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: 15-1312	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/29/2024 11:35 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/29/2024 Time: 11:35 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH WHITE HOSPITAL (15-1312) 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	Todd Williams		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	Todd Williams			2
3	Signatory Title	CHIEF FINANCIAL OFFICER			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	48,927	-918,409	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	45,427	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	TOTAL	0	94,354	-918,409	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: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2024 11:35 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 720 SOUTH SIXTH STREET	PO Box:			1.00
2.00	City: MONTICELLO	State: IN	Zip Code: 47960	County: WHITE	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	IU HEALTH WHITE HOSPITAL	151312	99915	1	07/01/1966	N	O	P	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	IU HEALTH WHITE HOSPITAL	15Z312	99915		02/16/1990	N	O	N	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	HOME CARE OF WHITE COUNTY	157514	99915		03/01/1997	N	N	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2023	12/31/2023	20.00
21.00	Type of Control (see instructions)	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.	N	N		22.00
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2024 11:35 am

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

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	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	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				58.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1312	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 11:35 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2024 11:35 am

				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2024 11:35 am

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

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

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	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: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 11:35 am

		V	XIX	
		1.00	2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		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.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2024 11:35 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	33,122	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.	Y	5.00	122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	Y	N	123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H059	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: INDIANA UNIVERSITY HEALTH	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 340 WEST 10TH STREET	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46202	143.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2024 11:35 am

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

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

			1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act			
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			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)	Y	68	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2024 11:35 am

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	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	04/01/2024	Y	04/01/2024	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: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II Date/Time Prepared: 5/29/2024 11:35 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RHONDA		UTTER		41.00
42.00	Enter the employer/company name of the cost report preparer.	INDIANA UNIVERSITY HEALTH				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317.556.3910		RUTTER@IUHEALTH.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1312	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/29/2024 11:35 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2024 11:35 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	24	8,760	44,112.00	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)		24	8,760	44,112.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		24	8,760	44,112.00	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	101.00				0	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)		24				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: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2024 11:35 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	895	18	1,838			1.00
2.00	HMO and other (see instructions)	504	110				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	236	0	236			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	346			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,131	18	2,420			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)	1,131	18	2,420	0.00	135.70	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	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			54			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	135.70	27.00
28.00	Observation Bed Days		3	678			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2024 11:35 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	264	4	516	1.00
2.00	HMO and other (see instructions)			134	31		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	264	4	516	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	0.00					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 UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1312	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/29/2024 11:35 am

		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)	0.243078	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	5,336,047	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	23,945,425	6.00
7.00	Medicaid cost (line 1 times line 6)	5,820,606	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	484,559	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)	33,649	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	138,460	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	33,657	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)	8	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)	484,567	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)	2,382,419	137,350	2,519,769	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	579,114	110,736	689,850	21.00
22.00	Payments received from patients for amounts previously written off as charity care	1,008	0	1,008	22.00
23.00	Cost of charity care (see instructions)	578,106	110,736	688,842	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)	35,161	25.01
26.00	Bad debt amount (see instructions)	2,796,191	26.00
27.00	Medicare reimbursable bad debts (see instructions)	304,551	27.00
27.01	Medicare allowable bad debts (see instructions)	468,540	27.01
28.00	Non-Medicare bad debt amount (see instructions)	2,327,651	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	729,790	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	1,418,632	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,903,199	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1312	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/29/2024 11:35 am

		1.00	
	PART II - HOSPITAL DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)		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)				20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)				21.00
22.00	Payments received from patients for amounts previously written off as charity care				22.00
23.00	Cost of charity care (see instructions)				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?		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		25.00
25.01	Charges for insured patients' liability (see instructions)		25.01
26.00	Bad debt amount (see instructions)		26.00
27.00	Medicare reimbursable bad debts (see instructions)		27.00
27.01	Medicare allowable bad debts (see instructions)		27.01
28.00	Non-Medicare bad debt amount (see instructions)		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)		29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/29/2024 11:35 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	0	0	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL		0	0	2,858,648	2,858,648	1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB		0	0	230,170	230,170	1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	797	50,075	50,872	1,889,090	1,939,962	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	431,438	11,328,176	11,759,614	-1,703,688	10,055,926	5.00
7.00	00700	OPERATION OF PLANT	511,921	2,142,202	2,654,123	-2,063,927	590,196	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	0	0	0	1,827,744	1,827,744	7.01
7.02	00702	OPERATION OF PLANT - TLMOB	0	0	0	392,508	392,508	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	57,349	57,349	8.00
9.00	00900	HOUSEKEEPING	358,933	548,926	907,859	-190,769	717,090	9.00
10.00	01000	DIETARY	462,403	446,825	909,228	-280,902	628,326	10.00
11.00	01100	CAFETERIA	0	0	0	134,768	134,768	11.00
13.00	01300	NURSING ADMINISTRATION	738,840	381,361	1,120,201	-28,655	1,091,546	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,697	3,697	297,126	300,823	14.00
15.00	01500	PHARMACY	630,676	9,169,441	9,800,117	-8,467,994	1,332,123	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,584,037	1,937,997	3,522,034	-529,360	2,992,674	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	305,970	749,485	1,055,455	-307,814	747,641	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	252,214	289,400	541,614	-217,120	324,494	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	72,709	134,488	207,197	-106,661	100,536	55.00
56.00	05600	RADIOISOTOPE	144,259	94,246	238,505	-79,866	158,639	56.00
57.00	05700	CT SCAN	490,742	204,253	694,995	-150,217	544,778	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	230,082	525,220	755,302	-504,370	250,932	58.00
60.00	06000	LABORATORY	0	2,754,066	2,754,066	-4,074	2,749,992	60.00
66.00	06600	PHYSICAL THERAPY	379,149	154,728	533,877	-99,278	434,599	66.00
67.00	06700	OCCUPATIONAL THERAPY	136,228	49,652	185,880	-15,406	170,474	67.00
68.00	06800	SPEECH PATHOLOGY	98,063	25,485	123,548	-18,182	105,366	68.00
69.00	06900	ELECTROCARDIOLOGY	131,987	72,086	204,073	-57,123	146,950	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	67,172	67,172	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,620	1,620	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	776,863	776,863	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	7,886,342	7,886,342	73.01
76.00	03160	CARDIOPULMONARY	596,094	558,283	1,154,377	-233,363	921,014	76.00
76.97	07697	CARDIAC REHABILITATION	142,092	79,229	221,321	-58,437	162,884	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	246,063	176,082	422,145	-121,688	300,457	90.00
91.00	09100	EMERGENCY	1,522,157	1,287,765	2,809,922	-535,002	2,274,920	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
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)	9,466,854	33,163,168	42,630,022	645,504	43,275,526	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	44,663	28,430	73,093	-22,826	50,267	192.00
192.02	19202	MOB	0	622,678	622,678	-622,678	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0	0	0	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	9,511,517	33,814,276	43,325,793	0	43,325,793	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/29/2024 11:35 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	23,976	23,976		1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL	216,521	3,075,169		1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB	242,024	472,194		1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-262,563	1,677,399		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,280,258	8,775,668		5.00
7.00	00700	OPERATION OF PLANT	-26,539	563,657		7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	50,637	1,878,381		7.01
7.02	00702	OPERATION OF PLANT - TLMOB	0	392,508		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	57,349		8.00
9.00	00900	HOUSEKEEPING	0	717,090		9.00
10.00	01000	DIETARY	-263,898	364,428		10.00
11.00	01100	CAFETERIA	0	134,768		11.00
13.00	01300	NURSING ADMINISTRATION	311,416	1,402,962		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	300,823		14.00
15.00	01500	PHARMACY	299,550	1,631,673		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-548,222	2,444,452		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-95,581	652,060		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	126,489	450,983		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	100,536		55.00
56.00	05600	RADIOISOTOPE	0	158,639		56.00
57.00	05700	CT SCAN	0	544,778		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	250,932		58.00
60.00	06000	LABORATORY	0	2,749,992		60.00
66.00	06600	PHYSICAL THERAPY	0	434,599		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	170,474		67.00
68.00	06800	SPEECH PATHOLOGY	0	105,366		68.00
69.00	06900	ELECTROCARDIOLOGY	0	146,950		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	67,172		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,620		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	776,863		73.00
73.01	07301	ONCOLOGY DRUGS	0	7,886,342		73.01
76.00	03160	CARDIOPULMONARY	31,915	952,929		76.00
76.97	07697	CARDIAC REHABILITATION	0	162,884		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	300,457		90.00
91.00	09100	EMERGENCY	39,869	2,314,789		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,134,664	42,140,862		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	50,267		192.00
192.02	19202	MOB	0	0		192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0		192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0		192.04
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,134,664	42,191,129		200.00

RECLASSIFICATIONS | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/29/2024 11:35 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	63,721	71,047		1.00
	0		63,721	71,047		
	B - DRUGS EXPENSE					
1.00	DRUGS CHARGED TO PATIENTS	73.00		776,863		1.00
2.00	ONCOLOGY DRUGS	73.01		7,886,342		2.00
3.00	DIETARY	10.00	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
	0		0	8,663,205		
	C - MEDICAL SUPPLIES AND REBATES					
1.00	CENTRAL SERVICES & SUPPLY	14.00		312,275		1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00		67,172		2.00
3.00	IMPL. DEV. CHARGED TO PATIENTS	72.00		1,620		3.00
4.00	ADMINISTRATIVE & GENERAL	5.00		58		4.00
5.00	HOUSEKEEPING	9.00		3		5.00
6.00	DIETARY	10.00		70		6.00
7.00	NURSING ADMINISTRATION	13.00		5		7.00
8.00	RADIOLOGY-THERAPEUTIC	55.00		110		8.00
9.00	CT SCAN					9.00
10.00	MAGNETIC RESONANCE IMAGING (MRI)					10.00
11.00	LABORATORY					11.00
12.00	PHYSICIANS PRIVATE OFFICES					12.00
13.00						13.00
14.00						14.00
15.00						15.00
16.00						16.00
	0		0	381,313		
	D - LAUNDRY					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	57,349		1.00
	0		0	57,349		
	E - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	0	1,885,991		1.00
2.00	CAP REL COSTS-BLDG & FIXT - TLMOB	1.02	0	215,285		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
	0		0	2,101,276		
	F - OTHER CAPITAL EXPENSES					
1.00	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01		42,854		1.00
2.00	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01		892,146		2.00
3.00	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01		37,657		3.00

RECLASSIFICATIONS | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/29/2024 11:35 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
4.00	CAP REL COSTS-BLDG & FIXT - TLMOB	1.02		14,885		4.00
	0		0	987,542		
	G - OPERATION OF PLANT					
1.00	OPERATION OF PLANT - HOSPITAL	7.01	0	1,827,744		1.00
2.00	OPERATION OF PLANT - TLMOB	7.02	0	392,508		2.00
	0		0	2,220,252		
	H - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,890,269		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
	0		0	1,890,269		
	I - HOUSEKEEPING SUPPLIES					
1.00	HOUSEKEEPING	9.00	0	4,901		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
	0		0	4,901		
	K - CNO					
1.00	NURSING ADMINISTRATION	13.00	121,164	0		1.00
	0		121,164	0		
500.00	Grand Total: Increases		184,885	16,377,154		500.00

RECLASSIFICATIONS | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/29/2024 11:35 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	63,721	71,047	0		1.00
	0		63,721	71,047			
	B - DRUGS EXPENSE						
1.00	PHARMACY	15.00		8,290,118	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00		15,147	0		2.00
3.00	ADULTS & PEDIATRICS	30.00		33,593	0		3.00
4.00	OPERATING ROOM	50.00		9,910	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00		2,085	0		5.00
6.00	RADIOLOGY-THERAPEUTIC	55.00		31,525	0		6.00
7.00	RADIOISOTOPE	56.00		11,424	0		7.00
8.00	CT SCAN	57.00		88,930	0		8.00
9.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00		34,600	0		9.00
10.00	ELECTROCARDIOLOGY	69.00		1,383	0		10.00
11.00	CARDIOPULMONARY	76.00		14,062	0		11.00
12.00	CLINIC	90.00		31,142	0		12.00
13.00	EMERGENCY	91.00		99,286	0		13.00
14.00	EMPLOYEE BENEFITS DEPARTMENT				0		14.00
	0		0	8,663,205			
	C - MEDICAL SUPPLIES AND REBATES						
1.00	OPERATION OF PLANT	7.00		33,647	0		1.00
2.00	PHARMACY	15.00		11,198	0		2.00
3.00	ADULTS & PEDIATRICS	30.00		75,984	0		3.00
4.00	OPERATING ROOM	50.00		66,890	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00		1,083	0		5.00
6.00	RADIOISOTOPE	56.00		12,414	0		6.00
7.00	CT SCAN	57.00		5,523	0		7.00
8.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00		550	0		8.00
9.00	LABORATORY	60.00		4,074	0		9.00
10.00	PHYSICAL THERAPY	66.00		1,612	0		10.00
11.00	ELECTROCARDIOLOGY	69.00		8,736	0		11.00
12.00	CARDIOPULMONARY	76.00		32,416	0		12.00
13.00	CARDIAC REHABILITATION	76.97		111	0		13.00
14.00	CLINIC	90.00		24,310	0		14.00
15.00	EMERGENCY	91.00		102,726	0		15.00
16.00	PHYSICIANS' PRIVATE OFFICES	192.00		39	0		16.00
	0		0	381,313			
	D - LAUNDRY						
1.00	HOUSEKEEPING	9.00	0	57,349	0		1.00
	0		0	57,349			
	E - DEPRECIATION						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,179	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	620,848	9		2.00
3.00	OPERATION OF PLANT	7.00	0	53,334	0		3.00
4.00	DIETARY	10.00	0	19,377	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	6,840	0		5.00
6.00	PHARMACY	15.00	0	51,825	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	107,760	0		7.00
8.00	OPERATING ROOM	50.00	0	188,830	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	169,632	0		9.00
10.00	RADIOLOGY-THERAPEUTIC	55.00	0	53,930	0		10.00
11.00	RADIOISOTOPE	56.00	0	23,015	0		11.00
12.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	441,273	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	527	0		13.00
14.00	ELECTROCARDIOLOGY	69.00	0	3,890	0		14.00
15.00	CARDIOPULMONARY	76.00	0	59,405	0		15.00
16.00	CARDIAC REHABILITATION	76.97	0	9,795	0		16.00
17.00	CLINIC	90.00	0	151	0		17.00
18.00	EMERGENCY	91.00	0	73,483	0		18.00
19.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	897	0		19.00
20.00	MOB	192.02	0	215,285	0		20.00
	0		0	2,101,276			
	F - OTHER CAPITAL EXPENSES						
1.00	OPERATION OF PLANT	7.00		42,854	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00		892,146	11		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00		37,657	12		3.00
4.00	MOB	192.02		14,885	13		4.00
	0		0	987,542			

RECLASSIFICATIONS | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/29/2024 11:35 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	G - OPERATION OF PLANT						
1.00	OPERATION OF PLANT	7.00	0	1,827,744	0		1.00
2.00	MOB	192.02	0	392,508	0		2.00
	0		0	2,220,252			
	H - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00		31,927	0		1.00
2.00	OPERATION OF PLANT	7.00		106,348	0		2.00
3.00	HOUSEKEEPING	9.00		138,324	0		3.00
4.00	DIETARY	10.00		126,827	0		4.00
5.00	NURSING ADMINISTRATION	13.00		142,941	0		5.00
6.00	PHARMACY	15.00		112,125	0		6.00
7.00	ADULTS & PEDIATRICS	30.00		310,709	0		7.00
8.00	OPERATING ROOM	50.00		42,176	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00		44,182	0		9.00
10.00	RADIOLOGY-THERAPEUTIC	55.00		21,316	0		10.00
11.00	RADIOISOTOPE	56.00		32,991	0		11.00
12.00	CT SCAN	57.00		55,748	0		12.00
13.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00		27,947	0		13.00
14.00	PHYSICAL THERAPY	66.00		97,125	0		14.00
15.00	OCCUPATIONAL THERAPY	67.00		15,406	0		15.00
16.00	SPEECH PATHOLOGY	68.00		18,179	0		16.00
17.00	ELECTROCARDIOLOGY	69.00		43,107	0		17.00
18.00	CARDIOPULMONARY	76.00		127,473	0		18.00
19.00	CARDIAC REHABILITATION	76.97		48,450	0		19.00
20.00	CLINIC	90.00		66,014	0		20.00
21.00	EMERGENCY	91.00		259,106	0		21.00
22.00	PHYSICIANS' PRIVATE OFFICES	192.00		21,848	0		22.00
	0		0	1,890,269			
	I - HOUSEKEEPING SUPPLIES						
1.00	ADMINISTRATIVE & GENERAL	5.00		4	0		1.00
2.00	NURSING ADMINISTRATION	13.00		43	0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00		2	0		3.00
4.00	PHARMACY	15.00		2,728	0		4.00
5.00	ADULTS & PEDIATRICS	30.00		1,314	0		5.00
6.00	OPERATING ROOM	50.00		8	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00		138	0		7.00
8.00	RADIOISOTOPE	56.00		22	0		8.00
9.00	CT SCAN	57.00		16	0		9.00
10.00	PHYSICAL THERAPY	66.00		14	0		10.00
11.00	SPEECH PATHOLOGY	68.00		3	0		11.00
12.00	ELECTROCARDIOLOGY	69.00		7	0		12.00
13.00	CARDIOPULMONARY	76.00		7	0		13.00
14.00	CARDIAC REHABILITATION	76.97		81	0		14.00
15.00	CLINIC	90.00		71	0		15.00
16.00	EMERGENCY	91.00		401	0		16.00
17.00	PHYSICIANS' PRIVATE OFFICES	192.00		42	0		17.00
18.00	PHYSICIANS PRIVATE OFFICES				0		18.00
	0		0	4,901			
	K - CNO						
1.00	ADMINISTRATIVE & GENERAL	5.00	121,164	0	0		1.00
	0		121,164	0			
500.00	Grand Total: Decreases		184,885	16,377,154			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 5/29/2024 11:35 am

		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	954,570	0	0	0	0	1.00
2.00	Land Improvements	704,200	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	37,698,656	0	0	0	3,280,996	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	11,698,266	769,352	0	769,352	767,624	6.00
7.00	HIT designated Assets	15,000	0	0	0	15,000	7.00
8.00	Subtotal (sum of lines 1-7)	51,070,692	769,352	0	769,352	4,063,620	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	51,070,692	769,352	0	769,352	4,063,620	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	954,570	0	1.00
2.00	Land Improvements	704,200	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	34,417,660	83,539	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	11,699,994	3,989,169	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	47,776,424	4,072,708	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	47,776,424	4,072,708	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part II | Date/Time Prepared: 5/29/2024 11:35 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0	0	0	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	0	0	0	1.02
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	1.02
3.00	Total (sum of lines 1-2)	0	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part III | Date/Time Prepared: 5/29/2024 11:35 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,658,770	0	1,658,770	0.034719	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	32,467,637	0	32,467,637	0.679575	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	13,650,018	0	13,650,018	0.285706	0	1.02
3.00	Total (sum of lines 1-2)	47,776,425	0	47,776,425	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	23,976	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0	0	2,145,410	42,854	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	0	457,309	0	1.02
3.00	Total (sum of lines 1-2)	0	0	0	2,626,695	42,854	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	23,976	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	849,248	37,657	0	0	3,075,169	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	14,885	0	472,194	1.02
3.00	Total (sum of lines 1-2)	849,248	37,657	14,885	0	3,571,339	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/29/2024 11:35 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT - HOSPITAL (chapter 2)	B	-2,303,837	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	11	1.01
1.02	Investment income - CAP REL COSTS-BLDG & FIXT - TLMOB (chapter 2)		0	CAP REL COSTS-BLDG & FIXT - TLMOB	1.02	0	1.02
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-772,530			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	6,587,028			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	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	*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	23,976	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT - HOSPITAL	A	161,891	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	9	26.01
26.02	Depreciation - CAP REL COSTS-BLDG & FIXT - TLMOB	A	242,024	CAP REL COSTS-BLDG & FIXT - TLMOB	1.02	9	26.02
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/29/2024 11:35 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
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
33.00	EMPLOYEE BENEFITS	A	-1,890,472	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	LOSS ON ABANDONMENT	A	97,528	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	9	33.01
33.02	MEDICAID HAF FEES	A	-2,928,993	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	MISCELLANEOUS INCOME	B	-5,313	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	MISCELLANEOUS INCOME	B	-36,067	PHARMACY	15.00	0	33.04
33.05	MISCELLANEOUS INCOME	B	-360	RADIOLOGY-DIAGNOSTIC	54.00	0	33.05
33.06	MISCELLANEOUS INCOME	B	-2,000	NURSING ADMINISTRATION	13.00	0	33.06
33.07	WIC PROGRAM COSTS	A	-263,898	DIETARY	10.00	0	33.07
33.08	WIC PROGRAM BENEFIT COSTS	A	-32,236	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.09	CONTRIBUTION EXPENSE	A	-11,405	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.10
33.11	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.11
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,134,664				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: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2024 11:35 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.01	CAP REL COSTS-BLDG & FIXT -	HOME OFFICE ALLOCATION	3,195,939	935,000	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOCATION	1,660,145	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	6,329,836	5,476,981	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	POOLED CAPITAL - H.O.	275,908	0	3.01
4.00	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY	1,688,140	1,151,450	4.00
4.01	7.00	OPERATION OF PLANT	RELATED PARTY	0	26,539	4.01
4.02	7.01	OPERATION OF PLANT - HOSPITA	RELATED PARTY	99,951	49,314	4.02
4.03	13.00	NURSING ADMINISTRATION	RELATED PARTY	399,788	86,372	4.03
4.04	15.00	PHARMACY	RELATED PARTY	725,913	390,296	4.04
4.05	30.00	ADULTS & PEDIATRICS	RELATED PARTY	173,914	147,405	4.05
4.06	50.00	OPERATING ROOM	RELATED PARTY	216,228	114,010	4.06
4.07	54.00	RADIOLOGY-DIAGNOSTIC	RELATED PARTY	126,849	0	4.07
4.08	76.00	CARDIOPULMONARY	RELATED PARTY	132,025	100,110	4.08
4.09	91.00	EMERGENCY	RELATED PARTY	119,842	79,973	4.09
4.10	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	574,731	574,731	4.10
4.12	50.00	OPERATING ROOM	SHARED EMPLOYEES	197,799	197,799	4.12
4.13	60.00	LABORATORY	SHARED EMPLOYEES	2,538,523	2,538,523	4.13
4.14	69.00	ELECTROCARDIOLOGY	SHARED EMPLOYEES	188	188	4.14
4.15	91.00	EMERGENCY	SHARED EMPLOYEES	265,879	265,879	4.15
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			18,721,598	12,134,570	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	IU HEALTH	100.00		0.00	6.00
7.00	B	IUH ARNETT	1.00		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: 15-1312	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8-1 Date/Time Prepared: 5/29/2024 11:35 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	2,260,939	11		1.00
2.00	1,660,145	0		2.00
3.00	852,855	0		3.00
3.01	275,908	0		3.01
4.00	536,690	0		4.00
4.01	-26,539	0		4.01
4.02	50,637	0		4.02
4.03	313,416	0		4.03
4.04	335,617	0		4.04
4.05	26,509	0		4.05
4.06	102,218	0		4.06
4.07	126,849	0		4.07
4.08	31,915	0		4.08
4.09	39,869	0		4.09
4.10	0	0		4.10
4.12	0	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
4.15	0	0		4.15
5.00	6,587,028			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: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2024 11:35 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	574,731	574,731	0	0	0	1.00
2.00	50.00	OPERATING ROOM	197,799	197,799	0	0	0	2.00
3.00	91.00	EMERGENCY	185,883	0	185,883	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			958,413	772,530	185,883		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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			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	30.00	ADULTS & PEDIATRICS	0	0	0	574,731		1.00
2.00	50.00	OPERATING ROOM	0	0	0	197,799		2.00
3.00	91.00	EMERGENCY	0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	772,530		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/29/2024 11:35 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	BLDG & FIXT - HOSPITAL	BLDG & FIXT - TLMOB	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	1.01	1.02	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	23,976	23,976				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL	3,075,169	0	3,075,169			1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB	472,194	0	0	472,194		1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,677,399	0	0	0	1,677,399	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,775,668	2,351	119,914	91,243	54,723	5.00
7.00	00700	OPERATION OF PLANT	563,657	0	0	0	90,287	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	1,878,381	1,517	315,295	0	0	7.01
7.02	00702	OPERATION OF PLANT - TLMOB	392,508	1,149	0	59,081	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	57,349	126	26,214	0	0	8.00
9.00	00900	HOUSEKEEPING	717,090	394	75,295	1,634	63,305	9.00
10.00	01000	DIETARY	364,428	951	0	48,916	70,315	10.00
11.00	01100	CAFETERIA	134,768	388	0	19,948	11,238	11.00
13.00	01300	NURSING ADMINISTRATION	1,402,962	397	43,761	9,592	151,678	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	300,823	1,119	232,535	0	0	14.00
15.00	01500	PHARMACY	1,631,673	475	98,849	0	111,232	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,444,452	2,630	546,846	0	279,377	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	652,060	2,055	427,144	0	53,964	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	450,983	759	157,712	0	44,483	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	100,536	157	32,563	0	12,824	55.00
56.00	05600	RADIOISOTOPE	158,639	108	22,438	0	25,443	56.00
57.00	05700	CT SCAN	544,778	148	30,676	0	86,552	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	250,932	208	43,246	0	40,579	58.00
60.00	06000	LABORATORY	2,749,992	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	434,599	671	139,392	0	66,870	66.00
67.00	06700	OCCUPATIONAL THERAPY	170,474	53	11,069	0	24,026	67.00
68.00	06800	SPEECH PATHOLOGY	105,366	25	5,191	0	17,295	68.00
69.00	06900	ELECTROCARDIOLOGY	146,950	224	46,507	0	23,278	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	67,172	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,620	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	776,863	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	7,886,342	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	952,929	475	98,677	0	105,133	76.00
76.97	07697	CARDIAC REHABILITATION	162,884	353	0	18,166	25,061	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	300,457	1,436	298,606	0	43,398	90.00
91.00	09100	EMERGENCY	2,314,789	1,459	303,239	0	268,461	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
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)	42,140,862	19,628	3,075,169	248,580	1,669,522	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	50,267	840	0	43,176	7,877	192.00
192.02	19202	MOB	0	2,694	0	138,578	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	814	0	41,860	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	42,191,129	23,976	3,075,169	472,194	1,677,399	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/29/2024 11:35 am

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - HOSPITAL	OPERATION OF PLANT - TLMOB	
			4A	5.00	7.00	7.01	7.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,043,899	9,043,899				5.00
7.00	00700	OPERATION OF PLANT	653,944	178,422	832,366			7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	2,195,193	598,936	58,378	2,852,507		7.01
7.02	00702	OPERATION OF PLANT - TLMOB	452,738	123,525	44,231	0	620,494	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	83,689	22,834	4,854	28,324	0	8.00
9.00	00900	HOUSEKEEPING	857,718	234,020	15,165	81,357	3,150	9.00
10.00	01000	DIETARY	484,610	132,221	36,621	0	94,299	10.00
11.00	01100	CAFETERIA	166,342	45,385	14,934	0	38,456	11.00
13.00	01300	NURSING ADMINISTRATION	1,608,390	438,833	15,276	47,285	18,492	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	534,477	145,827	43,055	251,257	0	14.00
15.00	01500	PHARMACY	1,842,229	502,634	18,302	106,807	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,273,305	893,089	101,251	590,871	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,135,223	309,734	79,088	461,534	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	653,937	178,420	29,201	170,410	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	146,080	39,856	6,029	35,185	0	55.00
56.00	05600	RADIOISOTOPE	206,628	56,376	4,155	24,245	0	56.00
57.00	05700	CT SCAN	662,154	180,662	5,680	33,146	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	334,965	91,392	8,007	46,728	0	58.00
60.00	06000	LABORATORY	2,749,992	750,308	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	641,532	175,036	25,809	150,615	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	205,622	56,102	2,049	11,960	0	67.00
68.00	06800	SPEECH PATHOLOGY	127,877	34,890	961	5,609	0	68.00
69.00	06900	ELECTROCARDIOLOGY	216,959	59,195	8,611	50,251	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	67,172	18,327	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,620	442	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	776,863	211,959	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	7,886,342	2,151,718	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	1,157,214	315,734	18,271	106,622	0	76.00
76.97	07697	CARDIAC REHABILITATION	206,464	56,332	13,600	0	35,020	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	643,897	175,681	55,288	322,647	0	90.00
91.00	09100	EMERGENCY	2,887,948	787,948	56,146	327,654	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
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)	41,905,023	8,965,838	664,962	2,852,507	189,417	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	102,160	27,873	32,323	0	83,233	192.00
192.02	19202	MOB	141,272	38,545	103,743	0	267,147	192.02
192.03	19203	ARNETT SURGERY OFFICE	42,674	11,643	31,338	0	80,697	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	42,191,129	9,043,899	832,366	2,852,507	620,494	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/29/2024 11:35 am

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - TLMOB						7.02
8.00	00800	LAUNDRY & LINEN SERVICE	139,701					8.00
9.00	00900	HOUSEKEEPING	0	1,191,410				9.00
10.00	01000	DIETARY	0	33,901	781,652			10.00
11.00	01100	CAFETERIA	0	13,813	0	278,930		11.00
13.00	01300	NURSING ADMINISTRATION	0	6,323	0	21,899	2,156,498	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,917	0	0	0	14.00
15.00	01500	PHARMACY	0	14,932	0	15,515	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	139,701	230,112	781,652	51,542	891,017	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	168,777	0	10,256	172,632	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	64,106	0	8,477	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	6,177	0	2,015	0	55.00
56.00	05600	RADIOISOTOPE	0	9,144	0	4,186	4,280	56.00
57.00	05700	CT SCAN	0	12,452	0	15,306	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	17,607	0	7,116	0	58.00
60.00	06000	LABORATORY	0	32,442	0	32,783	0	60.00
66.00	06600	PHYSICAL THERAPY	0	35,555	0	12,689	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,821	0	3,113	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,313	0	2,486	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	18,969	0	4,526	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	20,039	0	18,236	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	16,635	0	4,919	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	67,608	0	10,021	169,258	90.00
91.00	09100	EMERGENCY	0	217,610	0	51,202	919,311	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
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)	139,701	1,002,253	781,652	276,287	2,156,498	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	48,250	0	2,643	0	192.00
192.02	19202	MOB	0	91,052	0	0	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	49,855	0	0	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	139,701	1,191,410	781,652	278,930	2,156,498	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/29/2024 11:35 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	15.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - TLMOB						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	986,533					14.00
15.00	01500	PHARMACY	34,444	2,534,863				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	179,084	7,514	0	7,139,138	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	106,814	1,858	0	2,445,916	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,134	64	0	1,107,749	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,176	315	0	238,833	0	55.00
56.00	05600	RADIOISOTOPE	35,714	3,003	0	347,731	0	56.00
57.00	05700	CT SCAN	28,061	1,714	0	939,175	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,933	1,047	0	508,795	0	58.00
60.00	06000	LABORATORY	10,938	0	0	3,576,463	0	60.00
66.00	06600	PHYSICAL THERAPY	4,388	0	0	1,045,624	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	281,667	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	173,136	0	68.00
69.00	06900	ELECTROCARDIOLOGY	23,604	0	0	382,115	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	179,602	0	0	265,101	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,332	0	0	6,394	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	223,056	0	1,211,878	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	2,264,360	0	12,302,420	0	73.01
76.00	03160	CARDIOPULMONARY	89,510	16	0	1,725,642	0	76.00
76.97	07697	CARDIAC REHABILITATION	513	0	0	333,483	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	62,820	7,567	0	1,514,787	0	90.00
91.00	09100	EMERGENCY	218,169	24,349	0	5,490,337	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
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)	986,236	2,534,863	0	41,036,384	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	297	0	0	296,779	0	192.00
192.02	19202	MOB	0	0	0	641,759	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0	0	216,207	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	986,533	2,534,863	0	42,191,129	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/29/2024 11:35 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL			1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB			1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL			7.01
7.02	00702	OPERATION OF PLANT - TLMOB			7.02
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	7,139,138		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	2,445,916		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,107,749		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	238,833		55.00
56.00	05600	RADIOISOTOPE	347,731		56.00
57.00	05700	CT SCAN	939,175		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	508,795		58.00
60.00	06000	LABORATORY	3,576,463		60.00
66.00	06600	PHYSICAL THERAPY	1,045,624		66.00
67.00	06700	OCCUPATIONAL THERAPY	281,667		67.00
68.00	06800	SPEECH PATHOLOGY	173,136		68.00
69.00	06900	ELECTROCARDIOLOGY	382,115		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	265,101		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,394		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,211,878		73.00
73.01	07301	ONCOLOGY DRUGS	12,302,420		73.01
76.00	03160	CARDIOPULMONARY	1,725,642		76.00
76.97	07697	CARDIAC REHABILITATION	333,483		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		78.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	1,514,787		90.00
91.00	09100	EMERGENCY	5,490,337		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0		92.01
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		102.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	41,036,384		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
191.00	19100	RESEARCH	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	296,779		192.00
192.02	19202	MOB	641,759		192.02
192.03	19203	ARNETT SURGERY OFFICE	216,207		192.03
192.04	19201	OCCUPATIONAL MEDICINE	0		192.04
193.00	19300	NONPAID WORKERS	0		193.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	42,191,129		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/29/2024 11:35 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				BLDG & FIXT	BLDG & FIXT - HOSPITAL	BLDG & FIXT - TLMOB	Subtotal	
			0	1.00	1.01	1.02	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	275,908	2,351	119,914	91,243	489,416	5.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	0	1,517	315,295	0	316,812	7.01
7.02	00702	OPERATION OF PLANT - TLMOB	0	1,149	0	59,081	60,230	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	126	26,214	0	26,340	8.00
9.00	00900	HOUSEKEEPING	0	394	75,295	1,634	77,323	9.00
10.00	01000	DIETARY	0	951	0	48,916	49,867	10.00
11.00	01100	CAFETERIA	0	388	0	19,948	20,336	11.00
13.00	01300	NURSING ADMINISTRATION	0	397	43,761	9,592	53,750	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,119	232,535	0	233,654	14.00
15.00	01500	PHARMACY	0	475	98,849	0	99,324	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,630	546,846	0	549,476	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,055	427,144	0	429,199	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	759	157,712	0	158,471	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	157	32,563	0	32,720	55.00
56.00	05600	RADIOISOTOPE	0	108	22,438	0	22,546	56.00
57.00	05700	CT SCAN	0	148	30,676	0	30,824	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	208	43,246	0	43,454	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0	671	139,392	0	140,063	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	53	11,069	0	11,122	67.00
68.00	06800	SPEECH PATHOLOGY	0	25	5,191	0	5,216	68.00
69.00	06900	ELECTROCARDIOLOGY	0	224	46,507	0	46,731	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	475	98,677	0	99,152	76.00
76.97	07697	CARDIAC REHABILITATION	0	353	0	18,166	18,519	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,436	298,606	0	300,042	90.00
91.00	09100	EMERGENCY	0	1,459	303,239	0	304,698	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
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)	275,908	19,628	3,075,169	248,580	3,619,285	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	840	0	43,176	44,016	192.00
192.02	19202	MOB	0	2,694	0	138,578	141,272	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	814	0	41,860	42,674	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	275,908	23,976	3,075,169	472,194	3,847,247	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/29/2024 11:35 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - HOSPITAL	OPERATION OF PLANT - TLMOB	
			4.00	5.00	7.00	7.01	7.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	489,416				5.00
7.00	00700	OPERATION OF PLANT	0	9,655	9,655			7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	0	32,412	677	349,901		7.01
7.02	00702	OPERATION OF PLANT - TLMOB	0	6,685	513	0	67,428	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,236	56	3,474	0	8.00
9.00	00900	HOUSEKEEPING	0	12,664	176	9,980	342	9.00
10.00	01000	DIETARY	0	7,155	425	0	10,247	10.00
11.00	01100	CAFETERIA	0	2,456	173	0	4,179	11.00
13.00	01300	NURSING ADMINISTRATION	0	23,748	177	5,800	2,009	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,892	499	30,820	0	14.00
15.00	01500	PHARMACY	0	27,201	212	13,101	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	48,330	1,174	72,480	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	16,762	917	56,614	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,655	339	20,903	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,157	70	4,316	0	55.00
56.00	05600	RADIOISOTOPE	0	3,051	48	2,974	0	56.00
57.00	05700	CT SCAN	0	9,777	66	4,066	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	4,946	93	5,732	0	58.00
60.00	06000	LABORATORY	0	40,604	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0	9,472	299	18,475	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,036	24	1,467	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,888	11	688	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,203	100	6,164	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	992	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	24	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,470	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	116,439	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	17,086	212	13,079	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	3,048	158	0	3,806	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	9,507	641	39,577	0	90.00
91.00	09100	EMERGENCY	0	42,641	651	40,191	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	485,192	7,711	349,901	20,583	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,508	375	0	9,045	192.00
192.02	19202	MOB	0	2,086	1,205	0	29,031	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	630	364	0	8,769	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	0	489,416	9,655	349,901	67,428	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/29/2024 11:35 am

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - TLMOB						7.02
8.00	00800	LAUNDRY & LINEN SERVICE	31,106					8.00
9.00	00900	HOUSEKEEPING	0	100,485				9.00
10.00	01000	DIETARY	0	2,859	70,553			10.00
11.00	01100	CAFETERIA	0	1,165	0	28,309		11.00
13.00	01300	NURSING ADMINISTRATION	0	533	0	2,223	88,240	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,005	0	0	0	14.00
15.00	01500	PHARMACY	0	1,259	0	1,575	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	31,106	19,409	70,553	5,232	36,459	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	14,235	0	1,041	7,064	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,407	0	860	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	521	0	204	0	55.00
56.00	05600	RADIOISOTOPE	0	771	0	425	175	56.00
57.00	05700	CT SCAN	0	1,050	0	1,553	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,485	0	722	0	58.00
60.00	06000	LABORATORY	0	2,736	0	3,327	0	60.00
66.00	06600	PHYSICAL THERAPY	0	2,999	0	1,288	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	238	0	316	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	111	0	252	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,600	0	459	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	1,690	0	1,851	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,403	0	499	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	5,702	0	1,017	6,926	90.00
91.00	09100	EMERGENCY	0	18,354	0	5,197	37,616	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
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)	31,106	84,532	70,553	28,041	88,240	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,069	0	268	0	192.00
192.02	19202	MOB	0	7,679	0	0	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	4,205	0	0	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	31,106	100,485	70,553	28,309	88,240	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/29/2024 11:35 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	15.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - TLMOB						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	273,870					14.00
15.00	01500	PHARMACY	9,562	152,234				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	49,715	451	0	884,385	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	29,653	112	0	555,597	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	870	4	0	196,509	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	882	19	0	40,889	0	55.00
56.00	05600	RADIOISOTOPE	9,914	180	0	40,084	0	56.00
57.00	05700	CT SCAN	7,790	103	0	55,229	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	537	63	0	57,032	0	58.00
60.00	06000	LABORATORY	3,037	0	0	49,704	0	60.00
66.00	06600	PHYSICAL THERAPY	1,218	0	0	173,814	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	16,203	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	8,166	0	68.00
69.00	06900	ELECTROCARDIOLOGY	6,553	0	0	64,810	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	49,859	0	0	50,851	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,202	0	0	1,226	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,396	0	24,866	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	135,989	0	252,428	0	73.01
76.00	03160	CARDIOPULMONARY	24,849	1	0	157,920	0	76.00
76.97	07697	CARDIAC REHABILITATION	143	0	0	27,576	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	17,439	454	0	381,305	0	90.00
91.00	09100	EMERGENCY	60,565	1,462	0	511,375	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
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)	273,788	152,234	0	3,549,969	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	82	0	0	59,363	0	192.00
192.02	19202	MOB	0	0	0	181,273	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0	0	56,642	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	273,870	152,234	0	3,847,247	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/29/2024 11:35 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL			1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB			1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL			7.01
7.02	00702	OPERATION OF PLANT - TLMOB			7.02
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	884,385		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	555,597		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	196,509		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	40,889		55.00
56.00	05600	RADIOISOTOPE	40,084		56.00
57.00	05700	CT SCAN	55,229		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	57,032		58.00
60.00	06000	LABORATORY	49,704		60.00
66.00	06600	PHYSICAL THERAPY	173,814		66.00
67.00	06700	OCCUPATIONAL THERAPY	16,203		67.00
68.00	06800	SPEECH PATHOLOGY	8,166		68.00
69.00	06900	ELECTROCARDIOLOGY	64,810		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	50,851		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,226		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,866		73.00
73.01	07301	ONCOLOGY DRUGS	252,428		73.01
76.00	03160	CARDIOPULMONARY	157,920		76.00
76.97	07697	CARDIAC REHABILITATION	27,576		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		78.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	381,305		90.00
91.00	09100	EMERGENCY	511,375		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0		92.01
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		102.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,549,969		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
191.00	19100	RESEARCH	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	59,363		192.00
192.02	19202	MOB	181,273		192.02
192.03	19203	ARNETT SURGERY OFFICE	56,642		192.03
192.04	19201	OCCUPATIONAL MEDICINE	0		192.04
193.00	19300	NONPAID WORKERS	0		193.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	3,847,247		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 11:35 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BLDG & FIXT - HOSPITAL (SQUARE FEET)	BLDG & FIXT - TLMOB (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.00	1.01	1.02	4.00	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	116,177					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	71,677				1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	44,501			1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	9,510,720		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,394	2,795	8,599	310,274	-9,043,899	5.00
7.00	00700	OPERATION OF PLANT	0	0	0	511,921	0	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	7,349	7,349	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - TLMOB	5,568	0	5,568	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	611	611	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,909	1,755	154	358,933	0	9.00
10.00	01000	DIETARY	4,610	0	4,610	398,682	0	10.00
11.00	01100	CAFETERIA	1,880	0	1,880	63,721	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,923	1,020	904	860,004	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,420	5,420	0	0	0	14.00
15.00	01500	PHARMACY	2,304	2,304	0	630,676	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,746	12,746	0	1,584,037	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,956	9,956	0	305,970	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,676	3,676	0	252,214	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	759	759	0	72,709	0	55.00
56.00	05600	RADIOISOTOPE	523	523	0	144,259	0	56.00
57.00	05700	CT SCAN	715	715	0	490,742	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,008	1,008	0	230,082	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	3,249	3,249	0	379,149	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	258	258	0	136,228	0	67.00
68.00	06800	SPEECH PATHOLOGY	121	121	0	98,063	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,084	1,084	0	131,987	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	2,300	2,300	0	596,094	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,712	0	1,712	142,092	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,960	6,960	0	246,063	0	90.00
91.00	09100	EMERGENCY	7,068	7,068	0	1,522,157	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
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)	95,103	71,677	23,427	9,466,057	-9,043,899	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,069	0	4,069	44,663	0	192.00
192.02	19202	MOB	13,060	0	13,060	0	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	3,945	0	3,945	0	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	23,976	3,075,169	472,194	1,677,399		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.206375	42.903149	10.610863	0.176369		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 11:35 am

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	BLDG & FIXT - HOSPITAL (SQUARE FEET)	BLDG & FIXT - TLMOB (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
		1.00	1.01	1.02	4.00	5A	
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 11:35 am

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT - HOSPITAL (SQUARE FEET)	OPERATION OF PLANT - TLMOB (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	
			5.00	7.00	7.01	7.02	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	33,147,230					5.00
7.00	00700	OPERATION OF PLANT	653,944	104,783				7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	2,195,193	7,349	61,533			7.01
7.02	00702	OPERATION OF PLANT - TLMOB	452,738	5,568	0	30,334		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	83,689	611	611	0	2,420	8.00
9.00	00900	HOUSEKEEPING	857,718	1,909	1,755	154	0	9.00
10.00	01000	DIETARY	484,610	4,610	0	4,610	0	10.00
11.00	01100	CAFETERIA	166,342	1,880	0	1,880	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,608,390	1,923	1,020	904	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	534,477	5,420	5,420	0	0	14.00
15.00	01500	PHARMACY	1,842,229	2,304	2,304	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,273,305	12,746	12,746	0	2,420	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,135,223	9,956	9,956	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	653,937	3,676	3,676	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	146,080	759	759	0	0	55.00
56.00	05600	RADIOISOTOPE	206,628	523	523	0	0	56.00
57.00	05700	CT SCAN	662,154	715	715	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	334,965	1,008	1,008	0	0	58.00
60.00	06000	LABORATORY	2,749,992	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	641,532	3,249	3,249	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	205,622	258	258	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	127,877	121	121	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	216,959	1,084	1,084	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	67,172	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,620	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	776,863	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	7,886,342	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	1,157,214	2,300	2,300	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	206,464	1,712	0	1,712	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	643,897	6,960	6,960	0	0	90.00
91.00	09100	EMERGENCY	2,887,948	7,068	7,068	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
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)	32,861,124	83,709	61,533	9,260	2,420	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	102,160	4,069	0	4,069	0	192.00
192.02	19202	MOB	141,272	13,060	0	13,060	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	42,674	3,945	0	3,945	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	9,043,899	832,366	2,852,507	620,494	139,701	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.272840	7.943712	46.357353	20.455397	57.727686	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	489,416	9,655	349,901	67,428	31,106	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.014765	0.092143	5.686396	2.222852	12.853719	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: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 11:35 am

		Cost Center Description	HOUSEKEEPING (TIME SPENT)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURSING HOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - TLMOB						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	24,495					9.00
10.00	01000	DIETARY	697	2,420				10.00
11.00	01100	CAFETERIA	284	0	10,661			11.00
13.00	01300	NURSING ADMINISTRATION	130	0	837	59,449		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	245	0	0	0	368,967	14.00
15.00	01500	PHARMACY	307	0	593	0	12,882	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,731	2,420	1,970	24,563	66,978	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,470	0	392	4,759	39,949	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,318	0	324	0	1,172	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	127	0	77	0	1,188	55.00
56.00	05600	RADIOISOTOPE	188	0	160	118	13,357	56.00
57.00	05700	CT SCAN	256	0	585	0	10,495	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	362	0	272	0	723	58.00
60.00	06000	LABORATORY	667	0	1,253	0	4,091	60.00
66.00	06600	PHYSICAL THERAPY	731	0	485	0	1,641	66.00
67.00	06700	OCCUPATIONAL THERAPY	58	0	119	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	27	0	95	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	390	0	173	0	8,828	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	67,172	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,620	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	412	0	697	0	33,477	76.00
76.97	07697	CARDIAC REHABILITATION	342	0	188	0	192	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,390	0	383	4,666	23,495	90.00
91.00	09100	EMERGENCY	4,474	0	1,957	25,343	81,596	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
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)	20,606	2,420	10,560	59,449	368,856	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	992	0	101	0	111	192.00
192.02	19202	MOB	1,872	0	0	0	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	1,025	0	0	0	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,191,410	781,652	278,930	2,156,498	986,533	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	48.638906	322.996694	26.163587	36.274757	2.673770	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	100,485	70,553	28,309	88,240	273,870	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.102266	29.154132	2.655379	1.484297	0.742262	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

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		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			15.00	16.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL				1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB				1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL				7.01
7.02	00702	OPERATION OF PLANT - TLMOB				7.02
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY	8,828,455			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	26,170	0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	6,472	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	224	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,098	0		55.00
56.00	05600	RADIOISOTOPE	10,458	0		56.00
57.00	05700	CT SCAN	5,969	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,645	0		58.00
60.00	06000	LABORATORY	0	0		60.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	776,863	0		73.00
73.01	07301	ONCOLOGY DRUGS	7,886,342	0		73.01
76.00	03160	CARDIOPULMONARY	56	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	26,354	0		90.00
91.00	09100	EMERGENCY	84,804	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,828,455	0		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.02	19202	MOB	0	0		192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0		192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0		192.04
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,534,863	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.287124	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	152,234	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.017244	0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 11:35 am

Title XVIII | 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	7,139,138		7,139,138	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,445,916		2,445,916	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,107,749		1,107,749	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	238,833		238,833	0	0	55.00
56.00	05600	RADIOISOTOPE	347,731		347,731	0	0	56.00
57.00	05700	CT SCAN	939,175		939,175	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	508,795		508,795	0	0	58.00
60.00	06000	LABORATORY	3,576,463		3,576,463	0	0	60.00
66.00	06600	PHYSICAL THERAPY	1,045,624	0	1,045,624	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	281,667	0	281,667	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	173,136	0	173,136	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	382,115		382,115	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	265,101		265,101	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,394		6,394	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,211,878		1,211,878	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	12,302,420		12,302,420	0	0	73.01
76.00	03160	CARDIOPULMONARY	1,725,642		1,725,642	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	333,483		333,483	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,514,787		1,514,787	0	0	90.00
91.00	09100	EMERGENCY	5,490,337		5,490,337	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,736,141		1,736,141		0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0		0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	42,772,525	0	42,772,525	0	0	200.00
201.00		Less Observation Beds	1,736,141		1,736,141		0	201.00
202.00		Total (see instructions)	41,036,384	0	41,036,384	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 11:35 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,580,560		5,580,560			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,645	6,502,781	6,505,426	0.375981	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	93,470	7,255,214	7,348,684	0.150741	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	28,192	1,850,437	1,878,629	0.127132	0.000000	55.00
56.00	05600	RADIOISOTOPE	211,802	3,635,114	3,846,916	0.090392	0.000000	56.00
57.00	05700	CT SCAN	412,877	9,439,456	9,852,333	0.095325	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	91,707	3,480,557	3,572,264	0.142429	0.000000	58.00
60.00	06000	LABORATORY	1,543,876	10,365,272	11,909,148	0.300312	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	437,070	1,741,935	2,179,005	0.479863	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	308,931	159,053	467,984	0.601873	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	70,964	220,148	291,112	0.594740	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,961,650	1,961,650	0.194793	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	83,980	256,754	340,734	0.778029	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,672	117,042	130,714	0.048916	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,207,853	5,217,794	7,425,647	0.163202	0.000000	73.00
73.01	07301	ONCOLOGY DRUGS	0	44,500,468	44,500,468	0.276456	0.000000	73.01
76.00	03160	CARDIOPULMONARY	1,753,524	4,975,684	6,729,208	0.256441	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,980,946	1,980,946	0.168345	0.000000	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	9,468,749	9,468,749	0.159978	0.000000	90.00
91.00	09100	EMERGENCY	566,989	38,071,984	38,638,973	0.142093	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,350	4,206,136	4,210,486	0.412337	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0.000000	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	13,412,462	155,407,174	168,819,636			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	13,412,462	155,407,174	168,819,636			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 11:35 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	55.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
73.01	07301	ONCOLOGY DRUGS	0.000000	73.01
76.00	03160	CARDIOPULMONARY	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
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: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 11:35 am

Title XIX | 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	7,139,138		7,139,138	0	7,139,138	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,445,916		2,445,916	0	2,445,916	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,107,749		1,107,749	0	1,107,749	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	238,833		238,833	0	238,833	55.00
56.00	05600	RADIOISOTOPE	347,731		347,731	0	347,731	56.00
57.00	05700	CT SCAN	939,175		939,175	0	939,175	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	508,795		508,795	0	508,795	58.00
60.00	06000	LABORATORY	3,576,463		3,576,463	0	3,576,463	60.00
66.00	06600	PHYSICAL THERAPY	1,045,624	0	1,045,624	0	1,045,624	66.00
67.00	06700	OCCUPATIONAL THERAPY	281,667	0	281,667	0	281,667	67.00
68.00	06800	SPEECH PATHOLOGY	173,136	0	173,136	0	173,136	68.00
69.00	06900	ELECTROCARDIOLOGY	382,115		382,115	0	382,115	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	265,101		265,101	0	265,101	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,394		6,394	0	6,394	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,211,878		1,211,878	0	1,211,878	73.00
73.01	07301	ONCOLOGY DRUGS	12,302,420		12,302,420	0	12,302,420	73.01
76.00	03160	CARDIOPULMONARY	1,725,642		1,725,642	0	1,725,642	76.00
76.97	07697	CARDIAC REHABILITATION	333,483		333,483	0	333,483	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,514,787		1,514,787	0	1,514,787	90.00
91.00	09100	EMERGENCY	5,490,337		5,490,337	0	5,490,337	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,736,141		1,736,141		1,736,141	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0		0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	42,772,525	0	42,772,525	0	42,772,525	200.00
201.00		Less Observation Beds	1,736,141		1,736,141		1,736,141	201.00
202.00		Total (see instructions)	41,036,384	0	41,036,384	0	41,036,384	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 11:35 am

Title XIX | Hospital | PPS

		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	5,580,560		5,580,560			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,645	6,502,781	6,505,426	0.375981	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	93,470	7,255,214	7,348,684	0.150741	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	28,192	1,850,437	1,878,629	0.127132	0.000000	55.00
56.00	05600	RADIOISOTOPE	211,802	3,635,114	3,846,916	0.090392	0.000000	56.00
57.00	05700	CT SCAN	412,877	9,439,456	9,852,333	0.095325	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	91,707	3,480,557	3,572,264	0.142429	0.000000	58.00
60.00	06000	LABORATORY	1,543,876	10,365,272	11,909,148	0.300312	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	437,070	1,741,935	2,179,005	0.479863	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	308,931	159,053	467,984	0.601873	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	70,964	220,148	291,112	0.594740	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,961,650	1,961,650	0.194793	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	83,980	256,754	340,734	0.778029	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,672	117,042	130,714	0.048916	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,207,853	5,217,794	7,425,647	0.163202	0.000000	73.00
73.01	07301	ONCOLOGY DRUGS	0	44,500,468	44,500,468	0.276456	0.000000	73.01
76.00	03160	CARDIOPULMONARY	1,753,524	4,975,684	6,729,208	0.256441	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,980,946	1,980,946	0.168345	0.000000	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	9,468,749	9,468,749	0.159978	0.000000	90.00
91.00	09100	EMERGENCY	566,989	38,071,984	38,638,973	0.142093	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,350	4,206,136	4,210,486	0.412337	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0.000000	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	13,412,462	155,407,174	168,819,636			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	13,412,462	155,407,174	168,819,636			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 11:35 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.375981		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150741		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.127132		55.00
56.00	05600	RADIOISOTOPE	0.090392		56.00
57.00	05700	CT SCAN	0.095325		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.142429		58.00
60.00	06000	LABORATORY	0.300312		60.00
66.00	06600	PHYSICAL THERAPY	0.479863		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.601873		67.00
68.00	06800	SPEECH PATHOLOGY	0.594740		68.00
69.00	06900	ELECTROCARDIOLOGY	0.194793		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.778029		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.048916		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.163202		73.00
73.01	07301	ONCOLOGY DRUGS	0.276456		73.01
76.00	03160	CARDIOPULMONARY	0.256441		76.00
76.97	07697	CARDIAC REHABILITATION	0.168345		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000		78.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.159978		90.00
91.00	09100	EMERGENCY	0.142093		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.412337		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000		92.01
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
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

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part II | Date/Time Prepared: 5/29/2024 11:35 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,445,916	555,597	1,890,319	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,107,749	196,509	911,240	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	238,833	40,889	197,944	0	0	55.00
56.00	05600	RADIOISOTOPE	347,731	40,084	307,647	0	0	56.00
57.00	05700	CT SCAN	939,175	55,229	883,946	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	508,795	57,032	451,763	0	0	58.00
60.00	06000	LABORATORY	3,576,463	49,704	3,526,759	0	0	60.00
66.00	06600	PHYSICAL THERAPY	1,045,624	173,814	871,810	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	281,667	16,203	265,464	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	173,136	8,166	164,970	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	382,115	64,810	317,305	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	265,101	50,851	214,250	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,394	1,226	5,168	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,211,878	24,866	1,187,012	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	12,302,420	252,428	12,049,992	0	0	73.01
76.00	03160	CARDIOPULMONARY	1,725,642	157,920	1,567,722	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	333,483	27,576	305,907	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,514,787	381,305	1,133,482	0	0	90.00
91.00	09100	EMERGENCY	5,490,337	511,375	4,978,962	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,736,141	215,070	1,521,071	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
200.00		Subtotal (sum of lines 50 thru 199)	35,633,387	2,880,654	32,752,733	0	0	200.00
201.00		Less Observation Beds	1,736,141	215,070	1,521,071	0	0	201.00
202.00		Total (line 200 minus line 201)	33,897,246	2,665,584	31,231,662	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part II Date/Time Prepared: 5/29/2024 11:35 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,445,916	6,505,426	0.375981		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,107,749	7,348,684	0.150741		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	238,833	1,878,629	0.127132		55.00
56.00	05600	RADIOISOTOPE	347,731	3,846,916	0.090392		56.00
57.00	05700	CT SCAN	939,175	9,852,333	0.095325		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	508,795	3,572,264	0.142429		58.00
60.00	06000	LABORATORY	3,576,463	11,909,148	0.300312		60.00
66.00	06600	PHYSICAL THERAPY	1,045,624	2,179,005	0.479863		66.00
67.00	06700	OCCUPATIONAL THERAPY	281,667	467,984	0.601873		67.00
68.00	06800	SPEECH PATHOLOGY	173,136	291,112	0.594740		68.00
69.00	06900	ELECTROCARDIOLOGY	382,115	1,961,650	0.194793		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	265,101	340,734	0.778029		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,394	130,714	0.048916		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,211,878	7,425,647	0.163202		73.00
73.01	07301	ONCOLOGY DRUGS	12,302,420	44,500,468	0.276456		73.01
76.00	03160	CARDIOPULMONARY	1,725,642	6,729,208	0.256441		76.00
76.97	07697	CARDIAC REHABILITATION	333,483	1,980,946	0.168345		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000		78.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1,514,787	9,468,749	0.159978		90.00
91.00	09100	EMERGENCY	5,490,337	38,638,973	0.142093		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,736,141	4,210,486	0.412337		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000		92.01
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0.000000		102.00
200.00		Subtotal (sum of lines 50 thru 199)	35,633,387	163,239,076			200.00
201.00		Less Observation Beds	1,736,141	0			201.00
202.00		Total (line 200 minus line 201)	33,897,246	163,239,076			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/29/2024 11:35 am

Title XVIII | Hospital | Cost

		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	555,597	6,505,426	0.085405	2,645	226	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	196,509	7,348,684	0.026741	31,336	838	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	40,889	1,878,629	0.021765	0	0	55.00
56.00	05600	RADIOISOTOPE	40,084	3,846,916	0.010420	106,060	1,105	56.00
57.00	05700	CT SCAN	55,229	9,852,333	0.005606	99,534	558	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	57,032	3,572,264	0.015965	41,812	668	58.00
60.00	06000	LABORATORY	49,704	11,909,148	0.004174	586,690	2,449	60.00
66.00	06600	PHYSICAL THERAPY	173,814	2,179,005	0.079768	125,146	9,983	66.00
67.00	06700	OCCUPATIONAL THERAPY	16,203	467,984	0.034623	80,315	2,781	67.00
68.00	06800	SPEECH PATHOLOGY	8,166	291,112	0.028051	21,016	590	68.00
69.00	06900	ELECTROCARDIOLOGY	64,810	1,961,650	0.033039	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	50,851	340,734	0.149240	55,482	8,280	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,226	130,714	0.009379	13,672	128	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,866	7,425,647	0.003349	810,773	2,715	73.00
73.01	07301	ONCOLOGY DRUGS	252,428	44,500,468	0.005672	0	0	73.01
76.00	03160	CARDIOPULMONARY	157,920	6,729,208	0.023468	765,976	17,976	76.00
76.97	07697	CARDIAC REHABILITATION	27,576	1,980,946	0.013921	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	381,305	9,468,749	0.040270	0	0	90.00
91.00	09100	EMERGENCY	511,375	38,638,973	0.013235	27,493	364	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	215,070	4,210,486	0.051080	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000	0	0	92.01
200.00		Total (lines 50 through 199)	2,880,654	163,239,076		2,767,950	48,661	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/29/2024 11:35 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
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: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/29/2024 11:35 am

Title XVIII | Hospital | Cost

		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	6,505,426	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	7,348,684	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	1,878,629	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	3,846,916	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	9,852,333	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	3,572,264	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	11,909,148	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,179,005	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	467,984	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	291,112	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,961,650	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	340,734	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	130,714	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,425,647	0.000000	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	44,500,468	0.000000	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	6,729,208	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,980,946	0.000000	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	9,468,749	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	38,638,973	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	4,210,486	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0.000000	92.01
200.00		Total (lines 50 through 199)	0	0	0	163,239,076		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/29/2024 11:35 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	2,645	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	31,336	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	106,060	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	99,534	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	41,812	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	586,690	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.000000	125,146	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	80,315	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	21,016	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	55,482	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	13,672	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	810,773	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0.000000	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.000000	765,976	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	27,493	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	92.01
200.00		Total (lines 50 through 199)		2,767,950	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/29/2024 11:35 am

Title XVIII | 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	0.375981	0	1,652,014	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150741	0	1,299,758	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.127132	0	677,778	0	0	55.00
56.00	05600	RADIOISOTOPE	0.090392	0	910,558	0	0	56.00
57.00	05700	CT SCAN	0.095325	0	2,418,331	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.142429	0	779,937	0	0	58.00
60.00	06000	LABORATORY	0.300312	0	2,670,796	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.479863	0	475,866	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.601873	0	37,078	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.594740	0	26,546	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.194793	0	495,840	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.778029	0	59,579	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.048916	0	35,832	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.163202	0	1,082,420	4,516	0	73.00
73.01	07301	ONCOLOGY DRUGS	0.276456	0	22,945,373	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.256441	0	1,484,948	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.168345	0	882,572	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.159978	0	4,054,099	0	0	90.00
91.00	09100	EMERGENCY	0.142093	0	6,919,869	1,442	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.412337	0	976,053	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	92.01
200.00		Subtotal (see instructions)		0	49,885,247	5,958	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	49,885,247	5,958	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/29/2024 11:35 am

Title XVIII | 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	621,126	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	195,927	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	86,167	0		55.00
56.00	05600	RADIOISOTOPE	82,307	0		56.00
57.00	05700	CT SCAN	230,527	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	111,086	0		58.00
60.00	06000	LABORATORY	802,072	0		60.00
66.00	06600	PHYSICAL THERAPY	228,350	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	22,316	0		67.00
68.00	06800	SPEECH PATHOLOGY	15,788	0		68.00
69.00	06900	ELECTROCARDIOLOGY	96,586	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	46,354	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,753	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	176,653	737		73.00
73.01	07301	ONCOLOGY DRUGS	6,343,386	0		73.01
76.00	03160	CARDIOPULMONARY	380,802	0		76.00
76.97	07697	CARDIAC REHABILITATION	148,577	0		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	648,567	0		90.00
91.00	09100	EMERGENCY	983,265	205		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	402,463	0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
200.00		Subtotal (see instructions)	11,624,072	942		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	11,624,072	942		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part I Date/Time Prepared: 5/29/2024 11:35 am

Title XIX | 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	884,385	86,277	798,108	2,516	317.21	30.00
200.00	Total (lines 30 through 199)	884,385		798,108	2,516		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	18	5,710	30.00
200.00	Total (lines 30 through 199)	18	5,710	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/29/2024 11:35 am

Title XIX | 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	555,597	6,505,426	0.085405	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	196,509	7,348,684	0.026741	1,132	30	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	40,889	1,878,629	0.021765	12,056	262	55.00
56.00	05600	RADIOISOTOPE	40,084	3,846,916	0.010420	0	0	56.00
57.00	05700	CT SCAN	55,229	9,852,333	0.005606	1,782	10	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	57,032	3,572,264	0.015965	0	0	58.00
60.00	06000	LABORATORY	49,704	11,909,148	0.004174	15,079	63	60.00
66.00	06600	PHYSICAL THERAPY	173,814	2,179,005	0.079768	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	16,203	467,984	0.034623	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,166	291,112	0.028051	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	64,810	1,961,650	0.033039	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	50,851	340,734	0.149240	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,226	130,714	0.009379	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,866	7,425,647	0.003349	28,864	97	73.00
73.01	07301	ONCOLOGY DRUGS	252,428	44,500,468	0.005672	0	0	73.01
76.00	03160	CARDIOPULMONARY	157,920	6,729,208	0.023468	32,440	761	76.00
76.97	07697	CARDIAC REHABILITATION	27,576	1,980,946	0.013921	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	381,305	9,468,749	0.040270	0	0	90.00
91.00	09100	EMERGENCY	511,375	38,638,973	0.013235	13,968	185	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	215,070	4,210,486	0.051080	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000	0	0	92.01
200.00		Total (lines 50 through 199)	2,880,654	163,239,076		105,321	1,408	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part III Date/Time Prepared: 5/29/2024 11:35 am

Title XIX | 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
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	2,516	0.00	18	30.00
200.00		Total (lines 30 through 199)		0	2,516		18	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/29/2024 11:35 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
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: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/29/2024 11:35 am

Title XIX | 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	6,505,426	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	7,348,684	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	1,878,629	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	3,846,916	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	9,852,333	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	3,572,264	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	11,909,148	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,179,005	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	467,984	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	291,112	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,961,650	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	340,734	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	130,714	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,425,647	0.000000	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	44,500,468	0.000000	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	6,729,208	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,980,946	0.000000	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	9,468,749	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	38,638,973	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	4,210,486	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0.000000	92.01
200.00		Total (lines 50 through 199)	0	0	0	163,239,076		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/29/2024 11:35 am

Title XIX | 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	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,132	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	12,056	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	1,782	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	15,079	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	28,864	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0.000000	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.000000	32,440	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	13,968	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	92.01
200.00		Total (lines 50 through 199)		105,321	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/29/2024 11:35 am

Title XIX | 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	0.375981	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150741	0	52,381	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.127132	0	4,530	0	0	55.00
56.00	05600	RADIOISOTOPE	0.090392	0	25,742	0	0	56.00
57.00	05700	CT SCAN	0.095325	0	90,826	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.142429	0	26,747	0	0	58.00
60.00	06000	LABORATORY	0.300312	0	120,057	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.479863	0	14,566	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.601873	0	7,280	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.594740	0	17,602	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.194793	0	26,328	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.778029	0	694	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.048916	0	868	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.163202	0	43,333	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0.276456	0	146,003	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.256441	0	37,650	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.168345	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.159978	0	78,687	0	0	90.00
91.00	09100	EMERGENCY	0.142093	0	468,162	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.412337	0	28,833	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	92.01
200.00		Subtotal (see instructions)		0	1,190,289	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	1,190,289	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/29/2024 11:35 am

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,896	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	576	0		55.00
56.00	05600	RADIOISOTOPE	2,327	0		56.00
57.00	05700	CT SCAN	8,658	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,810	0		58.00
60.00	06000	LABORATORY	36,055	0		60.00
66.00	06600	PHYSICAL THERAPY	6,990	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	4,382	0		67.00
68.00	06800	SPEECH PATHOLOGY	10,469	0		68.00
69.00	06900	ELECTROCARDIOLOGY	5,129	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	540	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	42	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,072	0		73.00
73.01	07301	ONCOLOGY DRUGS	40,363	0		73.01
76.00	03160	CARDIOPULMONARY	9,655	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	12,588	0		90.00
91.00	09100	EMERGENCY	66,523	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	11,889	0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
200.00		Subtotal (see instructions)	234,964	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	234,964	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 11:35 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,098	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,516	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)	1,838	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	236	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	346	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)	895	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)	236	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	266.32	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)	7,139,138	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)	92,147	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)	696,467	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,442,671	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)	6,442,671	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)	2,560.68	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,291,809	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,291,809	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 11:35 am

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	704,320	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	2,996,129	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	604,320	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	604,320	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)	678	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,560.68	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,736,141	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 11:35 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	884,385	7,139,138	0.123878	1,736,141	215,070	90.00
91.00	Nursing Program cost	0	7,139,138	0.000000	1,736,141	0	91.00
92.00	Allied health cost	0	7,139,138	0.000000	1,736,141	0	92.00
93.00	All other Medical Education	0	7,139,138	0.000000	1,736,141	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 11:35 am

Title XIX | 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)	3,098	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,516	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)	1,838	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	236	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	346	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)	18	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	266.32	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)	7,139,138	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)	92,147	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)	696,467	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,442,671	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)	6,442,671	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)	2,560.68	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	46,092	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)	46,092	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 11:35 am

Title XIX | 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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	21,417	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)	67,509	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)	5,710	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,408	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	7,118	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	60,391	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)	678	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,560.68	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,736,141	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 11:35 am

Title XIX | 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	884,385	7,139,138	0.123878	1,736,141	215,070	90.00
91.00	Nursing Program cost	0	7,139,138	0.000000	1,736,141	0	91.00
92.00	Allied health cost	0	7,139,138	0.000000	1,736,141	0	92.00
93.00	All other Medical Education	0	7,139,138	0.000000	1,736,141	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/29/2024 11:35 am

Title XVIII | 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		2,197,272		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.375981	2,645	994	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150741	31,336	4,724	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.127132	0	0	55.00
56.00	05600	RADIOISOTOPE	0.090392	106,060	9,587	56.00
57.00	05700	CT SCAN	0.095325	99,534	9,488	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.142429	41,812	5,955	58.00
60.00	06000	LABORATORY	0.300312	586,690	176,190	60.00
66.00	06600	PHYSICAL THERAPY	0.479863	125,146	60,053	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.601873	80,315	48,339	67.00
68.00	06800	SPEECH PATHOLOGY	0.594740	21,016	12,499	68.00
69.00	06900	ELECTROCARDIOLOGY	0.194793	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.778029	55,482	43,167	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.048916	13,672	669	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.163202	810,773	132,320	73.00
73.01	07301	ONCOLOGY DRUGS	0.276456	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.256441	765,976	196,428	76.00
76.97	07697	CARDIAC REHABILITATION	0.168345	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.159978	0	0	90.00
91.00	09100	EMERGENCY	0.142093	27,493	3,907	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.412337	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	92.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,767,950	704,320	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		2,767,950		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3

Component CCN: 15-Z312 | Date/Time Prepared: 5/29/2024 11:35 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.375981	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150741	5,779	871	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.127132	0	0	55.00
56.00	05600	RADIOISOTOPE	0.090392	3,838	347	56.00
57.00	05700	CT SCAN	0.095325	6,775	646	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.142429	1,744	248	58.00
60.00	06000	LABORATORY	0.300312	81,528	24,484	60.00
66.00	06600	PHYSICAL THERAPY	0.479863	87,953	42,205	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.601873	62,920	37,870	67.00
68.00	06800	SPEECH PATHOLOGY	0.594740	4,494	2,673	68.00
69.00	06900	ELECTROCARDIOLOGY	0.194793	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.778029	3,012	2,343	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.048916	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.163202	66,762	10,896	73.00
73.01	07301	ONCOLOGY DRUGS	0.276456	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.256441	29,608	7,593	76.00
76.97	07697	CARDIAC REHABILITATION	0.168345	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.159978	0	0	90.00
91.00	09100	EMERGENCY	0.142093	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.412337	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	92.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		354,413	130,176	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)		354,413		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/29/2024 11:35 am

Title XIX | 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		41,766		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.375981	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150741	1,132	171	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.127132	12,056	1,533	55.00
56.00	05600	RADIOISOTOPE	0.090392	0	0	56.00
57.00	05700	CT SCAN	0.095325	1,782	170	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.142429	0	0	58.00
60.00	06000	LABORATORY	0.300312	15,079	4,528	60.00
66.00	06600	PHYSICAL THERAPY	0.479863	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.601873	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.594740	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.194793	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.778029	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.048916	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.163202	28,864	4,711	73.00
73.01	07301	ONCOLOGY DRUGS	0.276456	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.256441	32,440	8,319	76.00
76.97	07697	CARDIAC REHABILITATION	0.168345	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.159978	0	0	90.00
91.00	09100	EMERGENCY	0.142093	13,968	1,985	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.412337	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	92.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		105,321	21,417	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)		105,321		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part B Date/Time Prepared: 5/29/2024 11:35 am

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	11,625,014	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	11,625,014	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	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)	0	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)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	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)	11,741,264	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	75,192	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	9,194,418	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,471,654	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount (see instructions)		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	2,471,654	30.00
31.00	Primary payer payments	500	31.00
32.00	Subtotal (line 30 minus line 31)	2,471,154	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)	450,316	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	292,705	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	268,031	36.00
37.00	Subtotal (see instructions)	2,763,859	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,763,859	40.00
40.01	Sequestration adjustment (see instructions)	55,277	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	3,626,991	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)	-918,409	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	849,130	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: 15-1312	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/29/2024 11:35 am
	Title XVIII	Hospital	Cost

			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: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2024 11:35 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,328,912		3,626,991	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	09/18/2023	284,300		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)		284,300		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,613,212		3,626,991	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		48,927		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		918,409	6.02
7.00	Total Medicare program liability (see instructions)		2,662,139		2,708,582	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1312 | Component CCN: 15-Z312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2024 11:35 am

Title XVIII | Swing Beds - SNF | Cost

		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		645,953		0	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	09/18/2023	31,900		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)		31,900		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)		677,853		0	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		45,427		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		723,280		0	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: 15-1312	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/29/2024 11:35 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-1312 | Component CCN: 15-Z312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-2 | Date/Time Prepared: 5/29/2024 11:35 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	610,363	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	131,478	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	236	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	741,841	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	741,841	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	741,841	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	3,800	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	738,041	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	738,041	0	19.00
19.01	Sequestration adjustment (see instructions)	14,761	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	677,853	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	45,427	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	51,014	0	23.00
	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 swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1312	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part V Date/Time Prepared: 5/29/2024 11:35 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,996,129	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
3.01	Cellular therapy acquisition cost (see instructions)	0	3.01
4.00	Subtotal (sum of lines 1 through 3.01)	2,996,129	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,026,090	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	3,026,090	19.00
20.00	Deductibles (exclude professional component)	321,468	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,704,622	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	2,704,622	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	18,224	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	11,846	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	7,912	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,716,468	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	2,716,468	30.00
30.01	Sequestration adjustment (see instructions)	54,329	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	2,613,212	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	48,927	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	207,934	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G | Date/Time Prepared: 5/29/2024 11:35 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	49,833,621	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,376,116	0	0	0	4.00
5.00	Other receivable	336,592	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	900,336	0	0	0	7.00
8.00	Prepaid expenses	68,606	0	0	0	8.00
9.00	Other current assets	0	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)	56,515,271	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	972,779	0	0	0	12.00
13.00	Land improvements	122,178	0	0	0	13.00
14.00	Accumulated depreciation	-116,463	0	0	0	14.00
15.00	Buildings	30,277,094	0	0	0	15.00
16.00	Accumulated depreciation	-10,027,797	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	13,025,622	0	0	0	23.00
24.00	Accumulated depreciation	-8,833,241	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)	25,420,172	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	161,793	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	18,276	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	180,069	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	82,115,512	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,991,965	0	0	0	37.00
38.00	Salaries, wages, and fees payable	679,087	0	0	0	38.00
39.00	Payroll taxes payable	51,580	0	0	0	39.00
40.00	Notes and loans payable (short term)	810,000	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	2,779,403	0	0	0	43.00
44.00	Other current liabilities	10,928	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,322,963	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	16,680,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	32,205	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	16,712,205	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	25,035,168	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	57,080,344				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)	57,080,344	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	82,115,512	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 5/29/2024 11:35 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		48,781,642		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		8,286,451				2.00
3.00	Total (sum of line 1 and line 2)		57,068,093		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	NET INTERCOMPANY TRANSACTIONS	12,254		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)		12,254		0		10.00
11.00	Subtotal (line 3 plus line 10)		57,080,347		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	ROUNDING	3		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		3		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		57,080,344		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	NET INTERCOMPANY TRANSACTIONS		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	ROUNDING		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: 15-1312 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/29/2024 11:35 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	5,006,474		5,006,474	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	574,086		574,086	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)	5,580,560		5,580,560	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,580,560		5,580,560	17.00
18.00	Ancillary services	7,244,246	103,676,622	110,920,868	18.00
19.00	Outpatient services	571,339	51,746,869	52,318,208	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		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	13,396,145	155,423,491	168,819,636	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		43,325,793		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)		43,325,793		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1312	Period: From 01/01/2023 To 12/31/2023	Worksheet G-3 Date/Time Prepared: 5/29/2024 11:35 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	168,819,636	1.00
2.00	Less contractual allowances and discounts on patients' accounts	120,366,947	2.00
3.00	Net patient revenues (line 1 minus line 2)	48,452,689	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	43,325,793	4.00
5.00	Net income from service to patients (line 3 minus line 4)	5,126,896	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	3,159,555	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	3,159,555	25.00
26.00	Total (line 5 plus line 25)	8,286,451	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	8,286,451	29.00