTORATION PLAN EXP.	0	-3,385	4.57
4.58	4.00	EMPLOYEE BENEFITS DEPARTMENT	SELF INS_POOLING ADJ.	0	-198,437	4.58
4.59	5.00	ADMINISTRATIVE & GENERAL	STUDENT LOAN REPAYMENT BENEF	0	14,202	4.59
4.60	5.00	ADMINISTRATIVE & GENERAL	INTERCOMPANY INTEREST	0	-28,706,544	4.60
4.61	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE INTEREST	571,936	0	4.61
4.62	1.00	CAP REL COSTS-BLDG & FIXT	POB SPACE	85,803	0	4.62
4.63	5.00	ADMINISTRATIVE & GENERAL	POB SPACE	54,380	0	4.63
4.64	7.00	OPERATION OF PLANT	POB SPACE	62,653	0	4.64
4.65	1.00	CAP REL COSTS-BLDG & FIXT	PAVILLION SPACE	109,996	0	4.65
4.66	5.00	ADMINISTRATIVE & GENERAL	PAVILLION SPACE	379	0	4.66

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 1/29/2024 8:15 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	
4.67	7.00	OPERATION OF PLANT	PAVILLION SPACE	42,404	0	4.67
4.68	0.00			0	0	4.68
4.69	0.00			0	0	4.69
4.70	0.00			0	0	4.70
4.71	0.00			0	0	4.71
4.72	0.00			0	0	4.72
4.73	0.00			0	0	4.73
4.74	0.00			0	0	4.74
4.75	0.00			0	0	4.75
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			17,583,355	-8,528,075	5.00

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

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

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

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

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	B		100.00	PARALLON	100.00	6.00
7.00	B		67.10	HPG	65.02	7.00
8.00	B		100.00	HCI	100.00	8.00
9.00	B		100.00	CAPITAL DIVISIO	100.00	9.00
10.00	B		100.00	WORKFORCE MGT.	100.00	10.00
10.01	B		100.00	HCA	100.00	10.01
10.02	B		100.00	POB	100.00	10.02
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: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 1/29/2024 8:15 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	-109,335	0	1.00
2.00	-255,097	0	2.00
3.00	-2,118,617	0	3.00
4.00	202,216	0	4.00
4.01	106,458	0	4.01
4.02	17,182	0	4.02
4.03	-10,609	0	4.03
4.04	-5,629	0	4.04
4.05	-1,259	0	4.05
4.06	-29,970	0	4.06
4.07	-19,893	0	4.07
4.08	-1,544	0	4.08
4.09	-1,600	0	4.09
4.10	-5,054	0	4.10
4.11	-17	0	4.11
4.12	-8,996	0	4.12
4.13	-440	0	4.13
4.14	-4,108	0	4.14
4.15	-9	0	4.15
4.16	-23	0	4.16
4.17	-1,763	0	4.17
4.18	-1,282	0	4.18
4.19	-45	0	4.19
4.20	-6,615	0	4.20
4.21	-15,281	0	4.21
4.22	-20,877	0	4.22
4.23	-36,551	0	4.23
4.24	3,322	0	4.24
4.25	5,282	0	4.25
4.26	1,152	0	4.26
4.27	-947,409	0	4.27
4.28	-4,313	0	4.28
4.29	19,416	0	4.29
4.30	29,970	0	4.30
4.31	-1,762	0	4.31
4.32	0	0	4.32
4.33	783	0	4.33
4.34	4,013	0	4.34
4.35	14	0	4.35
4.36	2,710	0	4.36
4.37	11,284	0	4.37
4.38	-25,508	0	4.38
4.39	0	0	4.39
4.40	-13,880	0	4.40
4.41	2,348	0	4.41
4.42	349	0	4.42
4.43	-42	0	4.43
4.44	-657	0	4.44
4.45	4,282	0	4.45
4.46	-23,939	0	4.46
4.47	1,171	0	4.47
4.48	9,317	0	4.48
4.49	4,013	0	4.49
4.50	0	0	4.50
4.51	-50,536	0	4.51
4.52	-46,512	0	4.52
4.53	-218,263	0	4.53
4.54	-20,356	0	4.54
4.55	-126,784	0	4.55
4.56	-992	0	4.56
4.57	3,385	0	4.57
4.58	198,437	0	4.58
4.59	-14,202	0	4.59
4.60	28,706,544	0	4.60
4.61	571,936	0	4.61
4.62	85,803	9	4.62
4.63	54,380	0	4.63
4.64	62,653	0	4.64
4.65	109,996	9	4.65
4.66	379	0	4.66

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0046	Period: From 09/01/2022 To 08/31/2023	Worksheet A-8-1 Date/Time Prepared: 1/29/2024 8:15 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
4.67	42,404	0	4.67
4.68	0	0	4.68
4.69	0	0	4.69
4.70	0	0	4.70
4.71	0	0	4.71
4.72	0	0	4.72
4.73	0	0	4.73
4.74	0	0	4.74
4.75	0	0	4.75
5.00	26,111,430		5.00

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

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

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

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

	Type of Business	
6.00	MANAGEMENT	6.00
7.00	PURCHASING	7.00
8.00	INSURANCE	8.00
9.00	MANAGEMENT	9.00
10.00	STAFFING	10.00
10.01	HOSPITAL MGT.	10.01
10.02	PROFESSIONAL BU	10.02
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: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 1/29/2024 8:15 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	30.00	ADULTS & PEDIATRICS	1,617,961	1,617,961	0	211,500	0	1.00
2.00	35.00	NEONATAL INTENSIVE CARE UNIT	242,309	194,309	48,000	169,700	240	2.00
3.00	40.00	SUBPROVIDER - IPF	129,158	112,418	16,740	181,300	112	3.00
4.00	41.00	SUBPROVIDER - IRF	47,130	47,130	0	211,500	0	4.00
5.00	50.00	OPERATING ROOM	4,852,988	4,852,988	0	246,200	0	5.00
6.00	65.00	RESPIRATORY THERAPY	89,000	89,000	0	211,500	0	6.00
7.00	66.00	PHYSICAL THERAPY	96,450	338	96,112	211,500	643	7.00
8.00	69.00	ELECTROCARDIOLOGY	35,850	0	35,850	211,500	239	8.00
9.00	76.01	ENDOSCOPY	153,800	153,800	0	246,400	0	9.00
10.00	76.03	WOUND CARE	35,475	0	35,475	211,500	237	10.00
11.00	76.04	OPIC	33,660	0	33,660	33,660	180	11.00
12.00	91.00	EMERGENCY	3,612,451	3,607,451	5,000	211,500	20	12.00
13.00	5.00	ADMINISTRATIVE & GENERAL	2,108	85	2,023	211,500	11	13.00
200.00			10,948,340	10,675,480	272,860		1,682	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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	35.00	NEONATAL INTENSIVE CARE UNIT	19,581	979	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	9,762	488	0	0	0	3.00
4.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	6.00
7.00	66.00	PHYSICAL THERAPY	65,382	3,269	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	24,302	1,215	0	0	0	8.00
9.00	76.01	ENDOSCOPY	0	0	0	0	0	9.00
10.00	76.03	WOUND CARE	24,099	1,205	0	0	0	10.00
11.00	76.04	OPIC	2,913	146	0	0	0	11.00
12.00	91.00	EMERGENCY	2,034	102	0	0	0	12.00
13.00	5.00	ADMINISTRATIVE & GENERAL	1,118	56	0	0	0	13.00
200.00			149,191	7,460	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	30.00	ADULTS & PEDIATRICS	0	0	0	1,617,961		1.00
2.00	35.00	NEONATAL INTENSIVE CARE UNIT	0	19,581	28,419	222,728		2.00
3.00	40.00	SUBPROVIDER - IPF	0	9,762	6,978	119,396		3.00
4.00	41.00	SUBPROVIDER - IRF	0	0	0	47,130		4.00
5.00	50.00	OPERATING ROOM	0	0	0	4,852,988		5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	89,000		6.00
7.00	66.00	PHYSICAL THERAPY	0	65,382	30,730	31,068		7.00
8.00	69.00	ELECTROCARDIOLOGY	0	24,302	11,548	11,548		8.00
9.00	76.01	ENDOSCOPY	0	0	0	153,800		9.00
10.00	76.03	WOUND CARE	0	24,099	11,376	11,376		10.00
11.00	76.04	OPIC	0	2,913	30,747	30,747		11.00
12.00	91.00	EMERGENCY	0	2,034	2,966	3,610,417		12.00
13.00	5.00	ADMINISTRATIVE & GENERAL	0	1,118	905	990		13.00
200.00			0	149,191	123,669	10,799,149		200.00

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,510,263	3,510,263				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,192,529		3,192,529			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,347,390	8,816	8,018	6,364,224		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	29,733,891	257,504	234,196	703,751	30,929,342	5.00
7.00	00700	OPERATION OF PLANT	3,965,403	957,417	870,752	115,601	5,909,173	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	426,457	29,921	27,213	1,247	484,838	8.00
9.00	00900	HOUSEKEEPING	1,493,695	34,081	30,996	214,731	1,773,503	9.00
10.00	01000	DIETARY	1,451,762	58,606	53,301	0	1,563,669	10.00
11.00	01100	CAFETERIA	383,365	30,941	28,140	0	442,446	11.00
13.00	01300	NURSING ADMINISTRATION	1,477,559	4,575	4,161	145,691	1,631,986	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	770,737	7,119	6,475	0	784,331	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,146,832	471,733	429,034	937,645	7,985,244	30.00
31.00	03100	INTENSIVE CARE UNIT	3,104,943	110,913	100,874	447,506	3,764,236	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	468,060	4,439	4,038	86,674	563,211	35.00
40.00	04000	SUBPROVIDER - IPF	2,065,410	98,985	90,025	347,936	2,602,356	40.00
41.00	04100	SUBPROVIDER - IRF	1,246,948	90,079	81,925	213,355	1,632,307	41.00
43.00	04300	NURSERY	158,912	14,203	12,917	25,051	211,083	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,711,938	261,240	237,594	594,292	5,805,064	50.00
51.00	05100	RECOVERY ROOM	236,187	14,293	12,999	42,417	305,896	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,098,907	45,170	41,082	203,456	1,388,615	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	990,962	107,457	97,731	138,764	1,334,914	54.00
54.01	03630	ULTRA SOUND	181,579	7,408	6,738	32,553	228,278	54.01
54.02	03440	MAMMOGRAPHY	96,487	23,893	21,731	16,293	158,404	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	1,061,839	38,466	34,984	115,814	1,251,103	55.00
56.00	05600	RADIOISOTOPE	587,572	6,885	6,262	8,688	609,407	56.00
57.00	05700	CT SCAN	539,417	12,127	11,029	81,415	643,988	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	234,977	12,461	11,333	30,318	289,089	58.00
59.00	05900	CARDIAC CATHETERIZATION	876,581	17,379	15,806	103,843	1,013,609	59.00
60.00	06000	LABORATORY	2,680,680	58,173	52,907	214,545	3,006,305	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,802,533	2,824	2,569	12,052	1,819,978	62.00
65.00	06500	RESPIRATORY THERAPY	1,214,390	14,455	13,147	132,945	1,374,937	65.00
66.00	06600	PHYSICAL THERAPY	1,111,341	9,086	8,264	202,528	1,331,219	66.00
69.00	06900	ELECTROCARDIOLOGY	481,278	39,170	35,624	84,845	640,917	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	26,064	4,385	3,988	3,791	38,228	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,978,654	50,575	45,997	39,267	4,114,493	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,374,296	0	0	0	2,374,296	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,554,506	32,989	30,003	234,618	13,852,116	73.00
74.00	07400	RENAL DIALYSIS	516,434	12,587	11,448	139	540,608	74.00
76.00	03950	LITHOTRIPSY	69,400	0	0	0	69,400	76.00
76.01	03330	ENDOSCOPY	383,642	14,293	12,999	50,034	460,968	76.01
76.02	03040	PRISION CLINIC	221,285	39,991	36,371	40,691	338,338	76.02
76.03	03050	WOUND CARE	718,547	29,740	27,049	16,862	792,198	76.03
76.04	03060	OPIC	500,980	38,890	35,370	93,110	668,350	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,071,772	116,165	105,650	379,555	3,673,142	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)	109,266,404	3,189,434	2,900,740	6,112,023	108,401,585	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	22	5,107	4,645	0	9,774	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	926,931	21,466	19,523	160,754	1,128,674	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	294,256	267,621	0	561,877	194.01
194.02	07952	SITTERS	475,643	0	0	91,447	567,090	194.02
194.03	07953	UNLICENSED STAFF	0	0	0	0	0	194.03
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)	110,669,000	3,510,263	3,192,529	6,364,224	110,669,000	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet B Part I | Date/Time Prepared: 1/29/2024 8:15 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	30,929,342					5.00
7.00	00700	OPERATION OF PLANT	2,292,044	8,201,217				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	188,058	107,319	780,215			8.00
9.00	00900	HOUSEKEEPING	687,905	122,239	0	2,583,647		9.00
10.00	01000	DIETARY	606,514	210,205	0	68,128	2,448,516	10.00
11.00	01100	CAFETERIA	171,616	110,976	0	35,968	0	11.00
13.00	01300	NURSING ADMINISTRATION	633,013	16,409	0	5,318	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	304,226	25,535	0	8,276	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,097,308	1,691,991	428,278	548,380	1,082,742	30.00
31.00	03100	INTENSIVE CARE UNIT	1,460,068	397,819	100,511	128,935	129,356	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	218,458	15,923	5,404	5,161	2,835	35.00
40.00	04000	SUBPROVIDER - IPF	1,009,399	355,034	166,471	115,068	398,638	40.00
41.00	04100	SUBPROVIDER - IRF	633,138	323,091	69,136	104,715	162,178	41.00
43.00	04300	NURSERY	81,875	50,941	10,415	16,510	1,828	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,251,662	937,005	0	303,687	0	50.00
51.00	05100	RECOVERY ROOM	118,651	51,265	0	16,615	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	538,615	162,015	0	52,510	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	517,785	385,424	0	124,917	0	54.00
54.01	03630	ULTRA SOUND	88,544	26,571	0	8,612	0	54.01
54.02	03440	MAMMOGRAPHY	61,442	85,700	0	27,776	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	485,277	137,968	0	44,716	0	55.00
56.00	05600	RADIOISOTOPE	236,376	24,694	0	8,003	0	56.00
57.00	05700	CT SCAN	249,789	43,497	0	14,098	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	112,132	44,695	0	14,486	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	393,158	62,333	0	20,202	0	59.00
60.00	06000	LABORATORY	1,166,083	208,651	0	67,625	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	705,931	10,130	0	3,283	0	62.00
65.00	06500	RESPIRATORY THERAPY	533,309	51,847	0	16,804	0	65.00
66.00	06600	PHYSICAL THERAPY	516,352	32,591	0	10,563	0	66.00
69.00	06900	ELECTROCARDIOLOGY	248,598	140,492	0	45,534	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	14,828	15,729	0	5,098	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,595,925	181,401	0	58,793	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	920,940	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,372,947	118,323	0	38,349	0	73.00
74.00	07400	RENAL DIALYSIS	209,690	45,148	0	14,633	0	74.00
76.00	03950	LITHOTRIPSY	26,919	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	178,800	51,265	0	16,615	0	76.01
76.02	03040	PRISION CLINIC	131,234	143,438	0	46,489	0	76.02
76.03	03050	WOUND CARE	307,277	106,672	0	34,573	0	76.03
76.04	03060	OPIC	259,239	139,489	0	45,209	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,424,735	416,655	0	135,040	0	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)	30,049,860	7,050,480	780,215	2,210,689	1,777,577	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,791	18,318	0	5,937	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	437,789	76,994	0	24,954	0	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	217,940	1,055,425	0	342,067	670,939	194.01
194.02	07952	SITTERS	219,962	0	0	0	0	194.02
194.03	07953	UNLICENSED STAFF	0	0	0	0	0	194.03
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)	30,929,342	8,201,217	780,215	2,583,647	2,448,516	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet B Part I | Date/Time Prepared: 1/29/2024 8:15 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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	761,006					11.00
13.00	01300	NURSING ADMINISTRATION	20,806	2,307,532				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,122,368			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	133,903	634,907	30,810	15,633,563	0	30.00
31.00	03100	INTENSIVE CARE UNIT	63,907	443,528	18,584	6,506,944	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	12,378	83,566	952	907,888	0	35.00
40.00	04000	SUBPROVIDER - IPF	49,688	165,782	40,275	4,902,711	0	40.00
41.00	04100	SUBPROVIDER - IRF	30,469	182,274	5,716	3,143,024	0	41.00
43.00	04300	NURSERY	3,577	13,892	994	391,115	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	84,869	0	137,793	9,520,080	0	50.00
51.00	05100	RECOVERY ROOM	6,058	0	14,191	512,676	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	29,055	134,650	4,795	2,310,255	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,817	0	17,389	2,400,246	0	54.00
54.01	03630	ULTRA SOUND	4,649	0	5,428	362,082	0	54.01
54.02	03440	MAMMOGRAPHY	2,327	0	2,831	338,480	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	16,539	0	27,872	1,963,475	0	55.00
56.00	05600	RADIOISOTOPE	1,241	0	21,386	901,107	0	56.00
57.00	05700	CT SCAN	11,627	0	92,032	1,055,031	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,330	0	12,632	477,364	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	14,829	72,286	39,709	1,616,126	0	59.00
60.00	06000	LABORATORY	30,638	0	102,650	4,581,952	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,721	0	7,913	2,548,956	0	62.00
65.00	06500	RESPIRATORY THERAPY	18,985	62,069	24,457	2,082,408	0	65.00
66.00	06600	PHYSICAL THERAPY	28,922	304	15,594	1,935,545	0	66.00
69.00	06900	ELECTROCARDIOLOGY	12,117	27,738	32,755	1,148,151	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	541	0	1,156	75,580	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,608	0	63,796	6,020,016	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	24,431	3,319,667	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33,505	0	233,583	19,648,823	0	73.00
74.00	07400	RENAL DIALYSIS	20	0	1,682	811,781	0	74.00
76.00	03950	LITHOTRIPSY	0	0	1,447	97,766	0	76.00
76.01	03330	ENDOSCOPY	7,145	0	19,500	734,293	0	76.01
76.02	03040	PRISION CLINIC	5,811	15,353	1,103	681,766	0	76.02
76.03	03050	WOUND CARE	2,408	0	6,948	1,250,076	0	76.03
76.04	03060	OPIC	13,297	68,787	9,813	1,204,184	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	54,203	400,330	102,151	6,206,256	0	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)	724,990	2,305,466	1,122,368	105,289,387	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	37,820	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	22,957	0	0	1,691,368	0	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0	0	2,848,248	0	194.01
194.02	07952	SITTERS	13,059	2,066	0	802,177	0	194.02
194.03	07953	UNLICENSED STAFF	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	761,006	2,307,532	1,122,368	110,669,000	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet B Part I | Date/Time Prepared: 1/29/2024 8:15 am

		Cost Center Description	Total	
			26.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	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
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	15,633,563	30.00
31.00	03100	INTENSIVE CARE UNIT	6,506,944	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	907,888	35.00
40.00	04000	SUBPROVIDER - IPF	4,902,711	40.00
41.00	04100	SUBPROVIDER - IRF	3,143,024	41.00
43.00	04300	NURSERY	391,115	43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	9,520,080	50.00
51.00	05100	RECOVERY ROOM	512,676	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,310,255	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,400,246	54.00
54.01	03630	ULTRA SOUND	362,082	54.01
54.02	03440	MAMMOGRAPHY	338,480	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	1,963,475	55.00
56.00	05600	RADIOISOTOPE	901,107	56.00
57.00	05700	CT SCAN	1,055,031	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	477,364	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,616,126	59.00
60.00	06000	LABORATORY	4,581,952	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,548,956	62.00
65.00	06500	RESPIRATORY THERAPY	2,082,408	65.00
66.00	06600	PHYSICAL THERAPY	1,935,545	66.00
69.00	06900	ELECTROCARDIOLOGY	1,148,151	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	75,580	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,020,016	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,319,667	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,648,823	73.00
74.00	07400	RENAL DIALYSIS	811,781	74.00
76.00	03950	LITHOTRIPSY	97,766	76.00
76.01	03330	ENDOSCOPY	734,293	76.01
76.02	03040	PRISION CLINIC	681,766	76.02
76.03	03050	WOUND CARE	1,250,076	76.03
76.04	03060	OPIC	1,204,184	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	77.00
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	6,206,256	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
		OTHER REIMBURSABLE COST CENTERS		
102.00	10200	OPIOID TREATMENT PROGRAM	0	102.00
		SPECIAL PURPOSE COST CENTERS		
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	105,289,387	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	37,820	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	1,691,368	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	2,848,248	194.01
194.02	07952	SITTERS	802,177	194.02
194.03	07953	UNLICENSED STAFF	0	194.03
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	110,669,000	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet B Part II | Date/Time Prepared: 1/29/2024 8:15 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	8,816	8,018	16,834	16,834	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,367,657	257,504	234,196	2,859,357	1,861	5.00
7.00	00700	OPERATION OF PLANT	2,672	957,417	870,752	1,830,841	306	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	29,921	27,213	57,134	3	8.00
9.00	00900	HOUSEKEEPING	0	34,081	30,996	65,077	568	9.00
10.00	01000	DIETARY	0	58,606	53,301	111,907	0	10.00
11.00	01100	CAFETERIA	0	30,941	28,140	59,081	0	11.00
13.00	01300	NURSING ADMINISTRATION	38,445	4,575	4,161	47,181	385	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,085	7,119	6,475	18,679	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,398	471,733	429,034	902,165	2,484	30.00
31.00	03100	INTENSIVE CARE UNIT	929	110,913	100,874	212,716	1,184	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	72	4,439	4,038	8,549	229	35.00
40.00	04000	SUBPROVIDER - IPF	75	98,985	90,025	189,085	920	40.00
41.00	04100	SUBPROVIDER - IRF	236	90,079	81,925	172,240	564	41.00
43.00	04300	NURSERY	1	14,203	12,917	27,121	66	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	420	261,240	237,594	499,254	1,572	50.00
51.00	05100	RECOVERY ROOM	0	14,293	12,999	27,292	112	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	21	45,170	41,082	86,273	538	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	191	107,457	97,731	205,379	367	54.00
54.01	03630	ULTRA SOUND	0	7,408	6,738	14,146	86	54.01
54.02	03440	MAMMOGRAPHY	1	23,893	21,731	45,625	43	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	38,466	34,984	73,450	306	55.00
56.00	05600	RADIOISOTOPE	82	6,885	6,262	13,229	23	56.00
57.00	05700	CT SCAN	60	12,127	11,029	23,216	215	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2	12,461	11,333	23,796	80	58.00
59.00	05900	CARDIAC CATHETERIZATION	309	17,379	15,806	33,494	275	59.00
60.00	06000	LABORATORY	988	58,173	52,907	112,068	567	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	2,824	2,569	5,393	32	62.00
65.00	06500	RESPIRATORY THERAPY	714	14,455	13,147	28,316	352	65.00
66.00	06600	PHYSICAL THERAPY	0	9,086	8,264	17,350	536	66.00
69.00	06900	ELECTROCARDIOLOGY	0	39,170	35,624	74,794	224	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	4,385	3,988	8,373	10	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	50,575	45,997	96,572	104	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	32,989	30,003	62,992	620	73.00
74.00	07400	RENAL DIALYSIS	974	12,587	11,448	25,009	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0	14,293	12,999	27,292	132	76.01
76.02	03040	PRISION CLINIC	0	39,991	36,371	76,362	108	76.02
76.03	03050	WOUND CARE	0	29,740	27,049	56,789	45	76.03
76.04	03060	OPIC	0	38,890	35,370	74,260	246	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,706	116,165	105,650	223,521	1,004	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)	2,422,038	3,189,434	2,900,740	8,512,212	16,167	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,107	4,645	9,752	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	0	21,466	19,523	40,989	425	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	294,256	267,621	561,877	0	194.01
194.02	07952	SITTERS	0	0	0	0	242	194.02
194.03	07953	UNLICENSED STAFF	0	0	0	0	0	194.03
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)	2,422,038	3,510,263	3,192,529	9,124,830	16,834	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet B Part II | Date/Time Prepared: 1/29/2024 8:15 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	2,861,218					5.00
7.00	00700	OPERATION OF PLANT	212,033	2,043,180				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,397	26,737	101,271			8.00
9.00	00900	HOUSEKEEPING	63,637	30,454	0	159,736		9.00
10.00	01000	DIETARY	56,108	52,369	0	4,212	224,596	10.00
11.00	01100	CAFETERIA	15,876	27,648	0	2,224	0	11.00
13.00	01300	NURSING ADMINISTRATION	58,559	4,088	0	329	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	28,143	6,362	0	512	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	286,527	421,523	55,590	33,904	99,318	30.00
31.00	03100	INTENSIVE CARE UNIT	135,068	99,109	13,046	7,971	11,865	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	20,209	3,967	701	319	260	35.00
40.00	04000	SUBPROVIDER - IPF	93,378	88,450	21,608	7,114	36,566	40.00
41.00	04100	SUBPROVIDER - IRF	58,570	80,492	8,974	6,474	14,876	41.00
43.00	04300	NURSERY	7,574	12,691	1,352	1,021	168	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	208,297	233,437	0	18,776	0	50.00
51.00	05100	RECOVERY ROOM	10,976	12,772	0	1,027	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	49,826	40,363	0	3,246	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	47,899	96,021	0	7,723	0	54.00
54.01	03630	ULTRA SOUND	8,191	6,620	0	532	0	54.01
54.02	03440	MAMMOGRAPHY	5,684	21,351	0	1,717	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	44,892	34,372	0	2,765	0	55.00
56.00	05600	RADIOISOTOPE	21,867	6,152	0	495	0	56.00
57.00	05700	CT SCAN	23,108	10,837	0	872	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	10,373	11,135	0	896	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	36,370	15,529	0	1,249	0	59.00
60.00	06000	LABORATORY	107,872	51,982	0	4,181	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	65,304	2,524	0	203	0	62.00
65.00	06500	RESPIRATORY THERAPY	49,335	12,917	0	1,039	0	65.00
66.00	06600	PHYSICAL THERAPY	47,767	8,119	0	653	0	66.00
69.00	06900	ELECTROCARDIOLOGY	22,997	35,001	0	2,815	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,372	3,919	0	315	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	147,636	45,193	0	3,635	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	85,194	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	497,044	29,478	0	2,371	0	73.00
74.00	07400	RENAL DIALYSIS	19,398	11,248	0	905	0	74.00
76.00	03950	LITHOTRIPSY	2,490	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	16,540	12,772	0	1,027	0	76.01
76.02	03040	PRISION CLINIC	12,140	35,735	0	2,874	0	76.02
76.03	03050	WOUND CARE	28,426	26,575	0	2,137	0	76.03
76.04	03060	OPIC	23,982	34,751	0	2,795	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	131,800	103,802	0	8,349	0	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)	2,779,859	1,756,495	101,271	136,677	163,053	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	351	4,564	0	367	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	40,499	19,182	0	1,543	0	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	20,161	262,939	0	21,149	61,543	194.01
194.02	07952	SITTERS	20,348	0	0	0	0	194.02
194.03	07953	UNLICENSED STAFF	0	0	0	0	0	194.03
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)	2,861,218	2,043,180	101,271	159,736	224,596	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet B Part II | Date/Time Prepared: 1/29/2024 8:15 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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	104,829					11.00
13.00	01300	NURSING ADMINISTRATION	2,866	113,408				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	53,696			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,436	31,204	1,476	1,852,627	0	30.00
31.00	03100	INTENSIVE CARE UNIT	8,804	21,798	890	512,451	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	1,705	4,107	46	40,092	0	35.00
40.00	04000	SUBPROVIDER - IPF	6,845	8,147	1,929	454,042	0	40.00
41.00	04100	SUBPROVIDER - IRF	4,197	8,958	274	355,619	0	41.00
43.00	04300	NURSERY	493	683	48	51,217	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,692	0	6,600	979,628	0	50.00
51.00	05100	RECOVERY ROOM	835	0	680	53,694	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,003	6,617	230	191,096	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,730	0	833	360,952	0	54.00
54.01	03630	ULTRA SOUND	640	0	260	30,475	0	54.01
54.02	03440	MAMMOGRAPHY	321	0	136	74,877	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	2,278	0	1,335	159,398	0	55.00
56.00	05600	RADIOISOTOPE	171	0	1,024	42,961	0	56.00
57.00	05700	CT SCAN	1,602	0	4,408	64,258	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	596	0	605	47,481	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,043	3,553	1,902	94,415	0	59.00
60.00	06000	LABORATORY	4,221	0	4,916	285,807	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	237	0	379	74,072	0	62.00
65.00	06500	RESPIRATORY THERAPY	2,616	3,050	1,171	98,796	0	65.00
66.00	06600	PHYSICAL THERAPY	3,984	15	747	79,171	0	66.00
69.00	06900	ELECTROCARDIOLOGY	1,669	1,363	1,569	140,432	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	75	0	55	14,119	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	773	0	3,056	296,969	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,170	86,364	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,616	0	11,124	608,245	0	73.00
74.00	07400	RENAL DIALYSIS	3	0	81	56,644	0	74.00
76.00	03950	LITHOTRIPSY	0	0	69	2,559	0	76.00
76.01	03330	ENDOSCOPY	984	0	934	59,681	0	76.01
76.02	03040	PRISION CLINIC	801	755	53	128,828	0	76.02
76.03	03050	WOUND CARE	332	0	333	114,637	0	76.03
76.04	03060	OPIC	1,832	3,381	470	141,717	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	7,467	19,675	4,893	500,511	0	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)	99,867	113,306	53,696	8,053,835	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	15,034	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	3,163	0	0	105,801	0	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0	0	927,669	0	194.01
194.02	07952	SITTERS	1,799	102	0	22,491	0	194.02
194.03	07953	UNLICENSED STAFF	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	104,829	113,408	53,696	9,124,830	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet B Part II | Date/Time Prepared: 1/29/2024 8:15 am

		Cost Center Description	Total	
			26.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	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
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	1,852,627	30.00
31.00	03100	INTENSIVE CARE UNIT	512,451	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	40,092	35.00
40.00	04000	SUBPROVIDER - IPF	454,042	40.00
41.00	04100	SUBPROVIDER - IRF	355,619	41.00
43.00	04300	NURSERY	51,217	43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	979,628	50.00
51.00	05100	RECOVERY ROOM	53,694	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	191,096	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	360,952	54.00
54.01	03630	ULTRA SOUND	30,475	54.01
54.02	03440	MAMMOGRAPHY	74,877	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	159,398	55.00
56.00	05600	RADIOISOTOPE	42,961	56.00
57.00	05700	CT SCAN	64,258	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	47,481	58.00
59.00	05900	CARDIAC CATHETERIZATION	94,415	59.00
60.00	06000	LABORATORY	285,807	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	74,072	62.00
65.00	06500	RESPIRATORY THERAPY	98,796	65.00
66.00	06600	PHYSICAL THERAPY	79,171	66.00
69.00	06900	ELECTROCARDIOLOGY	140,432	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	14,119	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	296,969	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	86,364	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	608,245	73.00
74.00	07400	RENAL DIALYSIS	56,644	74.00
76.00	03950	LITHOTRIPSY	2,559	76.00
76.01	03330	ENDOSCOPY	59,681	76.01
76.02	03040	PRISION CLINIC	128,828	76.02
76.03	03050	WOUND CARE	114,637	76.03
76.04	03060	OPIC	141,717	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	77.00
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	500,511	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
		OTHER REIMBURSABLE COST CENTERS		
102.00	10200	OPIOID TREATMENT PROGRAM	0	102.00
		SPECIAL PURPOSE COST CENTERS		
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,053,835	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,034	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	105,801	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	927,669	194.01
194.02	07952	SITTERS	22,491	194.02
194.03	07953	UNLICENSED STAFF	0	194.03
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	9,124,830	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet B-1 | Date/Time Prepared: 1/29/2024 8:15 am

		Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	389,026					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		389,026				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	977	977	30,657,921			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	28,538	28,538	3,390,131	-30,929,342	79,739,658	5.00
7.00	00700	OPERATION OF PLANT	106,106	106,106	556,878	0	5,909,173	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,316	3,316	6,009	0	484,838	8.00
9.00	00900	HOUSEKEEPING	3,777	3,777	1,034,411	0	1,773,503	9.00
10.00	01000	DIETARY	6,495	6,495	0	0	1,563,669	10.00
11.00	01100	CAFETERIA	3,429	3,429	0	0	442,446	11.00
13.00	01300	NURSING ADMINISTRATION	507	507	701,829	0	1,631,986	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	789	789	0	0	784,331	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	52,280	52,280	4,516,816	0	7,985,244	30.00
31.00	03100	INTENSIVE CARE UNIT	12,292	12,292	2,155,743	0	3,764,236	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	492	492	417,528	0	563,211	35.00
40.00	04000	SUBPROVIDER - IPF	10,970	10,970	1,676,091	0	2,602,356	40.00
41.00	04100	SUBPROVIDER - IRF	9,983	9,983	1,027,782	0	1,632,307	41.00
43.00	04300	NURSERY	1,574	1,574	120,677	0	211,083	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	28,952	28,952	2,862,843	0	5,805,064	50.00
51.00	05100	RECOVERY ROOM	1,584	1,584	204,335	0	305,896	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,006	5,006	980,093	0	1,388,615	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,909	11,909	668,461	0	1,334,914	54.00
54.01	03630	ULTRA SOUND	821	821	156,816	0	228,278	54.01
54.02	03440	MAMMOGRAPHY	2,648	2,648	78,488	0	158,404	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	4,263	4,263	557,901	0	1,251,103	55.00
56.00	05600	RADIOISOTOPE	763	763	41,853	0	609,407	56.00
57.00	05700	CT SCAN	1,344	1,344	392,193	0	643,988	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,381	1,381	146,049	0	289,089	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,926	1,926	500,234	0	1,013,609	59.00
60.00	06000	LABORATORY	6,447	6,447	1,033,513	0	3,006,305	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	313	313	58,055	0	1,819,978	62.00
65.00	06500	RESPIRATORY THERAPY	1,602	1,602	640,428	0	1,374,937	65.00
66.00	06600	PHYSICAL THERAPY	1,007	1,007	975,625	0	1,331,219	66.00
69.00	06900	ELECTROCARDIOLOGY	4,341	4,341	408,720	0	640,917	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	486	486	18,262	0	38,228	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,605	5,605	189,156	0	4,114,493	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2,374,296	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,656	3,656	1,130,211	0	13,852,116	73.00
74.00	07400	RENAL DIALYSIS	1,395	1,395	670	0	540,608	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	69,400	76.00
76.01	03330	ENDOSCOPY	1,584	1,584	241,027	0	460,968	76.01
76.02	03040	PRISION CLINIC	4,432	4,432	196,016	0	338,338	76.02
76.03	03050	WOUND CARE	3,296	3,296	81,228	0	792,198	76.03
76.04	03060	OPIC	4,310	4,310	448,535	0	668,350	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	12,874	12,874	1,828,404	0	3,673,142	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)	353,470	353,470	29,443,011	-30,929,342	77,472,243	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	566	566	0	0	9,774	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	2,379	2,379	774,390	0	1,128,674	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	32,611	32,611	0	0	561,877	194.01
194.02	07952	SITTERS	0	0	440,520	0	567,090	194.02
194.03	07953	UNLICENSED STAFF	0	0	0	0	0	194.03
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)	3,510,263	3,192,529	6,364,224		30,929,342	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.023209	8.206467	0.207588		0.387879	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			16,834		2,861,218	204.00

COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 15-0046	Period: From 09/01/2022 To 08/31/2023	Worksheet B-1 Date/Time Prepared: 1/29/2024 8:15 am

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000549		0.035882	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: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet B-1 | Date/Time Prepared: 1/29/2024 8:15 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FOOTAGE)	DIETARY (MEALS SERVED)	CAFETERIA (GROSS SALARIES)	
			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	253,405					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,316	23,823				8.00
9.00	00900	HOUSEKEEPING	3,777	0	246,312			9.00
10.00	01000	DIETARY	6,495	0	6,495	92,428		10.00
11.00	01100	CAFETERIA	3,429	0	3,429	0	25,670,492	11.00
13.00	01300	NURSING ADMINISTRATION	507	0	507	0	701,829	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	789	0	789	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	52,280	13,077	52,280	40,872	4,516,816	30.00
31.00	03100	INTENSIVE CARE UNIT	12,292	3,069	12,292	4,883	2,155,743	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	492	165	492	107	417,528	35.00
40.00	04000	SUBPROVIDER - IPF	10,970	5,083	10,970	15,048	1,676,091	40.00
41.00	04100	SUBPROVIDER - IRF	9,983	2,111	9,983	6,122	1,027,782	41.00
43.00	04300	NURSERY	1,574	318	1,574	69	120,677	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	28,952	0	28,952	0	2,862,843	50.00
51.00	05100	RECOVERY ROOM	1,584	0	1,584	0	204,335	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,006	0	5,006	0	980,093	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,909	0	11,909	0	668,461	54.00
54.01	03630	ULTRA SOUND	821	0	821	0	156,816	54.01
54.02	03440	MAMMOGRAPHY	2,648	0	2,648	0	78,488	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	4,263	0	4,263	0	557,901	55.00
56.00	05600	RADIOISOTOPE	763	0	763	0	41,853	56.00
57.00	05700	CT SCAN	1,344	0	1,344	0	392,193	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,381	0	1,381	0	146,049	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,926	0	1,926	0	500,234	59.00
60.00	06000	LABORATORY	6,447	0	6,447	0	1,033,513	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	313	0	313	0	58,055	62.00
65.00	06500	RESPIRATORY THERAPY	1,602	0	1,602	0	640,428	65.00
66.00	06600	PHYSICAL THERAPY	1,007	0	1,007	0	975,625	66.00
69.00	06900	ELECTROCARDIOLOGY	4,341	0	4,341	0	408,720	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	486	0	486	0	18,262	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,605	0	5,605	0	189,156	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,656	0	3,656	0	1,130,211	73.00
74.00	07400	RENAL DIALYSIS	1,395	0	1,395	0	670	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	1,584	0	1,584	0	241,027	76.01
76.02	03040	PRISION CLINIC	4,432	0	4,432	0	196,016	76.02
76.03	03050	WOUND CARE	3,296	0	3,296	0	81,228	76.03
76.04	03060	OPIC	4,310	0	4,310	0	448,535	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	12,874	0	12,874	0	1,828,404	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)	217,849	23,823	210,756	67,101	24,455,582	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	566	0	566	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	2,379	0	2,379	0	774,390	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	32,611	0	32,611	25,327	0	194.01
194.02	07952	SITTERS	0	0	0	0	440,520	194.02
194.03	07953	UNLICENSED STAFF	0	0	0	0	0	194.03
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)	8,201,217	780,215	2,583,647	2,448,516	761,006	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	32.364069	32.750493	10.489327	26.491063	0.029645	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	2,043,180	101,271	159,736	224,596	104,829	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	8.062903	4.250976	0.648511	2.429956	0.004084	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet B-1 | Date/Time Prepared: 1/29/2024 8:15 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FOOTAGE)	DIETARY (MEALS SERVED)	CAFETERIA (GROSS SALARIES)	
			7.00	8.00	9.00	10.00	11.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet B-1 | Date/Time Prepared: 1/29/2024 8:15 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. SALARIES)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			13.00	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	11,324,726		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	814,448,550	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	3,115,977	22,358,711	30.00
31.00	03100	INTENSIVE CARE UNIT	2,176,705	13,486,438	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	410,117	691,101	35.00
40.00	04000	SUBPROVIDER - IPF	813,610	29,227,374	40.00
41.00	04100	SUBPROVIDER - IRF	894,547	4,147,867	41.00
43.00	04300	NURSERY	68,179	721,640	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	99,995,237	50.00
51.00	05100	RECOVERY ROOM	0	10,298,054	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	660,823	3,479,756	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,619,129	54.00
54.01	03630	ULTRA SOUND	0	3,939,011	54.01
54.02	03440	MAMMOGRAPHY	0	2,054,088	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	20,226,420	55.00
56.00	05600	RADIOISOTOPE	0	15,519,570	56.00
57.00	05700	CT SCAN	0	66,786,753	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	9,167,187	58.00
59.00	05900	CARDIAC CATHETERIZATION	354,758	28,816,497	59.00
60.00	06000	LABORATORY	0	74,491,771	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	5,742,475	62.00
65.00	06500	RESPIRATORY THERAPY	304,618	17,748,416	65.00
66.00	06600	PHYSICAL THERAPY	1,493	11,316,220	66.00
69.00	06900	ELECTROCARDIOLOGY	136,128	23,770,158	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	839,136	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	46,296,392	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	17,728,997	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	169,464,839	73.00
74.00	07400	RENAL DIALYSIS	0	1,220,663	74.00
76.00	03950	LITHOTRIPSY	0	1,050,039	76.00
76.01	03330	ENDOSCOPY	0	14,151,090	76.01
76.02	03040	PRISION CLINIC	75,346	800,198	76.02
76.03	03050	WOUND CARE	0	5,041,909	76.03
76.04	03060	OPIC	337,585	7,121,260	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	1,964,703	74,130,154	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)	11,314,589	814,448,550	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	OCCUPATIONAL MEDICINE	0	0	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0	194.01
194.02	07952	SITTERS	10,137	0	194.02
194.03	07953	UNLICENSED STAFF	0	0	194.03
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,307,532	1,122,368	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.203761	0.001378	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	113,408	53,696	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.010014	0.000066	205.00

COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 15-0046	Period: From 09/01/2022 To 08/31/2023	Worksheet B-1 Date/Time Prepared: 1/29/2024 8:15 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. SALARIES)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	16.00		
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: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet C Part I | Date/Time Prepared: 1/29/2024 8:15 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	15,633,563		15,633,563	0	15,633,563	30.00
31.00	03100	INTENSIVE CARE UNIT	6,506,944		6,506,944	0	6,506,944	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	907,888		907,888	28,419	936,307	35.00
40.00	04000	SUBPROVIDER - IPF	4,902,711		4,902,711	6,978	4,909,689	40.00
41.00	04100	SUBPROVIDER - IRF	3,143,024		3,143,024	0	3,143,024	41.00
43.00	04300	NURSERY	391,115		391,115	0	391,115	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,520,080		9,520,080	0	9,520,080	50.00
51.00	05100	RECOVERY ROOM	512,676		512,676	0	512,676	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,310,255		2,310,255	0	2,310,255	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,400,246		2,400,246	0	2,400,246	54.00
54.01	03630	ULTRA SOUND	362,082		362,082	0	362,082	54.01
54.02	03440	MAMMOGRAPHY	338,480		338,480	0	338,480	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	1,963,475		1,963,475	0	1,963,475	55.00
56.00	05600	RADIOISOTOPE	901,107		901,107	0	901,107	56.00
57.00	05700	CT SCAN	1,055,031		1,055,031	0	1,055,031	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	477,364		477,364	0	477,364	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,616,126		1,616,126	0	1,616,126	59.00
60.00	06000	LABORATORY	4,581,952		4,581,952	0	4,581,952	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,548,956		2,548,956	0	2,548,956	62.00
65.00	06500	RESPIRATORY THERAPY	2,082,408	0	2,082,408	0	2,082,408	65.00
66.00	06600	PHYSICAL THERAPY	1,935,545	0	1,935,545	30,730	1,966,275	66.00
69.00	06900	ELECTROCARDIOLOGY	1,148,151		1,148,151	11,548	1,159,699	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	75,580		75,580	0	75,580	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,020,016		6,020,016	0	6,020,016	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,319,667		3,319,667	0	3,319,667	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,648,823		19,648,823	0	19,648,823	73.00
74.00	07400	RENAL DIALYSIS	811,781		811,781	0	811,781	74.00
76.00	03950	LITHOTRIPSY	97,766		97,766	0	97,766	76.00
76.01	03330	ENDOSCOPY	734,293		734,293	0	734,293	76.01
76.02	03040	PRISION CLINIC	681,766		681,766	0	681,766	76.02
76.03	03050	WOUND CARE	1,250,076		1,250,076	11,376	1,261,452	76.03
76.04	03060	OPIC	1,204,184		1,204,184	30,747	1,234,931	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,206,256		6,206,256	2,966	6,209,222	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	958,151		958,151		958,151	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	106,247,538	0	106,247,538	122,764	106,370,302	200.00
201.00		Less Observation Beds	958,151		958,151		958,151	201.00
202.00		Total (see instructions)	105,289,387	0	105,289,387	122,764	105,412,151	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet C Part I Date/Time Prepared: 1/29/2024 8:15 am

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		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,443,334		21,443,334			30.00
31.00	03100	INTENSIVE CARE UNIT	13,486,438		13,486,438			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	691,101		691,101			35.00
40.00	04000	SUBPROVIDER - IPF	29,227,374		29,227,374			40.00
41.00	04100	SUBPROVIDER - IRF	4,147,867		4,147,867			41.00
43.00	04300	NURSERY	721,640		721,640			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	46,797,870	53,197,367	99,995,237	0.095205	0.000000	50.00
51.00	05100	RECOVERY ROOM	3,886,646	6,411,408	10,298,054	0.049784	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,377,463	102,293	3,479,756	0.663913	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,780,296	8,838,833	12,619,129	0.190207	0.000000	54.00
54.01	03630	ULTRA SOUND	1,257,923	2,681,088	3,939,011	0.091922	0.000000	54.01
54.02	03440	MAMMOGRAPHY	1,128	2,052,960	2,054,088	0.164784	0.000000	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	220,994	20,005,426	20,226,420	0.097075	0.000000	55.00
56.00	05600	RADIOISOTOPE	281,497	15,238,073	15,519,570	0.058063	0.000000	56.00
57.00	05700	CT SCAN	21,530,282	45,256,471	66,786,753	0.015797	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,532,522	5,634,665	9,167,187	0.052073	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	18,813,525	10,002,972	28,816,497	0.056083	0.000000	59.00
60.00	06000	LABORATORY	36,386,136	38,105,635	74,491,771	0.061510	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	4,286,152	1,456,323	5,742,475	0.443878	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	17,057,160	691,256	17,748,416	0.117329	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	11,113,274	202,946	11,316,220	0.171042	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	13,846,238	9,923,920	23,770,158	0.048302	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	552,024	287,112	839,136	0.090069	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	28,846,209	17,450,183	46,296,392	0.130032	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,044,676	8,684,321	17,728,997	0.187245	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	88,659,380	80,805,459	169,464,839	0.115946	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,167,130	53,533	1,220,663	0.665033	0.000000	74.00
76.00	03950	LITHOTRIPSY	0	1,050,039	1,050,039	0.093107	0.000000	76.00
76.01	03330	ENDOSCOPY	2,558,748	11,592,342	14,151,090	0.051890	0.000000	76.01
76.02	03040	PRISION CLINIC	2,120	798,078	800,198	0.851997	0.000000	76.02
76.03	03050	WOUND CARE	60,428	4,981,481	5,041,909	0.247937	0.000000	76.03
76.04	03060	OPIC	37,223	7,084,037	7,121,260	0.169097	0.000000	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	21,021,651	53,108,503	74,130,154	0.083721	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	192,626	722,751	915,377	1.046728	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	408,029,075	406,419,475	814,448,550			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	408,029,075	406,419,475	814,448,550			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet C Part I | Date/Time Prepared: 1/29/2024 8:15 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
31.00	03100	INTENSIVE CARE UNIT		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		35.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.095205	50.00
51.00	05100	RECOVERY ROOM	0.049784	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.663913	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.190207	54.00
54.01	03630	ULTRA SOUND	0.091922	54.01
54.02	03440	MAMMOGRAPHY	0.164784	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.097075	55.00
56.00	05600	RADIOISOTOPE	0.058063	56.00
57.00	05700	CT SCAN	0.015797	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.052073	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.056083	59.00
60.00	06000	LABORATORY	0.061510	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.443878	62.00
65.00	06500	RESPIRATORY THERAPY	0.117329	65.00
66.00	06600	PHYSICAL THERAPY	0.173757	66.00
69.00	06900	ELECTROCARDIOLOGY	0.048788	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.090069	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.130032	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.187245	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.115946	73.00
74.00	07400	RENAL DIALYSIS	0.665033	74.00
76.00	03950	LITHOTRIPSY	0.093107	76.00
76.01	03330	ENDOSCOPY	0.051890	76.01
76.02	03040	PRISION CLINIC	0.851997	76.02
76.03	03050	WOUND CARE	0.250193	76.03
76.04	03060	OPIC	0.173415	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.083761	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.046728	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: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet C Part I | Date/Time Prepared: 1/29/2024 8:15 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	15,633,563		15,633,563	0	15,633,563	30.00
31.00	03100	INTENSIVE CARE UNIT	6,506,944		6,506,944	0	6,506,944	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	907,888		907,888	28,419	936,307	35.00
40.00	04000	SUBPROVIDER - IPF	4,902,711		4,902,711	6,978	4,909,689	40.00
41.00	04100	SUBPROVIDER - IRF	3,143,024		3,143,024	0	3,143,024	41.00
43.00	04300	NURSERY	391,115		391,115	0	391,115	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,520,080		9,520,080	0	9,520,080	50.00
51.00	05100	RECOVERY ROOM	512,676		512,676	0	512,676	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,310,255		2,310,255	0	2,310,255	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,400,246		2,400,246	0	2,400,246	54.00
54.01	03630	ULTRA SOUND	362,082		362,082	0	362,082	54.01
54.02	03440	MAMMOGRAPHY	338,480		338,480	0	338,480	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	1,963,475		1,963,475	0	1,963,475	55.00
56.00	05600	RADIOISOTOPE	901,107		901,107	0	901,107	56.00
57.00	05700	CT SCAN	1,055,031		1,055,031	0	1,055,031	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	477,364		477,364	0	477,364	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,616,126		1,616,126	0	1,616,126	59.00
60.00	06000	LABORATORY	4,581,952		4,581,952	0	4,581,952	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,548,956		2,548,956	0	2,548,956	62.00
65.00	06500	RESPIRATORY THERAPY	2,082,408	0	2,082,408	0	2,082,408	65.00
66.00	06600	PHYSICAL THERAPY	1,935,545	0	1,935,545	30,730	1,966,275	66.00
69.00	06900	ELECTROCARDIOLOGY	1,148,151		1,148,151	11,548	1,159,699	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	75,580		75,580	0	75,580	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,020,016		6,020,016	0	6,020,016	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,319,667		3,319,667	0	3,319,667	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,648,823		19,648,823	0	19,648,823	73.00
74.00	07400	RENAL DIALYSIS	811,781		811,781	0	811,781	74.00
76.00	03950	LITHOTRIPSY	97,766		97,766	0	97,766	76.00
76.01	03330	ENDOSCOPY	734,293		734,293	0	734,293	76.01
76.02	03040	PRISION CLINIC	681,766		681,766	0	681,766	76.02
76.03	03050	WOUND CARE	1,250,076		1,250,076	11,376	1,261,452	76.03
76.04	03060	OPIC	1,204,184		1,204,184	30,747	1,234,931	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,206,256		6,206,256	2,966	6,209,222	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	958,151		958,151		958,151	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	106,247,538	0	106,247,538	122,764	106,370,302	200.00
201.00		Less Observation Beds	958,151		958,151		958,151	201.00
202.00		Total (see instructions)	105,289,387	0	105,289,387	122,764	105,412,151	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet C Part I | Date/Time Prepared: 1/29/2024 8:15 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,443,334		21,443,334			30.00
31.00	03100	INTENSIVE CARE UNIT	13,486,438		13,486,438			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	691,101		691,101			35.00
40.00	04000	SUBPROVIDER - IPF	29,227,374		29,227,374			40.00
41.00	04100	SUBPROVIDER - IRF	4,147,867		4,147,867			41.00
43.00	04300	NURSERY	721,640		721,640			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	46,797,870	53,197,367	99,995,237	0.095205	0.000000	50.00
51.00	05100	RECOVERY ROOM	3,886,646	6,411,408	10,298,054	0.049784	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,377,463	102,293	3,479,756	0.663913	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,780,296	8,838,833	12,619,129	0.190207	0.000000	54.00
54.01	03630	ULTRA SOUND	1,257,923	2,681,088	3,939,011	0.091922	0.000000	54.01
54.02	03440	MAMMOGRAPHY	1,128	2,052,960	2,054,088	0.164784	0.000000	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	220,994	20,005,426	20,226,420	0.097075	0.000000	55.00
56.00	05600	RADIOISOTOPE	281,497	15,238,073	15,519,570	0.058063	0.000000	56.00
57.00	05700	CT SCAN	21,530,282	45,256,471	66,786,753	0.015797	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,532,522	5,634,665	9,167,187	0.052073	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	18,813,525	10,002,972	28,816,497	0.056083	0.000000	59.00
60.00	06000	LABORATORY	36,386,136	38,105,635	74,491,771	0.061510	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	4,286,152	1,456,323	5,742,475	0.443878	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	17,057,160	691,256	17,748,416	0.117329	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	11,113,274	202,946	11,316,220	0.171042	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	13,846,238	9,923,920	23,770,158	0.048302	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	552,024	287,112	839,136	0.090069	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	28,846,209	17,450,183	46,296,392	0.130032	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,044,676	8,684,321	17,728,997	0.187245	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	88,659,380	80,805,459	169,464,839	0.115946	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,167,130	53,533	1,220,663	0.665033	0.000000	74.00
76.00	03950	LITHOTRIPSY	0	1,050,039	1,050,039	0.093107	0.000000	76.00
76.01	03330	ENDOSCOPY	2,558,748	11,592,342	14,151,090	0.051890	0.000000	76.01
76.02	03040	PRISION CLINIC	2,120	798,078	800,198	0.851997	0.000000	76.02
76.03	03050	WOUND CARE	60,428	4,981,481	5,041,909	0.247937	0.000000	76.03
76.04	03060	OPIC	37,223	7,084,037	7,121,260	0.169097	0.000000	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	21,021,651	53,108,503	74,130,154	0.083721	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	192,626	722,751	915,377	1.046728	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	408,029,075	406,419,475	814,448,550			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	408,029,075	406,419,475	814,448,550			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet C Part I Date/Time Prepared: 1/29/2024 8:15 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
31.00	03100	INTENSIVE CARE UNIT		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		35.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	03630	ULTRA SOUND	0.000000	54.01
54.02	03440	MAMMOGRAPHY	0.000000	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	55.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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
74.00	07400	RENAL DIALYSIS	0.000000	74.00
76.00	03950	LITHOTRIPSY	0.000000	76.00
76.01	03330	ENDOSCOPY	0.000000	76.01
76.02	03040	PRISION CLINIC	0.000000	76.02
76.03	03050	WOUND CARE	0.000000	76.03
76.04	03060	OPIC	0.000000	76.04
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: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet D Part I | Date/Time Prepared: 1/29/2024 8:15 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,852,627	0	1,852,627	13,771	134.53	30.00
31.00	INTENSIVE CARE UNIT	512,451		512,451	3,069	166.98	31.00
35.00	NEONATAL INTENSIVE CARE UNIT	40,092		40,092	165	242.98	35.00
40.00	SUBPROVIDER - IPF	454,042	0	454,042	5,083	89.33	40.00
41.00	SUBPROVIDER - IRF	355,619	0	355,619	2,111	168.46	41.00
43.00	NURSERY	51,217		51,217	318	161.06	43.00
200.00	Total (lines 30 through 199)	3,266,048		3,266,048	24,517		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	4,206	565,833	30.00
31.00	INTENSIVE CARE UNIT	1,155	192,862	31.00
35.00	NEONATAL INTENSIVE CARE UNIT	0	0	35.00
40.00	SUBPROVIDER - IPF	378	33,767	40.00
41.00	SUBPROVIDER - IRF	1,230	207,206	41.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	6,969	999,668	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet D Part II | Date/Time Prepared: 1/29/2024 8:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	979,628	99,995,237	0.009797	16,029,023	157,036	50.00
51.00	05100	RECOVERY ROOM	53,694	10,298,054	0.005214	1,269,773	6,621	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	191,096	3,479,756	0.054916	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	360,952	12,619,129	0.028604	1,344,497	38,458	54.00
54.01	03630	ULTRA SOUND	30,475	3,939,011	0.007737	425,811	3,294	54.01
54.02	03440	MAMMOGRAPHY	74,877	2,054,088	0.036453	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	159,398	20,226,420	0.007881	96,714	762	55.00
56.00	05600	RADIOISOTOPE	42,961	15,519,570	0.002768	84,496	234	56.00
57.00	05700	CT SCAN	64,258	66,786,753	0.000962	6,936,405	6,673	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	47,481	9,167,187	0.005179	1,144,110	5,925	58.00
59.00	05900	CARDIAC CATHETERIZATION	94,415	28,816,497	0.003276	5,710,581	18,708	59.00
60.00	06000	LABORATORY	285,807	74,491,771	0.003837	11,506,324	44,150	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	74,072	5,742,475	0.012899	1,597,076	20,601	62.00
65.00	06500	RESPIRATORY THERAPY	98,796	17,748,416	0.005566	6,201,410	34,517	65.00
66.00	06600	PHYSICAL THERAPY	79,171	11,316,220	0.006996	2,122,134	14,846	66.00
69.00	06900	ELECTROCARDIOLOGY	140,432	23,770,158	0.005908	4,934,982	29,156	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	14,119	839,136	0.016826	190,632	3,208	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	296,969	46,296,392	0.006415	10,057,178	64,517	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	86,364	17,728,997	0.004871	3,274,684	15,951	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	608,245	169,464,839	0.003589	27,027,401	97,001	73.00
74.00	07400	RENAL DIALYSIS	56,644	1,220,663	0.046404	446,908	20,738	74.00
76.00	03950	LITHOTRIPSY	2,559	1,050,039	0.002437	0	0	76.00
76.01	03330	ENDOSCOPY	59,681	14,151,090	0.004217	911,367	3,843	76.01
76.02	03040	PRISION CLINIC	128,828	800,198	0.160995	0	0	76.02
76.03	03050	WOUND CARE	114,637	5,041,909	0.022737	19,552	445	76.03
76.04	03060	OPIC	141,717	7,121,260	0.019901	19,619	390	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	500,511	74,130,154	0.006752	6,434,993	43,449	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	113,544	915,377	0.124041	47,683	5,915	92.00
200.00		Total (lines 50 through 199)	4,901,331	744,730,796		107,833,353	636,438	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet D Part III | Date/Time Prepared: 1/29/2024 8:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	35.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	13,771	0.00	4,206	30.00
31.00	03100	INTENSIVE CARE UNIT		0	3,069	0.00	1,155	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0	165	0.00	0	35.00
40.00	04000	SUBPROVIDER - IPF	0	0	5,083	0.00	378	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	2,111	0.00	1,230	41.00
43.00	04300	NURSERY		0	318	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	24,517		6,969	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	35.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet D Part IV | Date/Time Prepared: 1/29/2024 8:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	0	0	0	76.01
76.02	03040	PRISION CLINIC	0	0	0	0	0	76.02
76.03	03050	WOUND CARE	0	0	0	0	0	76.03
76.04	03060	OPIC	0	0	0	0	0	76.04
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: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet D Part IV | Date/Time Prepared: 1/29/2024 8:15 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	99,995,237	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	10,298,054	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,479,756	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,619,129	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	3,939,011	0.000000	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	2,054,088	0.000000	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	20,226,420	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	15,519,570	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	66,786,753	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	9,167,187	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	28,816,497	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	74,491,771	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	5,742,475	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	17,748,416	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	11,316,220	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	23,770,158	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	839,136	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	46,296,392	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	17,728,997	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	169,464,839	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,220,663	0.000000	74.00
76.00	03950	LITHOTRIPSY	0	0	0	1,050,039	0.000000	76.00
76.01	03330	ENDOSCOPY	0	0	0	14,151,090	0.000000	76.01
76.02	03040	PRISION CLINIC	0	0	0	800,198	0.000000	76.02
76.03	03050	WOUND CARE	0	0	0	5,041,909	0.000000	76.03
76.04	03060	OPIC	0	0	0	7,121,260	0.000000	76.04
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	74,130,154	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	915,377	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	744,730,796		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet D Part IV Date/Time Prepared: 1/29/2024 8:15 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	16,029,023	0	12,891,420	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	1,269,773	0	1,534,137	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,344,497	0	1,372,324	0	54.00
54.01	03630	ULTRA SOUND	0.000000	425,811	0	466,642	0	54.01
54.02	03440	MAMMOGRAPHY	0.000000	0	0	125,586	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	96,714	0	7,758,442	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	84,496	0	4,500,342	0	56.00
57.00	05700	CT SCAN	0.000000	6,936,405	0	9,342,007	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	1,144,110	0	982,608	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	5,710,581	0	3,952,861	0	59.00
60.00	06000	LABORATORY	0.000000	11,506,324	0	4,974,032	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	1,597,076	0	531,572	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	6,201,410	0	109,989	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	2,122,134	0	6,165	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	4,934,982	0	2,776,013	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	190,632	0	4,888	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	10,057,178	0	4,637,793	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	3,274,684	0	2,743,695	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	27,027,401	0	28,840,798	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	446,908	0	48,774	0	74.00
76.00	03950	LITHOTRIPSY	0.000000	0	0	251,446	0	76.00
76.01	03330	ENDOSCOPY	0.000000	911,367	0	2,726,274	0	76.01
76.02	03040	PRISION CLINIC	0.000000	0	0	0	0	76.02
76.03	03050	WOUND CARE	0.000000	19,552	0	1,591,642	0	76.03
76.04	03060	OPIC	0.000000	19,619	0	2,514,778	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	6,434,993	0	6,519,612	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	47,683	0	92,875	0	92.00
200.00		Total (lines 50 through 199)		107,833,353	0	101,296,715	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet D Part V Date/Time Prepared: 1/29/2024 8:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.095205	12,891,420	0	0	1,227,328	50.00
51.00	05100	RECOVERY ROOM	0.049784	1,534,137	0	0	76,375	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.663913	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.190207	1,372,324	0	0	261,026	54.00
54.01	03630	ULTRA SOUND	0.091922	466,642	0	0	42,895	54.01
54.02	03440	MAMMOGRAPHY	0.164784	125,586	0	0	20,695	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.097075	7,758,442	0	0	753,151	55.00
56.00	05600	RADIOISOTOPE	0.058063	4,500,342	0	0	261,303	56.00
57.00	05700	CT SCAN	0.015797	9,342,007	0	0	147,576	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.052073	982,608	0	0	51,167	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.056083	3,952,861	0	0	221,688	59.00
60.00	06000	LABORATORY	0.061510	4,974,032	0	0	305,953	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.443878	531,572	0	0	235,953	62.00
65.00	06500	RESPIRATORY THERAPY	0.117329	109,989	0	0	12,905	65.00
66.00	06600	PHYSICAL THERAPY	0.171042	6,165	0	0	1,054	66.00
69.00	06900	ELECTROCARDIOLOGY	0.048302	2,776,013	0	0	134,087	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.090069	4,888	0	0	440	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.130032	4,637,793	0	0	603,061	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.187245	2,743,695	0	0	513,743	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.115946	28,840,798	0	13,965	3,343,975	73.00
74.00	07400	RENAL DIALYSIS	0.665033	48,774	0	0	32,436	74.00
76.00	03950	LITHOTRIPSY	0.093107	251,446	0	0	23,411	76.00
76.01	03330	ENDOSCOPY	0.051890	2,726,274	0	0	141,466	76.01
76.02	03040	PRISION CLINIC	0.851997	0	0	0	0	76.02
76.03	03050	WOUND CARE	0.247937	1,591,642	0	0	394,627	76.03
76.04	03060	OPIC	0.169097	2,514,778	0	0	425,241	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.083721	6,519,612	0	0	545,828	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.046728	92,875	0	0	97,215	92.00
200.00		Subtotal (see instructions)		101,296,715	0	13,965	9,874,599	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		101,296,715	0	13,965	9,874,599	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet D Part V Date/Time Prepared: 1/29/2024 8:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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	1,619	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	76.01
76.02	03040	PRISION CLINIC	0	0	76.02
76.03	03050	WOUND CARE	0	0	76.03
76.04	03060	OPIC	0	0	76.04
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	1,619	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	1,619	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet D Part II | Date/Time Prepared: 1/29/2024 8:15 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	979,628	99,995,237	0.009797	0	0	50.00
51.00	05100	RECOVERY ROOM	53,694	10,298,054	0.005214	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	191,096	3,479,756	0.054916	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	360,952	12,619,129	0.028604	3,330	95	54.00
54.01	03630	ULTRA SOUND	30,475	3,939,011	0.007737	2,105	16	54.01
54.02	03440	MAMMOGRAPHY	74,877	2,054,088	0.036453	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	159,398	20,226,420	0.007881	0	0	55.00
56.00	05600	RADIOISOTOPE	42,961	15,519,570	0.002768	0	0	56.00
57.00	05700	CT SCAN	64,258	66,786,753	0.000962	26,727	26	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	47,481	9,167,187	0.005179	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	94,415	28,816,497	0.003276	7,696	25	59.00
60.00	06000	LABORATORY	285,807	74,491,771	0.003837	142,746	548	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	74,072	5,742,475	0.012899	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	98,796	17,748,416	0.005566	10,675	59	65.00
66.00	06600	PHYSICAL THERAPY	79,171	11,316,220	0.006996	4,498	31	66.00
69.00	06900	ELECTROCARDIOLOGY	140,432	23,770,158	0.005908	5,480	32	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	14,119	839,136	0.016826	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	296,969	46,296,392	0.006415	6,435	41	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	86,364	17,728,997	0.004871	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	608,245	169,464,839	0.003589	219,575	788	73.00
74.00	07400	RENAL DIALYSIS	56,644	1,220,663	0.046404	0	0	74.00
76.00	03950	LITHOTRIPSY	2,559	1,050,039	0.002437	0	0	76.00
76.01	03330	ENDOSCOPY	59,681	14,151,090	0.004217	0	0	76.01
76.02	03040	PRISION CLINIC	128,828	800,198	0.160995	0	0	76.02
76.03	03050	WOUND CARE	114,637	5,041,909	0.022737	0	0	76.03
76.04	03060	OPIC	141,717	7,121,260	0.019901	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	500,511	74,130,154	0.006752	122,889	830	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	915,377	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	4,787,787	744,730,796		552,156	2,491	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0046 Component CCN: 15-S046	Period: From 09/01/2022 To 08/31/2023	Worksheet D Part IV Date/Time Prepared: 1/29/2024 8:15 am
	Title XVIII	Subprovider - IPF	PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	0	0	0	76.01
76.02	03040	PRISION CLINIC	0	0	0	0	0	76.02
76.03	03050	WOUND CARE	0	0	0	0	0	76.03
76.04	03060	OPIC	0	0	0	0	0	76.04
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: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet D Part IV | Date/Time Prepared: 1/29/2024 8:15 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	99,995,237	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	10,298,054	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,479,756	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,619,129	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	3,939,011	0.000000	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	2,054,088	0.000000	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	20,226,420	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	15,519,570	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	66,786,753	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	9,167,187	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	28,816,497	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	74,491,771	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	5,742,475	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	17,748,416	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	11,316,220	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	23,770,158	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	839,136	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	46,296,392	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	17,728,997	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	169,464,839	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,220,663	0.000000	74.00
76.00	03950	LITHOTRIPSY	0	0	0	1,050,039	0.000000	76.00
76.01	03330	ENDOSCOPY	0	0	0	14,151,090	0.000000	76.01
76.02	03040	PRISION CLINIC	0	0	0	800,198	0.000000	76.02
76.03	03050	WOUND CARE	0	0	0	5,041,909	0.000000	76.03
76.04	03060	OPIC	0	0	0	7,121,260	0.000000	76.04
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	74,130,154	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	915,377	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	744,730,796		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet D Part IV | Date/Time Prepared: 1/29/2024 8:15 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	3,330	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.000000	2,105	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0.000000	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	26,727	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	7,696	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	142,746	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	10,675	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	4,498	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	5,480	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	6,435	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	219,575	0	738	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0.000000	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0.000000	0	0	0	0	76.01
76.02	03040	PRISION CLINIC	0.000000	0	0	0	0	76.02
76.03	03050	WOUND CARE	0.000000	0	0	0	0	76.03
76.04	03060	OPIC	0.000000	0	0	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	122,889	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		552,156	0	738	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet D Part V | Date/Time Prepared: 1/29/2024 8:15 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.095205	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.049784	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.663913	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.190207	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.091922	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0.164784	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.097075	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.058063	0	0	0	0	56.00
57.00	05700	CT SCAN	0.015797	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.052073	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.056083	0	0	0	0	59.00
60.00	06000	LABORATORY	0.061510	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.443878	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.117329	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.171042	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.048302	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.090069	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.130032	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.187245	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.115946	738	0	717	86	73.00
74.00	07400	RENAL DIALYSIS	0.665033	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0.093107	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0.051890	0	0	0	0	76.01
76.02	03040	PRISION CLINIC	0.851997	0	0	0	0	76.02
76.03	03050	WOUND CARE	0.247937	0	0	0	0	76.03
76.04	03060	OPIC	0.169097	0	0	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.083721	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.046728	0	0	0	0	92.00
200.00		Subtotal (see instructions)		738	0	717	86	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		738	0	717	86	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet D Part V | Date/Time Prepared: 1/29/2024 8:15 am

Title XVIII | Subprovider - IPF | 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
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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	83	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	76.01
76.02	03040	PRISION CLINIC	0	0	76.02
76.03	03050	WOUND CARE	0	0	76.03
76.04	03060	OPIC	0	0	76.04
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	83	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	83	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 15-0046 Component CCN: 15-T046	Period: From 09/01/2022 To 08/31/2023	Worksheet D Part II Date/Time Prepared: 1/29/2024 8:15 am
	Title XVIII	Subprovider - IRF	PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	979,628	99,995,237	0.009797	99,966	979	50.00
51.00	05100	RECOVERY ROOM	53,694	10,298,054	0.005214	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	191,096	3,479,756	0.054916	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	360,952	12,619,129	0.028604	92,580	2,648	54.00
54.01	03630	ULTRA SOUND	30,475	3,939,011	0.007737	75,359	583	54.01
54.02	03440	MAMMOGRAPHY	74,877	2,054,088	0.036453	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	159,398	20,226,420	0.007881	0	0	55.00
56.00	05600	RADIOISOTOPE	42,961	15,519,570	0.002768	0	0	56.00
57.00	05700	CT SCAN	64,258	66,786,753	0.000962	133,117	128	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	47,481	9,167,187	0.005179	6,088	32	58.00
59.00	05900	CARDIAC CATHETERIZATION	94,415	28,816,497	0.003276	192,022	629	59.00
60.00	06000	LABORATORY	285,807	74,491,771	0.003837	681,598	2,615	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	74,072	5,742,475	0.012899	78,205	1,009	62.00
65.00	06500	RESPIRATORY THERAPY	98,796	17,748,416	0.005566	171,210	953	65.00
66.00	06600	PHYSICAL THERAPY	79,171	11,316,220	0.006996	3,188,869	22,309	66.00
69.00	06900	ELECTROCARDIOLOGY	140,432	23,770,158	0.005908	22,324	132	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	14,119	839,136	0.016826	4,568	77	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	296,969	46,296,392	0.006415	479,216	3,074	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	86,364	17,728,997	0.004871	69,664	339	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	608,245	169,464,839	0.003589	1,806,036	6,482	73.00
74.00	07400	RENAL DIALYSIS	56,644	1,220,663	0.046404	64,673	3,001	74.00
76.00	03950	LITHOTRIPSY	2,559	1,050,039	0.002437	0	0	76.00
76.01	03330	ENDOSCOPY	59,681	14,151,090	0.004217	0	0	76.01
76.02	03040	PRISION CLINIC	128,828	800,198	0.160995	0	0	76.02
76.03	03050	WOUND CARE	114,637	5,041,909	0.022737	0	0	76.03
76.04	03060	OPIC	141,717	7,121,260	0.019901	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	500,511	74,130,154	0.006752	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	915,377	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	4,787,787	744,730,796		7,165,495	44,990	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0046 | Component CCN: 15-T046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet D Part IV | Date/Time Prepared: 1/29/2024 8:15 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	0	0	0	76.01
76.02	03040	PRISION CLINIC	0	0	0	0	0	76.02
76.03	03050	WOUND CARE	0	0	0	0	0	76.03
76.04	03060	OPIC	0	0	0	0	0	76.04
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: 15-0046 Component CCN: 15-T046	Period: From 09/01/2022 To 08/31/2023	Worksheet D Part IV Date/Time Prepared: 1/29/2024 8:15 am
	Title XVIII	Subprovider - IRF	PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	99,995,237	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	10,298,054	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,479,756	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,619,129	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	3,939,011	0.000000	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	2,054,088	0.000000	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	20,226,420	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	15,519,570	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	66,786,753	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	9,167,187	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	28,816,497	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	74,491,771	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	5,742,475	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	17,748,416	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	11,316,220	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	23,770,158	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	839,136	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	46,296,392	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	17,728,997	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	169,464,839	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,220,663	0.000000	74.00
76.00	03950	LITHOTRIPSY	0	0	0	1,050,039	0.000000	76.00
76.01	03330	ENDOSCOPY	0	0	0	14,151,090	0.000000	76.01
76.02	03040	PRISION CLINIC	0	0	0	800,198	0.000000	76.02
76.03	03050	WOUND CARE	0	0	0	5,041,909	0.000000	76.03
76.04	03060	OPIC	0	0	0	7,121,260	0.000000	76.04
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	74,130,154	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	915,377	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	744,730,796		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0046 | Component CCN: 15-T046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet D Part IV | Date/Time Prepared: 1/29/2024 8:15 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	99,966	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	92,580	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.000000	75,359	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0.000000	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	133,117	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	6,088	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	192,022	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	681,598	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	78,205	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	171,210	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	3,188,869	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	22,324	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	4,568	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	479,216	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	69,664	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,806,036	0	738	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	64,673	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0.000000	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0.000000	0	0	0	0	76.01
76.02	03040	PRISION CLINIC	0.000000	0	0	0	0	76.02
76.03	03050	WOUND CARE	0.000000	0	0	0	0	76.03
76.04	03060	OPIC	0.000000	0	0	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		7,165,495	0	738	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0046 | Component CCN: 15-T046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet D Part V | Date/Time Prepared: 1/29/2024 8:15 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.095205	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.049784	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.663913	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.190207	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.091922	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0.164784	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.097075	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.058063	0	0	0	0	56.00
57.00	05700	CT SCAN	0.015797	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.052073	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.056083	0	0	0	0	59.00
60.00	06000	LABORATORY	0.061510	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.443878	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.117329	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.171042	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.048302	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.090069	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.130032	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.187245	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.115946	738	0	1,151	86	73.00
74.00	07400	RENAL DIALYSIS	0.665033	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0.093107	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0.051890	0	0	0	0	76.01
76.02	03040	PRISION CLINIC	0.851997	0	0	0	0	76.02
76.03	03050	WOUND CARE	0.247937	0	0	0	0	76.03
76.04	03060	OPIC	0.169097	0	0	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.083721	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.046728	0	0	0	0	92.00
200.00		Subtotal (see instructions)		738	0	1,151	86	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		738	0	1,151	86	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet D Part V | Date/Time Prepared: 1/29/2024 8:15 am
Component CCN: 15-T046

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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	133	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	76.01
76.02	03040	PRISION CLINIC	0	0	76.02
76.03	03050	WOUND CARE	0	0	76.03
76.04	03060	OPIC	0	0	76.04
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	133	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	133	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet D Part V Date/Time Prepared: 1/29/2024 8:15 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	0.095205	0	0	10,089,947	0	50.00
51.00	05100	RECOVERY ROOM	0.049784	0	0	1,316,312	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.663913	0	0	64,306	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.190207	0	0	2,891,888	0	54.00
54.01	03630	ULTRA SOUND	0.091922	0	0	906,626	0	54.01
54.02	03440	MAMMOGRAPHY	0.164784	0	0	204,519	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.097075	0	0	1,430,827	0	55.00
56.00	05600	RADIOISOTOPE	0.058063	0	0	2,174,239	0	56.00
57.00	05700	CT SCAN	0.015797	0	0	14,108,632	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.052073	0	0	949,207	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.056083	0	0	1,039,429	0	59.00
60.00	06000	LABORATORY	0.061510	0	0	12,614,114	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.443878	0	0	268,836	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.117329	0	0	179,310	0	65.00
66.00	06600	PHYSICAL THERAPY	0.171042	0	0	35,579	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.048302	0	0	1,998,343	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.090069	0	0	194,880	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.130032	0	0	3,305,765	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.187245	0	0	1,213,973	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.115946	0	0	12,065,991	0	73.00
74.00	07400	RENAL DIALYSIS	0.665033	0	0	2,291	0	74.00
76.00	03950	LITHOTRIPSY	0.093107	0	0	168,972	0	76.00
76.01	03330	ENDOSCOPY	0.051890	0	0	1,610,496	0	76.01
76.02	03040	PRISION CLINIC	0.851997	0	0	3,418	0	76.02
76.03	03050	WOUND CARE	0.247937	0	0	1,437,266	0	76.03
76.04	03060	OPIC	0.169097	0	0	715,637	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.083721	0	0	24,794,588	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.046728	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	95,785,391	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	95,785,391	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet D Part V Date/Time Prepared: 1/29/2024 8:15 am

Title XIX | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	960,613	50.00
51.00	05100	RECOVERY ROOM	0	65,531	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	42,694	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	550,057	54.00
54.01	03630	ULTRA SOUND	0	83,339	54.01
54.02	03440	MAMMOGRAPHY	0	33,701	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	138,898	55.00
56.00	05600	RADIOISOTOPE	0	126,243	56.00
57.00	05700	CT SCAN	0	222,874	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	49,428	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	58,294	59.00
60.00	06000	LABORATORY	0	775,894	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	119,330	62.00
65.00	06500	RESPIRATORY THERAPY	0	21,038	65.00
66.00	06600	PHYSICAL THERAPY	0	6,086	66.00
69.00	06900	ELECTROCARDIOLOGY	0	96,524	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	17,553	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	429,855	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	227,310	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,399,003	73.00
74.00	07400	RENAL DIALYSIS	0	1,524	74.00
76.00	03950	LITHOTRIPSY	0	15,732	76.00
76.01	03330	ENDOSCOPY	0	83,569	76.01
76.02	03040	PRISION CLINIC	0	2,912	76.02
76.03	03050	WOUND CARE	0	356,351	76.03
76.04	03060	OPIC	0	121,012	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0	2,075,828	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	8,081,193	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	8,081,193	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet D-1 | Date/Time Prepared: 1/29/2024 8:15 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	13,771	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	13,771	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)	12,927	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)	4,206	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)	15,633,563	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)	15,633,563	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)	15,633,563	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)	1,135.25	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,774,862	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)	4,774,862	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet D-1 | Date/Time Prepared: 1/29/2024 8:15 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	6,506,944	3,069	2,120.22	1,155	2,448,854	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	NEONATAL INTENSIVE CARE UNIT	936,307	165	5,674.59	0	0	47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	11,155,132	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)	18,378,848	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)	758,695	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	636,438	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,395,133	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	16,983,715	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)	844	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,135.25	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	958,151	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0046	Period: From 09/01/2022 To 08/31/2023	Worksheet D-1 Date/Time Prepared: 1/29/2024 8:15 am
	Title XVIII	Hospital	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,852,627	15,633,563	0.118503	958,151	113,544	90.00
91.00	Nursing Program cost	0	15,633,563	0.000000	958,151	0	91.00
92.00	Allied health cost	0	15,633,563	0.000000	958,151	0	92.00
93.00	All other Medical Education	0	15,633,563	0.000000	958,151	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet D-1 | Date/Time Prepared: 1/29/2024 8:15 am

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,083	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,083	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)	5,083	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)	378	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,909,689	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,909,689	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,909,689	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)	965.90	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	365,110	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)	365,110	41.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0046 Component CCN: 15-S046	Period: From 09/01/2022 To 08/31/2023	Worksheet D-1 Date/Time Prepared: 1/29/2024 8:15 am
	Title XVIII	Subprovider - IPF	PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	49,350	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)	414,460	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)	33,767	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	2,491	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	36,258	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	378,202	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0046 Component CCN: 15-S046	Period: From 09/01/2022 To 08/31/2023	Worksheet D-1 Date/Time Prepared: 1/29/2024 8:15 am
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	454,042	4,909,689	0.092479	0	0	90.00
91.00	Nursing Program cost	0	4,909,689	0.000000	0	0	91.00
92.00	Allied health cost	0	4,909,689	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,909,689	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0046 Component CCN: 15-T046	Period: From 09/01/2022 To 08/31/2023	Worksheet D-1 Date/Time Prepared: 1/29/2024 8:15 am
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,111	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,111	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)	2,111	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,230	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)	3,143,024	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,143,024	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,143,024	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)	1,488.88	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,831,322	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,831,322	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0046 | Component CCN: 15-T046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet D-1 | Date/Time Prepared: 1/29/2024 8:15 am

Title XVIII | Subprovider - IRF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,027,326	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	2,858,648	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)	207,206	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	44,990	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	252,196	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,606,452	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0046 Component CCN: 15-T046	Period: From 09/01/2022 To 08/31/2023	Worksheet D-1 Date/Time Prepared: 1/29/2024 8:15 am
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	355,619	3,143,024	0.113145	0	0	90.00
91.00	Nursing Program cost	0	3,143,024	0.000000	0	0	91.00
92.00	Allied health cost	0	3,143,024	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,143,024	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet D-1 | Date/Time Prepared: 1/29/2024 8:15 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)	13,771	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	13,771	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)	12,927	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)	952	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)	318	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)	15,633,563	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)	15,633,563	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)	15,633,563	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)	1,135.25	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,080,758	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,080,758	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet D-1 | Date/Time Prepared: 1/29/2024 8:15 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	391,115	318	1,229.92	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	6,506,944	3,069	2,120.22	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	NEONATAL INTENSIVE CARE UNIT	907,888	165	5,502.35	0	0	47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	7,970,240	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)	9,050,998	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)	844	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,135.25	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	958,151	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet D-1 | Date/Time Prepared: 1/29/2024 8:15 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	1,852,627	15,633,563	0.118503	958,151	113,544	90.00
91.00	Nursing Program cost	0	15,633,563	0.000000	958,151	0	91.00
92.00	Allied health cost	0	15,633,563	0.000000	958,151	0	92.00
93.00	All other Medical Education	0	15,633,563	0.000000	958,151	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet D-1

Component CCN: 15-S046 | Date/Time Prepared: 1/29/2024 8:15 am

Title XIX | Subprovider - IPF | 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)	5,083	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,083	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)	5,083	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)	3,292	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)	318	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,902,711	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,902,711	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,902,711	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)	964.53	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,175,233	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3,175,233	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet D-1
Component CCN: 15-S046 | Date/Time Prepared: 1/29/2024 8:15 am

Title XIX | Subprovider - IPF | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	437,366	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	3,612,599	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0046 Component CCN: 15-S046	Period: From 09/01/2022 To 08/31/2023	Worksheet D-1 Date/Time Prepared: 1/29/2024 8:15 am
	Title XIX	Subprovider - IPF	Cost

	Cost Center Description	1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	454,042	4,902,711	0.092610	0	0	90.00
91.00	Nursing Program cost	0	4,902,711	0.000000	0	0	91.00
92.00	Allied health cost	0	4,902,711	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,902,711	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0046 Component CCN: 15-T046	Period: From 09/01/2022 To 08/31/2023	Worksheet D-1 Date/Time Prepared: 1/29/2024 8:15 am
	Title XIX	Subprovider - IRF	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,111	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,111	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)	2,111	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)	88	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)	318	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)	3,143,024	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,143,024	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,143,024	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)	1,488.88	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	131,021	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)	131,021	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet D-1
Component CCN: 15-T046 | Date/Time Prepared: 1/29/2024 8:15 am

Title XIX | Subprovider - IRF | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	216,483	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)	347,504	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0046 Component CCN: 15-T046	Period: From 09/01/2022 To 08/31/2023	Worksheet D-1 Date/Time Prepared: 1/29/2024 8:15 am
	Title XIX	Subprovider - IRF	Cost

	Cost Center Description	1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	355,619	3,143,024	0.113145	0	0	90.00
91.00	Nursing Program cost	0	3,143,024	0.000000	0	0	91.00
92.00	Allied health cost	0	3,143,024	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,143,024	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet D-3 | Date/Time Prepared: 1/29/2024 8:15 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		6,764,288		30.00
31.00	03100	INTENSIVE CARE UNIT		5,094,688		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0		35.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.095205	16,029,023	1,526,043	50.00
51.00	05100	RECOVERY ROOM	0.049784	1,269,773	63,214	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.663913	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.190207	1,344,497	255,733	54.00
54.01	03630	ULTRA SOUND	0.091922	425,811	39,141	54.01
54.02	03440	MAMMOGRAPHY	0.164784	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.097075	96,714	9,389	55.00
56.00	05600	RADIOISOTOPE	0.058063	84,496	4,906	56.00
57.00	05700	CT SCAN	0.015797	6,936,405	109,574	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.052073	1,144,110	59,577	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.056083	5,710,581	320,267	59.00
60.00	06000	LABORATORY	0.061510	11,506,324	707,754	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.443878	1,597,076	708,907	62.00
65.00	06500	RESPIRATORY THERAPY	0.117329	6,201,410	727,605	65.00
66.00	06600	PHYSICAL THERAPY	0.173757	2,122,134	368,736	66.00
69.00	06900	ELECTROCARDIOLOGY	0.048788	4,934,982	240,768	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.090069	190,632	17,170	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.130032	10,057,178	1,307,755	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.187245	3,274,684	613,168	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.115946	27,027,401	3,133,719	73.00
74.00	07400	RENAL DIALYSIS	0.665033	446,908	297,209	74.00
76.00	03950	LITHOTRIPSY	0.093107	0	0	76.00
76.01	03330	ENDOSCOPY	0.051890	911,367	47,291	76.01
76.02	03040	PRISION CLINIC	0.851997	0	0	76.02
76.03	03050	WOUND CARE	0.250193	19,552	4,892	76.03
76.04	03060	OPIC	0.173415	19,619	3,402	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.083761	6,434,993	539,001	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.046728	47,683	49,911	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		107,833,353	11,155,132	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)		107,833,353		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet D-3

Component CCN: 15-S046 | Date/Time Prepared: 1/29/2024 8:15 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT				35.00
40.00	04000	SUBPROVIDER - IPF		2,159,526		40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.095205	0	0	50.00
51.00	05100	RECOVERY ROOM	0.049784	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.663913	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.190207	3,330	633	54.00
54.01	03630	ULTRA SOUND	0.091922	2,105	193	54.01
54.02	03440	MAMMOGRAPHY	0.164784	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.097075	0	0	55.00
56.00	05600	RADIOISOTOPE	0.058063	0	0	56.00
57.00	05700	CT SCAN	0.015797	26,727	422	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.052073	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.056083	7,696	432	59.00
60.00	06000	LABORATORY	0.061510	142,746	8,780	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.443878	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.117329	10,675	1,252	65.00
66.00	06600	PHYSICAL THERAPY	0.173757	4,498	782	66.00
69.00	06900	ELECTROCARDIOLOGY	0.048788	5,480	267	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.090069	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.130032	6,435	837	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.187245	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.115946	219,575	25,459	73.00
74.00	07400	RENAL DIALYSIS	0.665033	0	0	74.00
76.00	03950	LITHOTRIPSY	0.093107	0	0	76.00
76.01	03330	ENDOSCOPY	0.051890	0	0	76.01
76.02	03040	PRISION CLINIC	0.851997	0	0	76.02
76.03	03050	WOUND CARE	0.250193	0	0	76.03
76.04	03060	OPIC	0.173415	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.083761	122,889	10,293	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.046728	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		552,156	49,350	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)		552,156		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0046 Component CCN: 15-T046	Period: From 09/01/2022 To 08/31/2023	Worksheet D-3 Date/Time Prepared: 1/29/2024 8:15 am
	Title XVIII	Subprovider - IRF	PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT				35.00
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF		2,396,317		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.095205	99,966	9,517	50.00
51.00	05100	RECOVERY ROOM	0.049784	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.663913	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.190207	92,580	17,609	54.00
54.01	03630	ULTRA SOUND	0.091922	75,359	6,927	54.01
54.02	03440	MAMMOGRAPHY	0.164784	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.097075	0	0	55.00
56.00	05600	RADIOISOTOPE	0.058063	0	0	56.00
57.00	05700	CT SCAN	0.015797	133,117	2,103	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.052073	6,088	317	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.056083	192,022	10,769	59.00
60.00	06000	LABORATORY	0.061510	681,598	41,925	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.443878	78,205	34,713	62.00
65.00	06500	RESPIRATORY THERAPY	0.117329	171,210	20,088	65.00
66.00	06600	PHYSICAL THERAPY	0.173757	3,188,869	554,088	66.00
69.00	06900	ELECTROCARDIOLOGY	0.048788	22,324	1,089	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.090069	4,568	411	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.130032	479,216	62,313	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.187245	69,664	13,044	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.115946	1,806,036	209,403	73.00
74.00	07400	RENAL DIALYSIS	0.665033	64,673	43,010	74.00
76.00	03950	LITHOTRIPSY	0.093107	0	0	76.00
76.01	03330	ENDOSCOPY	0.051890	0	0	76.01
76.02	03040	PRISION CLINIC	0.851997	0	0	76.02
76.03	03050	WOUND CARE	0.250193	0	0	76.03
76.04	03060	OPIC	0.173415	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.083761	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.046728	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		7,165,495	1,027,326	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		7,165,495		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet D-3 | Date/Time Prepared: 1/29/2024 8:15 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		4,927,261		30.00
31.00	03100	INTENSIVE CARE UNIT		2,832,783		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		507,018		35.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		486,179		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.095205	9,449,030	899,595	50.00
51.00	05100	RECOVERY ROOM	0.049784	792,957	39,477	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.663913	2,372,992	1,575,460	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.190207	702,109	133,546	54.00
54.01	03630	ULTRA SOUND	0.091922	253,465	23,299	54.01
54.02	03440	MAMMOGRAPHY	0.164784	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.097075	0	0	55.00
56.00	05600	RADIOISOTOPE	0.058063	29,912	1,737	56.00
57.00	05700	CT SCAN	0.015797	4,173,146	65,923	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.052073	757,091	39,424	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.056083	3,336,057	187,096	59.00
60.00	06000	LABORATORY	0.061510	6,888,429	423,707	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.443878	754,658	334,976	62.00
65.00	06500	RESPIRATORY THERAPY	0.117329	4,315,212	506,300	65.00
66.00	06600	PHYSICAL THERAPY	0.171042	835,987	142,989	66.00
69.00	06900	ELECTROCARDIOLOGY	0.048302	2,416,065	116,701	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.090069	117,312	10,566	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.130032	4,216,909	548,333	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.187245	1,377,454	257,921	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.115946	18,446,583	2,138,808	73.00
74.00	07400	RENAL DIALYSIS	0.665033	210,797	140,187	74.00
76.00	03950	LITHOTRIPSY	0.093107	0	0	76.00
76.01	03330	ENDOSCOPY	0.051890	438,109	22,733	76.01
76.02	03040	PRISION CLINIC	0.851997	2,120	1,806	76.02
76.03	03050	WOUND CARE	0.247937	37,404	9,274	76.03
76.04	03060	OPIC	0.169097	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.083721	4,185,110	350,382	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.046728	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		66,108,908	7,970,240	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)		66,108,908		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0046 Component CCN: 15-S046	Period: From 09/01/2022 To 08/31/2023	Worksheet D-3 Date/Time Prepared: 1/29/2024 8:15 am
	Title XIX	Subprovider - IPF	Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT				35.00
40.00	04000	SUBPROVIDER - IPF		18,775,468		40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.095205	0	0	50.00
51.00	05100	RECOVERY ROOM	0.049784	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.663913	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.190207	30,015	5,709	54.00
54.01	03630	ULTRA SOUND	0.091922	6,778	623	54.01
54.02	03440	MAMMOGRAPHY	0.164784	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.097075	0	0	55.00
56.00	05600	RADIOISOTOPE	0.058063	0	0	56.00
57.00	05700	CT SCAN	0.015797	205,198	3,242	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.052073	15,851	825	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.056083	0	0	59.00
60.00	06000	LABORATORY	0.061510	1,368,710	84,189	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.443878	9,460	4,199	62.00
65.00	06500	RESPIRATORY THERAPY	0.117329	89,788	10,535	65.00
66.00	06600	PHYSICAL THERAPY	0.171042	8,122	1,389	66.00
69.00	06900	ELECTROCARDIOLOGY	0.048302	41,384	1,999	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.090069	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.130032	4,691	610	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.187245	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.115946	1,865,826	216,335	73.00
74.00	07400	RENAL DIALYSIS	0.665033	0	0	74.00
76.00	03950	LITHOTRIPSY	0.093107	0	0	76.00
76.01	03330	ENDOSCOPY	0.051890	0	0	76.01
76.02	03040	PRISION CLINIC	0.851997	0	0	76.02
76.03	03050	WOUND CARE	0.247937	0	0	76.03
76.04	03060	OPIC	0.169097	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.083721	1,286,550	107,711	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.046728	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,932,373	437,366	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)		4,932,373		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0046 Component CCN: 15-T046	Period: From 09/01/2022 To 08/31/2023	Worksheet D-3 Date/Time Prepared: 1/29/2024 8:15 am
	Title XIX	Subprovider - IRF	Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT				35.00
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF		567,453		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.095205	32,277	3,073	50.00
51.00	05100	RECOVERY ROOM	0.049784	3,641	181	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.663913	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.190207	7,137	1,358	54.00
54.01	03630	ULTRA SOUND	0.091922	900	83	54.01
54.02	03440	MAMMOGRAPHY	0.164784	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.097075	0	0	55.00
56.00	05600	RADIOISOTOPE	0.058063	0	0	56.00
57.00	05700	CT SCAN	0.015797	48,543	767	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.052073	15,851	825	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.056083	0	0	59.00
60.00	06000	LABORATORY	0.061510	75,569	4,648	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.443878	870	386	62.00
65.00	06500	RESPIRATORY THERAPY	0.117329	72,545	8,512	65.00
66.00	06600	PHYSICAL THERAPY	0.171042	804,185	137,549	66.00
69.00	06900	ELECTROCARDIOLOGY	0.048302	12,080	583	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.090069	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.130032	45,837	5,960	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.187245	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.115946	440,031	51,020	73.00
74.00	07400	RENAL DIALYSIS	0.665033	2,291	1,524	74.00
76.00	03950	LITHOTRIPSY	0.093107	0	0	76.00
76.01	03330	ENDOSCOPY	0.051890	0	0	76.01
76.02	03040	PRISION CLINIC	0.851997	0	0	76.02
76.03	03050	WOUND CARE	0.247937	0	0	76.03
76.04	03060	OPIC	0.169097	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.083721	165	14	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.046728	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,561,922	216,483	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,561,922		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0046	Period: From 09/01/2022 To 08/31/2023	Worksheet E Part A Date/Time Prepared: 1/29/2024 8:15 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	800,463	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	11,593,092	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)	52,041	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	466,608	2.04
3.00	Managed Care Simulated Payments	8,756,186	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	138.45	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)	6.85	30.00
31.00	Percentage of Medicaid patient days (see instructions)	23.57	31.00
32.00	Sum of lines 30 and 31	30.42	32.00
33.00	Allowable disproportionate share percentage (see instructions)	14.31	33.00
34.00	Disproportionate share adjustment (see instructions)	443,380	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet E Part A | Date/Time Prepared: 1/29/2024 8:15 am

		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Payment Adjustment			
35.00	Total uncompensated care amount (see instructions)	7,192,008,710	6,874,403,459	35.00
35.01	Factor 3 (see instructions)	0.000180454	0.000176746	35.01
35.02	Hospital UCP, including supplemental UCP (If line 34 is zero, enter zero on this line) (see instructions)	1,297,826	1,215,023	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	106,671	1,115,158	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	1,221,829		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)	14,577,413		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)	14,577,413	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,060,761	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	24,476	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)	15,662,650	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	15,662,650	61.00
62.00	Deductibles billed to program beneficiaries	1,345,376	62.00
63.00	Coinsurance billed to program beneficiaries	8,712	63.00
64.00	Allowable bad debts (see instructions)	99,153	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	64,449	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	17,287	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	14,373,011	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)	0	70.75
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	0	70.93
70.94	HRR adjustment amount (see instructions)	-68,698	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet E Part A Date/Time Prepared: 1/29/2024 8:15 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)		14,304,313	71.00
71.01	Sequestration adjustment (see instructions)		286,086	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		13,495,024	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)		523,203	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		1,535,624	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0046	Period: From 09/01/2022 To 08/31/2023	Worksheet E Part B Date/Time Prepared: 1/29/2024 8:15 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,619	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	9,874,599	2.00
3.00	OPPS or REH payments	11,235,679	3.00
4.00	Outlier payment (see instructions)	38,006	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)	1,619	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	13,965	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	13,965	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	13,965	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	12,346	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)	1,619	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)	11,273,685	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)	1,946,991	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)	9,328,313	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)	9,328,313	30.00
31.00	Primary payer payments	3,698	31.00
32.00	Subtotal (line 30 minus line 31)	9,324,615	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)	137,020	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	89,063	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	89,798	36.00
37.00	Subtotal (see instructions)	9,413,678	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-449	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)	9,414,127	40.00
40.01	Sequestration adjustment (see instructions)	188,283	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	9,207,313	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)	18,531	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	398,201	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: 15-0046	Period: From 09/01/2022 To 08/31/2023	Worksheet E Part B Date/Time Prepared: 1/29/2024 8:15 am
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0046 Component CCN: 15-S046	Period: From 09/01/2022 To 08/31/2023	Worksheet E Part B Date/Time Prepared: 1/29/2024 8:15 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	83	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	86	2.00
3.00	OPPS or REH payments	114	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs 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)	83	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	717	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)	717	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)	717	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	634	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)	83	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)	114	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	197	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)	197	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	197	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	197	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)	197	40.00
40.01	Sequestration adjustment (see instructions)	4	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	252	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)	-59	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0046 Component CCN: 15-S046	Period: From 09/01/2022 To 08/31/2023	Worksheet E Part B Date/Time Prepared: 1/29/2024 8:15 am
	Title XVIII	Subprovider - IPF	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0046 Component CCN: 15-T046	Period: From 09/01/2022 To 08/31/2023	Worksheet E Part B Date/Time Prepared: 1/29/2024 8:15 am
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	133	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	86	2.00
3.00	OPPS or REH payments	115	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs 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)	133	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	1,151	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)	1,151	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)	1,151	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	1,018	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)	133	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)	115	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	248	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)	248	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	248	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	248	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)	248	40.00
40.01	Sequestration adjustment (see instructions)	5	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	339	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)	-96	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

		1.00	
94.00	Total (sum of lines 91 and 93)	0	94.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet E-1 Part I Date/Time Prepared: 1/29/2024 8:15 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		13,495,024		9,207,313	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)		13,495,024		9,207,313	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		523,203		18,531	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		14,018,227		9,225,844	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 1/29/2024 8:15 am

Title XVIII | Subprovider - IPF | 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		248,192		252	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)		248,192		252	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		7,764		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		59	6.02
7.00	Total Medicare program liability (see instructions)		255,956		193	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0046 | Component CCN: 15-T046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 1/29/2024 8:15 am

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,471,913		339	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,471,913		339	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		28,564		96	6.02
7.00	Total Medicare program liability (see instructions)		2,443,349		243	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: 15-0046	Period: From 09/01/2022 To 08/31/2023	Worksheet E-1 Part II Date/Time Prepared: 1/29/2024 8:15 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: 15-0046 Component CCN: 15-S046	Period: From 09/01/2022 To 08/31/2023	Worksheet E-3 Part II Date/Time Prepared: 1/29/2024 8:15 am
Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	332,792	1.00
2.00	Net IPF PPS Outlier Payments	0	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	13.926027	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	332,792	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	332,792	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	332,792	18.00
19.00	Deductibles	50,716	19.00
20.00	Subtotal (line 18 minus line 19)	282,076	20.00
21.00	Coinsurance	28,800	21.00
22.00	Subtotal (line 20 minus line 21)	253,276	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	12,160	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	7,904	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,556	25.00
26.00	Subtotal (sum of lines 22 and 24)	261,180	26.00
27.00	Direct graduate medical education payments (see instructions)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.98	Recovery of accelerated depreciation.	0	30.98
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	261,180	31.00
31.01	Sequestration adjustment (see instructions)	5,224	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	248,192	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	7,764	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)		
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0.000000	99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0.000000	99.01

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0046 | Component CCN: 15-T046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet E-3 Part III | Date/Time Prepared: 1/29/2024 8:15 am

Title XVIII | Subprovider - IRF | PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	2,137,419	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0265	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	113,283	3.00
4.00	Outlier Payments	250,067	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	5.783562	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	2,500,769	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	2,500,769	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	2,500,769	19.00
20.00	Deductibles	4,756	20.00
21.00	Subtotal (line 19 minus line 20)	2,496,013	21.00
22.00	Coinsurance	2,800	22.00
23.00	Subtotal (line 21 minus line 22)	2,493,213	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	2,493,213	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.98	Recovery of accelerated depreciation.	0	31.98
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	2,493,213	32.00
32.01	Sequestration adjustment (see instructions)	49,864	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	2,471,913	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	-28,564	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	250,067	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)		
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0.000000	99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0.000000	99.01

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0046	Period: From 09/01/2022 To 08/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 1/29/2024 8:15 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	9,050,998		1.00
2.00	Medical and other services		8,081,193	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	9,050,998	8,081,193	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)	9,050,998	8,081,193	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	8,753,241		8.00
9.00	Ancillary service charges	66,108,908	95,785,391	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)	74,862,149	95,785,391	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)	74,862,149	95,785,391	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	65,811,151	87,704,198	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)	9,050,998	8,081,193	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)	9,050,998	8,081,193	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)	9,050,998	8,081,193	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)	9,050,998	8,081,193	36.00
37.00	TO ZERO OUT MEDICAID SETTLEMENT	1,905,240	-1,009,540	37.00
38.00	Subtotal (line 36 ± line 37)	10,956,238	7,071,653	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)	10,956,238	7,071,653	40.00
41.00	Interim payments	10,956,238	7,071,653	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0046 | Component CCN: 15-S046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet E-3 Part VII | Date/Time Prepared: 1/29/2024 8:15 am

Title XIX | Subprovider - IPF | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	3,612,599		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	3,612,599	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	3,612,599	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	18,775,468		8.00
9.00	Ancillary service charges	4,932,373	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	23,707,841	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	23,707,841	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	20,095,242	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	3,612,599	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	3,612,599	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	3,612,599	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	3,612,599	0	36.00
37.00	TO ZERO OUT MEDICAID SETTLEMENT	-942,854	0	37.00
38.00	Subtotal (line 36 ± line 37)	2,669,745	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	2,669,745	0	40.00
41.00	Interim payments	2,669,745	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0046 | Component CCN: 15-T046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet E-3 Part VII | Date/Time Prepared: 1/29/2024 8:15 am

Title XIX | Subprovider - IRF | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	347,504		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	347,504	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	347,504	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	567,453		8.00
9.00	Ancillary service charges	1,561,922	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	2,129,375	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	2,129,375	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,781,871	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	347,504	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	347,504	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	347,504	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	347,504	0	36.00
37.00	TO ZERO OUT MEDICAID SETTLEMENT	-19,729	0	37.00
38.00	Subtotal (line 36 ± line 37)	327,775	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	327,775	0	40.00
41.00	Interim payments	327,775	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0046	Period: From 09/01/2022 To 08/31/2023	Worksheet E-5 Date/Time Prepared: 1/29/2024 8:15 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: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet G | Date/Time Prepared: 1/29/2024 8:15 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	12,439	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	23,733,550	0	0	0	4.00
5.00	Other receivable	77,050	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,768,567	0	0	0	6.00
7.00	Inventory	6,983,278	0	0	0	7.00
8.00	Prepaid expenses	528,459	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	112,584	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	26,678,793	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,262,718	0	0	0	12.00
13.00	Land improvements	3,238,473	0	0	0	13.00
14.00	Accumulated depreciation	-3,154,404	0	0	0	14.00
15.00	Buildings	38,668,254	0	0	0	15.00
16.00	Accumulated depreciation	-30,808,801	0	0	0	16.00
17.00	Leasehold improvements	9,587,944	0	0	0	17.00
18.00	Accumulated depreciation	-8,456,409	0	0	0	18.00
19.00	Fixed equipment	35,120,542	0	0	0	19.00
20.00	Accumulated depreciation	-26,830,764	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	47,459,727	0	0	0	23.00
24.00	Accumulated depreciation	-41,168,662	0	0	0	24.00
25.00	Minor equipment depreciable	8,182,886	0	0	0	25.00
26.00	Accumulated depreciation	-6,134,491	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	709,904	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	27,676,917	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	3,063,197	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	2,472,140	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,535,337	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	59,891,047	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,828,749	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,510,907	0	0	0	38.00
39.00	Payroll taxes payable	4,787,141	0	0	0	39.00
40.00	Notes and loans payable (short term)	275,764	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	27,078	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	10,429,639	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	487,301	0	0	0	47.00
48.00	Unsecured loans	-319,205,374	0	0	0	48.00
49.00	Other long term liabilities	121,702	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-318,596,371	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-308,166,732	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	368,057,779				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)	368,057,779	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	59,891,047	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0046

Period: From 09/01/2022 To 08/31/2023

Worksheet G-1

Date/Time Prepared: 1/29/2024 8:15 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		355,066,603		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		16,572,403				2.00
3.00	Total (sum of line 1 and line 2)		371,639,006		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)		371,639,006		0		11.00
12.00	FEDERAL TAX LIABILITY ENTRY	2,943,911		0		0	12.00
13.00	XFR 252001 FROM 25704	637,316		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)		3,581,227		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		368,057,779		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	FEDERAL TAX LIABILITY ENTRY		0		12.00
13.00	XFR 252001 FROM 25704		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: 15-0046 | Period: From 09/01/2022 To 08/31/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 1/29/2024 8:15 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	22,200,353		22,200,353	1.00
2.00	SUBPROVIDER - IPF	29,227,374		29,227,374	2.00
3.00	SUBPROVIDER - IRF	4,147,867		4,147,867	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)	55,575,594		55,575,594	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	13,474,642		13,474,642	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	NEONATAL INTENSIVE CARE UNIT	691,101		691,101	15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	14,165,743		14,165,743	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	69,741,337		69,741,337	17.00
18.00	Ancillary services	317,097,044	353,480,015	670,577,059	18.00
19.00	Outpatient services	21,021,651	53,108,503	74,130,154	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	OCCUPATIONAL MEDICINE	0	315,429	315,429	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	407,860,032	406,903,947	814,763,979	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		96,104,721		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)		96,104,721		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0046	Period: From 09/01/2022 To 08/31/2023	Worksheet G-3 Date/Time Prepared: 1/29/2024 8:15 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	814,763,979	1.00
2.00	Less contractual allowances and discounts on patients' accounts	702,425,666	2.00
3.00	Net patient revenues (line 1 minus line 2)	112,338,313	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	96,104,721	4.00
5.00	Net income from service to patients (line 3 minus line 4)	16,233,592	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	193,965	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	15,291	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	129,559	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	338,815	25.00
26.00	Total (line 5 plus line 25)	16,572,407	26.00
27.00	ROUNDING	4	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	4	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	16,572,403	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0046	Period: From 09/01/2022 To 08/31/2023	Worksheet L Parts I-III Date/Time Prepared: 1/29/2024 8:15 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	925,686	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	76,294	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)	44.48	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)	6.85	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	23.57	8.00
9.00	Sum of lines 7 and 8	30.42	9.00
10.00	Allowable disproportionate share percentage (see instructions)	6.35	10.00
11.00	Disproportionate share adjustment (see instructions)	58,781	11.00
12.00	Total prospective capital payments (see instructions)	1,060,761	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