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: 15-0007	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/24/2024 12:12 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/24/2024 Time: 12:12 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 COMMUNITY HOWARD REGIONAL HEALTH (15-0007) 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	Holly Millard		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	Holly Millard			2
3	Signatory Title	SVP FINANCE			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	107,083	-3,746	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	107,083	-3,746	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2024 12:12 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 3500 SOUTH LAFOUNTAIN	PO Box:			1.00
2.00	City: KOKOMO	State: IN	Zip Code: 46902	County: HOWARD	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	COMMUNITY HOWARD REGIONAL HEALTH	150007	29020	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2024 12:12 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.	808	160	0	10	4,700	13	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2024 12:12 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2024 12:12 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: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2024 12:12 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.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	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)	N	N	0	76.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2024 12:12 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	N	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.	1			118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2024 12:12 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	1,057,191	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	Y	123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0720	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: COMMUNITY HEALTH NETWORK	Contractor's Name: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 08101	141.00
142.00	Street: 1500 NORTH RITTER	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46219-3095	143.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0007	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/24/2024 12:12 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)	0.00	169.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 5/24/2024 12:12 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)	N			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	03/28/2024	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	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.	Y	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/11/2024	Y	04/11/2024	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II Date/Time Prepared: 5/24/2024 12:12 pm

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

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			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.	SHIRLEY	BISHOP	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH NETWORK		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-355-4135	SBISHOP@ECOMMUNITY.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0007	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/24/2024 12:12 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2024 12:12 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	99	36,135	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)		99	36,135	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	8	2,920	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)		107	39,055	0.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		107				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2024 12:12 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)	3,830	646	15,620			1.00
2.00	HMO and other (see instructions)	4,538	4,464				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,830	646	15,620			7.00
8.00	INTENSIVE CARE UNIT	396	87	1,545			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		481	625			13.00
14.00	Total (see instructions)	4,226	1,214	17,790	0.00	636.02	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits	0	0	0			15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			56			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	636.02	27.00
28.00	Observation Bed Days		420	2,415			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			80			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	13	86			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: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2024 12:12 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	1,121	157	4,749	1.00
2.00	HMO and other (see instructions)			1,060	1,088		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,121	157	4,749	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part II Date/Time Prepared: 5/24/2024 12:12 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	54,255,450	-286,997	53,968,453	1,322,913.00	40.80	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		102,930	0	102,930	616.00	167.09	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		1,361,829	0	1,361,829	9,409.00	144.74	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		6,272,846	-2,761	6,270,085	190,722.00	32.88	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		920,356	0	920,356	7,116.00	129.34	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		175,886	0	175,886	1,729.00	101.73	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		12,661,432	0	12,661,432	276,760.00	45.75	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)		11,368,436	0	11,368,436			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		1,815,699	0	1,815,699			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		7,859	0	7,859			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		120,043	0	120,043			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)		3,374,255	0	3,374,255			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: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part II Date/Time Prepared: 5/24/2024 12:12 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	1,000	-1,000	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	3,825,313	-222,629	3,602,684	59,584.00	60.46	27.00
28.00	Administrative & General under contract (see inst.)		2,746,737	0	2,746,737	20,344.00	135.01	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	817,439	-2,670	814,769	30,153.00	27.02	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,317,166	-6,418	1,310,748	63,865.00	20.52	32.00
33.00	Housekeeping under contract (see instructions)		311,233	0	311,233	6,292.00	49.46	33.00
34.00	Dietary	10.00	1,111,108	-703,346	407,762	19,823.00	20.57	34.00
35.00	Dietary under contract (see instructions)		172,750	0	172,750	2,309.00	74.82	35.00
36.00	Cafeteria	11.00	0	699,998	699,998	35,124.00	19.93	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,216,339	0	1,216,339	26,297.00	46.25	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	679,501	0	679,501	16,402.00	41.43	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part III Date/Time Prepared: 5/24/2024 12:12 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)		56,124,341	-286,997	55,837,344	1,342,449.00	41.59	1.00
2.00	Excluded area salaries (see instructions)		6,272,846	-2,761	6,270,085	190,722.00	32.88	2.00
3.00	Subtotal salaries (line 1 minus line 2)		49,851,495	-284,236	49,567,259	1,151,727.00	43.04	3.00
4.00	Subtotal other wages & related costs (see inst.)		13,757,674	0	13,757,674	285,605.00	48.17	4.00
5.00	Subtotal wage-related costs (see inst.)		14,750,550	0	14,750,550	0.00	29.76	5.00
6.00	Total (sum of lines 3 thru 5)		78,359,719	-284,236	78,075,483	1,437,332.00	54.32	6.00
7.00	Total overhead cost (see instructions)		12,198,586	-236,065	11,962,521	280,193.00	42.69	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part IV Date/Time Prepared: 5/24/2024 12:12 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	2,016,105	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)	5,232,518	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	1,297,346	9.00
10.00	Dental, Hearing and Vision Plan	44,543	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	22,041	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)	620,393	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	171,059	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	3,908,032	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	13,312,037	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: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part V | Date/Time Prepared: 5/24/2024 12:12 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	920,356	13,312,037	1.00
2.00	Hospital	920,356	11,354,757	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I	0	0	17.00
18.00	Other	0	1,957,280	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 5/24/2024 12:12 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)	0.189501	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	36,643,628	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	-10,152,514	5.00
6.00	Medicaid charges	150,421,277	6.00
7.00	Medicaid cost (line 1 times line 6)	28,504,982	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	2,013,868	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)	2,013,868	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)	3,239,997	1,978,999	5,218,996	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	613,983	1,131,198	1,745,181	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)	613,983	1,131,198	1,745,181	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)	1,046,024	25.01
26.00	Bad debt amount (see instructions)	5,876,638	26.00
27.00	Medicare reimbursable bad debts (see instructions)	127,768	27.00
27.01	Medicare allowable bad debts (see instructions)	196,566	27.01
28.00	Non-Medicare bad debt amount (see instructions)	5,680,072	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	1,145,177	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	2,890,358	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,904,226	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0007	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/24/2024 12:12 pm

		1.00	
	PART II - HOSPITAL DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.189501	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)	3,239,997	1,978,999	5,218,996	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	613,983	1,131,198	1,745,181	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)	613,983	1,131,198	1,745,181	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)	1,046,024	25.01
26.00	Bad debt amount (see instructions)	5,876,638	26.00
27.00	Medicare reimbursable bad debts (see instructions)	127,768	27.00
27.01	Medicare allowable bad debts (see instructions)	196,566	27.01
28.00	Non-Medicare bad debt amount (see instructions)	5,680,072	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	1,145,177	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	2,890,358	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,890,358	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/24/2024 12:12 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	4,446,248	4,446,248	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	3,781,228	3,781,228	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,000	65,162	66,162	-6,484	59,678	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,825,313	54,514,213	58,339,526	-3,902,883	54,436,643	5.00
7.00	00700	OPERATION OF PLANT	817,439	4,907,768	5,725,207	-740,090	4,985,117	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	284,694	284,694	0	284,694	8.00
9.00	00900	HOUSEKEEPING	1,317,166	908,705	2,225,871	-17,749	2,208,122	9.00
10.00	01000	DIETARY	1,111,108	1,357,391	2,468,499	-1,638,050	830,449	10.00
11.00	01100	CAFETERIA	0	90	90	1,555,065	1,555,155	11.00
13.00	01300	NURSING ADMINISTRATION	1,216,339	386,425	1,602,764	-93,497	1,509,267	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	679,501	162,521	842,022	0	842,022	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PASTORAL CARE	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,810,765	7,887,151	20,697,916	-2,905,617	17,792,299	30.00
31.00	03100	INTENSIVE CARE UNIT	1,719,619	931,232	2,650,851	-245,580	2,405,271	31.00
43.00	04300	NURSERY	0	0	0	550,942	550,942	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,988,145	8,290,509	12,278,654	-5,457,693	6,820,961	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,422,797	1,422,797	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,151,598	2,619,632	4,771,230	-724,828	4,046,402	54.00
54.01	03480	ONCOLOGY	2,199,616	2,346,337	4,545,953	-847,828	3,698,125	54.01
57.00	05700	CT SCAN	709,567	935,929	1,645,496	-506,126	1,139,370	57.00
58.00	05800	MRI	441,752	1,197,820	1,639,572	-1,045,850	593,722	58.00
59.00	05900	CARDIAC CATHETERIZATION	953,015	4,484,277	5,437,292	-3,775,732	1,661,560	59.00
60.00	06000	LABORATORY	0	7,196,152	7,196,152	-4,364	7,191,788	60.00
65.00	06500	RESPIRATORY THERAPY	1,403,832	739,437	2,143,269	-213,105	1,930,164	65.00
66.00	06600	PHYSICAL THERAPY	1,065,339	361,161	1,426,500	-698,122	728,378	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	533,857	533,857	67.00
68.00	06800	SPEECH PATHOLOGY	0	-797	-797	160,416	159,619	68.00
69.00	06900	ELECTROCARDIOLOGY	1,182,533	643,492	1,826,025	-52,257	1,773,768	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	190,874	72,261	263,135	-9,076	254,059	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	406,579	1,122,399	1,528,978	5,077,693	6,606,671	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,469,857	5,469,857	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,478,252	23,105,771	25,584,023	70,410	25,654,433	73.00
74.00	07400	RENAL DIALYSIS	0	388,954	388,954	-3,260	385,694	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	WOUND CARE CENTER	533,286	355,324	888,610	-89,639	798,971	75.01
76.00	03160	CARDIOPULMONARY	188,113	112,001	300,114	-18,192	281,922	76.00
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						
91.00	09100	EMERGENCY	3,932,878	2,324,425	6,257,303	-462,677	5,794,626	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
93.01	04951	GENESIS	1,707,374	840,965	2,548,339	485,183	3,033,522	93.01
93.02	04952	HOWARD COUNTY CSS	238,568	130,349	368,917	33,332	402,249	93.02
93.03	04953	TIPTON BH CLINIC	592,472	318,155	910,627	122,670	1,033,297	93.03
93.04	04954	PSYCH MEDICATION	120,561	33,107	153,668	-153,668	0	93.04
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,587,286	1,088,610	2,675,896	-248,857	2,427,039	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)	49,569,890	130,111,622	179,681,512	-151,526	179,529,986	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	COMMUNITY HOWARD FOUNDATION	91,226	27,201	118,427	-367	118,060	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	489,367	486,357	975,724	0	975,724	192.00
194.00	07951	MISC BH NRCC	4,033,359	2,175,179	6,208,538	151,893	6,360,431	194.00
194.08	07958	SOUTH BERKLEY BLDG	0	0	0	0	0	194.08
194.09	07959	MOBILE CLINIC	71,608	27,479	99,087	0	99,087	194.09
194.10	07960	PLASTIC SURGERY	0	455	455	0	455	194.10
194.11	07961	MISC NRCC	0	15	15	0	15	194.11
194.15	07965	INDIANA SURGERY CENTER	0	821	821	0	821	194.15
194.16	07966	PASTORAL CARE ALLIED HEALTH	0	0	0	0	0	194.16
200.00		TOTAL (SUM OF LINES 118 through 199)	54,255,450	132,829,129	187,084,579	0	187,084,579	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/24/2024 12:12 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	4,446,248		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	3,781,228		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,076,393	2,136,071		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-29,411,467	25,025,176		5.00
7.00	00700	OPERATION OF PLANT	0	4,985,117		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	284,694		8.00
9.00	00900	HOUSEKEEPING	0	2,208,122		9.00
10.00	01000	DIETARY	-4,501	825,948		10.00
11.00	01100	CAFETERIA	-571,282	983,873		11.00
13.00	01300	NURSING ADMINISTRATION	0	1,509,267		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	969,386	969,386		16.00
17.00	01700	SOCIAL SERVICE	0	842,022		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
23.00	02300	PASTORAL CARE	0	0		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-3,729,507	14,062,792		30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,405,271		31.00
43.00	04300	NURSERY	0	550,942		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	6,820,961		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,422,797		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	116,173	4,162,575		54.00
54.01	03480	ONCOLOGY	2,185,119	5,883,244		54.01
57.00	05700	CT SCAN	-49,831	1,089,539		57.00
58.00	05800	MRI	0	593,722		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,661,560		59.00
60.00	06000	LABORATORY	0	7,191,788		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,930,164		65.00
66.00	06600	PHYSICAL THERAPY	0	728,378		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	533,857		67.00
68.00	06800	SPEECH PATHOLOGY	0	159,619		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,773,768		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	63,052	317,111		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	513,791	7,120,462		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,469,857		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	391,365	26,045,798		73.00
74.00	07400	RENAL DIALYSIS	0	385,694		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
75.01	03950	WOUND CARE CENTER	-59,297	739,674		75.01
76.00	03160	CARDIOPULMONARY	0	281,922		76.00
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				
91.00	09100	EMERGENCY	108,479	5,903,105		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
93.00	04950	OTHER OUTPATIENT SERVICES	0	0		93.00
93.01	04951	GENESIS	-479,875	2,553,647		93.01
93.02	04952	HOWARD COUNTY CSS	-12,170	390,079		93.02
93.03	04953	TIPTON BH CLINIC	-195,312	837,985		93.03
93.04	04954	PSYCH MEDICATION	-69,647	-69,647		93.04
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	2,427,039		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)	-28,159,131	151,370,855		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	COMMUNITY HOWARD FOUNDATION	0	118,060		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	975,724		192.00
194.00	07951	MISC BH NRCC	0	6,360,431		194.00
194.08	07958	SOUTH BERKLEY BLDG	0	0		194.08
194.09	07959	MOBILE CLINIC	0	99,087		194.09
194.10	07960	PLASTIC SURGERY	0	455		194.10
194.11	07961	MISC NRCC	0	15		194.11
194.15	07965	INDIANA SURGERY CENTER	0	821		194.15
194.16	07966	PASTORAL CARE ALLIED HEALTH	0	0		194.16
200.00		TOTAL (SUM OF LINES 118 through 199)	-28,159,131	158,925,448		200.00

RECLASSIFICATIONS | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/24/2024 12:12 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - Chargeable Medical Supplies					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	5,129,132		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
	TOTALS		0	5,129,132		
	B - Implantable Device Reclass					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00		5,469,857		1.00
2.00						2.00
3.00						3.00
			0	5,469,857		
	C - Drugs Charges to Pat					
1.00	ONCOLOGY	54.01	0	117		1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	207,143		2.00
3.00	DRUGS CHARGED TO PATIENTS	73.00	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
	TOTALS		0	207,260		
	D - Depreciation Expense					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	8,004,388		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

RECLASSIFICATIONS | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/24/2024 12:12 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
	TOTALS		0	8,004,388		
	E - Interest Expense					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	28,293		1.00
	TOTALS		0	28,293		
	F - Infusion Equipment Rental					
1.00	ONCOLOGY	54.01	0	0		1.00
	TOTALS		0	0		
	G - STD BENEFIT RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	33,878		1.00
2.00	OPERATION OF PLANT	7.00	0	2,670		2.00
3.00	HOUSEKEEPING	9.00	0	6,418		3.00
4.00	DIETARY	10.00	0	3,348		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	62,670		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	8,377		6.00
7.00	OPERATING ROOM	50.00	0	17,711		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,236		8.00
9.00	ONCOLOGY	54.01	0	16,054		9.00
10.00	CT SCAN	57.00	0	129		10.00
11.00	CARDIAC CATHETERIZATION	59.00	0	2,569		11.00
12.00	RESPIRATORY THERAPY	65.00	0	5,820		12.00
13.00	PHYSICAL THERAPY	66.00	0	4,240		13.00
14.00	ELECTROCARDIOLOGY	69.00	0	3,269		14.00
15.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,036		15.00
16.00	DRUGS CHARGED TO PATIENTS	73.00	0	35,514		16.00
17.00	WOUND CARE CENTER	75.01	0	3,125		17.00
18.00	CARDIOPULMONARY	76.00	0	229		18.00
19.00	EMERGENCY	91.00	0	9,099		19.00
20.00	GENESIS	93.01	0	6,230		20.00
21.00	AMBULANCE SERVICES	95.00	0	6,158		21.00
22.00	MISC BH NRCC	194.00	0	53,217		22.00
	TOTALS		0	286,997		
	H - Labor and Delivery					
1.00	NURSERY	43.00	312,114	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	806,029	0		2.00
3.00	NURSERY	43.00	0	238,828		3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	0	616,768		4.00
	TOTALS		1,118,143	855,596		
	I - Cafeteria Salary					
1.00	CAFETERIA	11.00	699,998	0		1.00
2.00	CAFETERIA	11.00	0	855,157		2.00
	TOTALS		699,998	855,157		
	J - Therapy Reclass					
1.00	OCCUPATIONAL THERAPY	67.00	399,750	0		1.00
2.00	SPEECH PATHOLOGY	68.00	120,119	0		2.00
3.00	OCCUPATIONAL THERAPY	67.00	0	134,107		3.00
4.00	SPEECH PATHOLOGY	68.00	0	40,297		4.00
	TOTALS		519,869	174,404		
	K - Depreciation Expense					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,223,160		1.00
	TOTALS		0	4,223,160		
	L - Capital Insurance Costs					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	194,795		1.00
	TOTALS		0	194,795		
	M - Psych Admin Reclass					
1.00	GENESIS	93.01	111,899	0		1.00
2.00	HOWARD COUNTY CSS	93.02	8,838	0		2.00
3.00	TIPTON BH CLINIC	93.03	23,254	0		3.00
4.00	MISC BH NRCC	194.00	45,760	0		4.00
5.00	GENESIS	93.01	0	294,896		5.00
6.00	HOWARD COUNTY CSS	93.02	0	23,293		6.00
7.00	TIPTON BH CLINIC	93.03	0	61,284		7.00
8.00	MISC BH NRCC	194.00	0	120,599		8.00
	TOTALS		189,751	500,072		
	O - Psych Medicine Clinic Reclass					
1.00	GENESIS	93.01	61,633	0		1.00
2.00	HOWARD COUNTY CSS	93.02	2,450	0		2.00
3.00	TIPTON BH CLINIC	93.03	45,624	0		3.00
4.00	MISC BH NRCC	194.00	10,854	0		4.00
5.00	GENESIS	93.01	0	16,881		5.00
6.00	HOWARD COUNTY CSS	93.02	0	671		6.00
7.00	TIPTON BH CLINIC	93.03	0	12,497		7.00

RECLASSIFICATIONS | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/24/2024 12:12 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
8.00	MISC BH NRCC	194.00	0	2,973		8.00
	TOTALS		120,561	33,022		
	P - REWARD & RECOGNITION					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	0		1.00
	TOTALS		0	0		
	Q - SPECIAL PAY					
1.00	ADMINISTRATIVE & GENERAL	5.00	1,000	0		1.00
	TOTALS		1,000	0		
500.00	Grand Total: Increases		2,649,322	25,962,133		500.00

RECLASSIFICATIONS | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/24/2024 12:12 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - Chargeable Medical Supplies						
1.00	ADULTS & PEDIATRICS	30.00	0	591,882	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	141,289	0		2.00
3.00	OPERATING ROOM	50.00	0	1,198,364	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	316,472	0		4.00
5.00	ONCOLOGY	54.01	0	68,440	0		5.00
6.00	CT SCAN	57.00	0	162,484	0		6.00
7.00	MRI	58.00	0	366,180	0		7.00
8.00	CARDIAC CATHETERIZATION	59.00	0	1,733,976	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	136,091	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	84	0		10.00
11.00	ELECTROCARDIOLOGY	69.00	0	642	0		11.00
12.00	ELECTROENCEPHALOGRAPHY	70.00	0	1,837	0		12.00
13.00	DRUGS CHARGED TO PATIENTS	73.00	0	16,222	0		13.00
14.00	RENAL DIALYSIS	74.00	0	2,359	0		14.00
15.00	WOUND CARE CENTER	75.01	0	14,873	0		15.00
16.00	CARDIOPULMONARY	76.00	0	8,096	0		16.00
17.00	EMERGENCY	91.00	0	337,331	0		17.00
18.00	PSYCH MEDICATION	93.04	0	85	0		18.00
19.00	AMBULANCE SERVICES	95.00	0	32,425	0		19.00
	TOTALS		0	5,129,132			
	B - Implantable Device Reclass						
1.00	OPERATING ROOM	50.00		3,720,265			1.00
2.00	CARDIAC CATHETERIZATION	59.00		1,696,056			2.00
3.00	WOUND CARE CENTER	75.01		53,536			3.00
			0	5,469,857			
	C - Drugs Charges to Pat						
1.00	ADULTS & PEDIATRICS	30.00	0	7,365	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	914	0		2.00
3.00	OPERATING ROOM	50.00	0	1,216	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	6,029	0		4.00
5.00	CT SCAN	57.00	0	114,427	0		5.00
6.00	MRI	58.00	0	46,431	0		6.00
7.00	CARDIAC CATHETERIZATION	59.00	0	5,099	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	213	0		8.00
9.00	ELECTROCARDIOLOGY	69.00	0	7,624	0		9.00
10.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	100	0		10.00
11.00	RENAL DIALYSIS	74.00	0	901	0		11.00
12.00	WOUND CARE CENTER	75.01	0	14,701	0		12.00
13.00	EMERGENCY	91.00	0	1,864	0		13.00
14.00	GENESIS	93.01	0	126	0		14.00
15.00	TIPTON BH CLINIC	93.03	0	131	0		15.00
16.00	AMBULANCE SERVICES	95.00	0	119	0		16.00
	TOTALS		0	207,260			
	D - Depreciation Expense						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	5,484	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	3,019,265	0		2.00
3.00	OPERATION OF PLANT	7.00	0	740,090	0		3.00
4.00	HOUSEKEEPING	9.00	0	17,749	0		4.00
5.00	DIETARY	10.00	0	82,895	0		5.00
6.00	CAFETERIA	11.00	0	90	0		6.00
7.00	NURSING ADMINISTRATION	13.00	0	93,497	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	332,631	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	103,377	0		9.00
10.00	OPERATING ROOM	50.00	0	537,848	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	402,327	0		11.00
12.00	ONCOLOGY	54.01	0	779,505	0		12.00
13.00	CT SCAN	57.00	0	229,215	0		13.00
14.00	MRI	58.00	0	633,239	0		14.00
15.00	CARDIAC CATHETERIZATION	59.00	0	340,601	0		15.00
16.00	LABORATORY	60.00	0	4,364	0		16.00
17.00	RESPIRATORY THERAPY	65.00	0	76,801	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	3,765	0		18.00
19.00	ELECTROCARDIOLOGY	69.00	0	43,991	0		19.00
20.00	ELECTROENCEPHALOGRAPHY	70.00	0	7,239	0		20.00
21.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	51,339	0		21.00
22.00	DRUGS CHARGED TO PATIENTS	73.00	0	120,511	0		22.00
23.00	WOUND CARE CENTER	75.01	0	6,529	0		23.00
24.00	CARDIOPULMONARY	76.00	0	10,096	0		24.00
25.00	EMERGENCY	91.00	0	123,482	0		25.00
26.00	HOWARD COUNTY CSS	93.02	0	1,920	0		26.00
27.00	TIPTON BH CLINIC	93.03	0	19,858	0		27.00

RECLASSIFICATIONS | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/24/2024 12:12 pm

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
28.00	AMBULANCE SERVICES	95.00	0	216,313	0	28.00
29.00	COMMUNITY HOWARD FOUNDATION	190.01	0	367	0	29.00
	TOTALS		0	8,004,388		
	E - Interest Expense					
1.00	MISC BH NRCC	194.00	0	28,293	11	1.00
	TOTALS		0	28,293		
	F - Infusion Equipment Rental					
1.00	OPERATION OF PLANT	7.00	0	0	10	1.00
	TOTALS		0	0		
	G - STD BENEFIT RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	33,878	0	0	1.00
2.00	OPERATION OF PLANT	7.00	2,670	0	0	2.00
3.00	HOUSEKEEPING	9.00	6,418	0	0	3.00
4.00	DIETARY	10.00	3,348	0	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	62,670	0	0	5.00
6.00	INTENSIVE CARE UNIT	31.00	8,377	0	0	6.00
7.00	OPERATING ROOM	50.00	17,711	0	0	7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	4,236	0	0	8.00
9.00	ONCOLOGY	54.01	16,054	0	0	9.00
10.00	CT SCAN	57.00	129	0	0	10.00
11.00	CARDIAC CATHETERIZATION	59.00	2,569	0	0	11.00
12.00	RESPIRATORY THERAPY	65.00	5,820	0	0	12.00
13.00	PHYSICAL THERAPY	66.00	4,240	0	0	13.00
14.00	ELECTROCARDIOLOGY	69.00	3,269	0	0	14.00
15.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	2,036	0	0	15.00
16.00	DRUGS CHARGED TO PATIENTS	73.00	35,514	0	0	16.00
17.00	WOUND CARE CENTER	75.01	3,125	0	0	17.00
18.00	CARDIOPULMONARY	76.00	229	0	0	18.00
19.00	EMERGENCY	91.00	9,099	0	0	19.00
20.00	GENESIS	93.01	6,230	0	0	20.00
21.00	AMBULANCE SERVICES	95.00	6,158	0	0	21.00
22.00	MISC BH NRCC	194.00	53,217	0	0	22.00
	TOTALS		286,997	0		
	H - Labor and Delivery					
1.00	ADULTS & PEDIATRICS	30.00	1,118,143	0	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	0	0	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	855,596	0	3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	0	0	0	4.00
	TOTALS		1,118,143	855,596		
	I - Cafeteria Salary					
1.00	DIETARY	10.00	699,998	0	0	1.00
2.00	DIETARY	10.00	0	855,157	0	2.00
	TOTALS		699,998	855,157		
	J - Therapy Reclass					
1.00	PHYSICAL THERAPY	66.00	519,869	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00	PHYSICAL THERAPY	66.00	0	174,404	0	3.00
4.00		0.00	0	0	0	4.00
	TOTALS		519,869	174,404		
	K - Depreciation Expense					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,223,160	9	1.00
	TOTALS		0	4,223,160		
	L - Capital Insurance Costs					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	194,795	12	1.00
	TOTALS		0	194,795		
	M - Psych Admin Reclass					
1.00	ADMINISTRATIVE & GENERAL	5.00	189,751	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	0	0	4.00
5.00	ADMINISTRATIVE & GENERAL	5.00	0	500,072	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
	TOTALS		189,751	500,072		
	O - Psych Medicine Clinic Reclass					
1.00	PSYCH MEDICATION	93.04	120,561	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	PSYCH MEDICATION	93.04	0	33,022	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00

RECLASSIFICATIONS | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/24/2024 12:12 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
8.00		0.00	0	0	0		8.00
	TOTALS		120,561	33,022			
	P - REWARD & RECOGNITION						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	0	0		1.00
	TOTALS		0	0			
	Q - SPECIAL PAY						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1,000	0	0		1.00
	TOTALS		1,000	0			
500.00	Grand Total: Decreases		2,936,319	25,675,136			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 5/24/2024 12:12 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	4,259,963	0	0	0	0	1.00
2.00	Land Improvements	4,370,643	170,339	0	170,339	0	2.00
3.00	Buildings and Fixtures	109,009,841	3,742,143	0	3,742,143	14,646	3.00
4.00	Building Improvements	139,419	285,737	0	285,737	104,019	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	41,047,400	4,589,180	0	4,589,180	844,613	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	158,827,266	8,787,399	0	8,787,399	963,278	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	158,827,266	8,787,399	0	8,787,399	963,278	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	4,259,963	0	1.00
2.00	Land Improvements	4,540,982	0	2.00
3.00	Buildings and Fixtures	112,737,338	0	3.00
4.00	Building Improvements	321,137	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	44,791,967	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	166,651,387	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	166,651,387	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part II Date/Time Prepared: 5/24/2024 12:12 pm

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

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

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part III Date/Time Prepared: 5/24/2024 12:12 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	121,859,420	0	121,859,420	0.731224	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	44,791,968	0	44,791,968	0.268776	0	2.00
3.00	Total (sum of lines 1-2)	166,651,388	0	166,651,388	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	4,223,160	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,781,228	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	8,004,388	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	CAP REL COSTS-BLDG & FIXT	28,293	194,795	0	0	4,446,248	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	3,781,228	2.00
3.00	Total (sum of lines 1-2)	28,293	194,795	0	0	8,227,476	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/24/2024 12:12 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 - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	0	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	0	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,235,182			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	-3,834,949			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-568,246	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/24/2024 12:12 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	
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
33.01	Misc Revenue	B	-58	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	MISC INCOME - SALES	B	327	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	Purchased Discounts	B	-9,572	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	Investment Income	B	-2,316,513	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	Hospitalist Loss	A	-2,445,348	ADULTS & PEDIATRICS	30.00	0	33.05
33.06	Hospitalist Loss	A	-742,064	ADULTS & PEDIATRICS	30.00	0	33.06
33.07	Loss on Assets	A	-268	ADMINISTRATIVE & GENERAL	5.00	0	33.07
34.00	HAF Tax Offset	A	-9,637,668	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01	Bad Debt	A	-6,485,246	ADMINISTRATIVE & GENERAL	5.00	0	34.01
34.02	Bad Debt	A	-4,804	WOUND CARE CENTER	75.01	0	34.02
34.03	Bad Debt	A	-121,533	GENESIS	93.01	0	34.03
34.04	Bad Debt	A	-79,714	GENESIS	93.01	0	34.04
34.05	Bad Debt	A	-1,802	HOWARD COUNTY CSS	93.02	0	34.05
34.06	Bad Debt	A	-47,217	TIPTON BH CLINIC	93.03	0	34.06
34.07	Vending Revenue	B	-4,501	DIETARY	10.00	0	34.07
34.08	Charitable Contributions-Offset	A	-29,386	ADMINISTRATIVE & GENERAL	5.00	0	34.08
34.09	Governing Board-Offset	A	-1,440	ADMINISTRATIVE & GENERAL	5.00	0	34.09
34.10	Advertising Expense Offset	A	-66,720	ADMINISTRATIVE & GENERAL	5.00	0	34.10
34.11	APP	A	-683	ADULTS & PEDIATRICS	30.00	0	34.11
34.12	APP	A	-278,628	GENESIS	93.01	0	34.12
34.13	APP	A	-10,368	HOWARD COUNTY CSS	93.02	0	34.13
34.14	APP	A	-148,095	TIPTON BH CLINIC	93.03	0	34.14
34.15	APP	A	-69,647	PSYCH MEDICATION	93.04	0	34.15
34.16	EPIC Amortization	A	66,050	ADMINISTRATIVE & GENERAL	5.00	0	34.16
35.05	Misc Revenue Rental Lease	B	-3,036	CAFETERIA	11.00	0	35.05
35.07	Sponsorship	A	-82,820	ADMINISTRATIVE & GENERAL	5.00	0	35.07
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-28,159,131				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 5/24/2024 12:12 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	2,076,393	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	20,556,602	30,830,850	2.00
3.00	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	969,386	0	3.00
3.01	30.00	ADULTS & PEDIATRICS	HOME OFFICE	5,496	0	3.01
3.02	54.00	RADIOLOGY-DIAGNOSTIC	HOME OFFICE	116,173	0	3.02
3.03	54.01	ONCOLOGY	HOME OFFICE	2,185,119	0	3.03
3.04	70.00	ELECTROENCEPHALOGRAPHY	HOME OFFICE	63,052	0	3.04
3.05	71.00	MEDICAL SUPPLIES CHARGED TO	HOME OFFICE	513,791	0	3.05
3.06	73.00	DRUGS CHARGED TO PATIENTS	HOME OFFICE	391,365	0	3.06
4.00	5.00	ADMINISTRATIVE & GENERAL	CPN MEDICAL DIRECTOR	10,045	0	4.00
4.01	91.00	EMERGENCY	CPN CALL	108,479	0	4.01
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			26,995,901	30,830,850	5.00

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

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

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

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

6.00	B	CHNW	100.00		0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0007	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8-1 Date/Time Prepared: 5/24/2024 12:12 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	2,076,393	0		1.00
2.00	-10,274,248	0		2.00
3.00	969,386	0		3.00
3.01	5,496	0		3.01
3.02	116,173	0		3.02
3.03	2,185,119	0		3.03
3.04	63,052	0		3.04
3.05	513,791	0		3.05
3.06	391,365	0		3.06
4.00	10,045	0		4.00
4.01	108,479	0		4.01
5.00	-3,834,949			5.00

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

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

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

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

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 5/24/2024 12:12 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	583,950	583,950	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	546,908	546,908	0	0	0	2.00
3.00	57.00	CT SCAN	49,831	49,831	0	0	0	3.00
4.00	75.01	WOUND CARE CENTER	54,493	54,493	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,235,182	1,235,182	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	57.00	CT SCAN	0	0	0	0	0	3.00
4.00	75.01	WOUND CARE CENTER	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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	583,950		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	546,908		2.00
3.00	57.00	CT SCAN	0	0	0	49,831		3.00
4.00	75.01	WOUND CARE CENTER	0	0	0	54,493		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	1,235,182		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/24/2024 12:12 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	4,446,248	4,446,248				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,781,228		3,781,228			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,136,071	40,312	34,283	2,210,666		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	25,025,176	1,157,906	984,717	147,573	27,315,372	5.00
7.00	00700	OPERATION OF PLANT	4,985,117	450,711	383,299	33,375	5,852,502	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	284,694	23,306	19,820	0	327,820	8.00
9.00	00900	HOUSEKEEPING	2,208,122	25,176	21,411	53,691	2,308,400	9.00
10.00	01000	DIETARY	825,948	42,763	36,367	16,703	921,781	10.00
11.00	01100	CAFETERIA	983,873	75,776	64,442	28,673	1,152,764	11.00
13.00	01300	NURSING ADMINISTRATION	1,509,267	7,815	6,646	49,824	1,573,552	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	969,386	31,981	27,198	0	1,028,565	16.00
17.00	01700	SOCIAL SERVICE	842,022	0	0	27,834	869,856	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PASTORAL CARE	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,062,792	554,878	471,886	476,396	15,565,952	30.00
31.00	03100	INTENSIVE CARE UNIT	2,405,271	56,168	47,767	70,096	2,579,302	31.00
43.00	04300	NURSERY	550,942	23,499	19,985	12,785	607,211	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,820,961	212,870	181,031	162,637	7,377,499	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,422,797	60,683	51,607	33,017	1,568,104	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,162,575	206,409	175,537	87,960	4,632,481	54.00
54.01	03480	ONCOLOGY	5,883,244	220,739	187,723	89,443	6,381,149	54.01
57.00	05700	CT SCAN	1,089,539	6,450	5,485	29,060	1,130,534	57.00
58.00	05800	MRI	593,722	0	0	18,095	611,817	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,661,560	45,150	38,397	38,932	1,784,039	59.00
60.00	06000	LABORATORY	7,191,788	52,728	44,842	0	7,289,358	60.00
65.00	06500	RESPIRATORY THERAPY	1,930,164	47,235	40,170	57,265	2,074,834	65.00
66.00	06600	PHYSICAL THERAPY	728,378	6,289	5,348	22,170	762,185	66.00
67.00	06700	OCCUPATIONAL THERAPY	533,857	12,169	10,349	16,375	572,750	67.00
68.00	06800	SPEECH PATHOLOGY	159,619	5,171	4,397	4,920	174,107	68.00
69.00	06900	ELECTROCARDIOLOGY	1,773,768	4,547	3,867	48,305	1,830,487	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	317,111	0	0	7,819	324,930	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,120,462	69,219	58,866	16,571	7,265,118	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,469,857	0	0	0	5,469,857	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,045,798	36,754	31,257	100,059	26,213,868	73.00
74.00	07400	RENAL DIALYSIS	385,694	0	0	0	385,694	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	WOUND CARE CENTER	739,674	22,209	18,887	21,716	802,486	75.01
76.00	03160	CARDIOPULMONARY	281,922	0	0	7,696	289,618	76.00
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						
91.00	09100	EMERGENCY	5,903,105	245,775	209,015	160,726	6,518,621	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.00	04950	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
93.01	04951	GENESIS	2,553,647	0	0	76,790	2,630,437	93.01
93.02	04952	HOWARD COUNTY CSS	390,079	0	0	10,235	400,314	93.02
93.03	04953	TIPTON BH CLINIC	837,985	0	0	27,090	865,075	93.03
93.04	04954	PSYCH MEDICATION	-69,647	0	0	0	-69,647	93.04
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,427,039	18,597	15,816	64,766	2,526,218	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)	151,370,855	3,763,285	3,200,415	2,018,597	149,915,010	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	COMMUNITY HOWARD FOUNDATION	118,060	0	0	3,737	121,797	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	975,724	323,830	275,395	20,045	1,594,994	192.00
194.00	07951	MISC BH NRCC	6,360,431	0	0	165,354	6,525,785	194.00
194.08	07958	SOUTH BERKLEY BLDG	0	0	0	0	0	194.08
194.09	07959	MOBILE CLINIC	99,087	0	0	2,933	102,020	194.09
194.10	07960	PLASTIC SURGERY	455	0	0	0	455	194.10
194.11	07961	MISC NRCC	15	0	0	0	15	194.11
194.15	07965	INDIANA SURGERY CENTER	821	359,133	305,418	0	665,372	194.15
194.16	07966	PASTORAL CARE ALLIED HEALTH	0	0	0	0	0	194.16
200.00		Cross Foot Adjustments					0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/24/2024 12:12 pm

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	158,925,448	4,446,248	3,781,228	2,210,666	158,925,448	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/24/2024 12:12 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	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	27,315,372					5.00
7.00	00700	OPERATION OF PLANT	1,214,031	7,066,533				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	68,002	43,317	439,139			8.00
9.00	00900	HOUSEKEEPING	478,850	46,794	0	2,834,044		9.00
10.00	01000	DIETARY	191,212	79,481	0	32,288	1,224,762	10.00
11.00	01100	CAFETERIA	239,127	140,840	0	57,214	0	11.00
13.00	01300	NURSING ADMINISTRATION	326,414	14,526	0	5,901	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	213,363	59,441	0	24,147	0	16.00
17.00	01700	SOCIAL SERVICE	180,441	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PASTORAL CARE	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,228,970	1,031,317	386,233	418,954	1,075,368	30.00
31.00	03100	INTENSIVE CARE UNIT	535,045	104,396	37,668	42,409	106,366	31.00
43.00	04300	NURSERY	125,959	43,677	15,238	17,743	43,028	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,530,374	395,648	0	160,725	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	325,284	112,788	0	45,818	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	960,953	383,640	0	155,847	0	54.00
54.01	03480	ONCOLOGY	1,323,693	410,273	0	166,666	0	54.01
57.00	05700	CT SCAN	234,516	11,988	0	4,870	0	57.00
58.00	05800	MRI	126,914	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	370,077	83,917	0	34,090	0	59.00
60.00	06000	LABORATORY	1,512,090	98,003	0	39,812	0	60.00
65.00	06500	RESPIRATORY THERAPY	430,399	87,793	0	35,664	0	65.00
66.00	06600	PHYSICAL THERAPY	158,106	11,688	0	4,748	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	118,810	22,618	0	9,188	0	67.00
68.00	06800	SPEECH PATHOLOGY	36,116	9,610	0	3,904	0	68.00
69.00	06900	ELECTROCARDIOLOGY	379,713	8,452	0	3,433	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	67,403	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,507,062	128,652	0	52,263	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,134,656	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,437,748	68,312	0	27,751	0	73.00
74.00	07400	RENAL DIALYSIS	80,008	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	WOUND CARE CENTER	166,466	41,279	0	16,769	0	75.01
76.00	03160	CARDIOPULMONARY	60,078	0	0	0	0	76.00
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						
91.00	09100	EMERGENCY	1,352,210	456,807	0	185,570	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
93.01	04951	GENESIS	545,653	638,387	0	259,333	0	93.01
93.02	04952	HOWARD COUNTY CSS	83,040	199,582	0	81,077	0	93.02
93.03	04953	TIPTON BH CLINIC	179,449	33,267	0	13,514	0	93.03
93.04	04954	PSYCH MEDICATION	0	0	0	0	0	93.04
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	524,034	34,566	0	14,042	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)	25,446,266	4,801,059	439,139	1,913,740	1,224,762	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	COMMUNITY HOWARD FOUNDATION	25,265	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	330,862	1,590,084	0	645,939	0	192.00
194.00	07951	MISC BH NRCC	1,353,696	7,892	0	3,206	0	194.00
194.08	07958	SOUTH BERKLEY BLDG	0	0	0	0	0	194.08
194.09	07959	MOBILE CLINIC	21,163	0	0	0	0	194.09
194.10	07960	PLASTIC SURGERY	94	0	0	0	0	194.10
194.11	07961	MISC NRCC	3	0	0	0	0	194.11
194.15	07965	INDIANA SURGERY CENTER	138,023	667,498	0	271,159	0	194.15
194.16	07966	PASTORAL CARE ALLIED HEALTH	0	0	0	0	0	194.16
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)	27,315,372	7,066,533	439,139	2,834,044	1,224,762	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/24/2024 12:12 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
			11.00	13.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,589,945					11.00
13.00	01300	NURSING ADMINISTRATION	51,062	1,971,455				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,325,516			16.00
17.00	01700	SOCIAL SERVICE	28,525	34,332	0	1,113,154		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PASTORAL CARE	0	0	0	0		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	490,864	821,346	98,928	977,373	0	30.00
31.00	03100	INTENSIVE CARE UNIT	72,190	123,026	16,301	96,674	0	31.00
43.00	04300	NURSERY	13,103	27,762	1,904	39,107	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	167,422	346,854	142,803	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	33,837	71,695	4,918	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	90,324	0	56,832	0	0	54.00
54.01	03480	ONCOLOGY	92,340	101,767	90,718	0	0	54.01
57.00	05700	CT SCAN	29,788	0	97,793	0	0	57.00
58.00	05800	MRI	2,678	0	34,456	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	40,008	62,203	97,294	0	0	59.00
60.00	06000	LABORATORY	0	0	78,514	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	58,933	0	29,844	0	0	65.00
66.00	06600	PHYSICAL THERAPY	22,899	0	2,564	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	16,782	0	1,901	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,043	0	574	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	49,643	26,689	27,082	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,013	0	2,909	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,068	0	25,290	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	24,856	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	104,037	0	270,339	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	1,720	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	WOUND CARE CENTER	22,387	42,550	7,864	0	0	75.01
76.00	03160	CARDIOPULMONARY	7,897	13,815	3,547	0	0	76.00
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						
91.00	09100	EMERGENCY	165,102	299,416	185,141	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
93.01	04951	GENESIS	0	0	7,070	0	0	93.01
93.02	04952	HOWARD COUNTY CSS	0	0	141	0	0	93.02
93.03	04953	TIPTON BH CLINIC	0	0	668	0	0	93.03
93.04	04954	PSYCH MEDICATION	0	0	0	0	0	93.04
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	13,545	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)	1,589,945	1,971,455	1,325,516	1,113,154	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	COMMUNITY HOWARD FOUNDATION	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	MISC BH NRCC	0	0	0	0	0	194.00
194.08	07958	SOUTH BERKLEY BLDG	0	0	0	0	0	194.08
194.09	07959	MOBILE CLINIC	0	0	0	0	0	194.09
194.10	07960	PLASTIC SURGERY	0	0	0	0	0	194.10
194.11	07961	MISC NRCC	0	0	0	0	0	194.11
194.15	07965	INDIANA SURGERY CENTER	0	0	0	0	0	194.15
194.16	07966	PASTORAL CARE ALLIED HEALTH	0	0	0	0	0	194.16
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)	1,589,945	1,971,455	1,325,516	1,113,154	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/24/2024 12:12 pm

		Cost Center Description	PASTORAL CARE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
23.00	02300	PASTORAL CARE	0					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	24,095,305	0	24,095,305		30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,713,377	0	3,713,377		31.00
43.00	04300	NURSERY	0	934,732	0	934,732		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	10,121,325	0	10,121,325		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,162,444	0	2,162,444		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,280,077	0	6,280,077		54.00
54.01	03480	ONCOLOGY	0	8,566,606	0	8,566,606		54.01
57.00	05700	CT SCAN	0	1,509,489	0	1,509,489		57.00
58.00	05800	MRI	0	775,865	0	775,865		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,471,628	0	2,471,628		59.00
60.00	06000	LABORATORY	0	9,017,777	0	9,017,777		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,717,467	0	2,717,467		65.00
66.00	06600	PHYSICAL THERAPY	0	962,190	0	962,190		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	742,049	0	742,049		67.00
68.00	06800	SPEECH PATHOLOGY	0	229,354	0	229,354		68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,325,499	0	2,325,499		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	403,255	0	403,255		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	8,995,453	0	8,995,453		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,629,369	0	6,629,369		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	32,122,055	0	32,122,055		73.00
74.00	07400	RENAL DIALYSIS	0	467,422	0	467,422		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0		75.00
75.01	03950	WOUND CARE CENTER	0	1,099,801	0	1,099,801		75.01
76.00	03160	CARDIOPULMONARY	0	374,955	0	374,955		76.00
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						
91.00	09100	EMERGENCY	0	9,162,867	0	9,162,867		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
93.00	04950	OTHER OUTPATIENT SERVICES	0	0	0	0		93.00
93.01	04951	GENESIS	0	4,080,880	0	4,080,880		93.01
93.02	04952	HOWARD COUNTY CSS	0	764,154	0	764,154		93.02
93.03	04953	TIPTON BH CLINIC	0	1,091,973	0	1,091,973		93.03
93.04	04954	PSYCH MEDICATION	0	-69,647	0	-69,647		93.04
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	3,112,405	0	3,112,405		95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	144,860,126	0	144,860,126		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
190.01	19001	COMMUNITY HOWARD FOUNDATION	0	147,062	0	147,062		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,161,879	0	4,161,879		192.00
194.00	07951	MISC BH NRCC	0	7,890,579	0	7,890,579		194.00
194.08	07958	SOUTH BERKLEY BLDG	0	0	0	0		194.08
194.09	07959	MOBILE CLINIC	0	123,183	0	123,183		194.09
194.10	07960	PLASTIC SURGERY	0	549	0	549		194.10
194.11	07961	MISC NRCC	0	18	0	18		194.11
194.15	07965	INDIANA SURGERY CENTER	0	1,742,052	0	1,742,052		194.15
194.16	07966	PASTORAL CARE ALLIED HEALTH	0	0	0	0		194.16
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	158,925,448	0	158,925,448		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/24/2024 12:12 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	171	40,312	34,283	74,766	74,766	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,236,061	1,157,906	984,717	3,378,684	4,990	5.00
7.00	00700	OPERATION OF PLANT	226,097	450,711	383,299	1,060,107	1,128	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	23,306	19,820	43,126	0	8.00
9.00	00900	HOUSEKEEPING	7,281	25,176	21,411	53,868	1,815	9.00
10.00	01000	DIETARY	0	42,763	36,367	79,130	565	10.00
11.00	01100	CAFETERIA	0	75,776	64,442	140,218	969	11.00
13.00	01300	NURSING ADMINISTRATION	0	7,815	6,646	14,461	1,685	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	31,981	27,198	59,179	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	941	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PASTORAL CARE	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	140	554,878	471,886	1,026,904	16,131	30.00
31.00	03100	INTENSIVE CARE UNIT	13	56,168	47,767	103,948	2,370	31.00
43.00	04300	NURSERY	0	23,499	19,985	43,484	432	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	102,436	212,870	181,031	496,337	5,499	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	60,683	51,607	112,290	1,116	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	228,490	206,409	175,537	610,436	2,974	54.00
54.01	03480	ONCOLOGY	1,620	220,739	187,723	410,082	3,024	54.01
57.00	05700	CT SCAN	0	6,450	5,485	11,935	983	57.00
58.00	05800	MRI	80	0	0	80	612	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	45,150	38,397	83,547	1,316	59.00
60.00	06000	LABORATORY	0	52,728	44,842	97,570	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	47,235	40,170	87,405	1,936	65.00
66.00	06600	PHYSICAL THERAPY	0	6,289	5,348	11,637	750	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	12,169	10,349	22,518	554	67.00
68.00	06800	SPEECH PATHOLOGY	0	5,171	4,397	9,568	166	68.00
69.00	06900	ELECTROCARDIOLOGY	119,848	4,547	3,867	128,262	1,633	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	264	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	858,703	69,219	58,866	986,788	560	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	267,536	36,754	31,257	335,547	3,383	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	WOUND CARE CENTER	18,177	22,209	18,887	59,273	734	75.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	260	76.00
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						
91.00	09100	EMERGENCY	5	245,775	209,015	454,795	5,434	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04950	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
93.01	04951	GENESIS	1,428	0	0	1,428	2,596	93.01
93.02	04952	HOWARD COUNTY CSS	311	0	0	311	346	93.02
93.03	04953	TIPTON BH CLINIC	50,540	0	0	50,540	916	93.03
93.04	04954	PSYCH MEDICATION	0	0	0	0	0	93.04
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	18,597	15,816	34,413	2,190	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)	3,118,937	3,763,285	3,200,415	10,082,637	68,272	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	COMMUNITY HOWARD FOUNDATION	0	0	0	0	126	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	248,582	323,830	275,395	847,807	678	192.00
194.00	07951	MISC BH NRCC	215,496	0	0	215,496	5,591	194.00
194.08	07958	SOUTH BERKLEY BLDG	0	0	0	0	0	194.08
194.09	07959	MOBILE CLINIC	0	0	0	0	99	194.09
194.10	07960	PLASTIC SURGERY	455	0	0	455	0	194.10
194.11	07961	MISC NRCC	0	0	0	0	0	194.11
194.15	07965	INDIANA SURGERY CENTER	0	359,133	305,418	664,551	0	194.15
194.16	07966	PASTORAL CARE ALLIED HEALTH	0	0	0	0	0	194.16
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/24/2024 12:12 pm

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
202.00	TOTAL (sum lines 118 through 201)	3,583,470	4,446,248	3,781,228	11,810,946	74,766	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/24/2024 12:12 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	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,383,674					5.00
7.00	00700	OPERATION OF PLANT	150,386	1,211,621				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,424	7,427	58,977			8.00
9.00	00900	HOUSEKEEPING	59,317	8,023	0	123,023		9.00
10.00	01000	DIETARY	23,686	13,628	0	1,402	118,411	10.00
11.00	01100	CAFETERIA	29,621	24,148	0	2,484	0	11.00
13.00	01300	NURSING ADMINISTRATION	40,434	2,491	0	256	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	26,430	10,192	0	1,048	0	16.00
17.00	01700	SOCIAL SERVICE	22,352	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PASTORAL CARE	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	399,983	176,829	51,872	18,186	103,967	30.00
31.00	03100	INTENSIVE CARE UNIT	66,278	17,900	5,059	1,841	10,284	31.00
43.00	04300	NURSERY	15,603	7,489	2,046	770	4,160	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	189,572	67,837	0	6,977	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	40,294	19,339	0	1,989	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	119,036	65,778	0	6,765	0	54.00
54.01	03480	ONCOLOGY	163,970	70,345	0	7,235	0	54.01
57.00	05700	CT SCAN	29,050	2,055	0	211	0	57.00
58.00	05800	MRI	15,721	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	45,843	14,388	0	1,480	0	59.00
60.00	06000	LABORATORY	187,307	16,803	0	1,728	0	60.00
65.00	06500	RESPIRATORY THERAPY	53,315	15,053	0	1,548	0	65.00
66.00	06600	PHYSICAL THERAPY	19,585	2,004	0	206	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	14,717	3,878	0	399	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,474	1,648	0	169	0	68.00
69.00	06900	ELECTROCARDIOLOGY	47,036	1,449	0	149	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,349	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	186,684	22,059	0	2,269	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	140,553	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	673,624	11,713	0	1,205	0	73.00
74.00	07400	RENAL DIALYSIS	9,911	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	WOUND CARE CENTER	20,621	7,078	0	728	0	75.01
76.00	03160	CARDIOPULMONARY	7,442	0	0	0	0	76.00
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						
91.00	09100	EMERGENCY	167,502	78,324	0	8,055	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
93.01	04951	GENESIS	67,592	109,457	0	11,257	0	93.01
93.02	04952	HOWARD COUNTY CSS	10,286	34,220	0	3,519	0	93.02
93.03	04953	TIPTON BH CLINIC	22,229	5,704	0	587	0	93.03
93.04	04954	PSYCH MEDICATION	0	0	0	0	0	93.04
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	64,914	5,927	0	610	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)	3,152,141	823,186	58,977	83,073	118,411	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	COMMUNITY HOWARD FOUNDATION	3,130	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	40,985	272,633	0	28,040	0	192.00
194.00	07951	MISC BH NRCC	167,687	1,353	0	139	0	194.00
194.08	07958	SOUTH BERKLEY BLDG	0	0	0	0	0	194.08
194.09	07959	MOBILE CLINIC	2,622	0	0	0	0	194.09
194.10	07960	PLASTIC SURGERY	12	0	0	0	0	194.10
194.11	07961	MISC NRCC	0	0	0	0	0	194.11
194.15	07965	INDIANA SURGERY CENTER	17,097	114,449	0	11,771	0	194.15
194.16	07966	PASTORAL CARE ALLIED HEALTH	0	0	0	0	0	194.16
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)	3,383,674	1,211,621	58,977	123,023	118,411	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/24/2024 12:12 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
			11.00	13.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	197,440					11.00
13.00	01300	NURSING ADMINISTRATION	6,341	65,668				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	96,849			16.00
17.00	01700	SOCIAL SERVICE	3,542	1,144	0	27,979		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PASTORAL CARE	0	0	0	0		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	60,958	27,357	7,250	24,566		30.00
31.00	03100	INTENSIVE CARE UNIT	8,964	4,098	1,195	2,430		31.00
43.00	04300	NURSERY	1,627	925	140	983		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,790	11,554	10,465	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,202	2,388	360	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,216	0	4,165	0		54.00
54.01	03480	ONCOLOGY	11,467	3,390	6,648	0		54.01
57.00	05700	CT SCAN	3,699	0	7,167	0		57.00
58.00	05800	MRI	333	0	2,525	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	4,968	2,072	7,130	0		59.00
60.00	06000	LABORATORY	0	0	5,754	0		60.00
65.00	06500	RESPIRATORY THERAPY	7,318	0	2,187	0		65.00
66.00	06600	PHYSICAL THERAPY	2,844	0	188	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	2,084	0	139	0		67.00
68.00	06800	SPEECH PATHOLOGY	626	0	42	0		68.00
69.00	06900	ELECTROCARDIOLOGY	6,165	889	1,985	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	995	0	213	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,119	0	1,853	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,822	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,919	0	19,521	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	126	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0		75.00
75.01	03950	WOUND CARE CENTER	2,780	1,417	576	0		75.01
76.00	03160	CARDIOPULMONARY	981	460	260	0		76.00
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						
91.00	09100	EMERGENCY	20,502	9,974	13,568	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OTHER OUTPATIENT SERVICES	0	0	0	0		93.00
93.01	04951	GENESIS	0	0	518	0		93.01
93.02	04952	HOWARD COUNTY CSS	0	0	10	0		93.02
93.03	04953	TIPTON BH CLINIC	0	0	49	0		93.03
93.04	04954	PSYCH MEDICATION	0	0	0	0		93.04
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	993	0		95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	197,440	65,668	96,849	27,979	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
190.01	19001	COMMUNITY HOWARD FOUNDATION	0	0	0	0		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07951	MISC BH NRCC	0	0	0	0		194.00
194.08	07958	SOUTH BERKLEY BLDG	0	0	0	0		194.08
194.09	07959	MOBILE CLINIC	0	0	0	0		194.09
194.10	07960	PLASTIC SURGERY	0	0	0	0		194.10
194.11	07961	MISC NRCC	0	0	0	0		194.11
194.15	07965	INDIANA SURGERY CENTER	0	0	0	0		194.15
194.16	07966	PASTORAL CARE ALLIED HEALTH	0	0	0	0		194.16
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)	197,440	65,668	96,849	27,979	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/24/2024 12:12 pm

		Cost Center Description	PASTORAL CARE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
23.00	02300	PASTORAL CARE	0					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		1,914,003	0	1,914,003		30.00
31.00	03100	INTENSIVE CARE UNIT		224,367	0	224,367		31.00
43.00	04300	NURSERY		77,659	0	77,659		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		809,031	0	809,031		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		181,978	0	181,978		52.00
53.00	05300	ANESTHESIOLOGY		0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		820,370	0	820,370		54.00
54.01	03480	ONCOLOGY		676,161	0	676,161		54.01
57.00	05700	CT SCAN		55,100	0	55,100		57.00
58.00	05800	MRI		19,271	0	19,271		58.00
59.00	05900	CARDIAC CATHETERIZATION		160,744	0	160,744		59.00
60.00	06000	LABORATORY		309,162	0	309,162		60.00
65.00	06500	RESPIRATORY THERAPY		168,762	0	168,762		65.00
66.00	06600	PHYSICAL THERAPY		37,214	0	37,214		66.00
67.00	06700	OCCUPATIONAL THERAPY		44,289	0	44,289		67.00
68.00	06800	SPEECH PATHOLOGY		16,693	0	16,693		68.00
69.00	06900	ELECTROCARDIOLOGY		187,568	0	187,568		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		9,821	0	9,821		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		1,202,332	0	1,202,332		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		142,375	0	142,375		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		1,057,912	0	1,057,912		73.00
74.00	07400	RENAL DIALYSIS		10,037	0	10,037		74.00
75.00	07500	ASC (NON-DISTINCT PART)		0	0	0		75.00
75.01	03950	WOUND CARE CENTER		93,207	0	93,207		75.01
76.00	03160	CARDIOPULMONARY		9,403	0	9,403		76.00
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						
91.00	09100	EMERGENCY		758,154	0	758,154		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
93.00	04950	OTHER OUTPATIENT SERVICES		0	0	0		93.00
93.01	04951	GENESIS		192,848	0	192,848		93.01
93.02	04952	HOWARD COUNTY CSS		48,692	0	48,692		93.02
93.03	04953	TIPTON BH CLINIC		80,025	0	80,025		93.03
93.04	04954	PSYCH MEDICATION		0	0	0		93.04
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES		109,047	0	109,047		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)	0	9,416,225	0	9,416,225		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	0		190.00
190.01	19001	COMMUNITY HOWARD FOUNDATION		3,256	0	3,256		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES		1,190,143	0	1,190,143		192.00
194.00	07951	MISC BH NRCC		390,266	0	390,266		194.00
194.08	07958	SOUTH BERKLEY BLDG		0	0	0		194.08
194.09	07959	MOBILE CLINIC		2,721	0	2,721		194.09
194.10	07960	PLASTIC SURGERY		467	0	467		194.10
194.11	07961	MISC NRCC		0	0	0		194.11
194.15	07965	INDIANA SURGERY CENTER		807,868	0	807,868		194.15
194.16	07966	PASTORAL CARE ALLIED HEALTH		0	0	0		194.16
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	11,810,946	0	11,810,946		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/24/2024 12:12 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	413,608					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		413,608				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,750	3,750	53,968,453			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	107,713	107,713	3,602,684	-27,315,372	131,679,723	5.00
7.00	00700	OPERATION OF PLANT	41,927	41,927	814,769	0	5,852,502	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,168	2,168	0	0	327,820	8.00
9.00	00900	HOUSEKEEPING	2,342	2,342	1,310,748	0	2,308,400	9.00
10.00	01000	DIETARY	3,978	3,978	407,762	0	921,781	10.00
11.00	01100	CAFETERIA	7,049	7,049	699,998	0	1,152,764	11.00
13.00	01300	NURSING ADMINISTRATION	727	727	1,216,339	0	1,573,552	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,975	2,975	0	0	1,028,565	16.00
17.00	01700	SOCIAL SERVICE	0	0	679,501	0	869,856	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PASTORAL CARE	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	51,617	51,617	11,629,952	0	15,565,952	30.00
31.00	03100	INTENSIVE CARE UNIT	5,225	5,225	1,711,242	0	2,579,302	31.00
43.00	04300	NURSERY	2,186	2,186	312,114	0	607,211	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,802	19,802	3,970,434	0	7,377,499	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,645	5,645	806,029	0	1,568,104	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,201	19,201	2,147,362	0	4,632,481	54.00
54.01	03480	ONCOLOGY	20,534	20,534	2,183,562	0	6,381,149	54.01
57.00	05700	CT SCAN	600	600	709,438	0	1,130,534	57.00
58.00	05800	MRI	0	0	441,752	0	611,817	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,200	4,200	950,446	0	1,784,039	59.00
60.00	06000	LABORATORY	4,905	4,905	0	0	7,289,358	60.00
65.00	06500	RESPIRATORY THERAPY	4,394	4,394	1,398,012	0	2,074,834	65.00
66.00	06600	PHYSICAL THERAPY	585	585	541,230	0	762,185	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,132	1,132	399,750	0	572,750	67.00
68.00	06800	SPEECH PATHOLOGY	481	481	120,119	0	174,107	68.00
69.00	06900	ELECTROCARDIOLOGY	423	423	1,179,264	0	1,830,487	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	190,874	0	324,930	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,439	6,439	404,543	0	7,265,118	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	5,469,857	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,419	3,419	2,442,738	0	26,213,868	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	385,694	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	WOUND CARE CENTER	2,066	2,066	530,161	0	802,486	75.01
76.00	03160	CARDIOPULMONARY	0	0	187,884	0	289,618	76.00
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						
91.00	09100	EMERGENCY	22,863	22,863	3,923,779	0	6,518,621	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
93.01	04951	GENESIS	0	0	1,874,676	0	2,630,437	93.01
93.02	04952	HOWARD COUNTY CSS	0	0	249,856	0	400,314	93.02
93.03	04953	TIPTON BH CLINIC	0	0	661,350	0	865,075	93.03
93.04	04954	PSYCH MEDICATION	0	0	0	69,647	0	93.04
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,730	1,730	1,581,128	0	2,526,218	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)	350,076	350,076	49,279,496	-27,245,725	122,669,285	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	COMMUNITY HOWARD FOUNDATION	0	0	91,226	0	121,797	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	30,124	30,124	489,367	0	1,594,994	192.00
194.00	07951	MISC BH NRCC	0	0	4,036,756	0	6,525,785	194.00
194.08	07958	SOUTH BERKLEY BLDG	0	0	0	0	0	194.08
194.09	07959	MOBILE CLINIC	0	0	71,608	0	102,020	194.09
194.10	07960	PLASTIC SURGERY	0	0	0	0	455	194.10
194.11	07961	MISC NRCC	0	0	0	0	15	194.11
194.15	07965	INDIANA SURGERY CENTER	33,408	33,408	0	0	665,372	194.15
194.16	07966	PASTORAL CARE ALLIED HEALTH	0	0	0	0	0	194.16
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/24/2024 12:12 pm

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	4,446,248	3,781,228	2,210,666		27,315,372	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	10.749908	9.142057	0.040962		0.207438	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			74,766		3,383,674	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.001385		0.025696	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: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/24/2024 12:12 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (SALARIES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	353,677					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,168	18,012				8.00
9.00	00900	HOUSEKEEPING	2,342	0	349,167			9.00
10.00	01000	DIETARY	3,978	0	3,978	17,790		10.00
11.00	01100	CAFETERIA	7,049	0	7,049	0	37,873,638	11.00
13.00	01300	NURSING ADMINISTRATION	727	0	727	0	1,216,339	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,975	0	2,975	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	679,501	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PASTORAL CARE	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	51,617	15,842	51,617	15,620	11,692,622	30.00
31.00	03100	INTENSIVE CARE UNIT	5,225	1,545	5,225	1,545	1,719,619	31.00
43.00	04300	NURSERY	2,186	625	2,186	625	312,114	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,802	0	19,802	0	3,988,145	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,645	0	5,645	0	806,028	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,201	0	19,201	0	2,151,598	54.00
54.01	03480	ONCOLOGY	20,534	0	20,534	0	2,199,616	54.01
57.00	05700	CT SCAN	600	0	600	0	709,567	57.00
58.00	05800	MRI	0	0	0	0	63,788	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,200	0	4,200	0	953,015	59.00
60.00	06000	LABORATORY	4,905	0	4,905	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	4,394	0	4,394	0	1,403,832	65.00
66.00	06600	PHYSICAL THERAPY	585	0	585	0	545,470	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,132	0	1,132	0	399,750	67.00
68.00	06800	SPEECH PATHOLOGY	481	0	481	0	120,119	68.00
69.00	06900	ELECTROCARDIOLOGY	423	0	423	0	1,182,533	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	190,874	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,439	0	6,439	0	406,579	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,419	0	3,419	0	2,478,252	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	WOUND CARE CENTER	2,066	0	2,066	0	533,286	75.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	188,113	76.00
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						
91.00	09100	EMERGENCY	22,863	0	22,863	0	3,932,878	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
93.01	04951	GENESIS	31,951	0	31,951	0	0	93.01
93.02	04952	HOWARD COUNTY CSS	9,989	0	9,989	0	0	93.02
93.03	04953	TIPTON BH CLINIC	1,665	0	1,665	0	0	93.03
93.04	04954	PSYCH MEDICATION	0	0	0	0	0	93.04
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,730	0	1,730	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)	240,291	18,012	235,781	17,790	37,873,638	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	COMMUNITY HOWARD FOUNDATION	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	79,583	0	79,583	0	0	192.00
194.00	07951	MISC BH NRCC	395	0	395	0	0	194.00
194.08	07958	SOUTH BERKLEY BLDG	0	0	0	0	0	194.08
194.09	07959	MOBILE CLINIC	0	0	0	0	0	194.09
194.10	07960	PLASTIC SURGERY	0	0	0	0	0	194.10
194.11	07961	MISC NRCC	0	0	0	0	0	194.11
194.15	07965	INDIANA SURGERY CENTER	33,408	0	33,408	0	0	194.15
194.16	07966	PASTORAL CARE ALLIED HEALTH	0	0	0	0	0	194.16
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	7,066,533	439,139	2,834,044	1,224,762	1,589,945	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/24/2024 12:12 pm

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (SALARIES)	
		7.00	8.00	9.00	10.00	11.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	19.980188	24.380358	8.116586	68.845531	0.041980	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	1,211,621	58,977	123,023	118,411	197,440	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	3.425784	3.274317	0.352333	6.656043	0.005213	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: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/24/2024 12:12 pm

		Cost Center Description	NURSING ADMINISTRATION (NURSING SALARIES)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	PASTORAL CARE (ASSIGNED TIME)	
			13.00	16.00	17.00	19.00	23.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	15,816,637					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	764,796,423				16.00
17.00	01700	SOCIAL SERVICE	275,439	0	17,790			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
23.00	02300	PASTORAL CARE	0	0	0		0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,589,482	57,084,854	15,620	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	987,020	9,406,217	1,545	0	0	31.00
43.00	04300	NURSERY	222,732	1,098,864	625	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,782,758	82,402,233	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	575,201	2,837,793	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	32,794,088	0	0	0	54.00
54.01	03480	ONCOLOGY	816,459	52,347,253	0	0	0	54.01
57.00	05700	CT SCAN	0	56,430,092	0	0	0	57.00
58.00	05800	MRI	0	19,882,470	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	499,047	56,142,079	0	0	0	59.00
60.00	06000	LABORATORY	0	45,305,286	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	17,221,219	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,479,486	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,097,185	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	331,055	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	214,125	15,627,480	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,678,704	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	14,593,256	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,342,894	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	155,921,339	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	992,759	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	WOUND CARE CENTER	341,374	4,537,896	0	0	0	75.01
76.00	03160	CARDIOPULMONARY	110,834	2,046,524	0	0	0	76.00
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						
91.00	09100	EMERGENCY	2,402,166	106,832,629	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
93.01	04951	GENESIS	0	4,079,899	0	0	0	93.01
93.02	04952	HOWARD COUNTY CSS	0	81,402	0	0	0	93.02
93.03	04953	TIPTON BH CLINIC	0	385,569	0	0	0	93.03
93.04	04954	PSYCH MEDICATION	0	0	0	0	0	93.04
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	7,815,898	0	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)	15,816,637	764,796,423	17,790	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	COMMUNITY HOWARD FOUNDATION	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	MISC BH NRCC	0	0	0	0	0	194.00
194.08	07958	SOUTH BERKLEY BLDG	0	0	0	0	0	194.08
194.09	07959	MOBILE CLINIC	0	0	0	0	0	194.09
194.10	07960	PLASTIC SURGERY	0	0	0	0	0	194.10
194.11	07961	MISC NRCC	0	0	0	0	0	194.11
194.15	07965	INDIANA SURGERY CENTER	0	0	0	0	0	194.15
194.16	07966	PASTORAL CARE ALLIED HEALTH	0	0	0	0	0	194.16
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/24/2024 12:12 pm

		Cost Center Description	NURSING ADMINISTRATION (NURSING SALARIES)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	PASTORAL CARE (ASSIGNED TIME)	
			13.00	16.00	17.00	19.00	23.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	1,971,455	1,325,516	1,113,154	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.124644	0.001733	62.571894	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	65,668	96,849	27,979	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.004152	0.000127	1.572737	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/24/2024 12:12 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	24,095,305		24,095,305	0	24,095,305	30.00
31.00	03100	INTENSIVE CARE UNIT	3,713,377		3,713,377	0	3,713,377	31.00
43.00	04300	NURSERY	934,732		934,732	0	934,732	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,121,325		10,121,325	0	10,121,325	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,162,444		2,162,444	0	2,162,444	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,280,077		6,280,077	0	6,280,077	54.00
54.01	03480	ONCOLOGY	8,566,606		8,566,606	0	8,566,606	54.01
57.00	05700	CT SCAN	1,509,489		1,509,489	0	1,509,489	57.00
58.00	05800	MRI	775,865		775,865	0	775,865	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,471,628		2,471,628	0	2,471,628	59.00
60.00	06000	LABORATORY	9,017,777		9,017,777	0	9,017,777	60.00
65.00	06500	RESPIRATORY THERAPY	2,717,467	0	2,717,467	0	2,717,467	65.00
66.00	06600	PHYSICAL THERAPY	962,190	0	962,190	0	962,190	66.00
67.00	06700	OCCUPATIONAL THERAPY	742,049	0	742,049	0	742,049	67.00
68.00	06800	SPEECH PATHOLOGY	229,354	0	229,354	0	229,354	68.00
69.00	06900	ELECTROCARDIOLOGY	2,325,499		2,325,499	0	2,325,499	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	403,255		403,255	0	403,255	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,995,453		8,995,453	0	8,995,453	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,629,369		6,629,369	0	6,629,369	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,122,055		32,122,055	0	32,122,055	73.00
74.00	07400	RENAL DIALYSIS	467,422		467,422	0	467,422	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
75.01	03950	WOUND CARE CENTER	1,099,801		1,099,801	0	1,099,801	75.01
76.00	03160	CARDIOPULMONARY	374,955		374,955	0	374,955	76.00
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						
91.00	09100	EMERGENCY	9,162,867		9,162,867	0	9,162,867	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,226,512		3,226,512		3,226,512	92.00
93.00	04950	OTHER OUTPATIENT SERVICES	0		0	0	0	93.00
93.01	04951	GENESIS	4,080,880		4,080,880	0	4,080,880	93.01
93.02	04952	HOWARD COUNTY CSS	764,154		764,154	0	764,154	93.02
93.03	04953	TIPTON BH CLINIC	1,091,973		1,091,973	0	1,091,973	93.03
93.04	04954	PSYCH MEDICATION	0		0	0	0	93.04
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,112,405		3,112,405	0	3,112,405	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	148,156,285	0	148,156,285	0	148,156,285	200.00
201.00		Less Observation Beds	3,226,512		3,226,512		3,226,512	201.00
202.00		Total (see instructions)	144,929,773	0	144,929,773	0	144,929,773	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I | Date/Time Prepared: 5/24/2024 12:12 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	52,510,968		52,510,968			30.00
31.00	03100	INTENSIVE CARE UNIT	9,406,217		9,406,217			31.00
43.00	04300	NURSERY	1,098,864		1,098,864			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,016,336	55,385,897	82,402,233	0.122828	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,837,793	0	2,837,793	0.762016	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,668,827	29,125,261	32,794,088	0.191500	0.000000	54.00
54.01	03480	ONCOLOGY	231,612	52,115,641	52,347,253	0.163650	0.000000	54.01
57.00	05700	CT SCAN	11,571,271	44,858,821	56,430,092	0.026750	0.000000	57.00
58.00	05800	MRI	1,539,020	18,343,450	19,882,470	0.039023	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	18,604,927	37,537,152	56,142,079	0.044025	0.000000	59.00
60.00	06000	LABORATORY	13,827,050	31,478,236	45,305,286	0.199045	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	12,074,436	5,146,783	17,221,219	0.157798	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,009,042	470,444	1,479,486	0.650354	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	860,285	236,900	1,097,185	0.676321	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	207,586	123,469	331,055	0.692797	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	3,604,547	12,022,933	15,627,480	0.148808	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,016	1,675,688	1,678,704	0.240218	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,438,404	8,154,852	14,593,256	0.616412	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,441,902	10,900,992	14,342,894	0.462206	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,457,683	141,463,656	155,921,339	0.206014	0.000000	73.00
74.00	07400	RENAL DIALYSIS	992,759	0	992,759	0.470831	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
75.01	03950	WOUND CARE CENTER	263,996	4,273,900	4,537,896	0.242359	0.000000	75.01
76.00	03160	CARDIOPULMONARY	1,674	2,044,850	2,046,524	0.183216	0.000000	76.00
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						
91.00	09100	EMERGENCY	20,759,469	86,073,160	106,832,629	0.085768	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	852,634	3,721,252	4,573,886	0.705420	0.000000	92.00
93.00	04950	OTHER OUTPATIENT SERVICES	0	0	0	0.000000	0.000000	93.00
93.01	04951	GENESIS	9,799	4,070,100	4,079,899	1.000240	0.000000	93.01
93.02	04952	HOWARD COUNTY CSS	0	81,402	81,402	9.387411	0.000000	93.02
93.03	04953	TIPTON BH CLINIC	2,269	383,300	385,569	2.832108	0.000000	93.03
93.04	04954	PSYCH MEDICATION	0	0	0	0.000000	0.000000	93.04
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	7,815,898	7,815,898	0.398215	0.000000	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	207,292,386	557,504,037	764,796,423			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	207,292,386	557,504,037	764,796,423			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/24/2024 12:12 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
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.122828		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.762016		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.191500		54.00
54.01	03480	ONCOLOGY	0.163650		54.01
57.00	05700	CT SCAN	0.026750		57.00
58.00	05800	MRI	0.039023		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.044025		59.00
60.00	06000	LABORATORY	0.199045		60.00
65.00	06500	RESPIRATORY THERAPY	0.157798		65.00
66.00	06600	PHYSICAL THERAPY	0.650354		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.676321		67.00
68.00	06800	SPEECH PATHOLOGY	0.692797		68.00
69.00	06900	ELECTROCARDIOLOGY	0.148808		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.240218		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.616412		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.462206		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.206014		73.00
74.00	07400	RENAL DIALYSIS	0.470831		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
75.01	03950	WOUND CARE CENTER	0.242359		75.01
76.00	03160	CARDIOPULMONARY	0.183216		76.00
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			
91.00	09100	EMERGENCY	0.085768		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.705420		92.00
93.00	04950	OTHER OUTPATIENT SERVICES	0.000000		93.00
93.01	04951	GENESIS	1.000240		93.01
93.02	04952	HOWARD COUNTY CSS	9.387411		93.02
93.03	04953	TIPTON BH CLINIC	2.832108		93.03
93.04	04954	PSYCH MEDICATION	0.000000		93.04
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.398215		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: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/24/2024 12:12 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	24,095,305		24,095,305	0	24,095,305	30.00
31.00	03100	INTENSIVE CARE UNIT	3,713,377		3,713,377	0	3,713,377	31.00
43.00	04300	NURSERY	934,732		934,732	0	934,732	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,121,325		10,121,325	0	10,121,325	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,162,444		2,162,444	0	2,162,444	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,280,077		6,280,077	0	6,280,077	54.00
54.01	03480	ONCOLOGY	8,566,606		8,566,606	0	8,566,606	54.01
57.00	05700	CT SCAN	1,509,489		1,509,489	0	1,509,489	57.00
58.00	05800	MRI	775,865		775,865	0	775,865	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,471,628		2,471,628	0	2,471,628	59.00
60.00	06000	LABORATORY	9,017,777		9,017,777	0	9,017,777	60.00
65.00	06500	RESPIRATORY THERAPY	2,717,467	0	2,717,467	0	2,717,467	65.00
66.00	06600	PHYSICAL THERAPY	962,190	0	962,190	0	962,190	66.00
67.00	06700	OCCUPATIONAL THERAPY	742,049	0	742,049	0	742,049	67.00
68.00	06800	SPEECH PATHOLOGY	229,354	0	229,354	0	229,354	68.00
69.00	06900	ELECTROCARDIOLOGY	2,325,499		2,325,499	0	2,325,499	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	403,255		403,255	0	403,255	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,995,453		8,995,453	0	8,995,453	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,629,369		6,629,369	0	6,629,369	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,122,055		32,122,055	0	32,122,055	73.00
74.00	07400	RENAL DIALYSIS	467,422		467,422	0	467,422	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
75.01	03950	WOUND CARE CENTER	1,099,801		1,099,801	0	1,099,801	75.01
76.00	03160	CARDIOPULMONARY	374,955		374,955	0	374,955	76.00
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						
91.00	09100	EMERGENCY	9,162,867		9,162,867	0	9,162,867	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,226,512		3,226,512		3,226,512	92.00
93.00	04950	OTHER OUTPATIENT SERVICES	0		0	0	0	93.00
93.01	04951	GENESIS	4,080,880		4,080,880	0	4,080,880	93.01
93.02	04952	HOWARD COUNTY CSS	764,154		764,154	0	764,154	93.02
93.03	04953	TIPTON BH CLINIC	1,091,973		1,091,973	0	1,091,973	93.03
93.04	04954	PSYCH MEDICATION	0		0	0	0	93.04
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,112,405		3,112,405	0	3,112,405	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	148,156,285	0	148,156,285	0	148,156,285	200.00
201.00		Less Observation Beds	3,226,512		3,226,512		3,226,512	201.00
202.00		Total (see instructions)	144,929,773	0	144,929,773	0	144,929,773	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/24/2024 12:12 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	52,510,968		52,510,968			30.00
31.00	03100	INTENSIVE CARE UNIT	9,406,217		9,406,217			31.00
43.00	04300	NURSERY	1,098,864		1,098,864			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,016,336	55,385,897	82,402,233	0.122828	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,837,793	0	2,837,793	0.762016	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,668,827	29,125,261	32,794,088	0.191500	0.000000	54.00
54.01	03480	ONCOLOGY	231,612	52,115,641	52,347,253	0.163650	0.000000	54.01
57.00	05700	CT SCAN	11,571,271	44,858,821	56,430,092	0.026750	0.000000	57.00
58.00	05800	MRI	1,539,020	18,343,450	19,882,470	0.039023	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	18,604,927	37,537,152	56,142,079	0.044025	0.000000	59.00
60.00	06000	LABORATORY	13,827,050	31,478,236	45,305,286	0.199045	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	12,074,436	5,146,783	17,221,219	0.157798	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,009,042	470,444	1,479,486	0.650354	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	860,285	236,900	1,097,185	0.676321	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	207,586	123,469	331,055	0.692797	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	3,604,547	12,022,933	15,627,480	0.148808	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,016	1,675,688	1,678,704	0.240218	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,438,404	8,154,852	14,593,256	0.616412	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,441,902	10,900,992	14,342,894	0.462206	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,457,683	141,463,656	155,921,339	0.206014	0.000000	73.00
74.00	07400	RENAL DIALYSIS	992,759	0	992,759	0.470831	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
75.01	03950	WOUND CARE CENTER	263,996	4,273,900	4,537,896	0.242359	0.000000	75.01
76.00	03160	CARDIOPULMONARY	1,674	2,044,850	2,046,524	0.183216	0.000000	76.00
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						
91.00	09100	EMERGENCY	20,759,469	86,073,160	106,832,629	0.085768	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	852,634	3,721,252	4,573,886	0.705420	0.000000	92.00
93.00	04950	OTHER OUTPATIENT SERVICES	0	0	0	0.000000	0.000000	93.00
93.01	04951	GENESIS	9,799	4,070,100	4,079,899	1.000240	0.000000	93.01
93.02	04952	HOWARD COUNTY CSS	0	81,402	81,402	9.387411	0.000000	93.02
93.03	04953	TIPTON BH CLINIC	2,269	383,300	385,569	2.832108	0.000000	93.03
93.04	04954	PSYCH MEDICATION	0	0	0	0.000000	0.000000	93.04
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	7,815,898	7,815,898	0.398215	0.000000	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	207,292,386	557,504,037	764,796,423			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	207,292,386	557,504,037	764,796,423			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/24/2024 12:12 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
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	03480	ONCOLOGY	0.000000		54.01
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
75.01	03950	WOUND CARE CENTER	0.000000		75.01
76.00	03160	CARDIOPULMONARY	0.000000		76.00
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			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04950	OTHER OUTPATIENT SERVICES	0.000000		93.00
93.01	04951	GENESIS	0.000000		93.01
93.02	04952	HOWARD COUNTY CSS	0.000000		93.02
93.03	04953	TIPTON BH CLINIC	0.000000		93.03
93.04	04954	PSYCH MEDICATION	0.000000		93.04
		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: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part I Date/Time Prepared: 5/24/2024 12:12 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	1,914,003	0	1,914,003	18,035	106.13	30.00
31.00	INTENSIVE CARE UNIT	224,367		224,367	1,545	145.22	31.00
43.00	NURSERY	77,659		77,659	625	124.25	43.00
200.00	Total (lines 30 through 199)	2,216,029		2,216,029	20,205		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	3,830	406,478				30.00
31.00	INTENSIVE CARE UNIT	396	57,507				31.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	4,226	463,985				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/24/2024 12:12 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	809,031	82,402,233	0.009818	8,735,760	85,768	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	181,978	2,837,793	0.064127	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	820,370	32,794,088	0.025016	1,173,114	29,347	54.00
54.01	03480	ONCOLOGY	676,161	52,347,253	0.012917	64,886	838	54.01
57.00	05700	CT SCAN	55,100	56,430,092	0.000976	3,584,133	3,498	57.00
58.00	05800	MRI	19,271	19,882,470	0.000969	433,968	421	58.00
59.00	05900	CARDIAC CATHETERIZATION	160,744	56,142,079	0.002863	5,094,683	14,586	59.00
60.00	06000	LABORATORY	309,162	45,305,286	0.006824	4,310,124	29,412	60.00
65.00	06500	RESPIRATORY THERAPY	168,762	17,221,219	0.009800	3,824,105	37,476	65.00
66.00	06600	PHYSICAL THERAPY	37,214	1,479,486	0.025153	395,397	9,945	66.00
67.00	06700	OCCUPATIONAL THERAPY	44,289	1,097,185	0.040366	318,791	12,868	67.00
68.00	06800	SPEECH PATHOLOGY	16,693	331,055	0.050424	77,195	3,892	68.00
69.00	06900	ELECTROCARDIOLOGY	187,568	15,627,480	0.012002	1,237,610	14,854	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	9,821	1,678,704	0.005850	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,202,332	14,593,256	0.082390	2,116,874	174,409	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	142,375	14,342,894	0.009927	1,642,226	16,302	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,057,912	155,921,339	0.006785	3,816,667	25,896	73.00
74.00	07400	RENAL DIALYSIS	10,037	992,759	0.010110	290,257	2,934	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	03950	WOUND CARE CENTER	93,207	4,537,896	0.020540	99,495	2,044	75.01
76.00	03160	CARDIOPULMONARY	9,403	2,046,524	0.004595	372	2	76.00
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						
91.00	09100	EMERGENCY	758,154	106,832,629	0.007097	5,962,073	42,313	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	256,298	4,573,886	0.056035	409,537	22,948	92.00
93.00	04950	OTHER OUTPATIENT SERVICES	0	0	0.000000	0	0	93.00
93.01	04951	GENESIS	192,848	4,079,899	0.047268	1,420	67	93.01
93.02	04952	HOWARD COUNTY CSS	48,692	81,402	0.598167	0	0	93.02
93.03	04953	TIPTON BH CLINIC	80,025	385,569	0.207550	0	0	93.03
93.04	04954	PSYCH MEDICATION	0	0	0.000000	0	0	93.04
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	7,347,447	693,964,476		43,588,687	529,820	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part III Date/Time Prepared: 5/24/2024 12:12 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
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	18,035	0.00	3,830	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,545	0.00	396	31.00
43.00	04300	NURSERY		0	625	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	20,205		4,226	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
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/24/2024 12:12 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	WOUND CARE CENTER	0	0	0	0	0	75.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
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						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
93.00	04950	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
93.01	04951	GENESIS	0	0	0	0	0	93.01
93.02	04952	HOWARD COUNTY CSS	0	0	0	0	0	93.02
93.03	04953	TIPTON BH CLINIC	0	0	0	0	0	93.03
93.04	04954	PSYCH MEDICATION	0	0	0	0	0	93.04
		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: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/24/2024 12:12 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	82,402,233	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,837,793	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	32,794,088	0.000000	54.00
54.01	03480	ONCOLOGY	0	0	0	52,347,253	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	56,430,092	0.000000	57.00
58.00	05800	MRI	0	0	0	19,882,470	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	56,142,079	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	45,305,286	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	17,221,219	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,479,486	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,097,185	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	331,055	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	15,627,480	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,678,704	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	14,593,256	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14,342,894	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	155,921,339	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	992,759	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
75.01	03950	WOUND CARE CENTER	0	0	0	4,537,896	0.000000	75.01
76.00	03160	CARDIOPULMONARY	0	0	0	2,046,524	0.000000	76.00
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						
91.00	09100	EMERGENCY	0	0	0	106,832,629	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,573,886	0.000000	92.00
93.00	04950	OTHER OUTPATIENT SERVICES	0	0	0	0	0.000000	93.00
93.01	04951	GENESIS	0	0	0	4,079,899	0.000000	93.01
93.02	04952	HOWARD COUNTY CSS	0	0	0	81,402	0.000000	93.02
93.03	04953	TIPTON BH CLINIC	0	0	0	385,569	0.000000	93.03
93.04	04954	PSYCH MEDICATION	0	0	0	0	0.000000	93.04
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	693,964,476		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/24/2024 12:12 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	8,735,760	0	10,152,964	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,173,114	0	5,781,940	0	54.00
54.01	03480	ONCOLOGY	0.000000	64,886	0	19,320,336	0	54.01
57.00	05700	CT SCAN	0.000000	3,584,133	0	9,313,198	0	57.00
58.00	05800	MRI	0.000000	433,968	0	4,332,117	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	5,094,683	0	11,912,609	0	59.00
60.00	06000	LABORATORY	0.000000	4,310,124	0	4,197,766	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	3,824,105	0	1,001,639	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	395,397	0	34,363	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	318,791	0	4,550	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	77,195	0	1,658	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,237,610	0	2,962,654	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	258,739	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	2,116,874	0	1,778,201	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,642,226	0	2,364,649	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	3,816,667	0	48,796,287	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	290,257	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	03950	WOUND CARE CENTER	0.000000	99,495	0	1,319,583	0	75.01
76.00	03160	CARDIOPULMONARY	0.000000	372	0	751,465	0	76.00
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						
91.00	09100	EMERGENCY	0.000000	5,962,073	0	10,661,462	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	409,537	0	362,588	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICES	0.000000	0	0	0	0	93.00
93.01	04951	GENESIS	0.000000	1,420	0	205,556	0	93.01
93.02	04952	HOWARD COUNTY CSS	0.000000	0	0	0	0	93.02
93.03	04953	TIPTON BH CLINIC	0.000000	0	0	0	0	93.03
93.04	04954	PSYCH MEDICATION	0.000000	0	0	0	0	93.04
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		43,588,687	0	135,514,324	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/24/2024 12:12 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	0.122828	10,152,964	0	0	1,247,068	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.762016	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.191500	5,781,940	0	0	1,107,242	54.00
54.01	03480	ONCOLOGY	0.163650	19,320,336	60	120	3,161,773	54.01
57.00	05700	CT SCAN	0.026750	9,313,198	0	0	249,128	57.00
58.00	05800	MRI	0.039023	4,332,117	0	0	169,052	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.044025	11,912,609	0	0	524,453	59.00
60.00	06000	LABORATORY	0.199045	4,197,766	940	0	835,544	60.00
65.00	06500	RESPIRATORY THERAPY	0.157798	1,001,639	0	0	158,057	65.00
66.00	06600	PHYSICAL THERAPY	0.650354	34,363	0	0	22,348	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.676321	4,550	0	0	3,077	67.00
68.00	06800	SPEECH PATHOLOGY	0.692797	1,658	0	0	1,149	68.00
69.00	06900	ELECTROCARDIOLOGY	0.148808	2,962,654	0	0	440,867	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.240218	258,739	0	0	62,154	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.616412	1,778,201	0	0	1,096,104	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.462206	2,364,649	0	0	1,092,955	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.206014	48,796,287	0	34,145	10,052,718	73.00
74.00	07400	RENAL DIALYSIS	0.470831	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	03950	WOUND CARE CENTER	0.242359	1,319,583	0	0	319,813	75.01
76.00	03160	CARDIOPULMONARY	0.183216	751,465	0	0	137,680	76.00
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						
91.00	09100	EMERGENCY	0.085768	10,661,462	0	628	914,412	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.705420	362,588	0	0	255,777	92.00
93.00	04950	OTHER OUTPATIENT SERVICES	0.000000	0	0	0	0	93.00
93.01	04951	GENESIS	1.000240	205,556	0	0	205,605	93.01
93.02	04952	HOWARD COUNTY CSS	9.387411	0	0	0	0	93.02
93.03	04953	TIPTON BH CLINIC	2.832108	0	0	0	0	93.03
93.04	04954	PSYCH MEDICATION	0.000000	0	0	0	0	93.04
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.398215		0			95.00
200.00		Subtotal (see instructions)		135,514,324	1,000	34,893	22,056,976	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		135,514,324	1,000	34,893	22,056,976	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/24/2024 12:12 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03480	ONCOLOGY	10	20		54.01
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	187	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,034		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
75.01	03950	WOUND CARE CENTER	0	0		75.01
76.00	03160	CARDIOPULMONARY	0	0		76.00
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				
91.00	09100	EMERGENCY	0	54		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.00	04950	OTHER OUTPATIENT SERVICES	0	0		93.00
93.01	04951	GENESIS	0	0		93.01
93.02	04952	HOWARD COUNTY CSS	0	0		93.02
93.03	04953	TIPTON BH CLINIC	0	0		93.03
93.04	04954	PSYCH MEDICATION	0	0		93.04
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	197	7,108		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	197	7,108		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/24/2024 12:12 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.122828	0	685,530	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.762016	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.191500	0	422,910	0	0	54.00
54.01	03480	ONCOLOGY	0.163650	0	539,855	0	0	54.01
57.00	05700	CT SCAN	0.026750	0	1,031,915	0	0	57.00
58.00	05800	MRI	0.039023	0	180,508	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.044025	0	56,900	0	0	59.00
60.00	06000	LABORATORY	0.199045	0	566,481	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.157798	0	82,534	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.650354	0	6,772	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.676321	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.692797	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.148808	0	134,817	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.240218	0	9,810	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.616412	0	13,327	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.462206	0	50,024	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.206014	0	1,972,539	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.470831	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	03950	WOUND CARE CENTER	0.242359	0	66,871	0	0	75.01
76.00	03160	CARDIOPULMONARY	0.183216	0	15,577	0	0	76.00
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						
91.00	09100	EMERGENCY	0.085768	0	3,360,647	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.705420	0	0	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICES	0.000000	0	0	0	0	93.00
93.01	04951	GENESIS	1.000240	0	239,851	0	0	93.01
93.02	04952	HOWARD COUNTY CSS	9.387411	0	11,298	0	0	93.02
93.03	04953	TIPTON BH CLINIC	2.832108	0	37,045	0	0	93.03
93.04	04954	PSYCH MEDICATION	0.000000	0	0	0	0	93.04
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.398215	0	0			95.00
200.00		Subtotal (see instructions)		0	9,485,211	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	9,485,211	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/24/2024 12:12 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	84,202	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	80,987	0		54.00
54.01	03480	ONCOLOGY	88,347	0		54.01
57.00	05700	CT SCAN	27,604	0		57.00
58.00	05800	MRI	7,044	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	2,505	0		59.00
60.00	06000	LABORATORY	112,755	0		60.00
65.00	06500	RESPIRATORY THERAPY	13,024	0		65.00
66.00	06600	PHYSICAL THERAPY	4,404	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	20,062	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,357	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,215	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,121	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	406,371	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
75.01	03950	WOUND CARE CENTER	16,207	0		75.01
76.00	03160	CARDIOPULMONARY	2,854	0		76.00
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				
91.00	09100	EMERGENCY	288,236	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.00	04950	OTHER OUTPATIENT SERVICES	0	0		93.00
93.01	04951	GENESIS	239,909	0		93.01
93.02	04952	HOWARD COUNTY CSS	106,059	0		93.02
93.03	04953	TIPTON BH CLINIC	104,915	0		93.03
93.04	04954	PSYCH MEDICATION	0	0		93.04
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	1,639,178	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	1,639,178	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/24/2024 12:12 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)	18,035	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	18,035	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)	15,620	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	3,830	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)	24,095,305	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	24,095,305	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	24,095,305	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)	1,336.03	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	5,116,995	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)	5,116,995	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/24/2024 12:12 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	3,713,377	1,545	2,403.48	396	951,778	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)	7,629,830	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)	13,698,603	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)	463,985	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	529,820	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	993,805	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	12,704,798	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)	2,415	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,336.03	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,226,512	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/24/2024 12:12 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,914,003	24,095,305	0.079435	3,226,512	256,298	90.00
91.00	Nursing Program cost	0	24,095,305	0.000000	3,226,512	0	91.00
92.00	Allied health cost	0	24,095,305	0.000000	3,226,512	0	92.00
93.00	All other Medical Education	0	24,095,305	0.000000	3,226,512	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/24/2024 12:12 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		10,208,819		30.00
31.00	03100	INTENSIVE CARE UNIT		2,358,425		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.122828	8,735,760	1,072,996	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.762016	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.191500	1,173,114	224,651	54.00
54.01	03480	ONCOLOGY	0.163650	64,886	10,619	54.01
57.00	05700	CT SCAN	0.026750	3,584,133	95,876	57.00
58.00	05800	MRI	0.039023	433,968	16,935	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.044025	5,094,683	224,293	59.00
60.00	06000	LABORATORY	0.199045	4,310,124	857,909	60.00
65.00	06500	RESPIRATORY THERAPY	0.157798	3,824,105	603,436	65.00
66.00	06600	PHYSICAL THERAPY	0.650354	395,397	257,148	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.676321	318,791	215,605	67.00
68.00	06800	SPEECH PATHOLOGY	0.692797	77,195	53,480	68.00
69.00	06900	ELECTROCARDIOLOGY	0.148808	1,237,610	184,166	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.240218	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.616412	2,116,874	1,304,867	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.462206	1,642,226	759,047	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.206014	3,816,667	786,287	73.00
74.00	07400	RENAL DIALYSIS	0.470831	290,257	136,662	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	03950	WOUND CARE CENTER	0.242359	99,495	24,114	75.01
76.00	03160	CARDIOPULMONARY	0.183216	372	68	76.00
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				
91.00	09100	EMERGENCY	0.085768	5,962,073	511,355	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.705420	409,537	288,896	92.00
93.00	04950	OTHER OUTPATIENT SERVICES	0.000000	0	0	93.00
93.01	04951	GENESIS	1.000240	1,420	1,420	93.01
93.02	04952	HOWARD COUNTY CSS	9.387411	0	0	93.02
93.03	04953	TIPTON BH CLINIC	2.832108	0	0	93.03
93.04	04954	PSYCH MEDICATION	0.000000	0	0	93.04
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		43,588,687	7,629,830	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)		43,588,687		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/24/2024 12:12 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,843,504		30.00
31.00	03100	INTENSIVE CARE UNIT		502,863		31.00
43.00	04300	NURSERY		490,058		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.122828	767,799	94,307	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.762016	96,267	73,357	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.191500	112,358	21,517	54.00
54.01	03480	ONCOLOGY	0.163650	1,003	164	54.01
57.00	05700	CT SCAN	0.026750	389,008	10,406	57.00
58.00	05800	MRI	0.039023	49,509	1,932	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.044025	322,124	14,182	59.00
60.00	06000	LABORATORY	0.199045	494,358	98,399	60.00
65.00	06500	RESPIRATORY THERAPY	0.157798	471,883	74,462	65.00
66.00	06600	PHYSICAL THERAPY	0.650354	39,205	25,497	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.676321	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.692797	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.148808	106,593	15,862	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.240218	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.616412	170,609	105,165	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.462206	68,601	31,708	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.206014	681,393	140,376	73.00
74.00	07400	RENAL DIALYSIS	0.470831	26,990	12,708	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	03950	WOUND CARE CENTER	0.242359	11,870	2,877	75.01
76.00	03160	CARDIOPULMONARY	0.183216	0	0	76.00
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				
91.00	09100	EMERGENCY	0.085768	714,102	61,247	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.705420	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICES	0.000000	0	0	93.00
93.01	04951	GENESIS	1.000240	285	285	93.01
93.02	04952	HOWARD COUNTY CSS	9.387411	0	0	93.02
93.03	04953	TIPTON BH CLINIC	2.832108	0	0	93.03
93.04	04954	PSYCH MEDICATION	0.000000	0	0	93.04
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,523,957	784,451	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		4,523,957		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0007	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/24/2024 12:12 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)	8,061,875	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	2,683,829	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)	46,482	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	32,046	2.04
3.00	Managed Care Simulated Payments	10,426,803	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	100.23	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)	5.25	30.00
31.00	Percentage of Medicaid patient days (see instructions)	31.69	31.00
32.00	Sum of lines 30 and 31	36.94	32.00
33.00	Allowable disproportionate share percentage (see instructions)	19.69	33.00
34.00	Disproportionate share adjustment (see instructions)	528,958	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0007	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/24/2024 12:12 pm
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Payment Adjustment			
35.00	Total uncompensated care amount (see instructions)	6,874,403,459	5,938,006,757	35.00
35.01	Factor 3 (see instructions)	0.000059646	0.000077262	35.01
35.02	Hospital UCP, including supplemental UCP (see instructions)	410,029	458,783	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	306,679	115,322	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	422,001		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)	11,775,191		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)	11,775,191	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	882,644	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	69,772	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)	12,727,607	59.00
60.00	Primary payer payments	3,400	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	12,724,207	61.00
62.00	Deductibles billed to program beneficiaries	1,311,252	62.00
63.00	Coinsurance billed to program beneficiaries	1,600	63.00
64.00	Allowable bad debts (see instructions)	68,344	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	44,424	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	20,896	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	11,455,779	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)	4,270	70.93
70.94	HRR adjustment amount (see instructions)	-1,627	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Date/Time Prepared: 5/24/2024 12:12 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)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3	0	0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		11,458,422	71.00
71.01	Sequestration adjustment (see instructions)		229,168	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		11,122,171	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)		107,083	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		288,795	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0007	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/24/2024 12:12 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,305	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	22,056,976	2.00
3.00	OPPS or REH payments	20,126,100	3.00
4.00	Outlier payment (see instructions)	39,034	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)	7,305	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	35,893	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)	35,893	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)	35,893	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	28,588	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)	7,305	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)	20,165,134	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)	3,389,196	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)	16,783,243	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)	16,783,243	30.00
31.00	Primary payer payments	3,284	31.00
32.00	Subtotal (line 30 minus line 31)	16,779,959	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)	128,222	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	83,344	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	68,657	36.00
37.00	Subtotal (see instructions)	16,863,303	37.00
38.00	MSP-LCC reconciliation amount from PS&R	302	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)	16,863,001	40.00
40.01	Sequestration adjustment (see instructions)	337,260	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	16,529,487	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)	-3,746	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: 15-0007	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/24/2024 12:12 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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I Date/Time Prepared: 5/24/2024 12:12 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		11,084,571		16,529,487	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	09/01/2023	37,600		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)		37,600		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)		11,122,171		16,529,487	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		107,083		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		3,746	6.02
7.00	Total Medicare program liability (see instructions)		11,229,254		16,525,741	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: 15-0007	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/24/2024 12:12 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

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0007	Period: From 01/01/2023 To 12/31/2023	Worksheet E-5 Date/Time Prepared: 5/24/2024 12:12 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: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G | Date/Time Prepared: 5/24/2024 12:12 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	113,377	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	10,000	0	0	0	3.00
4.00	Accounts receivable	85,494,019	0	0	0	4.00
5.00	Other receivable	4,919,661	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-65,818,797	0	0	0	6.00
7.00	Inventory	4,858,362	0	0	0	7.00
8.00	Prepaid expenses	363,003	0	0	0	8.00
9.00	Other current assets	1,366,935	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)	31,306,560	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	4,259,963	0	0	0	12.00
13.00	Land improvements	4,540,982	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	112,737,338	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	321,137	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	43,817,369	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	974,600	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	-77,524,776	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)	89,126,613	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	347,515	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	259,491,626	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	259,839,141	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	380,272,314	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	426,741	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	529,031	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	6,231,220	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,186,992	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	1,569,429	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	1,569,429	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	8,756,421	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	371,515,893				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)	371,515,893	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	380,272,314	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 5/24/2024 12:12 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		338,049,434		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		33,466,459				2.00
3.00	Total (sum of line 1 and line 2)		371,515,893		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		371,515,893		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)		371,515,893		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: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/24/2024 12:12 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	46,598,426		46,598,426	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	46,598,426		46,598,426	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	9,289,803		9,289,803	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)	9,289,803		9,289,803	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	55,888,229		55,888,229	17.00
18.00	Ancillary services	141,545,940	585,203,815	726,749,755	18.00
19.00	Outpatient services	0	0	0	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	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	387,692	387,692	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	197,434,169	585,591,507	783,025,676	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		187,084,579		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)		187,084,579		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0007 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-3 | Date/Time Prepared: 5/24/2024 12:12 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	783,025,676	1.00
2.00	Less contractual allowances and discounts on patients' accounts	577,161,978	2.00
3.00	Net patient revenues (line 1 minus line 2)	205,863,698	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	187,084,579	4.00
5.00	Net income from service to patients (line 3 minus line 4)	18,779,119	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	1,409,471	6.00
7.00	Income from investments	2,316,513	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	563,745	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	1,811,300	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC REVENUE	8,586,311	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	14,687,340	25.00
26.00	Total (line 5 plus line 25)	33,466,459	26.00
27.00	ROUNDING	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)	33,466,459	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0007	Period: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III Date/Time Prepared: 5/24/2024 12:12 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	814,134	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	5,252	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)	47.48	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	5.25	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	31.69	8.00
9.00	Sum of lines 7 and 8	36.94	9.00
10.00	Allowable disproportionate share percentage (see instructions)	7.77	10.00
11.00	Disproportionate share adjustment (see instructions)	63,258	11.00
12.00	Total prospective capital payments (see instructions)	882,644	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