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: 15-0104	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/30/2024 1:52 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/30/2024 Time: 1:52 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WITHAM MEMORIAL HOSPITAL (15-0104) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	George Pogas		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	George Pogas			2
3	Signatory Title	SENIOR VP/CFO			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	111,416	50,804	0	-342,388	1.00
2.00	SUBPROVIDER - IPF	0	10,032	-432		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER (OTHER)						4.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	372	-159		0	7.00
200.00	TOTAL	0	121,820	50,213	0	-342,388	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 1:52 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2605 N. LEBANON STREET	PO Box:			1.00
2.00	City: LEBANON	State: IN	Zip Code: 46052-	County: BOONE	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	WITHAM MEMORIAL HOSPITAL	150104	26900	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	WITHAM HOSPITAL GEROPSYCH	15S104	26900	4	01/01/2000	N	P	N	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	WITHAM HOSPITAL ECU	155832	26900		05/07/2015	N	P	N	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)	01/01/2023	12/31/2023	20.00
21.00	Type of Control (see instructions)	9		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: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2024 1:52 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	231	69	1	1	1,713	84	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.				57.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2024 1:52 pm

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

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	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)				0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 1:52 pm

				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2024 1:52 pm

				1.00	
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)				
68.00	For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?				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.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

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

		Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
		1.00	2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.	N	0	88.00

		Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge	
		1.00	2.00	3.00	
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.	0.00		0	89.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 1:52 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2024 1:52 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	984,175	0	0	118.01

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 1:52 pm

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

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

			1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act			
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)		9.99	169.00
		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 5/30/2024 1:52 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	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	07/01/2022	Y	07/01/2022	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II Date/Time Prepared: 5/30/2024 1:52 pm

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		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.		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		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.		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		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		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.		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.		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?			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.			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.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TINA	SEVERS	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7946	TSEVERS@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0104	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/30/2024 1:52 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I Date/Time Prepared: 5/30/2024 1:52 pm

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	34	12,410	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)		34	12,410	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	16	5,840	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		50	18,250	0.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
16.00	SUBPROVIDER - IPF	40.00	10	3,650		0	16.00
17.00	SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00	SUBPROVIDER	42.00	0	0		0	18.00
19.00	SKILLED NURSING FACILITY	44.00	18	6,570		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		78				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: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2024 1:52 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,010	199	6,860			1.00
2.00	HMO and other (see instructions)	2,703	1,784				2.00
3.00	HMO IPF Subprovider	764	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,010	199	6,860			7.00
8.00	INTENSIVE CARE UNIT	484	32	1,971			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	731			13.00
14.00	Total (see instructions)	2,494	231	9,562	0.00	614.11	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits	0	0	0			15.10
16.00	SUBPROVIDER - IPF	1,185	0	2,280	0.00	10.38	16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00	SUBPROVIDER		0	0	0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY	2,195	0	4,377	0.00	12.90	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)			17			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	637.39	27.00
28.00	Observation Bed Days		15	2,009			28.00
29.00	Ambulance Trips	992					29.00
30.00	Employee discount days (see instruction)			114			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	84	121			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2024 1:52 pm

	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	669	55	2,180	1.00
2.00	HMO and other (see instructions)			566	423		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	669	55	2,180	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF	0.00	0	104	0	200	16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER	0.00	0		0	0	18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part II Date/Time Prepared: 5/30/2024 1:52 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	72,996,995	0	72,996,995	968,977.00	75.33	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	1,077,511	7,937	1,085,448	32,718.00	33.18	9.00
10.00	Excluded area salaries (see instructions)		37,461,358	0	37,461,358	649,727.00	57.66	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		6,061,741	0	6,061,741	66,643.00	90.96	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		0	0	0	0.00	0.00	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		0	0	0	0.00	0.00	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)		14,699,225	0	14,699,225			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		7,295,064	0	7,295,064			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)		0	0	0			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: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part II Date/Time Prepared: 5/30/2024 1:52 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	407,626	-245,765	161,861	15,164.00	10.67	26.00
27.00	Administrative & General	5.00	8,074,503	106,490	8,180,993	222,795.00	36.72	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	739,843	3,536	743,379	20,687.00	35.93	30.00
31.00	Laundry & Linen Service	8.00	43,475	0	43,475	2,077.00	20.93	31.00
32.00	Housekeeping	9.00	543,041	5,000	548,041	26,041.00	21.05	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	835,346	-440,875	394,471	22,203.00	17.77	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	442,573	442,573	16,454.00	26.90	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	494,482	6,890	501,372	9,059.00	55.35	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	685,612	0	685,612	14,446.00	47.46	40.00
41.00	Medical Records & Medical Records Library	16.00	1,089,315	2,288	1,091,603	37,818.00	28.86	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: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part III Date/Time Prepared: 5/30/2024 1:52 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		72,996,995	0	72,996,995	968,977.00	75.33	1.00
2.00	Excluded area salaries (see instructions)		38,538,869	7,937	38,546,806	682,445.00	56.48	2.00
3.00	Subtotal salaries (line 1 minus line 2)		34,458,126	-7,937	34,450,189	286,532.00	120.23	3.00
4.00	Subtotal other wages & related costs (see inst.)		6,061,741	0	6,061,741	66,643.00	90.96	4.00
5.00	Subtotal wage-related costs (see inst.)		14,699,225	0	14,699,225	0.00	42.67	5.00
6.00	Total (sum of lines 3 thru 5)		55,219,092	-7,937	55,211,155	353,175.00	156.33	6.00
7.00	Total overhead cost (see instructions)		12,913,243	-119,863	12,793,380	386,744.00	33.08	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part IV | Date/Time Prepared: 5/30/2024 1:52 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	3,196,428	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	9,862,058	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	2,817,199	9.00
10.00	Dental, Hearing and Vision Plan	345,846	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	76,637	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)	221,333	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	588,217	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	4,730,362	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	156,209	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	21,994,289	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: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part V | Date/Time Prepared: 5/30/2024 1:52 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	6,061,741	21,994,289	1.00
2.00	Hospital	6,061,741	21,994,289	2.00
3.00	SUBPROVIDER - IPF	0	0	3.00
4.00	SUBPROVIDER - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY	0	0	8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 5/30/2024 1:52 pm

		1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.203940	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	8,750,469	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?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	1,724,304	5.00
6.00	Medicaid charges	78,639,132	6.00
7.00	Medicaid cost (line 1 times line 6)	16,037,665	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	5,562,892	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	5,562,892	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	3,773,917	894,366	4,668,283	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	769,653	871,454	1,641,107	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (see instructions)	769,653	871,454	1,641,107	23.00

		1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
25.01	Charges for insured patients' liability (see instructions)	28,782	25.01
26.00	Bad debt amount (see instructions)	10,591,751	26.00
27.00	Medicare reimbursable bad debts (see instructions)	180,703	27.00
27.01	Medicare allowable bad debts (see instructions)	278,004	27.01
28.00	Non-Medicare bad debt amount (see instructions)	10,313,747	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	2,200,687	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	3,841,794	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	9,404,686	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 5/30/2024 1:52 pm

		1.00	
	PART II - HOSPITAL DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.193600	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		5.00
6.00	Medicaid charges		6.00
7.00	Medicaid cost (line 1 times line 6)		7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)		8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP		9.00
10.00	Stand-alone CHIP charges		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)		12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)		16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	3,773,917	894,366	4,668,283	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	730,630	871,156	1,601,786	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (see instructions)	730,630	871,156	1,601,786	23.00

		1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
25.01	Charges for insured patients' liability (see instructions)	28,782	25.01
26.00	Bad debt amount (see instructions)	10,591,751	26.00
27.00	Medicare reimbursable bad debts (see instructions)	170,094	27.00
27.01	Medicare allowable bad debts (see instructions)	261,683	27.01
28.00	Non-Medicare bad debt amount (see instructions)	10,330,068	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	2,091,490	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	3,693,276	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,693,276	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/30/2024 1:52 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		4,905,187	4,905,187	247,964	5,153,151	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	4,160,724	4,160,724	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	407,626	17,147,218	17,554,844	274,638	17,829,482	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,074,503	22,509,690	30,584,193	-2,473,244	28,110,949	5.00
7.00	00700	OPERATION OF PLANT	739,843	4,195,850	4,935,693	-126,356	4,809,337	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	43,475	550,799	594,274	-594	593,680	8.00
9.00	00900	HOUSEKEEPING	543,041	530,580	1,073,621	3,058	1,076,679	9.00
10.00	01000	DIETARY	835,346	1,678,609	2,513,955	-829,704	1,684,251	10.00
11.00	01100	CAFETERIA	0	0	0	801,080	801,080	11.00
13.00	01300	NURSING ADMINISTRATION	494,482	161,763	656,245	6,205	662,450	13.00
15.00	01500	PHARMACY	685,612	12,851,881	13,537,493	-12,168,568	1,368,925	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,089,315	659,545	1,748,860	-1,000	1,747,860	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,991,413	1,899,914	5,891,327	-343,355	5,547,972	30.00
31.00	03100	INTENSIVE CARE UNIT	1,512,467	518,174	2,030,641	-187,061	1,843,580	31.00
40.00	04000	SUBPROVIDER - IPF	1,270,029	155,035	1,425,064	-29,599	1,395,465	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,077,511	524,720	1,602,231	-79,565	1,522,666	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,284,636	7,225,883	9,510,519	-5,391,060	4,119,459	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,745,194	3,351,495	5,096,689	-631,461	4,465,228	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	518,915	680,501	1,199,416	-34,163	1,165,253	55.01
57.00	05700	CT SCAN	339,354	479,790	819,144	-32,816	786,328	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	329,129	313,951	643,080	-22,568	620,512	58.00
59.00	05900	CARDIAC CATHETERIZATION	336,473	1,322,116	1,658,589	-1,430,498	228,091	59.00
60.00	06000	LABORATORY	3,100,913	4,735,553	7,836,466	-249,963	7,586,503	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	83,135	83,135	-5	83,130	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,428,842	431,360	1,860,202	1,545	1,861,747	66.00
67.00	06700	OCCUPATIONAL THERAPY	369,745	124,822	494,567	-126	494,441	67.00
67.01	06701	AUDIOLOGY	228,381	141,229	369,610	-18,402	351,208	67.01
68.00	06800	SPEECH PATHOLOGY	178,176	15,758	193,934	2,773	196,707	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	1,662,951	777,915	2,440,866	-342,965	2,097,901	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	-534,737	-534,737	3,837,607	3,302,870	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	4,535,240	4,535,240	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	11,705,939	11,705,939	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	3,407	3,407	0	3,407	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	391	391	-391	0	90.05
90.07	09007	UROLOGY CLINIC	53,244	450	53,694	-293	53,401	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	10,620	10,620	-4,034	6,586	90.12
90.13	09013	ALLERGY CLINIC	66,278	44,679	110,957	-863	110,094	90.13
90.14	09014	WOUND CARE	268,333	467,635	735,968	-296,154	439,814	90.14
91.00	09100	EMERGENCY	3,130,439	4,974,992	8,105,431	-426,329	7,679,102	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,506,262	582,227	3,088,489	-131,670	2,956,819	95.00
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)	39,311,928	93,522,137	132,834,065	323,966	133,158,031	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	33,372,774	11,472,044	44,844,818	-322,784	44,522,034	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	3,991	23,936	27,927	-434	27,493	194.01
194.02	07952	OTHER NONREIMB	0	44,837	44,837	-748	44,089	194.02
194.03	07953	RETAIL PHARMACY	308,302	2,676,293	2,984,595	0	2,984,595	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	72,996,995	107,739,247	180,736,242	0	180,736,242	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/30/2024 1:52 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-130,905	5,022,246		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-391	4,160,333		2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-5,083,795	12,745,687		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-9,444,332	18,666,617		5.00
7.00	00700	OPERATION OF PLANT	-101,792	4,707,545		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	593,680		8.00
9.00	00900	HOUSEKEEPING	0	1,076,679		9.00
10.00	01000	DIETARY	-371,172	1,313,079		10.00
11.00	01100	CAFETERIA	0	801,080		11.00
13.00	01300	NURSING ADMINISTRATION	0	662,450		13.00
15.00	01500	PHARMACY	-76,979	1,291,946		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,553	1,746,307		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	5,547,972		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,843,580		31.00
40.00	04000	SUBPROVIDER - IPF	0	1,395,465		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	-3	1,522,663		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	4,119,459		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-4,553	4,460,675		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
55.01	05501	ULTRA SOUND	0	1,165,253		55.01
57.00	05700	CT SCAN	0	786,328		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	620,512		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	228,091		59.00
60.00	06000	LABORATORY	-271,920	7,314,583		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	83,130		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	1,861,747		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	494,441		67.00
67.01	06701	AUDIOLOGY	-185,515	165,693		67.01
68.00	06800	SPEECH PATHOLOGY	0	196,707		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIOLOGY	0	2,097,901		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,302,870		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	4,535,240		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,705,939		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0		90.01
90.02	09002	CLINIC	0	0		90.02
90.03	09003	DERMATOLOGY CLINIC	-3,407	0		90.03
90.04	09004	ENT CLINIC	0	0		90.04
90.05	09005	SURGERY CLINIC	0	0		90.05
90.07	09007	UROLOGY CLINIC	-21,632	31,769		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0		90.09
90.11	09011	NEUROLOGY CLINIC	0	0		90.11
90.12	09012	OPTHAMOLOGY CLINIC	-6,586	0		90.12
90.13	09013	ALLERGY CLINIC	0	110,094		90.13
90.14	09014	WOUND CARE	-111,931	327,883		90.14
91.00	09100	EMERGENCY	-2,602,200	5,076,902		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-18,035	2,938,784		95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-18,436,701	114,721,330		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-7,160	44,514,874		192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0		194.00
194.01	07951	CAFE/BOUTIQUE	0	27,493		194.01
194.02	07952	OTHER NONREIMB	0	44,089		194.02
194.03	07953	RETAIL PHARMACY	0	2,984,595		194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-18,443,861	162,292,381		200.00

RECLASSIFICATIONS | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/30/2024 1:52 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INSURANCE RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	425,014		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	527,173		2.00
	0		0	952,187		
	B - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	442,573	358,507		1.00
	0		442,573	358,507		
	C - MME DEPRECIATION RECLASS					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	4,160,724		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
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
33.00		0.00	0	0		33.00
34.00		0.00	0	0		34.00
35.00		0.00	0	0		35.00
36.00		0.00	0	0		36.00
37.00		0.00	0	0		37.00
38.00		0.00	0	0		38.00
39.00		0.00	0	0		39.00
40.00		0.00	0	0		40.00
41.00		0.00	0	0		41.00
	0		0	4,160,724		
	D - DRUGS RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	12,137,409		1.00
	0		0	12,137,409		
	E - IMPLANTABLES RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	4,535,240		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
	0		0	4,535,240		
	F - CHARGEABLE MEDICAL SUPPLIES RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,864,229		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

RECLASSIFICATIONS | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/30/2024 1:52 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
35.00		0.00	0	0	35.00
36.00		0.00	0	0	36.00
37.00		0.00	0	0	37.00
	0		0	3,864,229	
	G - BONUS RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	106,490	0	1.00
2.00	OPERATION OF PLANT	7.00	3,536	0	2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	0	3.00
4.00	HOUSEKEEPING	9.00	5,000	0	4.00
5.00	DIETARY	10.00	1,698	0	5.00
6.00	NURSING ADMINISTRATION	13.00	6,890	0	6.00
7.00	PHARMACY	15.00	0	0	7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	2,288	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	17,498	0	9.00
10.00	INTENSIVE CARE UNIT	31.00	15,428	0	10.00
11.00	SUBPROVIDER - IPF	40.00	0	0	11.00
12.00	SKILLED NURSING FACILITY	44.00	7,937	0	12.00
13.00	OPERATING ROOM	50.00	9,428	0	13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	4,053	0	14.00
15.00	ULTRA SOUND	55.01	33,578	0	15.00
16.00	CT SCAN	57.00	0	0	16.00
17.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	0	17.00
18.00	CARDIAC CATHETERIZATION	59.00	0	0	18.00
19.00	LABORATORY	60.00	7,614	0	19.00
20.00	PHYSICAL THERAPY	66.00	5,824	0	20.00
21.00	OCCUPATIONAL THERAPY	67.00	0	0	21.00
22.00	AUDIOLOGY	67.01	0	0	22.00
23.00	SPEECH PATHOLOGY	68.00	2,773	0	23.00
24.00	CARDIOLOGY	69.01	2,771	0	24.00
25.00	DRUGS CHARGED TO PATIENTS	73.00	0	0	25.00
26.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	0	26.00
27.00	UROLOGY CLINIC	90.07	0	0	27.00
28.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	0	28.00
29.00	ALLERGY CLINIC	90.13	0	0	29.00
30.00	WOUND CARE	90.14	100	0	30.00
31.00	EMERGENCY	91.00	12,859	0	31.00
32.00	AMBULANCE SERVICES	95.00	0	0	32.00
	0		245,765	0	
500.00	Grand Total: Increases		688,338	26,008,296	500.00

RECLASSIFICATIONS | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/30/2024 1:52 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	952,187	12		1.00
2.00		0.00	0	0	0		2.00
	0		0	952,187			
	B - CAFETERIA RECLASS						
1.00	DIETARY	10.00	442,573	358,507	0		1.00
	0		442,573	358,507			
	C - MME DEPRECIATION RECLASS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	177,050	9		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	5,677	0		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	1,612,163	0		3.00
4.00	OPERATION OF PLANT	7.00	0	129,671	0		4.00
5.00	LAUNDRY & LINEN SERVICE	8.00	0	445	0		5.00
6.00	HOUSEKEEPING	9.00	0	1,349	0		6.00
7.00	DIETARY	10.00	0	30,099	0		7.00
8.00	NURSING ADMINISTRATION	13.00	0	685	0		8.00
9.00	PHARMACY	15.00	0	3,201	0		9.00
10.00	MEDICAL RECORDS & LIBRARY	16.00	0	3,215	0		10.00
11.00	ADULTS & PEDIATRICS	30.00	0	96,010	0		11.00
12.00	INTENSIVE CARE UNIT	31.00	0	75,422	0		12.00
13.00	SUBPROVIDER - IPF	40.00	0	10,256	0		13.00
14.00	SKILLED NURSING FACILITY	44.00	0	48,451	0		14.00
15.00	OPERATING ROOM	50.00	0	375,288	0		15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	320,132	0		16.00
17.00	ULTRA SOUND	55.01	0	62,830	0		17.00
18.00	CT SCAN	57.00	0	18,995	0		18.00
19.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	17,926	0		19.00
20.00	CARDIAC CATHETERIZATION	59.00	0	130,283	0		20.00
21.00	LABORATORY	60.00	0	231,084	0		21.00
22.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	0	0		22.00
23.00	PHYSICAL THERAPY	66.00	0	3,135	0		23.00
24.00	OCCUPATIONAL THERAPY	67.00	0	77	0		24.00
25.00	AUDIOLOGY	67.01	0	18,371	0		25.00
26.00	CARDIOLOGY	69.01	0	324,165	0		26.00
27.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	6,798	0		27.00
28.00	DRUGS CHARGED TO PATIENTS	73.00	0	542	0		28.00
29.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	4,150	0		29.00
30.00	ENT CLINIC	90.04	0	0	0		30.00
31.00	SURGERY CLINIC	90.05	0	391	0		31.00
32.00	UROLOGY CLINIC	90.07	0	293	0		32.00
33.00	OPTHAMOLOGY CLINIC	90.12	0	4,034	0		33.00
34.00	ALLERGY CLINIC	90.13	0	647	0		34.00
35.00	WOUND CARE	90.14	0	19,238	0		35.00
36.00	EMERGENCY	91.00	0	78,835	0		36.00
37.00	AMBULANCE SERVICES	95.00	0	108,976	0		37.00
38.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	239,658	0		38.00
39.00	CAFE/BOUTIQUE	194.01	0	434	0		39.00
40.00	OTHER NONREIMB	194.02	0	748	0		40.00
41.00	RETAIL PHARMACY	194.03	0	0	0		41.00
	0		0	4,160,724			
	D - DRUGS RECLASS						
1.00	PHARMACY	15.00	0	12,137,409	0		1.00
	0		0	12,137,409			
	E - IMPLANTABLES RECLASS						
1.00	INTENSIVE CARE UNIT	31.00	0	2,580	0		1.00
2.00	OPERATING ROOM	50.00	0	3,067,869	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	235,425	0		3.00
4.00	CARDIAC CATHETERIZATION	59.00	0	519,422	0		4.00
5.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	19,824	0		5.00
6.00	DRUGS CHARGED TO PATIENTS	73.00	0	430,920	0		6.00
7.00	WOUND CARE	90.14	0	259,200	0		7.00
	0		0	4,535,240			
	F - CHARGEABLE MEDICAL SUPPLIES RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,093	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	15,384	0		2.00
3.00	OPERATION OF PLANT	7.00	0	221	0		3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	149	0		4.00
5.00	HOUSEKEEPING	9.00	0	593	0		5.00
6.00	DIETARY	10.00	0	223	0		6.00

RECLASSIFICATIONS | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/30/2024 1:52 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
7.00	PHARMACY	15.00	0	27,958	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	73	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	264,843	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	124,487	0		10.00
11.00	SUBPROVIDER - IPF	40.00	0	19,343	0		11.00
12.00	SKILLED NURSING FACILITY	44.00	0	39,051	0		12.00
13.00	OPERATING ROOM	50.00	0	1,957,331	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	79,957	0		14.00
15.00	ULTRA SOUND	55.01	0	4,911	0		15.00
16.00	CT SCAN	57.00	0	13,821	0		16.00
17.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	4,642	0		17.00
18.00	CARDIAC CATHETERIZATION	59.00	0	780,793	0		18.00
19.00	LABORATORY	60.00	0	26,493	0		19.00
20.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	5	0		20.00
21.00	PHYSICAL THERAPY	66.00	0	1,144	0		21.00
22.00	OCCUPATIONAL THERAPY	67.00	0	49	0		22.00
23.00	AUDIOLOGY	67.01	0	31	0		23.00
24.00	CARDIOLOGY	69.01	0	21,571	0		24.00
25.00	DRUGS CHARGED TO PATIENTS	73.00	0	8	0		25.00
26.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2,418	0		26.00
27.00	ENT CLINIC	90.04	0	0	0		27.00
28.00	SURGERY CLINIC	90.05	0	0	0		28.00
29.00	UROLOGY CLINIC	90.07	0	0	0		29.00
30.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	166	0		30.00
31.00	ALLERGY CLINIC	90.13	0	216	0		31.00
32.00	WOUND CARE	90.14	0	17,816	0		32.00
33.00	EMERGENCY	91.00	0	360,353	0		33.00
34.00	AMBULANCE SERVICES	95.00	0	22,694	0		34.00
35.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	76,392	0		35.00
36.00	CAFE/BOUTIQUE	194.01	0	0	0		36.00
37.00	RETAIL PHARMACY	194.03	0	0	0		37.00
	0		0	3,864,229			
	G - BONUS RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	245,765	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
27.00		0.00	0	0	0		27.00
28.00		0.00	0	0	0		28.00
29.00		0.00	0	0	0		29.00
30.00		0.00	0	0	0		30.00
31.00		0.00	0	0	0		31.00
32.00		0.00	0	0	0		32.00
	0		245,765	0			
500.00	Grand Total: Decreases		688,338	26,008,296			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 5/30/2024 1:52 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,895,261	0	0	0	0	1.00
2.00	Land Improvements	3,068,610	57,650	0	57,650	0	2.00
3.00	Buildings and Fixtures	133,034,143	2,176,495	0	2,176,495	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	5,170,672	12,509	0	12,509	0	5.00
6.00	Movable Equipment	76,496,016	3,724,063	0	3,724,063	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	220,664,702	5,970,717	0	5,970,717	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	220,664,702	5,970,717	0	5,970,717	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,895,261	0	1.00
2.00	Land Improvements	3,126,260	0	2.00
3.00	Buildings and Fixtures	135,210,638	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	5,183,181	0	5.00
6.00	Movable Equipment	80,220,079	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	226,635,419	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	226,635,419	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part II | Date/Time Prepared: 5/30/2024 1:52 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	4,905,187	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,905,187	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	4,905,187		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	4,905,187		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part III | Date/Time Prepared: 5/30/2024 1:52 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	146,415,340	0	146,415,340	0.646039	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	80,220,079	0	80,220,079	0.353961	0	2.00
3.00	Total (sum of lines 1-2)	226,635,419	0	226,635,419	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	4,728,137	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	4,160,333	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	8,888,470	0	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	NEW CAP REL COSTS-BLDG & FIXT	-130,905	425,014	0	0	5,022,246	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	4,160,333	2.00
3.00	Total (sum of lines 1-2)	-130,905	425,014	0	0	9,182,579	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/30/2024 1:52 pm

	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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW 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)	B	-4,066	ADMINISTRATIVE & GENERAL	5.00	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	-2,875,617			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	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-345,122	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,553	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-1,278	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	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 - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/30/2024 1:52 pm

	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	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	HOSPITAL ADMINISTRAT SPONSORSHIPS/DO	A	0	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	BANK FEES	A	0	OPERATING ROOM	50.00	0	33.01
33.02	HEARING AID COSTS	A	-185,515	AUDIOLOGY	67.01	0	33.02
33.03	BANK FEES	A	0	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	LOBBYING EXPENSE-IHA DUES	A	-5,557	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	LOBBYING EXPENSE-AHA DUES	A	-5,606	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	NON-REIMBURSABLE ADVERTISING COSTS	A	-68,323	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	SELF INSURANCE CLAIMS PAID	B	-3,987,376	EMPLOYEE BENEFITS DEPARTMENT	4.00	12	33.07
33.08	HAF FEE	A	-8,930,868	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	WIT EXTENDED CARE UNIT OTHER OPERATI	A	-3	SKILLED NURSING FACILITY	44.00	0	33.09
33.10	WIT AMBULANCE EDUCATION REIMBURSEM	A	-8,650	AMBULANCE SERVICES	95.00	0	33.10
33.11	WIT AMBULANCE OTHER OPERATING REVE	B	-6,208	AMBULANCE SERVICES	95.00	0	33.11
33.12	WIT AMBULANCE INSURANCE CLAIM PROC	B	-1,680	AMBULANCE SERVICES	95.00	0	33.12
33.13	WIT DERMATOLOGY CLINIC RENTAL REVENU	A	-3,407	DERMATOLOGY CLINIC	90.03	0	33.13
33.14	WIT SURGERY CLINIC RENTAL REVENUE	A	-391	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	33.14
33.15	WIT UROLOGY CLINIC RENTAL REVENUE	A	-21,632	UROLOGY CLINIC	90.07	0	33.15
33.16	WIT GASTROENTEROLOGY CLI RENTAL REVE	A	-7,160	PHYSICIANS' PRIVATE OFFICES	192.00	0	33.16
33.17	WIT DIALYSIS CENTER RENTAL REVENUE	A	-111,931	WOUND CARE	90.14	0	33.17
33.18	WIT EYE INSTITUTE RENTAL REVENUE	A	-6,586	OPTHAMOLOGY CLINIC	90.12	0	33.18
33.19	WIT RADIOLOGY LB PURCHASING REBATE	B	-4,553	RADIOLOGY-DIAGNOSTIC	54.00	0	33.19
33.20	WIT PHARMACY LB PURCHASING DISCOUNTS	B	-74,391	PHARMACY	15.00	0	33.20
33.21	WIT PHARMACY LB OTHER OPERATING REVE	A	-2,588	PHARMACY	15.00	0	33.21
33.22	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.22
33.23	WIT EDUCATION COVID VACCINE ADMINI	A	-47,029	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24	WIT EDUCATION OTHER OPERATING REVE	A	-192	ADMINISTRATIVE & GENERAL	5.00	0	33.24
33.25	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.25
33.26	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.26
33.27	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.27
33.28	WIT DIETARY HOME DELIVERED MEALS	B	-21,884	DIETARY	10.00	0	33.28
33.29	WIT DIETARY CICOA MEAL VOUCHERS	B	-2,096	DIETARY	10.00	0	33.29
33.30	WIT DIETARY OTHER OPERATING REVE	B	-792	DIETARY	10.00	0	33.30
33.31	WIT PLANT OPERATIONS LB WATER FOUNTA	B	-171	OPERATION OF PLANT	7.00	0	33.31
33.32	WIT PLANT OPERATIONS LB PURCHASING R	B	-866	OPERATION OF PLANT	7.00	0	33.32
33.33	WIT PLANT OPERATIONS LB ELECTRIC CAR	A	-1,115	OPERATION OF PLANT	7.00	0	33.33

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/30/2024 1:52 pm

	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	
33.34	WIT PLANT OPERATIONS LB KEY REVENUE	B	-50	OPERATION OF PLANT	7.00	0	33.34
33.35	WIT PLANT OPERATIONS LB OTHER OPERAT	A	-18,225	OPERATION OF PLANT	7.00	0	33.35
33.36	WIT PLANT OPERATIONS LB INSURANCE CL	B	-81,365	OPERATION OF PLANT	7.00	0	33.36
33.37	WIT FINANCE MATERIALS MG PURCHASING	B	-41,859	ADMINISTRATIVE & GENERAL	5.00	0	33.37
33.38	WIT FINANCE MATERIALS MG PURCHASING	B	-135,000	ADMINISTRATIVE & GENERAL	5.00	0	33.38
33.39	WIT FINANCE ACCOUNTING PURCHASING DI	B	-2,817	ADMINISTRATIVE & GENERAL	5.00	0	33.39
33.40	WIT FINANCE ACCOUNTING REVENUE SHARE	A	-22,724	ADMINISTRATIVE & GENERAL	5.00	0	33.40
33.41	WIT FINANCE HOSPITAL BIL RETURNED CH	B	-285	ADMINISTRATIVE & GENERAL	5.00	0	33.41
33.42	WIT FINANCE HOSPITAL BIL CASH (SHORT	B	189	ADMINISTRATIVE & GENERAL	5.00	0	33.42
33.43	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.43
33.44	WIT FINANCE INFORMATION FEDERAL FUND	B	-72,931	ADMINISTRATIVE & GENERAL	5.00	0	33.44
33.45	WIT ADMIN HOSPITAL LAND LEASE REVENU	B	-20,484	ADMINISTRATIVE & GENERAL	5.00	10	33.45
33.46	WIT ADMIN HOSPITAL MANAGEMENT FEE RE	B	-28,947	ADMINISTRATIVE & GENERAL	5.00	0	33.46
33.47	WIT ADMIN HOSPITAL OTHER OPERATING R	B	-975	ADMINISTRATIVE & GENERAL	5.00	0	33.47
33.48	WIT ADMIN HOSPITAL INTEREST ON INVES	B	-6,000	ADMINISTRATIVE & GENERAL	5.00	11	33.48
33.49	WIT ADMIN-FINANCE CASH (SHORT) OVER	B	-9	ADMINISTRATIVE & GENERAL	5.00	0	33.49
33.50	WIT ADMIN-FINANCE OTHER OPERATING RE	B	-10,158	ADMINISTRATIVE & GENERAL	5.00	0	33.50
33.51	WIT ADMIN-FINANCE UNRESTRICTED CONTR	B	-8,500	ADMINISTRATIVE & GENERAL	5.00	0	33.51
33.52	WIT HR EMPLOYEE BENEFITS EMPLOYEE DR	A	-1,063,348	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.52
33.53	WIT HR EMPLOYEE BENEFITS INTEREST ON	B	-961	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.53
33.54	WIT HR WELLNESS PROGRAM OTHER OPERAT	B	-24,817	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.54
33.55	WIT INSURANCE REFUND-PCF (PATIENT	B	-15,232	ADMINISTRATIVE & GENERAL	5.00	0	33.55
33.56	WIT INSURANCE INSURANCE CLAIM PROC	B	-500	ADMINISTRATIVE & GENERAL	5.00	12	33.56
33.57	VOL VOLUNTEERS VOLUNTEER MISC REV	B	-16,109	ADMINISTRATIVE & GENERAL	5.00	0	33.57
33.58	VOL VOLUNTEERS INTEREST ON INVESTME	B	-65	ADMINISTRATIVE & GENERAL	5.00	11	33.58
33.59	BCH 2015 BOND INTEREST ON INVESTME	A	-130,730	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.59
33.60	BCH 2017 BOND INTEREST ON INVESTME	B	-175	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.60
33.61	RECRUITING OFFSET-EH&W	A	-7,293	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.61
33.62	RECRUITING OFFSET -A&G	A	-285	ADMINISTRATIVE & GENERAL	5.00	0	33.62
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-18,443,861				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.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 5/30/2024 1:52 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	LABORATORY	271,920	271,920	0	0	0	1.00
2.00	91.00	EMERGENCY	2,602,200	2,602,200	0	0	0	2.00
3.00	95.00	AMBULANCE SERVICES	1,497	1,497	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,875,617	2,875,617	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	95.00	AMBULANCE SERVICES	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	0	0	271,920		1.00
2.00	91.00	EMERGENCY	0	0	0	2,602,200		2.00
3.00	95.00	AMBULANCE SERVICES	0	0	0	1,497		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,875,617		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/30/2024 1:52 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	5,022,246	5,022,246				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	4,160,333		4,160,333			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	12,745,687	29,560	24,487	12,799,734		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,666,617	388,317	321,674	1,437,695	20,814,303	5.00
7.00	00700	OPERATION OF PLANT	4,707,545	322,488	267,143	130,638	5,427,814	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	593,680	0	0	7,640	601,320	8.00
9.00	00900	HOUSEKEEPING	1,076,679	46,365	38,408	96,311	1,257,763	9.00
10.00	01000	DIETARY	1,313,079	103,784	85,972	69,323	1,572,158	10.00
11.00	01100	CAFETERIA	801,080	0	0	77,776	878,856	11.00
13.00	01300	NURSING ADMINISTRATION	662,450	0	0	88,109	750,559	13.00
15.00	01500	PHARMACY	1,291,946	32,039	26,540	120,487	1,471,012	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,746,307	50,611	41,925	191,834	2,030,677	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,547,972	336,632	278,859	704,510	6,867,973	30.00
31.00	03100	INTENSIVE CARE UNIT	1,843,580	92,449	76,583	268,506	2,281,118	31.00
40.00	04000	SUBPROVIDER - IPF	1,395,465	105,849	87,683	223,190	1,812,187	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,522,663	80,155	66,399	190,752	1,859,969	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,119,459	359,071	297,447	403,150	5,179,127	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,460,675	328,585	272,193	307,406	5,368,859	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	1,165,253	0	0	97,093	1,262,346	55.01
57.00	05700	CT SCAN	786,328	0	0	59,637	845,965	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	620,512	28,189	23,351	57,840	729,892	58.00
59.00	05900	CARDIAC CATHETERIZATION	228,091	23,761	19,683	59,130	330,665	59.00
60.00	06000	LABORATORY	7,314,583	165,912	137,438	546,280	8,164,213	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	83,130	0	0	0	83,130	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,861,747	148,314	122,861	252,122	2,385,044	66.00
67.00	06700	OCCUPATIONAL THERAPY	494,441	0	0	64,978	559,419	67.00
67.01	06701	AUDIOLOGY	165,693	14,755	12,223	40,135	232,806	67.01
68.00	06800	SPEECH PATHOLOGY	196,707	0	0	31,799	228,506	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	2,097,901	15,284	12,661	292,727	2,418,573	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,302,870	0	0	0	3,302,870	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,535,240	0	0	0	4,535,240	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,705,939	0	0	0	11,705,939	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	31,769	0	0	9,357	41,126	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	110,094	14,755	12,223	11,647	148,719	90.13
90.14	09014	WOUND CARE	327,883	124,587	103,205	47,173	602,848	90.14
91.00	09100	EMERGENCY	5,076,902	405,915	336,252	552,391	6,371,460	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,938,784	78,652	65,153	440,440	3,523,029	95.00
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)	114,721,330	3,296,029	2,730,363	6,880,076	105,645,485	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	10,311	8,541	0	18,852	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	44,514,874	1,508,521	1,249,635	5,864,777	53,137,807	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	27,493	23,397	19,382	701	70,973	194.01
194.02	07952	OTHER NONREIMB	44,089	177,379	146,937	0	368,405	194.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/30/2024 1:52 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
194.03	07953	RETAIL PHARMACY	2,984,595	6,609	5,475	54,180	3,050,859	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)	162,292,381	5,022,246	4,160,333	12,799,734	162,292,381	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/30/2024 1:52 pm

		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	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,814,303					5.00
7.00	00700	OPERATION OF PLANT	798,540	6,226,354				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	88,466	0	689,786			8.00
9.00	00900	HOUSEKEEPING	185,042	67,420	0	1,510,225		9.00
10.00	01000	DIETARY	231,296	150,914	0	100,777	2,055,145	10.00
11.00	01100	CAFETERIA	129,297	0	0	33,600	0	11.00
13.00	01300	NURSING ADMINISTRATION	110,422	0	0	15,193	0	13.00
15.00	01500	PHARMACY	216,415	46,588	0	30,678	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	298,753	73,595	0	67,200	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,010,416	489,502	38,102	510,499	873,734	30.00
31.00	03100	INTENSIVE CARE UNIT	335,598	134,431	7,843	135,569	269,884	31.00
40.00	04000	SUBPROVIDER - IPF	266,609	153,917	4,613	161,210	312,195	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	273,639	116,555	4,124	0	599,332	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	761,953	522,130	90,149	30,094	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	789,867	477,801	54,563	136,153	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	185,716	0	13,125	8,765	0	55.01
57.00	05700	CT SCAN	124,458	0	86,614	13,440	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	107,382	40,990	18,499	12,856	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	48,647	34,551	25,502	0	0	59.00
60.00	06000	LABORATORY	1,201,119	241,255	94,699	57,558	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	12,230	0	1,238	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	350,888	215,666	12,388	20,744	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	82,302	0	3,660	9,934	0	67.00
67.01	06701	AUDIOLOGY	34,250	21,456	1,357	7,304	0	67.01
68.00	06800	SPEECH PATHOLOGY	33,618	0	1,554	4,383	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	355,820	22,225	38,772	44,118	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	485,918	0	16,802	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	667,225	0	17,007	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,722,178	0	76,104	31,847	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	6,050	0	172	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	21,880	21,456	612	0	0	90.13
90.14	09014	WOUND CARE	88,691	181,163	9,401	0	0	90.14
91.00	09100	EMERGENCY	937,369	590,247	66,752	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	518,308	114,368	6,134	0	0	95.00
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)	12,480,362	3,716,230	689,786	1,431,922	2,055,145	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	2,774	14,993	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,817,683	2,193,568	0	78,303	0	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	10,442	34,022	0	0	0	194.01
194.02	07952	OTHER NONREIMB	54,200	257,930	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	448,842	9,611	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)	20,814,303	6,226,354	689,786	1,510,225	2,055,145	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/30/2024 1:52 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			11.00	13.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,041,753					11.00
13.00	01300	NURSING ADMINISTRATION	20,156	896,330				13.00
15.00	01500	PHARMACY	40,312	0	1,805,005			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	81,685	0	0	2,551,910		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	274,760	176,697	136	627,111	10,868,930	30.00
31.00	03100	INTENSIVE CARE UNIT	22,278	72,009	42	130,390	3,389,162	31.00
40.00	04000	SUBPROVIDER - IPF	35,008	58,339	22	155,226	2,959,326	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	69,594	26	0	2,923,239	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,400	125,776	2,554	225,077	6,961,260	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,704	15,288	903	602,276	7,475,414	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	3,183	0	282	65,195	1,538,612	55.01
57.00	05700	CT SCAN	4,243	0	19,220	74,508	1,168,448	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	10,608	0	9,808	40,359	970,394	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	18,922	1,633	0	459,920	59.00
60.00	06000	LABORATORY	86,990	0	1	62,090	9,907,925	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	96,598	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	43,495	62,997	200	121,076	3,212,498	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,034	21,241	0	52,777	747,367	67.00
67.01	06701	AUDIOLOGY	19,095	14,255	0	0	330,523	67.01
68.00	06800	SPEECH PATHOLOGY	20,156	8,961	0	0	297,178	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	43,495	84,903	2,853	116,419	3,127,178	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,278	0	0	0	3,827,868	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	5,219,472	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,174,874	0	14,710,942	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	47,348	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	3,086	38	0	195,791	90.13
90.14	09014	WOUND CARE	0	18,608	1,266	0	901,977	90.14
91.00	09100	EMERGENCY	67,894	107,288	9,435	0	8,150,445	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	137,910	0	1,590	0	4,301,339	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,005,684	857,964	1,224,883	2,272,504	93,789,154	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	36,619	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	36,069	38,366	331,890	279,406	63,913,092	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	0	0	0	0	115,437	194.01
194.02	07952	OTHER NONREIMB	0	0	0	0	680,535	194.02
194.03	07953	RETAIL PHARMACY	0	0	248,232	0	3,757,544	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,041,753	896,330	1,805,005	2,551,910	162,292,381	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/30/2024 1:52 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	10,868,930		30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,389,162		31.00
40.00	04000	SUBPROVIDER - IPF	0	2,959,326		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	2,923,239		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	6,961,260		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,475,414		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
55.01	05501	ULTRA SOUND	0	1,538,612		55.01
57.00	05700	CT SCAN	0	1,168,448		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	970,394		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	459,920		59.00
60.00	06000	LABORATORY	0	9,907,925		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	96,598		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	3,212,498		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	747,367		67.00
67.01	06701	AUDIOLOGY	0	330,523		67.01
68.00	06800	SPEECH PATHOLOGY	0	297,178		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIOLOGY	0	3,127,178		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,827,868		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	5,219,472		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	14,710,942		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0		90.01
90.02	09002	CLINIC	0	0		90.02
90.03	09003	DERMATOLOGY CLINIC	0	0		90.03
90.04	09004	ENT CLINIC	0	0		90.04
90.05	09005	SURGERY CLINIC	0	0		90.05
90.07	09007	UROLOGY CLINIC	0	47,348		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0		90.09
90.11	09011	NEUROLOGY CLINIC	0	0		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0		90.12
90.13	09013	ALLERGY CLINIC	0	195,791		90.13
90.14	09014	WOUND CARE	0	901,977		90.14
91.00	09100	EMERGENCY	0	8,150,445		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	4,301,339		95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	93,789,154		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	36,619		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	63,913,092		192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0		194.00
194.01	07951	CAFE/BOUTIQUE	0	115,437		194.01
194.02	07952	OTHER NONREIMB	0	680,535		194.02
194.03	07953	RETAIL PHARMACY	0	3,757,544		194.03
200.00		Cross Foot Adjustments	0	0		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/30/2024 1:52 pm

	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		25.00	26.00		
201.00	Negative Cost Centers	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	0	162,292,381		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/30/2024 1:52 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	29,560	24,487	54,047	54,047	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	388,317	321,674	709,991	6,070	5.00
7.00	00700	OPERATION OF PLANT	0	322,488	267,143	589,631	552	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	32	8.00
9.00	00900	HOUSEKEEPING	0	46,365	38,408	84,773	407	9.00
10.00	01000	DIETARY	0	103,784	85,972	189,756	293	10.00
11.00	01100	CAFETERIA	0	0	0	0	328	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	372	13.00
15.00	01500	PHARMACY	0	32,039	26,540	58,579	509	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	50,611	41,925	92,536	810	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	336,632	278,859	615,491	2,975	30.00
31.00	03100	INTENSIVE CARE UNIT	0	92,449	76,583	169,032	1,134	31.00
40.00	04000	SUBPROVIDER - IPF	0	105,849	87,683	193,532	942	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	80,155	66,399	146,554	805	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	359,071	297,447	656,518	1,702	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	328,585	272,193	600,778	1,298	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	0	0	410	55.01
57.00	05700	CT SCAN	0	0	0	0	252	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	28,189	23,351	51,540	244	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	23,761	19,683	43,444	250	59.00
60.00	06000	LABORATORY	0	165,912	137,438	303,350	2,307	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	148,314	122,861	271,175	1,065	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	274	67.00
67.01	06701	AUDIOLOGY	0	14,755	12,223	26,978	169	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	134	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0	15,284	12,661	27,945	1,236	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	40	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	14,755	12,223	26,978	49	90.13
90.14	09014	WOUND CARE	0	124,587	103,205	227,792	199	90.14
91.00	09100	EMERGENCY	0	405,915	336,252	742,167	2,332	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	78,652	65,153	143,805	1,860	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,296,029	2,730,363	6,026,392	29,050	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	10,311	8,541	18,852	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,508,521	1,249,635	2,758,156	24,765	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	0	23,397	19,382	42,779	3	194.01
194.02	07952	OTHER NONREIMB	0	177,379	146,937	324,316	0	194.02
194.03	07953	RETAIL PHARMACY	0	6,609	5,475	12,084	229	194.03

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/30/2024 1:52 pm

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	5,022,246	4,160,333	9,182,579	54,047	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/30/2024 1:52 pm

		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	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	716,061					5.00
7.00	00700	OPERATION OF PLANT	27,470	617,653				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,043	0	3,075			8.00
9.00	00900	HOUSEKEEPING	6,366	6,688	0	98,234		9.00
10.00	01000	DIETARY	7,957	14,971	0	6,555	219,532	10.00
11.00	01100	CAFETERIA	4,448	0	0	2,186	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,799	0	0	988	0	13.00
15.00	01500	PHARMACY	7,445	4,622	0	1,995	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,277	7,301	0	4,371	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	34,759	48,558	178	33,208	93,333	30.00
31.00	03100	INTENSIVE CARE UNIT	11,545	13,336	37	8,818	28,829	31.00
40.00	04000	SUBPROVIDER - IPF	9,171	15,269	22	10,486	33,349	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	9,413	11,562	19	0	64,021	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,212	51,795	421	1,957	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,172	47,398	255	8,856	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	6,389	0	61	570	0	55.01
57.00	05700	CT SCAN	4,281	0	404	874	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,694	4,066	86	836	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,673	3,427	119	0	0	59.00
60.00	06000	LABORATORY	41,319	23,932	297	3,744	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	421	0	6	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	12,071	21,394	58	1,349	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,831	0	17	646	0	67.00
67.01	06701	AUDIOLOGY	1,178	2,128	6	475	0	67.01
68.00	06800	SPEECH PATHOLOGY	1,156	0	7	285	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	12,240	2,205	181	2,870	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,716	0	78	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	22,953	0	79	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	59,244	0	355	2,072	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	208	0	1	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	753	2,128	3	0	0	90.13
90.14	09014	WOUND CARE	3,051	17,971	44	0	0	90.14
91.00	09100	EMERGENCY	32,246	58,552	312	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	17,830	11,345	29	0	0	95.00
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)	429,331	368,648	3,075	93,141	219,532	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	95	1,487	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	268,972	217,603	0	5,093	0	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	359	3,375	0	0	0	194.01
194.02	07952	OTHER NONREIMB	1,864	25,587	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	15,440	953	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)	716,061	617,653	3,075	98,234	219,532	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/30/2024 1:52 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			11.00	13.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW 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	6,962					11.00
13.00	01300	NURSING ADMINISTRATION	135	5,294				13.00
15.00	01500	PHARMACY	269	0	73,419			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	546	0	0	115,841		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,834	1,044	6	28,467	859,853	30.00
31.00	03100	INTENSIVE CARE UNIT	149	425	2	5,919	239,226	31.00
40.00	04000	SUBPROVIDER - IPF	234	345	1	7,046	270,397	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	411	1	0	232,786	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	163	743	104	10,217	749,832	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	199	90	37	27,340	713,423	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	21	0	11	2,959	10,421	55.01
57.00	05700	CT SCAN	28	0	782	3,382	10,003	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	71	0	399	1,832	62,768	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	112	66	0	49,091	59.00
60.00	06000	LABORATORY	581	0	0	2,819	378,349	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	427	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	291	372	8	5,496	313,279	66.00
67.00	06700	OCCUPATIONAL THERAPY	121	125	0	2,396	6,410	67.00
67.01	06701	AUDIOLOGY	128	84	0	0	31,146	67.01
68.00	06800	SPEECH PATHOLOGY	135	53	0	0	1,770	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	291	501	116	5,285	52,870	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	149	0	0	0	16,943	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	23,032	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	47,789	0	109,460	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	249	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	18	2	0	29,931	90.13
90.14	09014	WOUND CARE	0	110	51	0	249,218	90.14
91.00	09100	EMERGENCY	454	634	384	0	837,081	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	922	0	65	0	175,856	95.00
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)	6,721	5,067	49,824	103,158	5,423,821	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	20,434	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	241	227	13,499	12,683	3,301,239	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	0	0	0	0	46,516	194.01
194.02	07952	OTHER NONREIMB	0	0	0	0	351,767	194.02
194.03	07953	RETAIL PHARMACY	0	0	10,096	0	38,802	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,962	5,294	73,419	115,841	9,182,579	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/30/2024 1:52 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	859,853		30.00
31.00	03100	INTENSIVE CARE UNIT	0	239,226		31.00
40.00	04000	SUBPROVIDER - IPF	0	270,397		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	232,786		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	749,832		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	713,423		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
55.01	05501	ULTRA SOUND	0	10,421		55.01
57.00	05700	CT SCAN	0	10,003		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	62,768		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	49,091		59.00
60.00	06000	LABORATORY	0	378,349		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	427		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	313,279		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	6,410		67.00
67.01	06701	AUDIOLOGY	0	31,146		67.01
68.00	06800	SPEECH PATHOLOGY	0	1,770		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIOLOGY	0	52,870		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	16,943		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	23,032		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	109,460		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0		90.01
90.02	09002	CLINIC	0	0		90.02
90.03	09003	DERMATOLOGY CLINIC	0	0		90.03
90.04	09004	ENT CLINIC	0	0		90.04
90.05	09005	SURGERY CLINIC	0	0		90.05
90.07	09007	UROLOGY CLINIC	0	249		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0		90.09
90.11	09011	NEUROLOGY CLINIC	0	0		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0		90.12
90.13	09013	ALLERGY CLINIC	0	29,931		90.13
90.14	09014	WOUND CARE	0	249,218		90.14
91.00	09100	EMERGENCY	0	837,081		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	175,856		95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	5,423,821		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	20,434		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,301,239		192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0		194.00
194.01	07951	CAFE/BOUTIQUE	0	46,516		194.01
194.02	07952	OTHER NONREIMB	0	351,767		194.02
194.03	07953	RETAIL PHARMACY	0	38,802		194.03
200.00		Cross Foot Adjustments	0	0		200.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/30/2024 1:52 pm

	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		25.00	26.00		
201.00	Negative Cost Centers	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	0	9,182,579		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/30/2024 1:52 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	303,947					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		303,947				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,789	1,789	72,835,134			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	23,501	23,501	8,180,993	-20,814,303	141,478,078	5.00
7.00	00700	OPERATION OF PLANT	19,517	19,517	743,379	0	5,427,814	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	43,475	0	601,320	8.00
9.00	00900	HOUSEKEEPING	2,806	2,806	548,041	0	1,257,763	9.00
10.00	01000	DIETARY	6,281	6,281	394,471	0	1,572,158	10.00
11.00	01100	CAFETERIA	0	0	442,573	0	878,856	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	501,372	0	750,559	13.00
15.00	01500	PHARMACY	1,939	1,939	685,612	0	1,471,012	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,063	3,063	1,091,603	0	2,030,677	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,373	20,373	4,008,911	0	6,867,973	30.00
31.00	03100	INTENSIVE CARE UNIT	5,595	5,595	1,527,895	0	2,281,118	31.00
40.00	04000	SUBPROVIDER - IPF	6,406	6,406	1,270,029	0	1,812,187	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	4,851	4,851	1,085,448	0	1,859,969	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,731	21,731	2,294,064	0	5,179,127	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,886	19,886	1,749,247	0	5,368,859	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	552,493	0	1,262,346	55.01
57.00	05700	CT SCAN	0	0	339,354	0	845,965	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,706	1,706	329,129	0	729,892	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,438	1,438	336,473	0	330,665	59.00
60.00	06000	LABORATORY	10,041	10,041	3,108,527	0	8,164,213	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	83,130	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	8,976	8,976	1,434,666	0	2,385,044	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	369,745	0	559,419	67.00
67.01	06701	AUDIOLOGY	893	893	228,381	0	232,806	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	180,949	0	228,506	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	925	925	1,665,722	0	2,418,573	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	3,302,870	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	4,535,240	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	11,705,939	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	53,244	0	41,126	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	893	893	66,278	0	148,719	90.13
90.14	09014	WOUND CARE	7,540	7,540	268,433	0	602,848	90.14
91.00	09100	EMERGENCY	24,566	24,566	3,143,298	0	6,371,460	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,760	4,760	2,506,262	0	3,523,029	95.00
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)	199,476	199,476	39,150,067	-20,814,303	84,831,182	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	624	624	0	0	18,852	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	91,296	91,296	33,372,774	0	53,137,807	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	1,416	1,416	3,991	0	70,973	194.01
194.02	07952	OTHER NONREIMB	10,735	10,735	0	0	368,405	194.02

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/30/2024 1:52 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
194.03	07953	RETAIL PHARMACY	400	400	308,302	0	3,050,859	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)	5,022,246	4,160,333	12,799,734		20,814,303	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.523427	13.687692	0.175736		0.147120	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			54,047		716,061	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000742		0.005061	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: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/30/2024 1:52 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (GROSS CHARGES)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW 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	259,140					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	459,886,501				8.00
9.00	00900	HOUSEKEEPING	2,806	0	129,223			9.00
10.00	01000	DIETARY	6,281	0	8,623	45,027		10.00
11.00	01100	CAFETERIA	0	0	2,875	0	982	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,300	0	19	13.00
15.00	01500	PHARMACY	1,939	0	2,625	0	38	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,063	0	5,750	0	77	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,373	25,401,290	43,681	19,143	259	30.00
31.00	03100	INTENSIVE CARE UNIT	5,595	5,228,847	11,600	5,913	21	31.00
40.00	04000	SUBPROVIDER - IPF	6,406	3,075,004	13,794	6,840	33	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	4,851	2,749,597	0	13,131	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,731	60,099,112	2,575	0	23	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,886	36,375,100	11,650	0	28	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	8,750,115	750	0	3	55.01
57.00	05700	CT SCAN	0	57,742,492	1,150	0	4	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,706	12,332,477	1,100	0	10	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,438	17,001,459	0	0	0	59.00
60.00	06000	LABORATORY	10,041	63,162,560	4,925	0	82	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	825,446	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	8,976	8,258,634	1,775	0	41	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,439,762	850	0	17	67.00
67.01	06701	AUDIOLOGY	893	904,612	625	0	18	67.01
68.00	06800	SPEECH PATHOLOGY	0	1,035,723	375	0	19	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	925	25,848,314	3,775	0	41	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,201,532	0	0	21	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	11,337,757	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	50,736,170	2,725	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	114,426	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	893	407,864	0	0	0	90.13
90.14	09014	WOUND CARE	7,540	6,267,099	0	0	0	90.14
91.00	09100	EMERGENCY	24,566	44,501,640	0	0	64	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,760	4,089,469	0	0	130	95.00
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)	154,669	459,886,501	122,523	45,027	948	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	624	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	91,296	0	6,700	0	34	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	1,416	0	0	0	0	194.01
194.02	07952	OTHER NONREIMB	10,735	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	400	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/30/2024 1:52 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (GROSS CHARGES)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
			7.00	8.00	9.00	10.00	11.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	6,226,354	689,786	1,510,225	2,055,145	1,041,753	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	24.026989	0.001500	11.686967	45.642503	1,060.848269	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	617,653	3,075	98,234	219,532	6,962	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.383472	0.000007	0.760190	4.875564	7.089613	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: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/30/2024 1:52 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW 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	403,125				13.00
15.00	01500	PHARMACY	0	18,647,146			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	41,100		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	79,470	1,408	10,100		30.00
31.00	03100	INTENSIVE CARE UNIT	32,386	434	2,100		31.00
40.00	04000	SUBPROVIDER - IPF	26,238	231	2,500		40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0		41.00
42.00	04200	SUBPROVIDER	0	0	0		42.00
43.00	04300	NURSERY	0	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	31,300	265	0		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	56,568	26,380	3,625		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,876	9,332	9,700		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
55.01	05501	ULTRA SOUND	0	2,912	1,050		55.01
57.00	05700	CT SCAN	0	198,553	1,200		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	101,322	650		58.00
59.00	05900	CARDIAC CATHETERIZATION	8,510	16,867	0		59.00
60.00	06000	LABORATORY	0	15	1,000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
66.00	06600	PHYSICAL THERAPY	28,333	2,062	1,950		66.00
67.00	06700	OCCUPATIONAL THERAPY	9,553	0	850		67.00
67.01	06701	AUDIOLOGY	6,411	0	0		67.01
68.00	06800	SPEECH PATHOLOGY	4,030	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	06901	CARDIOLOGY	38,185	29,471	1,875		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,137,408	0		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		90.01
90.02	09002	CLINIC	0	0	0		90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0		90.03
90.04	09004	ENT CLINIC	0	0	0		90.04
90.05	09005	SURGERY CLINIC	0	0	0		90.05
90.07	09007	UROLOGY CLINIC	0	0	0		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0		90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0		90.12
90.13	09013	ALLERGY CLINIC	1,388	395	0		90.13
90.14	09014	WOUND CARE	8,369	13,076	0		90.14
91.00	09100	EMERGENCY	48,253	97,467	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	16,431	0		95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	385,870	12,654,029	36,600		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	17,255	3,428,683	4,500		192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0		194.00
194.01	07951	CAFE/BOUTIQUE	0	0	0		194.01
194.02	07952	OTHER NONREIMB	0	0	0		194.02
194.03	07953	RETAIL PHARMACY	0	2,564,434	0		194.03
200.00		Cross Foot Adjustments					200.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/30/2024 1:52 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	15.00	16.00		
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	896,330	1,805,005	2,551,910		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.223454	0.096798	62.090268		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	5,294	73,419	115,841		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.013132	0.003937	2.818516		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/30/2024 1:52 pm

Title XVIII | Hospital | PPS

		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	10,868,930		10,868,930	0	10,868,930	30.00
31.00	03100	INTENSIVE CARE UNIT	3,389,162		3,389,162	0	3,389,162	31.00
40.00	04000	SUBPROVIDER - IPF	2,959,326		2,959,326	0	2,959,326	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	0		0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	2,923,239		2,923,239	0	2,923,239	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,961,260		6,961,260	0	6,961,260	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,475,414		7,475,414	0	7,475,414	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
55.01	05501	ULTRA SOUND	1,538,612		1,538,612	0	1,538,612	55.01
57.00	05700	CT SCAN	1,168,448		1,168,448	0	1,168,448	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	970,394		970,394	0	970,394	58.00
59.00	05900	CARDIAC CATHETERIZATION	459,920		459,920	0	459,920	59.00
60.00	06000	LABORATORY	9,907,925		9,907,925	0	9,907,925	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	96,598		96,598	0	96,598	63.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	3,212,498	0	3,212,498	0	3,212,498	66.00
67.00	06700	OCCUPATIONAL THERAPY	747,367	0	747,367	0	747,367	67.00
67.01	06701	AUDIOLOGY	330,523	0	330,523	0	330,523	67.01
68.00	06800	SPEECH PATHOLOGY	297,178	0	297,178	0	297,178	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	06901	CARDIOLOGY	3,127,178		3,127,178	0	3,127,178	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,827,868		3,827,868	0	3,827,868	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,219,472		5,219,472	0	5,219,472	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,710,942		14,710,942	0	14,710,942	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	90.01
90.02	09002	CLINIC	0		0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0		0	0	0	90.03
90.04	09004	ENT CLINIC	0		0	0	0	90.04
90.05	09005	SURGERY CLINIC	0		0	0	0	90.05
90.07	09007	UROLOGY CLINIC	47,348		47,348	0	47,348	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0		0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0		0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0		0	0	0	90.12
90.13	09013	ALLERGY CLINIC	195,791		195,791	0	195,791	90.13
90.14	09014	WOUND CARE	901,977		901,977	0	901,977	90.14
91.00	09100	EMERGENCY	8,150,445		8,150,445	0	8,150,445	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,462,030		2,462,030		2,462,030	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,301,339		4,301,339	0	4,301,339	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	96,251,184	0	96,251,184	0	96,251,184	200.00
201.00		Less Observation Beds	2,462,030		2,462,030		2,462,030	201.00
202.00		Total (see instructions)	93,789,154	0	93,789,154	0	93,789,154	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/30/2024 1:52 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,880,072		17,880,072			30.00
31.00	03100	INTENSIVE CARE UNIT	5,228,847		5,228,847			31.00
40.00	04000	SUBPROVIDER - IPF	3,075,004		3,075,004			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	0		0			43.00
44.00	04400	SKILLED NURSING FACILITY	2,749,597		2,749,597			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,758,389	51,340,723	60,099,112	0.115830	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,793,939	34,581,161	36,375,100	0.205509	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
55.01	05501	ULTRA SOUND	664,346	8,085,769	8,750,115	0.175839	0.000000	55.01
57.00	05700	CT SCAN	7,746,725	49,995,767	57,742,492	0.020235	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	816,004	11,516,473	12,332,477	0.078686	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,756,472	12,244,987	17,001,459	0.027052	0.000000	59.00
60.00	06000	LABORATORY	12,070,539	51,092,021	63,162,560	0.156864	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	477,796	347,650	825,446	0.117025	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	1,857,586	6,401,048	8,258,634	0.388987	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,757,432	682,330	2,439,762	0.306328	0.000000	67.00
67.01	06701	AUDIOLOGY	0	904,612	904,612	0.365375	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	187,561	848,162	1,035,723	0.286928	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
69.01	06901	CARDIOLOGY	6,579,550	19,268,764	25,848,314	0.120982	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,891,827	8,309,705	11,201,532	0.341727	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,152,737	9,185,020	11,337,757	0.460362	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,982,110	41,754,060	50,736,170	0.289950	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	90.01
90.02	09002	CLINIC	0	0	0	0.000000	0.000000	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	ENT CLINIC	0	0	0	0.000000	0.000000	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0.000000	0.000000	90.05
90.07	09007	UROLOGY CLINIC	0	114,426	114,426	0.413787	0.000000	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0.000000	0.000000	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0.000000	0.000000	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0.000000	0.000000	90.12
90.13	09013	ALLERGY CLINIC	0	407,864	407,864	0.480040	0.000000	90.13
90.14	09014	WOUND CARE	11,900	6,255,199	6,267,099	0.143923	0.000000	90.14
91.00	09100	EMERGENCY	5,520,656	38,980,984	44,501,640	0.183149	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	186,232	7,334,986	7,521,218	0.327345	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	4,089,469	4,089,469	1.051809	0.000000	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	96,145,321	363,741,180	459,886,501			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	96,145,321	363,741,180	459,886,501			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/30/2024 1:52 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.115830		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205509		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
55.01	05501	ULTRA SOUND	0.175839		55.01
57.00	05700	CT SCAN	0.020235		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.078686		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.027052		59.00
60.00	06000	LABORATORY	0.156864		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.117025		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
66.00	06600	PHYSICAL THERAPY	0.388987		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.306328		67.00
67.01	06701	AUDIOLOGY	0.365375		67.01
68.00	06800	SPEECH PATHOLOGY	0.286928		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	CARDIOLOGY	0.120982		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.341727		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.460362		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.289950		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000		78.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		90.01
90.02	09002	CLINIC	0.000000		90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000		90.03
90.04	09004	ENT CLINIC	0.000000		90.04
90.05	09005	SURGERY CLINIC	0.000000		90.05
90.07	09007	UROLOGY CLINIC	0.413787		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000		90.09
90.11	09011	NEUROLOGY CLINIC	0.000000		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000		90.12
90.13	09013	ALLERGY CLINIC	0.480040		90.13
90.14	09014	WOUND CARE	0.143923		90.14
91.00	09100	EMERGENCY	0.183149		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.327345		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	1.051809		95.00
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: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/30/2024 1:52 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,868,930		10,868,930	0	10,868,930	30.00
31.00	03100	INTENSIVE CARE UNIT	3,389,162		3,389,162	0	3,389,162	31.00
40.00	04000	SUBPROVIDER - IPF	2,959,326		2,959,326	0	2,959,326	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	0		0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	2,923,239		2,923,239	0	2,923,239	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,961,260		6,961,260	0	6,961,260	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,475,414		7,475,414	0	7,475,414	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
55.01	05501	ULTRA SOUND	1,538,612		1,538,612	0	1,538,612	55.01
57.00	05700	CT SCAN	1,168,448		1,168,448	0	1,168,448	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	970,394		970,394	0	970,394	58.00
59.00	05900	CARDIAC CATHETERIZATION	459,920		459,920	0	459,920	59.00
60.00	06000	LABORATORY	9,907,925		9,907,925	0	9,907,925	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	96,598		96,598	0	96,598	63.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	3,212,498	0	3,212,498	0	3,212,498	66.00
67.00	06700	OCCUPATIONAL THERAPY	747,367	0	747,367	0	747,367	67.00
67.01	06701	AUDIOLOGY	330,523	0	330,523	0	330,523	67.01
68.00	06800	SPEECH PATHOLOGY	297,178	0	297,178	0	297,178	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	06901	CARDIOLOGY	3,127,178		3,127,178	0	3,127,178	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,827,868		3,827,868	0	3,827,868	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,219,472		5,219,472	0	5,219,472	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,710,942		14,710,942	0	14,710,942	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	90.01
90.02	09002	CLINIC	0		0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0		0	0	0	90.03
90.04	09004	ENT CLINIC	0		0	0	0	90.04
90.05	09005	SURGERY CLINIC	0		0	0	0	90.05
90.07	09007	UROLOGY CLINIC	47,348		47,348	0	47,348	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0		0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0		0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0		0	0	0	90.12
90.13	09013	ALLERGY CLINIC	195,791		195,791	0	195,791	90.13
90.14	09014	WOUND CARE	901,977		901,977	0	901,977	90.14
91.00	09100	EMERGENCY	8,150,445		8,150,445	0	8,150,445	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,462,030		2,462,030		2,462,030	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,301,339		4,301,339	0	4,301,339	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	96,251,184	0	96,251,184	0	96,251,184	200.00
201.00		Less Observation Beds	2,462,030		2,462,030		2,462,030	201.00
202.00		Total (see instructions)	93,789,154	0	93,789,154	0	93,789,154	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/30/2024 1:52 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,880,072		17,880,072			30.00
31.00	03100	INTENSIVE CARE UNIT	5,228,847		5,228,847			31.00
40.00	04000	SUBPROVIDER - IPF	3,075,004		3,075,004			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	0		0			43.00
44.00	04400	SKILLED NURSING FACILITY	2,749,597		2,749,597			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,758,389	51,340,723	60,099,112	0.115830	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,793,939	34,581,161	36,375,100	0.205509	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
55.01	05501	ULTRA SOUND	664,346	8,085,769	8,750,115	0.175839	0.000000	55.01
57.00	05700	CT SCAN	7,746,725	49,995,767	57,742,492	0.020235	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	816,004	11,516,473	12,332,477	0.078686	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,756,472	12,244,987	17,001,459	0.027052	0.000000	59.00
60.00	06000	LABORATORY	12,070,539	51,092,021	63,162,560	0.156864	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	477,796	347,650	825,446	0.117025	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	1,857,586	6,401,048	8,258,634	0.388987	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,757,432	682,330	2,439,762	0.306328	0.000000	67.00
67.01	06701	AUDIOLOGY	0	904,612	904,612	0.365375	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	187,561	848,162	1,035,723	0.286928	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
69.01	06901	CARDIOLOGY	6,579,550	19,268,764	25,848,314	0.120982	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,891,827	8,309,705	11,201,532	0.341727	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,152,737	9,185,020	11,337,757	0.460362	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,982,110	41,754,060	50,736,170	0.289950	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	90.01
90.02	09002	CLINIC	0	0	0	0.000000	0.000000	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	ENT CLINIC	0	0	0	0.000000	0.000000	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0.000000	0.000000	90.05
90.07	09007	UROLOGY CLINIC	0	114,426	114,426	0.413787	0.000000	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0.000000	0.000000	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0.000000	0.000000	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0.000000	0.000000	90.12
90.13	09013	ALLERGY CLINIC	0	407,864	407,864	0.480040	0.000000	90.13
90.14	09014	WOUND CARE	11,900	6,255,199	6,267,099	0.143923	0.000000	90.14
91.00	09100	EMERGENCY	5,520,656	38,980,984	44,501,640	0.183149	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	186,232	7,334,986	7,521,218	0.327345	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	4,089,469	4,089,469	1.051809	0.000000	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	96,145,321	363,741,180	459,886,501			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	96,145,321	363,741,180	459,886,501			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/30/2024 1:52 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
55.01	05501	ULTRA SOUND	0.000000		55.01
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
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
67.01	06701	AUDIOLOGY	0.000000		67.01
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	CARDIOLOGY	0.000000		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000		78.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		90.01
90.02	09002	CLINIC	0.000000		90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000		90.03
90.04	09004	ENT CLINIC	0.000000		90.04
90.05	09005	SURGERY CLINIC	0.000000		90.05
90.07	09007	UROLOGY CLINIC	0.000000		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000		90.09
90.11	09011	NEUROLOGY CLINIC	0.000000		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000		90.12
90.13	09013	ALLERGY CLINIC	0.000000		90.13
90.14	09014	WOUND CARE	0.000000		90.14
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
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: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part I Date/Time Prepared: 5/30/2024 1:52 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	859,853	0	859,853	8,869	96.95	30.00
31.00	INTENSIVE CARE UNIT	239,226		239,226	1,971	121.37	31.00
40.00	SUBPROVIDER - IPF	270,397	0	270,397	2,280	118.60	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	0		0	731	0.00	43.00
44.00	SKILLED NURSING FACILITY	232,786		232,786	4,377	53.18	44.00
200.00	Total (lines 30 through 199)	1,602,262		1,602,262	18,228		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	2,010	194,870	30.00
31.00	INTENSIVE CARE UNIT	484	58,743	31.00
40.00	SUBPROVIDER - IPF	1,185	140,541	40.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	2,195	116,730	44.00
200.00	Total (lines 30 through 199)	5,874	510,884	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/30/2024 1:52 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	749,832	60,099,112	0.012477	2,846,417	35,515	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	713,423	36,375,100	0.019613	909,852	17,845	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	10,421	8,750,115	0.001191	83,839	100	55.01
57.00	05700	CT SCAN	10,003	57,742,492	0.000173	2,881,753	499	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	62,768	12,332,477	0.005090	231,755	1,180	58.00
59.00	05900	CARDIAC CATHETERIZATION	49,091	17,001,459	0.002887	0	0	59.00
60.00	06000	LABORATORY	378,349	63,162,560	0.005990	3,848,283	23,051	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	427	825,446	0.000517	99,483	51	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
66.00	06600	PHYSICAL THERAPY	313,279	8,258,634	0.037934	297,753	11,295	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,410	2,439,762	0.002627	255,596	671	67.00
67.01	06701	AUDIOLOGY	31,146	904,612	0.034430	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	1,770	1,035,723	0.001709	61,502	105	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	52,870	25,848,314	0.002045	2,285,797	4,674	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,943	11,201,532	0.001513	1,815,712	2,747	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	23,032	11,337,757	0.002031	777,755	1,580	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	109,460	50,736,170	0.002157	1,754,779	3,785	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	90.01
90.02	09002	CLINIC	0	0	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	249	114,426	0.002176	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0.000000	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0.000000	0	0	90.12
90.13	09013	ALLERGY CLINIC	29,931	407,864	0.073385	0	0	90.13
90.14	09014	WOUND CARE	249,218	6,267,099	0.039766	0	0	90.14
91.00	09100	EMERGENCY	837,081	44,501,640	0.018810	1,757,658	33,062	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	194,774	7,521,218	0.025897	95,908	2,484	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	3,840,477	426,863,512		20,003,842	138,644	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part III Date/Time Prepared: 5/30/2024 1:52 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	8,869	0.00	2,010	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,971	0.00	484	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	2,280	0.00	1,185	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0.00	0	42.00
43.00	04300	NURSERY		0	731	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	4,377	0.00	2,195	44.00
200.00		Total (lines 30 through 199)		0	18,228		5,874	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
40.00	04000	SUBPROVIDER - IPF	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
42.00	04200	SUBPROVIDER	0	42.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/30/2024 1:52 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	0	0	0	55.01
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
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.01	06701	AUDIOLOGY	0	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	0	0	0	0	90.13
90.14	09014	WOUND CARE	0	0	0	0	0	90.14
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/30/2024 1:52 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	60,099,112	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	36,375,100	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
55.01	05501	ULTRA SOUND	0	0	0	8,750,115	0.000000	55.01
57.00	05700	CT SCAN	0	0	0	57,742,492	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	12,332,477	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	17,001,459	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	63,162,560	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	825,446	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,258,634	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,439,762	0.000000	67.00
67.01	06701	AUDIOLOGY	0	0	0	904,612	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,035,723	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
69.01	06901	CARDIOLOGY	0	0	0	25,848,314	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	11,201,532	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	11,337,757	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	50,736,170	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0.000000	90.01
90.02	09002	CLINIC	0	0	0	0	0.000000	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0.000000	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0.000000	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0.000000	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	114,426	0.000000	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0.000000	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0.000000	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0.000000	90.12
90.13	09013	ALLERGY CLINIC	0	0	0	407,864	0.000000	90.13
90.14	09014	WOUND CARE	0	0	0	6,267,099	0.000000	90.14
91.00	09100	EMERGENCY	0	0	0	44,501,640	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	7,521,218	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	426,863,512		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/30/2024 1:52 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	2,846,417	0	9,341,842	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	909,852	0	12,011,388	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0.000000	83,839	0	780,440	0	55.01
57.00	05700	CT SCAN	0.000000	2,881,753	0	9,557,089	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	231,755	0	2,600,821	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	413,514	0	59.00
60.00	06000	LABORATORY	0.000000	3,848,283	0	4,343,901	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	99,483	0	110,362	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.000000	297,753	0	15,604	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	255,596	0	10,743	0	67.00
67.01	06701	AUDIOLOGY	0.000000	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.000000	61,502	0	62,941	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0.000000	2,285,797	0	5,955,897	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,815,712	0	1,400,136	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	777,755	0	1,668,798	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,754,779	0	14,988,638	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.000000	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.000000	0	0	0	0	90.13
90.14	09014	WOUND CARE	0.000000	0	0	1,163,627	0	90.14
91.00	09100	EMERGENCY	0.000000	1,757,658	0	4,504,969	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	95,908	0	1,381,793	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		20,003,842	0	70,312,503	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/30/2024 1:52 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.115830	9,341,842	0	0	1,082,066	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205509	12,011,388	0	0	2,468,448	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0.175839	780,440	0	0	137,232	55.01
57.00	05700	CT SCAN	0.020235	9,557,089	0	0	193,388	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.078686	2,600,821	0	0	204,648	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.027052	413,514	0	0	11,186	59.00
60.00	06000	LABORATORY	0.156864	4,343,901	0	0	681,402	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.117025	110,362	0	0	12,915	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.388987	15,604	0	0	6,070	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.306328	10,743	0	0	3,291	67.00
67.01	06701	AUDIOLOGY	0.365375	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.286928	62,941	0	0	18,060	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0.120982	5,955,897	0	0	720,556	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.341727	1,400,136	0	0	478,464	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.460362	1,668,798	0	0	768,251	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.289950	14,988,638	0	23,043	4,345,956	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.413787	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.480040	0	0	0	0	90.13
90.14	09014	WOUND CARE	0.143923	1,163,627	0	1,779	167,473	90.14
91.00	09100	EMERGENCY	0.183149	4,504,969	0	0	825,081	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.327345	1,381,793	0	0	452,323	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1.051809		0			95.00
200.00		Subtotal (see instructions)		70,312,503	0	24,822	12,576,810	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		70,312,503	0	24,822	12,576,810	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/30/2024 1:52 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
55.01	05501	ULTRA SOUND	0	0		55.01
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
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
67.01	06701	AUDIOLOGY	0	0		67.01
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIOLOGY	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,681		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0		90.01
90.02	09002	CLINIC	0	0		90.02
90.03	09003	DERMATOLOGY CLINIC	0	0		90.03
90.04	09004	ENT CLINIC	0	0		90.04
90.05	09005	SURGERY CLINIC	0	0		90.05
90.07	09007	UROLOGY CLINIC	0	0		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0		90.09
90.11	09011	NEUROLOGY CLINIC	0	0		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0		90.12
90.13	09013	ALLERGY CLINIC	0	0		90.13
90.14	09014	WOUND CARE	0	256		90.14
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	6,937		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	6,937		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II | Date/Time Prepared: 5/30/2024 1:52 pm

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	749,832	60,099,112	0.012477	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	713,423	36,375,100	0.019613	20,342	399	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	10,421	8,750,115	0.001191	0	0	55.01
57.00	05700	CT SCAN	10,003	57,742,492	0.000173	52,096	9	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	62,768	12,332,477	0.005090	3,396	17	58.00
59.00	05900	CARDIAC CATHETERIZATION	49,091	17,001,459	0.002887	0	0	59.00
60.00	06000	LABORATORY	378,349	63,162,560	0.005990	316,531	1,896	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	427	825,446	0.000517	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
66.00	06600	PHYSICAL THERAPY	313,279	8,258,634	0.037934	7,943	301	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,410	2,439,762	0.002627	6,371	17	67.00
67.01	06701	AUDIOLOGY	31,146	904,612	0.034430	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	1,770	1,035,723	0.001709	4,037	7	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	52,870	25,848,314	0.002045	8,730	18	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,943	11,201,532	0.001513	37,339	56	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	23,032	11,337,757	0.002031	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	109,460	50,736,170	0.002157	124,963	270	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	90.01
90.02	09002	CLINIC	0	0	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	249	114,426	0.002176	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0.000000	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0.000000	0	0	90.12
90.13	09013	ALLERGY CLINIC	29,931	407,864	0.073385	0	0	90.13
90.14	09014	WOUND CARE	249,218	6,267,099	0.039766	0	0	90.14
91.00	09100	EMERGENCY	837,081	44,501,640	0.018810	24,891	468	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	7,521,218	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	3,645,703	426,863,512		606,639	3,458	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/30/2024 1:52 pm

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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	0	0	0	55.01
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
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.01	06701	AUDIOLOGY	0	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	0	0	0	0	90.13
90.14	09014	WOUND CARE	0	0	0	0	0	90.14
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/30/2024 1:52 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	60,099,112	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	36,375,100	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
55.01	05501	ULTRA SOUND	0	0	0	8,750,115	0.000000	55.01
57.00	05700	CT SCAN	0	0	0	57,742,492	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	12,332,477	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	17,001,459	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	63,162,560	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	825,446	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,258,634	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,439,762	0.000000	67.00
67.01	06701	AUDIOLOGY	0	0	0	904,612	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,035,723	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
69.01	06901	CARDIOLOGY	0	0	0	25,848,314	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	11,201,532	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	11,337,757	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	50,736,170	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0.000000	90.01
90.02	09002	CLINIC	0	0	0	0	0.000000	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0.000000	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0.000000	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0.000000	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	114,426	0.000000	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0.000000	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0.000000	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0.000000	90.12
90.13	09013	ALLERGY CLINIC	0	0	0	407,864	0.000000	90.13
90.14	09014	WOUND CARE	0	0	0	6,267,099	0.000000	90.14
91.00	09100	EMERGENCY	0	0	0	44,501,640	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	7,521,218	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	426,863,512		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/30/2024 1:52 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	20,342	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0.000000	0	0	0	0	55.01
57.00	05700	CT SCAN	0.000000	52,096	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	3,396	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	316,531	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.000000	7,943	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	6,371	0	0	0	67.00
67.01	06701	AUDIOLOGY	0.000000	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.000000	4,037	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0.000000	8,730	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	37,339	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	124,963	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.000000	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.000000	0	0	0	0	90.13
90.14	09014	WOUND CARE	0.000000	0	0	894	0	90.14
91.00	09100	EMERGENCY	0.000000	24,891	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		606,639	0	894	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V | Date/Time Prepared: 5/30/2024 1:52 pm

Title XVIII | Subprovider - IPF | 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	0.115830	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205509	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0.175839	0	0	0	0	55.01
57.00	05700	CT SCAN	0.020235	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.078686	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.027052	0	0	0	0	59.00
60.00	06000	LABORATORY	0.156864	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.117025	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.388987	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.306328	0	0	0	0	67.00
67.01	06701	AUDIOLOGY	0.365375	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.286928	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0.120982	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.341727	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.460362	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.289950	0	0	3,892	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.413787	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.480040	0	0	0	0	90.13
90.14	09014	WOUND CARE	0.143923	894	0	0	129	90.14
91.00	09100	EMERGENCY	0.183149	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.327345	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1.051809		0			95.00
200.00		Subtotal (see instructions)		894	0	3,892	129	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		894	0	3,892	129	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V | Date/Time Prepared: 5/30/2024 1:52 pm

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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
55.01	05501	ULTRA SOUND	0	0		55.01
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
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
67.01	06701	AUDIOLOGY	0	0		67.01
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIOLOGY	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,128		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0		90.01
90.02	09002	CLINIC	0	0		90.02
90.03	09003	DERMATOLOGY CLINIC	0	0		90.03
90.04	09004	ENT CLINIC	0	0		90.04
90.05	09005	SURGERY CLINIC	0	0		90.05
90.07	09007	UROLOGY CLINIC	0	0		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0		90.09
90.11	09011	NEUROLOGY CLINIC	0	0		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0		90.12
90.13	09013	ALLERGY CLINIC	0	0		90.13
90.14	09014	WOUND CARE	0	0		90.14
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	1,128		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	1,128		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0104 | Component CCN: 15-5832 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/30/2024 1:52 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	0	0	0	55.01
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
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.01	06701	AUDIOLOGY	0	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	0	0	0	0	90.13
90.14	09014	WOUND CARE	0	0	0	0	0	90.14
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 15-0104 | Component CCN: 15-5832 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/30/2024 1:52 pm

Title XVIII | Skilled Nursing Facility | 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	60,099,112	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	36,375,100	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
55.01	05501	ULTRA SOUND	0	0	0	8,750,115	0.000000	55.01
57.00	05700	CT SCAN	0	0	0	57,742,492	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	12,332,477	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	17,001,459	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	63,162,560	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	825,446	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,258,634	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,439,762	0.000000	67.00
67.01	06701	AUDIOLOGY	0	0	0	904,612	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,035,723	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
69.01	06901	CARDIOLOGY	0	0	0	25,848,314	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	11,201,532	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	11,337,757	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	50,736,170	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0.000000	90.01
90.02	09002	CLINIC	0	0	0	0	0.000000	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0.000000	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0.000000	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0.000000	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	114,426	0.000000	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0.000000	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0.000000	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0.000000	90.12
90.13	09013	ALLERGY CLINIC	0	0	0	407,864	0.000000	90.13
90.14	09014	WOUND CARE	0	0	0	6,267,099	0.000000	90.14
91.00	09100	EMERGENCY	0	0	0	44,501,640	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	7,521,218	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	426,863,512		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0104 | Component CCN: 15-5832 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/30/2024 1:52 pm

Title XVIII | Skilled Nursing Facility | 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	2,644	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	28,691	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0.000000	0	0	0	0	55.01
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	188,618	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.000000	569,075	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	618,690	0	0	0	67.00
67.01	06701	AUDIOLOGY	0.000000	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.000000	10,444	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0.000000	13,072	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	68,639	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	542,198	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.000000	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.000000	0	0	0	0	90.13
90.14	09014	WOUND CARE	0.000000	0	0	0	0	90.14
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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		2,042,071	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0104 | Component CCN: 15-5832 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V | Date/Time Prepared: 5/30/2024 1:52 pm

Title XVIII | Skilled Nursing Facility | 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	0.115830	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205509	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0.175839	0	0	0	0	55.01
57.00	05700	CT SCAN	0.020235	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.078686	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.027052	0	0	0	0	59.00
60.00	06000	LABORATORY	0.156864	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.117025	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.388987	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.306328	0	0	0	0	67.00
67.01	06701	AUDIOLOGY	0.365375	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.286928	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0.120982	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.341727	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.460362	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.289950	0	0	8,872	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.413787	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.480040	0	0	0	0	90.13
90.14	09014	WOUND CARE	0.143923	0	0	0	0	90.14
91.00	09100	EMERGENCY	0.183149	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.327345	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1.051809		0			95.00
200.00		Subtotal (see instructions)		0	0	8,872	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	8,872	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0104 | Component CCN: 15-5832 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V | Date/Time Prepared: 5/30/2024 1:52 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
55.01	05501	ULTRA SOUND	0	0		55.01
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
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
67.01	06701	AUDIOLOGY	0	0		67.01
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIOLOGY	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,572		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0		90.01
90.02	09002	CLINIC	0	0		90.02
90.03	09003	DERMATOLOGY CLINIC	0	0		90.03
90.04	09004	ENT CLINIC	0	0		90.04
90.05	09005	SURGERY CLINIC	0	0		90.05
90.07	09007	UROLOGY CLINIC	0	0		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0		90.09
90.11	09011	NEUROLOGY CLINIC	0	0		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0		90.12
90.13	09013	ALLERGY CLINIC	0	0		90.13
90.14	09014	WOUND CARE	0	0		90.14
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	2,572		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	2,572		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/30/2024 1:52 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	8,869	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	8,869	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)	6,860	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)	2,010	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)	10,868,930	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)	10,868,930	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)	10,868,930	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)	1,225.50	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,463,255	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)	2,463,255	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/30/2024 1:52 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,389,162	1,971	1,719.51	484	832,243	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	3,552,210	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)	6,847,708	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)	253,613	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	138,644	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	392,257	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	6,455,451	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	2,009	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,225.50	88.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/30/2024 1:52 pm

Title XVIII | Hospital | PPS

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,462,030	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	859,853	10,868,930	0.079111	2,462,030	194,774	90.00
91.00	Nursing Program cost	0	10,868,930	0.000000	2,462,030	0	91.00
92.00	Allied health cost	0	10,868,930	0.000000	2,462,030	0	92.00
93.00	All other Medical Education	0	10,868,930	0.000000	2,462,030	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0104 Component CCN: 15-S104	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/30/2024 1:52 pm
	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)	2,280	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,280	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)	2,280	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)	1,185	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)	2,959,326	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)	2,959,326	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)	2,959,326	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)	1,297.95	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,538,071	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)	1,538,071	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/30/2024 1:52 pm

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	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	115,961	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	1,654,032	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)	140,541	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	3,458	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	143,999	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,510,033	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0104 Component CCN: 15-S104	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/30/2024 1:52 pm
	Title XVIII	Subprovider - IPF	PPS

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

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	270,397	2,959,326	0.091371	0	0	90.00
91.00	Nursing Program cost	0	2,959,326	0.000000	0	0	91.00
92.00	Allied health cost	0	2,959,326	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,959,326	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0104 Component CCN: 15-5832	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/30/2024 1:52 pm
	Title XVIII	Skilled Nursing Facility	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)	4,377	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,377	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)	4,377	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)	2,195	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)	2,923,239	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)	2,923,239	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)	2,923,239	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0104 | Component CCN: 15-5832 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/30/2024 1:52 pm

Title XVIII | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)		48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
55.01	Permanent adjustment amount per discharge		55.01
55.02	Adjustment amount per discharge (contractor use only)		55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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)		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)		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	2,923,239	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	667.86	71.00
72.00	Program routine service cost (line 9 x line 71)	1,465,953	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	1,465,953	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	1,465,953	83.00
84.00	Program inpatient ancillary services (see instructions)	631,918	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	2,097,871	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0104 Component CCN: 15-5832	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/30/2024 1:52 pm
	Title XVIII	Skilled Nursing Facility	PPS

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

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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/30/2024 1:52 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	8,869	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	8,869	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)	6,860	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)	199	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)	731	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)	10,868,930	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)	10,868,930	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)	10,868,930	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)	1,225.50	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	243,875	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)	243,875	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/30/2024 1:52 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	731	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,389,162	1,971	1,719.51	32	55,024	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	168,226	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)	467,125	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	2,009	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,225.50	88.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/30/2024 1:52 pm

Title XIX | Hospital | Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,462,030	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	859,853	10,868,930	0.079111	2,462,030	194,774	90.00
91.00	Nursing Program cost	0	10,868,930	0.000000	2,462,030	0	91.00
92.00	Allied health cost	0	10,868,930	0.000000	2,462,030	0	92.00
93.00	All other Medical Education	0	10,868,930	0.000000	2,462,030	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/30/2024 1:52 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,260,476		30.00
31.00	03100	INTENSIVE CARE UNIT		1,304,112		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.115830	2,846,417	329,700	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205509	909,852	186,983	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	0.175839	83,839	14,742	55.01
57.00	05700	CT SCAN	0.020235	2,881,753	58,312	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.078686	231,755	18,236	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.027052	0	0	59.00
60.00	06000	LABORATORY	0.156864	3,848,283	603,657	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.117025	99,483	11,642	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.388987	297,753	115,822	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.306328	255,596	78,296	67.00
67.01	06701	AUDIOLOGY	0.365375	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.286928	61,502	17,647	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	0.120982	2,285,797	276,540	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.341727	1,815,712	620,478	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.460362	777,755	358,049	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.289950	1,754,779	508,798	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.413787	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.480040	0	0	90.13
90.14	09014	WOUND CARE	0.143923	0	0	90.14
91.00	09100	EMERGENCY	0.183149	1,757,658	321,913	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.327345	95,908	31,395	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		20,003,842	3,552,210	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)		20,003,842		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/30/2024 1:52 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF		1,581,198		40.00
41.00	04100	SUBPROVIDER - IRF				41.00
42.00	04200	SUBPROVIDER				42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.115830	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205509	20,342	4,180	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	0.175839	0	0	55.01
57.00	05700	CT SCAN	0.020235	52,096	1,054	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.078686	3,396	267	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.027052	0	0	59.00
60.00	06000	LABORATORY	0.156864	316,531	49,652	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.117025	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.388987	7,943	3,090	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.306328	6,371	1,952	67.00
67.01	06701	AUDIOLOGY	0.365375	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.286928	4,037	1,158	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	0.120982	8,730	1,056	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.341727	37,339	12,760	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.460362	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.289950	124,963	36,233	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.413787	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.480040	0	0	90.13
90.14	09014	WOUND CARE	0.143923	0	0	90.14
91.00	09100	EMERGENCY	0.183149	24,891	4,559	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.327345	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		606,639	115,961	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)		606,639		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0104 | Component CCN: 15-5832 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/30/2024 1:52 pm

Title XVIII | Skilled Nursing Facility | 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
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF				41.00
42.00	04200	SUBPROVIDER				42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.115830	2,644	306	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205509	28,691	5,896	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	0.175839	0	0	55.01
57.00	05700	CT SCAN	0.020235	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.078686	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.027052	0	0	59.00
60.00	06000	LABORATORY	0.156864	188,618	29,587	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.117025	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.388987	569,075	221,363	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.306328	618,690	189,522	67.00
67.01	06701	AUDIOLOGY	0.365375	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.286928	10,444	2,997	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	0.120982	13,072	1,581	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.341727	68,639	23,456	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.460362	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.289950	542,198	157,210	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.413787	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.480040	0	0	90.13
90.14	09014	WOUND CARE	0.143923	0	0	90.14
91.00	09100	EMERGENCY	0.183149	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.327345	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,042,071	631,918	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		2,042,071		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/30/2024 1:52 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		821,994		30.00
31.00	03100	INTENSIVE CARE UNIT		99,664		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.115830	185,029	21,432	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205509	24,715	5,079	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	0.175839	10,986	1,932	55.01
57.00	05700	CT SCAN	0.020235	115,330	2,334	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.078686	10,943	861	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.027052	37,747	1,021	59.00
60.00	06000	LABORATORY	0.156864	217,222	34,074	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.117025	12,364	1,447	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.388987	6,556	2,550	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.306328	4,899	1,501	67.00
67.01	06701	AUDIOLOGY	0.365375	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.286928	1,529	439	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	0.120982	80,825	9,778	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.341727	74,069	25,311	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.460362	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.289950	151,437	43,909	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.413787	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.000000	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.480040	0	0	90.13
90.14	09014	WOUND CARE	0.143923	0	0	90.14
91.00	09100	EMERGENCY	0.183149	90,408	16,558	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.327345	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,024,059	168,226	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)		1,024,059		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/30/2024 1:52 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	4,034,265	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1,482,718	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)	42,699	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	0	2.04
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	44.45	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)	2.04	30.00
31.00	Percentage of Medicaid patient days (see instructions)	21.42	31.00
32.00	Sum of lines 30 and 31	23.46	32.00
33.00	Allowable disproportionate share percentage (see instructions)	10.00	33.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/30/2024 1:52 pm
	Title XVIII	Hospital	PPS

			1.00	
34.00	Disproportionate share adjustment (see instructions)		137,925	34.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Payment Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital UCP, including supplemental UCP (see instructions)	851,785	744,154	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	637,088	187,055	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	824,143		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	6,521,750		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)	6,521,750	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	420,319	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	9,751	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
55.01	Cellular therapy acquisition cost (see instructions)	0	55.01
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	6,951,820	59.00
60.00	Primary payer payments	7,404	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	6,944,416	61.00
62.00	Deductibles billed to program beneficiaries	813,960	62.00
63.00	Coinsurance billed to program beneficiaries	0	63.00
64.00	Allowable bad debts (see instructions)	64,483	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	41,914	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	3,200	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	6,172,370	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)	4,587	70.93
70.94	HRR adjustment amount (see instructions)	-16,190	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Date/Time Prepared: 5/30/2024 1:52 pm

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)	2022	660,751	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)	2023	229,730	70.97
70.98	Low Volume Payment-3	0	0	70.98
70.99	HAC adjustment amount (see instructions)		20,540	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		7,030,708	71.00
71.01	Sequestration adjustment (see instructions)		140,614	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		6,778,678	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)		111,416	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		430,441	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/30/2024 1:52 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4,034,265	0	4,034,265		4,034,265	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,482,718	0		1,482,718	1,482,718	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	42,699	0	42,699		42,699	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1000	0.1000	0.1000	0.1000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	137,925	0	100,857	37,068	137,925	11.00
11.01	Uncompensated care payments	36.00	824,143	0	637,088	187,055	824,143	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	6,521,750	0	4,814,909	1,706,841	6,521,750	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	6,521,750	0	4,814,909	1,706,841	6,521,750	15.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/30/2024 1:52 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	420,319	0	305,874	114,445	420,319	16.00
17.00	Special add-on payments for new technologies	54.00	9,751	0	9,751	0	9,751	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	5,130,534	1,821,286	6,951,820	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	417,419	0	302,974	114,445	417,419	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	2,900	0	2,900	0	2,900	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	420,319	0	305,874	114,445	420,319	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.128788	0.126136		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			660,751		660,751	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				229,730	229,730	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/30/2024 1:52 pm

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4,034,265	4,034,265		4,034,265	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,482,718		1,482,718	1,482,718	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	42,699	42,699		42,699	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1000	0.1000	0.1000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	137,925	100,857	37,068	137,925	11.00
11.01	Uncompensated care payments	36.00	824,143	637,088	187,055	824,143	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	6,521,750	4,814,909	1,706,841	6,521,750	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	6,521,750	4,814,909	1,706,841	6,521,750	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	420,319	305,874	114,445	420,319	16.00
17.00	Special add-on payments for new technologies	54.00	9,751	9,751	0	9,751	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			5,130,534	1,821,286	6,951,820	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/30/2024 1:52 pm

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	417,419	302,974	114,445	417,419	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	2,900	2,900	0	2,900	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	420,319	305,874	114,445	420,319	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	660,751	660,751		660,751	28.00
29.00	Low volume adjustment on or after October 1	70.97	229,730		229,730	229,730	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	4,587	0	4,587	4,587	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-16,190	-14,559	-1,631	-16,190	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	20,540	20,540	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/30/2024 1:52 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,937	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	12,576,810	2.00
3.00	OPPS or REH payments	12,020,964	3.00
4.00	Outlier payment (see instructions)	12,777	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	6,937	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	24,822	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)	24,822	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)	24,822	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	17,885	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)	6,937	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)	12,033,741	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,137,009	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)	9,903,669	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount (see instructions)		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	9,903,669	30.00
31.00	Primary payer payments	2,142	31.00
32.00	Subtotal (line 30 minus line 31)	9,901,527	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)	197,200	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	128,180	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	37,211	36.00
37.00	Subtotal (see instructions)	10,029,707	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-43	38.00
39.00	OTHER ADJUSTMENT PER PS&R	17	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)	10,029,767	40.00
40.01	Sequestration adjustment (see instructions)	200,595	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	9,778,368	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)	50,804	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: 15-0104	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/30/2024 1:52 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104 Component CCN: 15-S104	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/30/2024 1:52 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,128	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	129	2.00
3.00	OPPS or REH payments	250	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	1,128	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	3,892	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)	3,892	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)	3,892	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	2,764	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)	1,128	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)	250	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)	1,378	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount (see instructions)		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	1,378	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	1,378	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)	1,378	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)	1,378	40.00
40.01	Sequestration adjustment (see instructions)	28	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	1,782	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)	-432	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104 Component CCN: 15-S104	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/30/2024 1:52 pm
	Title XVIII	Subprovider - IPF	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104 Component CCN: 15-5832	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/30/2024 1:52 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	2,572	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments		3.00
4.00	Outlier payment (see instructions)		4.00
4.01	Outlier reconciliation amount (see instructions)		4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	2,572	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	8,872	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)	8,872	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)	8,872	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	6,300	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)	2,572	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)	0	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)		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)	2,572	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount (see instructions)		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	2,572	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	2,572	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)	2,572	37.00
38.00	MSP-LCC reconciliation amount from PS&R		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)	2,572	40.00
40.01	Sequestration adjustment (see instructions)	51	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	2,680	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)	-159	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)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104 Component CCN: 15-5832	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/30/2024 1:52 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
93.00	Time Value of Money (see instructions)		93.00
94.00	Total (sum of lines 91 and 93)		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: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I Date/Time Prepared: 5/30/2024 1:52 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		6,778,678		9,705,070	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	12/31/2023	73,298	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		73,298	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)		6,778,678		9,778,368	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		111,416		50,804	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		6,890,094		9,829,172	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: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/30/2024 1:52 pm

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		1,169,192		1,782	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)		1,169,192		1,782	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		10,032		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		432	6.02
7.00	Total Medicare program liability (see instructions)		1,179,224		1,350	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: 15-0104 | Component CCN: 15-5832 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/30/2024 1:52 pm

Title XVIII | Skilled Nursing Facility | 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		1,166,416		2,680	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)		1,166,416		2,680	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		372		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		159	6.02
7.00	Total Medicare program liability (see instructions)		1,166,788		2,521	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: 15-0104	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/30/2024 1:52 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104 Component CCN: 15-S104	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part II Date/Time Prepared: 5/30/2024 1:52 pm
	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)	1,306,616	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)	6.246575	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)	1,306,616	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)	1,306,616	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	1,306,616	18.00
19.00	Deductibles	113,556	19.00
20.00	Subtotal (line 18 minus line 19)	1,193,060	20.00
21.00	Coinsurance	0	21.00
22.00	Subtotal (line 20 minus line 21)	1,193,060	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	15,738	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	10,230	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,203,290	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)	1,203,290	31.00
31.01	Sequestration adjustment (see instructions)	24,066	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	1,169,192	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)	10,032	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: 15-0104 Component CCN: 15-5832	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VI Date/Time Prepared: 5/30/2024 1:52 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	1,310,021	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,310,021	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	119,800	7.00
8.00	Allowable bad debts (see instructions)	583	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	379	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	1,190,600	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.98	Recovery of accelerated depreciation.	0	14.98
14.99	Demonstration payment adjustment amount before sequestration	0	14.99
15.00	Subtotal (see instructions	1,190,600	15.00
15.01	Sequestration adjustment (see instructions)	23,804	15.01
15.02	Demonstration payment adjustment amount after sequestration	0	15.02
15.75	Sequestration for non-claims based amounts (see instructions)	8	15.75
16.00	Interim payments	1,166,416	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)	372	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/30/2024 1:52 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	467,125		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)	467,125	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)	467,125	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	887,195		8.00
9.00	Ancillary service charges	1,024,059	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)	1,911,254	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)	1,911,254	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,444,129	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)	467,125	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)	467,125	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)	467,125	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)	467,125	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	467,125	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)	467,125	0	40.00
41.00	Interim payments	809,513	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-342,388	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: 15-0104	Period: From 01/01/2023 To 12/31/2023	Worksheet E-5 Date/Time Prepared: 5/30/2024 1:52 pm
	Title XVIII		PPS

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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G | Date/Time Prepared: 5/30/2024 1:52 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	44,104,038	0	0	0	1.00
2.00	Temporary investments	38,688,696	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	18,933,188	0	0	0	4.00
5.00	Other receivable	1,708,489	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	4,848,793	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	2,042,449	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	110,325,653	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,895,261	0	0	0	12.00
13.00	Land improvements	3,301,660	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	129,709,202	0	0	0	15.00
16.00	Accumulated depreciation	-45,300,226	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	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	90,931,056	0	0	0	23.00
24.00	Accumulated depreciation	-72,742,817	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	108,794,136	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	36,103,218	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	36,103,218	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	255,223,007	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	8,861,595	0	0	0	37.00
38.00	Salaries, wages, and fees payable	11,064,656	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	11,001,382	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	30,927,633	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	22,751,818	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	22,751,818	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	53,679,451	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	201,543,556				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)	201,543,556	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	255,223,007	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 5/30/2024 1:52 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		200,741,507		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		802,049				2.00
3.00	Total (sum of line 1 and line 2)		201,543,556		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)		201,543,556		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		201,543,556		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/30/2024 1:52 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	21,213,229		21,213,229	1.00
2.00	SUBPROVIDER - IPF	3,071,896		3,071,896	2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	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	2,725,043		2,725,043	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)	27,010,168		27,010,168	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	6,130,001		6,130,001	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	6,130,001		6,130,001	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	33,140,169		33,140,169	17.00
18.00	Ancillary services	63,495,663	316,115,257	379,610,920	18.00
19.00	Outpatient services	5,619,857	46,976,225	52,596,082	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	0	4,107,696	4,107,696	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	DIETARY, A&G, PHYSICIAN PRACTICES	0	54,945,047	54,945,047	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	102,255,689	422,144,225	524,399,914	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		180,736,242		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)		180,736,242		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0104 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-3 | Date/Time Prepared: 5/30/2024 1:52 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	524,399,914	1.00
2.00	Less contractual allowances and discounts on patients' accounts	359,097,120	2.00
3.00	Net patient revenues (line 1 minus line 2)	165,302,794	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	180,736,242	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-15,433,448	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	7,345,072	24.00
24.01	NON-OPERATING INCOME	8,890,425	24.01
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	16,235,497	25.00
26.00	Total (line 5 plus line 25)	802,049	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	802,049	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0104	Period: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III Date/Time Prepared: 5/30/2024 1:52 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	417,419	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	2,900	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)	24.84	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)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	420,319	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