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: 15-0059	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/29/2024 9:54 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/29/2024 Time: 9:54 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 RIVERVIEW HOSPITAL (15-0059) 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	Jayna Friend		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	Jayna Friend			2
3	Signatory Title	CONTROLLER			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	453,430	116,546	0	-114,955	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	-59,062	-118		-30,312	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	TOTAL	0	394,368	116,428	0	-145,267	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: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 9:54 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 395 WESTFIELD ROAD	PO Box:			1.00
2.00	City: NOBLESVILLE	State: IN	Zip Code: 46060-	County: HAMILTON	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	RIVERVIEW HOSPITAL	150059	26900	1	07/07/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	RIVERVIEW HOSPITAL REHAB	15T059	26900	5	01/01/1994	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2023	12/31/2023	20.00
21.00	Type of Control (see instructions)	9		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2024 9:54 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.	391	214	0	8	2,043	140	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.	7	0	0	0	156		25.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 9:54 am

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

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	Y	Y		60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1	60.01

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 9:54 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: 15-0059	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 9:54 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.		Y			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)		N	N	0	76.00

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2024 9:54 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	1,070,894	0	0	118.01

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

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2024 9:54 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)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		Y		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			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	02/23/2024	Y	02/23/2024 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: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II Date/Time Prepared: 5/29/2024 9:54 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		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
	Provider-Based Physicians		
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?			36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00

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

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		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER		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: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2024 9:54 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	106	38,690	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		106	38,690	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	15	5,475	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		121	44,165	0.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	14	5,110		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		135				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: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2024 9:54 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)	2,885	391	11,885			1.00
2.00	HMO and other (see instructions)	3,265	2,265				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	725	156				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,885	391	11,885			7.00
8.00	INTENSIVE CARE UNIT	610	0	2,507			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	0			13.00
14.00	Total (see instructions)	3,495	391	14,392	0.00	1,041.21	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	2,200	7	3,870	0.00	18.05	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			127			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	1,059.26	27.00
28.00	Observation Bed Days		102	3,659			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	140	254			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: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2024 9:54 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	881	83	3,956	1.00
2.00	HMO and other (see instructions)			623	788		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				15		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	881	83	3,956	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	0.00	0	209	1	357	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part II Date/Time Prepared: 5/29/2024 9:54 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	99,273,957	92,527	99,366,484	2,203,268.26	45.10	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		33,450,679	470,565	33,921,244	549,896.22	61.69	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		4,624,277	0	4,624,277	42,842.00	107.94	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		494,312	0	494,312	3,800.00	130.08	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		13,869,306	0	13,869,306			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		5,636,009	0	5,636,009			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part II | Date/Time Prepared: 5/29/2024 9:54 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	723,232	0	723,232	16,582.25	43.61	26.00
27.00	Administrative & General	5.00	9,550,726	-224,968	9,325,758	268,072.07	34.79	27.00
28.00	Administrative & General under contract (see inst.)		228,878	0	228,878	1,709.00	133.93	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,421,372	0	2,421,372	74,121.50	32.67	30.00
31.00	Laundry & Linen Service	8.00	88,318	0	88,318	4,576.00	19.30	31.00
32.00	Housekeeping	9.00	1,237,066	0	1,237,066	54,288.00	22.79	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,446,109	-1,118,819	327,290	14,761.66	22.17	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	948,638	948,638	42,786.19	22.17	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	669,154	0	669,154	12,615.00	53.04	38.00
39.00	Central Services and Supply	14.00	832,549	0	832,549	28,288.50	29.43	39.00
40.00	Pharmacy	15.00	2,919,386	-300,384	2,619,002	58,161.00	45.03	40.00
41.00	Medical Records & Medical Records Library	16.00	756,733	0	756,733	26,825.75	28.21	41.00
42.00	Social Service	17.00	771,926	0	771,926	19,369.50	39.85	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part III Date/Time Prepared: 5/29/2024 9:54 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		99,502,835	92,527	99,595,362	2,204,977.26	45.17	1.00
2.00	Excluded area salaries (see instructions)		33,450,679	470,565	33,921,244	549,896.22	61.69	2.00
3.00	Subtotal salaries (line 1 minus line 2)		66,052,156	-378,038	65,674,118	1,655,081.04	39.68	3.00
4.00	Subtotal other wages & related costs (see inst.)		5,118,589	0	5,118,589	46,642.00	109.74	4.00
5.00	Subtotal wage-related costs (see inst.)		13,869,306	0	13,869,306	0.00	21.12	5.00
6.00	Total (sum of lines 3 thru 5)		85,040,051	-378,038	84,662,013	1,701,723.04	49.75	6.00
7.00	Total overhead cost (see instructions)		21,645,449	-695,533	20,949,916	622,156.42	33.67	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part IV Date/Time Prepared: 5/29/2024 9:54 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,661,688	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	10,264,675	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	230,788	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	33,639	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	257,267	14.00
15.00	'Workers' Compensation Insurance	337,655	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	6,669,499	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	50,104	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	19,505,315	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part V | Date/Time Prepared: 5/29/2024 9:54 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	4,624,277	19,505,315	1.00
2.00	Hospital	4,624,277	19,505,315	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY	0	0	8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 5/29/2024 9:54 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)	0.260119	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,367,165	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	51,481,956	6.00
7.00	Medicaid cost (line 1 times line 6)	13,391,435	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	12,024,270	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	12,024,270	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)	6,245,147	899,996	7,145,143	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,624,481	846,860	2,471,341	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (see instructions)	1,624,481	846,860	2,471,341	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)	71,817	25.01
26.00	Bad debt amount (see instructions)	13,850,912	26.00
27.00	Medicare reimbursable bad debts (see instructions)	163,563	27.00
27.01	Medicare allowable bad debts (see instructions)	251,635	27.01
28.00	Non-Medicare bad debt amount (see instructions)	13,599,277	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	3,625,502	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	6,096,843	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	18,121,113	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 5/29/2024 9:54 am

		1.00	
	PART II - HOSPITAL DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.254226	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)	6,245,147	899,996	7,145,143	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,587,679	846,437	2,434,116	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (see instructions)	1,587,679	846,437	2,434,116	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)	71,817	25.01
26.00	Bad debt amount (see instructions)	13,850,912	26.00
27.00	Medicare reimbursable bad debts (see instructions)	151,300	27.00
27.01	Medicare allowable bad debts (see instructions)	232,769	27.01
28.00	Non-Medicare bad debt amount (see instructions)	13,618,143	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	3,543,555	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	5,977,671	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,977,671	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/29/2024 9:54 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		27,164,331	27,164,331	-624,114	26,540,217	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	723,232	9,364,873	10,088,105	4,655,918	14,744,023	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,550,726	42,452,428	52,003,154	550,293	52,553,447	5.00
7.00	00700	OPERATION OF PLANT	2,421,372	6,913,684	9,335,056	0	9,335,056	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	88,318	1,862,733	1,951,051	0	1,951,051	8.00
9.00	00900	HOUSEKEEPING	1,237,066	1,212,197	2,449,263	0	2,449,263	9.00
10.00	01000	DIETARY	1,446,109	2,320,917	3,767,026	-2,919,410	847,616	10.00
11.00	01100	CAFETERIA	0	0	0	2,471,144	2,471,144	11.00
13.00	01300	NURSING ADMINISTRATION	669,154	88,043	757,197	0	757,197	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	832,549	-9,594	822,955	8,353,167	9,176,122	14.00
15.00	01500	PHARMACY	2,919,386	20,724,010	23,643,396	-320,834	23,322,562	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	756,733	758,805	1,515,538	0	1,515,538	16.00
17.00	01700	SOCIAL SERVICE	771,926	341,629	1,113,555	0	1,113,555	17.00
23.00	02300	PARAMED ED PRGM PHARMACY	0	0	0	310,237	310,237	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,290,412	3,890,942	13,181,354	-557,256	12,624,098	30.00
31.00	03100	INTENSIVE CARE UNIT	2,339,935	904,463	3,244,398	-223,304	3,021,094	31.00
41.00	04100	SUBPROVIDER - IRF	1,492,395	1,034,835	2,527,230	-67,261	2,459,969	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,846,741	9,976,098	14,822,839	-4,254,453	10,568,386	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,117,479	726,921	2,844,400	-8,290	2,836,110	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	537,595	639,447	1,177,042	-1,769	1,175,273	55.00
57.00	05700	CT SCAN	479,645	227,921	707,566	-113,991	593,575	57.00
57.01	03630	ULTRA SOUND	467,341	43,785	511,126	-1,050	510,076	57.01
58.00	05800	MRI	355,549	45,896	401,445	-9,822	391,623	58.00
59.00	05900	CARDIAC CATHETERIZATION	958,007	2,347,489	3,305,496	-1,420,543	1,884,953	59.00
60.00	06000	LABORATORY	3,863,261	5,945,922	9,809,183	-3,894	9,805,289	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	486,661	486,661	0	486,661	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,569,230	372,265	1,941,495	-97,151	1,844,344	65.00
66.00	06600	PHYSICAL THERAPY	5,191,389	796,305	5,987,694	-11,528	5,976,166	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	679,619	199,152	878,771	-273	878,498	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,475,829	11,475,829	0	11,475,829	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	351,090	351,090	-3,013	348,077	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	884,715	356,635	1,241,350	-184,701	1,056,649	76.01
76.02	03070	WOMEN'S CENTER	510,314	168,771	679,085	-82,278	596,807	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL 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	366,797	131,719	498,516	-80,661	417,855	90.00
90.01	09001	OUTPATIENT	565,673	936,452	1,502,125	-375,814	1,126,311	90.01
90.02	09002	NEUROPSYCHOLOGY	368,798	89,813	458,611	-48,681	409,930	90.02
91.00	09100	EMERGENCY	9,014,207	22,136,687	31,150,894	-1,349,290	29,801,604	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	39,644	27,003	66,647	0	66,647	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	67,355,317	176,506,157	243,861,474	3,581,378	247,442,852	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	100,965	126,886	227,851	0	227,851	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	25,723,761	11,811,268	37,535,029	-3,703,938	33,831,091	192.00
192.01	19201	FOUNDATION	243,547	13,444	256,991	0	256,991	192.01
192.02	19202	CLINICS	1,206,666	261,843	1,468,509	-50,183	1,418,326	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	-995	-995	0	-995	192.03
192.04	19207	WESTFIELD SCHOOLS	1,405,880	202,340	1,608,220	-1,259	1,606,961	192.04
192.05	19203	PRACTICE MANAGEMENT	709,933	571,836	1,281,769	-75,165	1,206,604	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	266,330	266,330	0	266,330	192.06
192.07	19208	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.07
192.08	19205	RIVERVIEW MEDICAL ARTS	0	3,742	3,742	0	3,742	192.08

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/29/2024 9:54 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	
192.09	19209	BEHAVIOR CARE	498,561	118,666	617,227	-66,290	550,937	192.09
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	PHYSICIAN SERVICES-LYONS	0	0	0	0	0	193.01
193.02	19302	UNIVERSITY HS ATHLETICS	69,430	5,835	75,265	0	75,265	193.02
193.03	19303	OB/GYN SPEC NEMUNAITI	256,252	51,505	307,757	-34,645	273,112	193.03
193.04	19304	OB/GYN SPEC GATHERS	56,259	16,483	72,742	-7,606	65,136	193.04
193.05	19305	OB SPECIALISTS DAVENPORT	695,609	114,273	809,882	-83,277	726,605	193.05
193.06	19306	RETAIL PHARMACY	591,222	5,468,174	6,059,396	0	6,059,396	193.06
194.00	07950	WORKMED	360,555	267,220	627,775	-2,327	625,448	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	443,312	443,312	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	99,273,957	195,805,007	295,078,964	0	295,078,964	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/29/2024 9:54 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	-39,104	26,501,113		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-59,187	14,684,836		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-21,596,126	30,957,321		5.00
7.00	00700	OPERATION OF PLANT	0	9,335,056		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,951,051		8.00
9.00	00900	HOUSEKEEPING	0	2,449,263		9.00
10.00	01000	DIETARY	-135,148	712,468		10.00
11.00	01100	CAFETERIA	-897,596	1,573,548		11.00
13.00	01300	NURSING ADMINISTRATION	0	757,197		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	9,176,122		14.00
15.00	01500	PHARMACY	0	23,322,562		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,220	1,514,318		16.00
17.00	01700	SOCIAL SERVICE	0	1,113,555		17.00
23.00	02300	PARAMED ED PRGM PHARMACY	0	310,237		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	12,624,098		30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,021,094		31.00
41.00	04100	SUBPROVIDER - IRF	0	2,459,969		41.00
43.00	04300	NURSERY	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-2,596,367	7,972,019		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-4,139	2,831,971		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,175,273		55.00
57.00	05700	CT SCAN	-3,234	590,341		57.00
57.01	03630	ULTRA SOUND	-553	509,523		57.01
58.00	05800	MRI	0	391,623		58.00
59.00	05900	CARDIAC CATHETERIZATION	-735,000	1,149,953		59.00
60.00	06000	LABORATORY	-55,650	9,749,639		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	486,661		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	1,844,344		65.00
66.00	06600	PHYSICAL THERAPY	-83,968	5,892,198		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	-103,238	775,260		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,475,829		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	348,077		74.00
76.00	03020	OTHER ANCILLARY	0	0		76.00
76.01	03140	CARDIAC REHAB	-18,679	1,037,970		76.01
76.02	03070	WOMEN'S CENTER	0	596,807		76.02
76.03	03330	ENDOSCOPY	0	0		76.03
77.00	07700	ALLOGENEIC STEM CELL 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	417,855		90.00
90.01	09001	OUTPATIENT	-6,935	1,119,376		90.01
90.02	09002	NEUROPSYCHOLOGY	-159,991	249,939		90.02
91.00	09100	EMERGENCY	-14,496,156	15,305,448		91.00
91.01	09101	SHORT STAY	0	0		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	66,647		95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-40,992,291	206,450,561		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	227,851		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-17,248,509	16,582,582		192.00
192.01	19201	FOUNDATION	0	256,991		192.01
192.02	19202	CLINICS	-418,923	999,403		192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	-995		192.03
192.04	19207	WESTFIELD SCHOOLS	-2,639	1,604,322		192.04
192.05	19203	PRACTICE MANAGEMENT	-45,371	1,161,233		192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	266,330		192.06
192.07	19208	PHYSICIANS' PRIVATE OFFICES	0	0		192.07
192.08	19205	RIVERVIEW MEDICAL ARTS	0	3,742		192.08
192.09	19209	BEHAVIOR CARE	-387,738	163,199		192.09

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/29/2024 9:54 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	PHYSICIAN SERVICES-LYONS	0	0		193.01
193.02	19302	UNIVERSITY HS ATHLETICS	0	75,265		193.02
193.03	19303	OB/GYN SPEC NEMUNAITI	-264,205	8,907		193.03
193.04	19304	OB/GYN SPEC GATHERS	-58,005	7,131		193.04
193.05	19305	OB SPECIALISTS DAVENPORT	-717,197	9,408		193.05
193.06	19306	RETAIL PHARMACY	0	6,059,396		193.06
194.00	07950	WORKMED	-12,500	612,948		194.00
194.01	07951	MEALS ON WHEELS	0	443,312		194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-60,147,378	234,931,586		200.00

RECLASSIFICATIONS | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/29/2024 9:54 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	948,638	1,522,506	1.00
	0		948,638	1,522,506	
	B - MEALS ON WHEELS RECLASS				
1.00	MEALS ON WHEELS	194.01	170,181	273,131	1.00
	0		170,181	273,131	
	C - INSURANCE RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	624,114	1.00
	0		0	624,114	
	D - MEDICAL SUPPLY RECLASS				
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	8,353,167	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
	0		0	8,353,167	
	E - RSMA RECLASS				
1.00	OPERATING ROOM	50.00	317,495		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		18,919	2.00
	0		317,495	18,919	
	F - PARAMED ED RECLASS				
1.00	PARAMED ED PRGM PHARMACY	23.00	300,384	9,853	1.00
	0		300,384	9,853	
	G - COMMUNITY RELATIONS RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	224,968	1.00
	0		0	224,968	
	H - ALLOCATED BENEFITS RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4,640,018	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
	0		0	4,640,018	
500.00	Grand Total: Increases		1,736,698	15,666,676	500.00

RECLASSIFICATIONS | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/29/2024 9:54 am

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - CAFETERIA RECLASS					
1.00	DIETARY	10.00	948,638	1,522,506	0	1.00
	0		948,638	1,522,506		
	B - MEALS ON WHEELS RECLASS					
1.00	DIETARY	10.00	170,181	273,131	0	1.00
	0		170,181	273,131		
	C - INSURANCE RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	624,114	12	1.00
	0		0	624,114		
	D - MEDICAL SUPPLY RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		3,019	0	1.00
2.00	DIETARY	10.00		4,954	0	2.00
3.00	PHARMACY	15.00		10,597	0	3.00
4.00	ADULTS & PEDIATRICS	30.00		557,256	0	4.00
5.00	INTENSIVE CARE UNIT	31.00		223,304	0	5.00
6.00	SUBPROVIDER - IRF	41.00		67,261	0	6.00
7.00	OPERATING ROOM	50.00		4,145,801	0	7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00		8,290	0	8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00		1,769	0	9.00
10.00	CT SCAN	57.00		113,991	0	10.00
11.00	ULTRA SOUND	57.01		1,050	0	11.00
12.00	MRI	58.00		9,822	0	12.00
13.00	CARDIAC CATHETERIZATION	59.00		1,420,543	0	13.00
14.00	LABORATORY	60.00		3,894	0	14.00
15.00	RESPIRATORY THERAPY	65.00		97,151	0	15.00
16.00	PHYSICAL THERAPY	66.00		11,528	0	16.00
17.00	ELECTROCARDIOLOGY	69.00		273	0	17.00
18.00	RENAL DIALYSIS	74.00		3,013	0	18.00
19.00	CARDIAC REHAB	76.01		184,701	0	19.00
20.00	WOMEN'S CENTER	76.02		82,278	0	20.00
21.00	CLINIC	90.00		31,242	0	21.00
22.00	OUTPATIENT	90.01		375,814	0	22.00
23.00	EMERGENCY	91.00		525,845	0	23.00
24.00	PHYSICIANS' PRIVATE OFFICES	192.00		465,158	0	24.00
25.00	CLINICS	192.02		1,027	0	25.00
26.00	WESTFIELD SCHOOLS	192.04		1,259	0	26.00
27.00	WORKMED	194.00		2,327	0	27.00
	0		0	8,353,167		
	E - RSMA RECLASS					
1.00	OPERATING ROOM	50.00	0	336,414	0	1.00
2.00		0.00	0	0	0	2.00
	0		0	336,414		
	F - PARAMED ED RECLASS					
1.00	PHARMACY	15.00	300,384	9,853	0	1.00
	0		300,384	9,853		
	G - COMMUNITY RELATIONS RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	224,968	0	0	1.00
	0		224,968	0		
	H - ALLOCATED BENEFITS RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	73,821	0	1.00
2.00	OPERATING ROOM	50.00	0	89,733	0	2.00
3.00	CLINIC	90.00	0	49,419	0	3.00
4.00	NEUROPSYCHOLOGY	90.02	0	48,681	0	4.00
5.00	EMERGENCY	91.00	0	823,445	0	5.00
6.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	3,238,780	0	6.00
7.00	CLINICS	192.02	0	49,156	0	7.00
8.00	PRACTICE MANAGEMENT	192.05	0	75,165	0	8.00
9.00	BEHAVIOR CARE	192.09	0	66,290	0	9.00
10.00	OB/GYN SPEC NEMUNAITI	193.03	0	34,645	0	10.00
11.00	OB/GYN SPEC GATHERS	193.04	0	7,606	0	11.00
12.00	OB SPECIALISTS DAVENPORT	193.05	0	83,277	0	12.00
	0		0	4,640,018		
500.00	Grand Total: Decreases		1,644,171	15,759,203		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 5/29/2024 9:54 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	16,050,414	0	0	0	0	1.00
2.00	Land Improvements	3,330,308	139,030	0	139,030	0	2.00
3.00	Buildings and Fixtures	166,686,771	273,743	0	273,743	0	3.00
4.00	Building Improvements	18,834,183	17,671,126	0	17,671,126	0	4.00
5.00	Fixed Equipment	52,683,867	10,407,262	0	10,407,262	0	5.00
6.00	Movable Equipment	125,643,510	2,175,102	0	2,175,102	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	383,229,053	30,666,263	0	30,666,263	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	383,229,053	30,666,263	0	30,666,263	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	16,050,414	0	1.00
2.00	Land Improvements	3,469,338	0	2.00
3.00	Buildings and Fixtures	166,960,514	0	3.00
4.00	Building Improvements	36,505,309	0	4.00
5.00	Fixed Equipment	63,091,129	0	5.00
6.00	Movable Equipment	127,818,612	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	413,895,316	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	413,895,316	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part II | Date/Time Prepared: 5/29/2024 9:54 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	27,164,331	0	0	0	0	1.00
3.00	Total (sum of lines 1-2)	27,164,331	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	27,164,331		1.00
3.00	Total (sum of lines 1-2)	0	27,164,331		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part III Date/Time Prepared: 5/29/2024 9:54 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	413,895,316	0	413,895,316	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	413,895,316	0	413,895,316	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	27,164,331	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	27,164,331	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	-39,104	-624,114	0	0	26,501,113	1.00
3.00	Total (sum of lines 1-2)	-39,104	-624,114	0	0	26,501,113	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/29/2024 9:54 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** 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	-22,121,715			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	235,994			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-619,083	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** 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
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/29/2024 9:54 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	
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	HAF EXPENSE	A	-14,945,936	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	ADMINISTRATION RECRUITMENT/SPECIAL E	A	-1,023	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	OTHER REV MEDICAL REPORT	B	-1,220	MEDICAL RECORDS & LIBRARY	16.00	0	33.02
33.03	OTHER REVENUES ->PURCHASE DISCOUNTS	B	-41,800	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	RADIOLOGY- OTHER REVENUE-CDS FOR LEG	B	-4,039	RADIOLOGY-DIAGNOSTIC	54.00	0	33.04
33.05	AMBULANCE OTHER REVENUE	B	0	AMBULANCE SERVICES	95.00	0	33.05
33.06	LABORATORY -> OTHER REVENUE	B	-55,650	LABORATORY	60.00	0	33.06
33.07	EDUCATION -> OTHER REVENUE	B	-23,958	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	DIETARY SALES PR DEDUCT	B	-278,513	CAFETERIA	11.00	0	33.08
33.09	WELLNESS SERVICES - EXTERNAL->-OTHER	B	-23,262	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.09
33.10	WESTFIELD BISTRO-OTHER REVENUE	B	-135,148	DIETARY	10.00	0	33.10
33.11	NON-OP REV -> MISCELLANEOUS INTEREST	B	-39,104	CAP REL COSTS-BLDG & FIXT	1.00	11	33.11
33.12	COMMUNITY RELATIONS	A	-2,116,555	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	COMMUNITY RELATIONS BENEFITS	A	-23,425	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14	CRNA	A	-876,000	OPERATING ROOM	50.00	0	33.14
33.15	IHA LOBBYING EXPENSE	A	-8,148	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	CT SCAN-OTHER REVENUE	B	-3,234	CT SCAN	57.00	0	33.16
33.17	FISCAL SERVICES COMMERCE BANK REBATE	B	-109,635	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	ULTRASOUND - OTHER REVENUE	B	-553	ULTRA SOUND	57.01	0	33.18
33.19	WOUND CARE-OTHER REVENUE	B	-6,935	OUTPATIENT	90.01	0	33.19
33.20	NON-OP EXPENSE INVESTMENT FEES	A	184,046	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21	OTHER MISC REVENUE	B	-7,024	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22	NEUROPSYCHOLOGY OTHER REVENUE	B	30,729	NEUROPSYCHOLOGY	90.02	0	33.22
33.23	OTHER REV RADIOLOGY FILM	B	-100	RADIOLOGY-DIAGNOSTIC	54.00	0	33.23
33.24	ADMIN DONATIONS	B	-1,000	ADMINISTRATIVE & GENERAL	5.00	0	33.24
33.25	CENTRAL PROCESSING OTHER REVENUE	B	0	CENTRAL SERVICES & SUPPLY	14.00	0	33.25
33.26	PHYSICIAN WAGES-PHYSICIANS' PRIVATE	A	-17,248,509	PHYSICIANS' PRIVATE OFFICES	192.00	0	33.26
33.27	PHYSICIAN WAGES-CLINICS	A	-418,923	CLINICS	192.02	0	33.27
33.28	PHYSICIAN WAGES-WESTFIELD SCHOOLS	A	-2,639	WESTFIELD SCHOOLS	192.04	0	33.28
33.29	PHYSICIAN WAGES-PRACTICE MANAGEMENT	A	-45,371	PRACTICE MANAGEMENT	192.05	0	33.29
33.30	PHYSICIAN WAGES-BEHAVIOR CARE	A	-387,738	BEHAVIOR CARE	192.09	0	33.30
33.31	PHYSICIAN WAGES-OB/GYN SPEC NEMUNAIT	A	-264,205	OB/GYN SPEC NEMUNAITI	193.03	0	33.31
33.32	PHYSICIAN WAGES-OB/GYN SPEC GATHERS	A	-58,005	OB/GYN SPEC GATHERS	193.04	0	33.32
33.33	PHYSICIAN WAGES-OB SPECIALISTS DAVEN	A	-717,197	OB SPECIALISTS DAVENPORT	193.05	0	33.33
33.34	PHYSICIAN WAGES-WORKMED	A	-12,500	WORKMED	194.00	0	33.34
33.35	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.35
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-60,147,378				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: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2024 9:54 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	50.00	OPERATING ROOM	OPERATING ROOM	645,762	409,768	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	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			645,762	409,768	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	RSMA	51.00		0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0059	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8-1 Date/Time Prepared: 5/29/2024 9:54 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	235,994	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	235,994			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: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2024 9:54 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	4.00	EMPLOYEE BENEFITS DEPARTMENT	12,500	12,500	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	4,525,093	4,525,093	0	0	0	2.00
3.00	50.00	OPERATING ROOM	1,956,361	1,956,361	0	0	0	3.00
4.00	59.00	CARDIAC CATHETERIZATION	735,000	735,000	0	0	0	4.00
5.00	66.00	PHYSICAL THERAPY	83,968	83,968	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	103,238	103,238	0	0	0	6.00
7.00	76.01	CARDIAC REHAB	18,679	18,679	0	0	0	7.00
8.00	90.02	NEUROPSYCHOLOGY	190,720	190,720	0	0	0	8.00
9.00	91.00	EMERGENCY	14,496,156	14,496,156	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			22,121,715	22,121,715	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	4.00
5.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	6.00
7.00	76.01	CARDIAC REHAB	0	0	0	0	0	7.00
8.00	90.02	NEUROPSYCHOLOGY	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	12,500		1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	4,525,093		2.00
3.00	50.00	OPERATING ROOM	0	0	0	1,956,361		3.00
4.00	59.00	CARDIAC CATHETERIZATION	0	0	0	735,000		4.00
5.00	66.00	PHYSICAL THERAPY	0	0	0	83,968		5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	103,238		6.00
7.00	76.01	CARDIAC REHAB	0	0	0	18,679		7.00
8.00	90.02	NEUROPSYCHOLOGY	0	0	0	190,720		8.00
9.00	91.00	EMERGENCY	0	0	0	14,496,156		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	22,121,715		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/29/2024 9:54 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	26,501,113	26,501,113				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	14,684,836	91,727	14,776,563			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	30,957,321	1,979,689	1,396,980	34,333,990	34,333,990	5.00
7.00	00700	OPERATION OF PLANT	9,335,056	8,982,148	362,717	18,679,921	3,197,218	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,951,051	61,447	13,230	2,025,728	346,720	8.00
9.00	00900	HOUSEKEEPING	2,449,263	49,707	185,310	2,684,280	459,436	9.00
10.00	01000	DIETARY	712,468	535,623	49,027	1,297,118	222,012	10.00
11.00	01100	CAFETERIA	1,573,548	0	142,104	1,715,652	293,648	11.00
13.00	01300	NURSING ADMINISTRATION	757,197	0	100,238	857,435	146,757	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,176,122	178,471	124,714	9,479,307	1,622,459	14.00
15.00	01500	PHARMACY	23,322,562	315,850	392,321	24,030,733	4,112,989	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,514,318	97,597	113,357	1,725,272	295,294	16.00
17.00	01700	SOCIAL SERVICE	1,113,555	157,439	115,633	1,386,627	237,332	17.00
23.00	02300	PARAMED ED PRGM PHARMACY	310,237	6,546	44,997	361,780	61,922	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,624,098	4,077,585	1,391,685	18,093,368	3,096,825	30.00
31.00	03100	INTENSIVE CARE UNIT	3,021,094	601,715	350,518	3,973,327	680,067	31.00
41.00	04100	SUBPROVIDER - IRF	2,459,969	627,054	223,558	3,310,581	566,632	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,972,019	2,135,144	773,592	10,880,755	1,862,328	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,831,971	566,030	317,194	3,715,195	635,885	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,175,273	303,054	80,531	1,558,858	266,811	55.00
57.00	05700	CT SCAN	590,341	0	71,850	662,191	113,339	57.00
57.01	03630	ULTRA SOUND	509,523	0	70,007	579,530	99,191	57.01
58.00	05800	MRI	391,623	0	53,261	444,884	76,145	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,149,953	99,667	143,508	1,393,128	238,445	59.00
60.00	06000	LABORATORY	9,749,639	612,358	578,709	10,940,706	1,872,589	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	486,661	104,312	0	590,973	101,150	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,844,344	62,165	235,068	2,141,577	366,548	65.00
66.00	06600	PHYSICAL THERAPY	5,892,198	198,404	777,660	6,868,262	1,175,558	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	775,260	338,908	101,806	1,215,974	208,124	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,475,829	0	0	11,475,829	1,964,180	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	348,077	36,530	0	384,607	65,829	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	1,037,970	464,505	132,529	1,635,004	279,844	76.01
76.02	03070	WOMEN'S CENTER	596,807	389,248	76,444	1,062,499	181,855	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL 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	417,855	101,820	54,945	574,620	98,351	90.00
90.01	09001	OUTPATIENT	1,119,376	148,275	84,737	1,352,388	231,472	90.01
90.02	09002	NEUROPSYCHOLOGY	249,939	71,709	55,245	376,893	64,508	90.02
91.00	09100	EMERGENCY	15,305,448	895,394	1,350,310	17,551,152	3,004,020	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	66,647	11,529	5,939	84,115	14,397	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	206,450,561	24,301,650	9,969,724	199,444,259	28,259,880	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	227,851	250,391	15,124	493,366	84,444	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	16,582,582	1,897,845	3,853,367	22,333,794	3,822,608	192.00
192.01	19201	FOUNDATION	256,991	0	36,483	293,474	50,230	192.01
192.02	19202	CLINICS	999,403	0	180,756	1,180,159	201,994	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	-995	0	0	-995	0	192.03
192.04	19207	WESTFIELD SCHOOLS	1,604,322	0	210,598	1,814,920	310,638	192.04
192.05	19203	PRACTICE MANAGEMENT	1,161,233	0	106,347	1,267,580	216,956	192.05

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/29/2024 9:54 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
192.06	19204	MOB - NOBLESVILLE SQUARE	266,330	0	0	266,330	45,585	192.06
192.07	19208	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.07
192.08	19205	RIVERVIEW MEDICAL ARTS	3,742	0	0	3,742	640	192.08
192.09	19209	BEHAVIOR CARE	163,199	0	74,683	237,882	40,715	192.09
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	PHYSICIAN SERVICES-LYONS	0	0	0	0	0	193.01
193.02	19302	UNIVERSITY HS ATHLETICS	75,265	0	10,400	85,665	14,662	193.02
193.03	19303	OB/GYN SPEC NEMUNAITI	8,907	0	38,386	47,293	8,095	193.03
193.04	19304	OB/GYN SPEC GATHERS	7,131	0	8,427	15,558	2,663	193.04
193.05	19305	OB SPECIALISTS DAVENPORT	9,408	0	104,201	113,609	19,445	193.05
193.06	19306	RETAIL PHARMACY	6,059,396	51,227	88,564	6,199,187	1,061,040	193.06
194.00	07950	WORKMED	612,948	0	54,010	666,958	114,155	194.00
194.01	07951	MEALS ON WHEELS	443,312	0	25,493	468,805	80,240	194.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	234,931,586	26,501,113	14,776,563	234,931,586	34,333,990	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/29/2024 9:54 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	21,877,139					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	87,022	2,459,470				8.00
9.00	00900	HOUSEKEEPING	70,395	0	3,214,111			9.00
10.00	01000	DIETARY	758,560	0	339,712	2,617,402		10.00
11.00	01100	CAFETERIA	0	0	0	0	2,009,300	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	20,487	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	252,754	19,932	149,542	0	45,942	14.00
15.00	01500	PHARMACY	447,313	0	97,307	0	94,455	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	138,219	0	0	0	43,566	16.00
17.00	01700	SOCIAL SERVICE	222,969	0	19,387	0	31,457	17.00
23.00	02300	PARAMED ED PRGM PHARMACY	9,270	0	0	0	4,520	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,774,761	831,190	1,970,972	1,833,757	326,315	30.00
31.00	03100	INTENSIVE CARE UNIT	852,162	193,773	0	199,406	77,731	31.00
41.00	04100	SUBPROVIDER - IRF	888,047	207,182	0	584,239	60,981	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,023,835	257,373	69,893	0	222,815	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	801,623	155,287	121,264	0	87,160	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	429,191	21,454	0	0	20,130	55.00
57.00	05700	CT SCAN	0	0	121,264	0	17,726	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	14,200	57.01
58.00	05800	MRI	0	0	121,264	0	12,749	58.00
59.00	05900	CARDIAC CATHETERIZATION	141,150	68,420	0	0	24,245	59.00
60.00	06000	LABORATORY	867,234	0	149,542	0	179,138	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	147,729	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	88,039	0	0	0	55,811	65.00
66.00	06600	PHYSICAL THERAPY	280,984	22,360	51,741	0	206,930	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	479,969	22,758	0	0	28,927	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	51,735	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	657,842	1,957	0	0	42,230	76.01
76.02	03070	WOMEN'S CENTER	551,262	13,227	0	0	26,567	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL 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	144,200	3,588	0	0	11,898	90.00
90.01	09001	OUTPATIENT	209,990	72,044	0	0	27,037	90.01
90.02	09002	NEUROPSYCHOLOGY	101,556	0	0	0	10,043	90.02
91.00	09100	EMERGENCY	1,268,075	357,938	0	0	285,850	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	16,328	0	0	0	2,136	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,762,214	2,248,483	3,211,888	2,617,402	1,981,046	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	354,609	0	2,223	0	8,015	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,687,767	209,175	0	0	0	192.00
192.01	19201	FOUNDATION	0	0	0	0	7,773	192.01
192.02	19202	CLINICS	0	942	0	0	0	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	0	0	0	0	192.03
192.04	19207	WESTFIELD SCHOOLS	0	0	0	0	0	192.04
192.05	19203	PRACTICE MANAGEMENT	0	870	0	0	0	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	0	192.06
192.07	19208	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.07
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	0	192.08
192.09	19209	BEHAVIOR CARE	0	0	0	0	0	192.09
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/29/2024 9:54 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
193.01	19301	PHYSICIAN SERVICES-LYONS	0	0	0	0	0	193.01
193.02	19302	UNIVERSITY HS ATHLETICS	0	0	0	0	0	193.02
193.03	19303	OB/GYN SPEC NEMUNAITI	0	0	0	0	0	193.03
193.04	19304	OB/GYN SPEC GATHERS	0	0	0	0	0	193.04
193.05	19305	OB SPECIALISTS DAVENPORT	0	0	0	0	0	193.05
193.06	19306	RETAIL PHARMACY	72,549	0	0	0	0	193.06
194.00	07950	WORKMED	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	12,466	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	21,877,139	2,459,470	3,214,111	2,617,402	2,009,300	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/29/2024 9:54 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	1,024,679					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,569,936				14.00
15.00	01500	PHARMACY	0	0	28,782,797			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	2,202,351		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	1,897,772	17.00
23.00	02300	PARAMED ED PRGM PHARMACY	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	445,305	0	0	1,236,408	1,615,725	30.00
31.00	03100	INTENSIVE CARE UNIT	106,075	0	0	0	124,963	31.00
41.00	04100	SUBPROVIDER - IRF	83,217	0	0	0	157,084	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	0	57.01
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	11,569,936	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	28,782,797	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0	0	0	0	0	76.01
76.02	03070	WOMEN'S CENTER	0	0	0	0	0	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT	0	0	0	0	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	390,082	0	0	965,943	0	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,024,679	11,569,936	28,782,797	2,202,351	1,897,772	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FOUNDATION	0	0	0	0	0	192.01
192.02	19202	CLINICS	0	0	0	0	0	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	0	0	0	0	192.03
192.04	19207	WESTFIELD SCHOOLS	0	0	0	0	0	192.04
192.05	19203	PRACTICE MANAGEMENT	0	0	0	0	0	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	0	192.06
192.07	19208	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.07
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	0	192.08
192.09	19209	BEHAVIOR CARE	0	0	0	0	0	192.09

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/29/2024 9:54 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	PHYSICIAN SERVICES-LYONS	0	0	0	0	0	193.01
193.02	19302	UNIVERSITY HS ATHLETICS	0	0	0	0	0	193.02
193.03	19303	OB/GYN SPEC NEMUNAITI	0	0	0	0	0	193.03
193.04	19304	OB/GYN SPEC GATHERS	0	0	0	0	0	193.04
193.05	19305	OB SPECIALISTS DAVENPORT	0	0	0	0	0	193.05
193.06	19306	RETAIL PHARMACY	0	0	0	0	0	193.06
194.00	07950	WORKMED	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,024,679	11,569,936	28,782,797	2,202,351	1,897,772	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/29/2024 9:54 am

		Cost Center Description	PARAMED ED PRGM PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
23.00	02300	PARAMED ED PRGM PHARMACY	437,492					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	35,224,626	0	35,224,626		30.00
31.00	03100	INTENSIVE CARE UNIT	0	6,207,504	0	6,207,504		31.00
41.00	04100	SUBPROVIDER - IRF	0	5,857,963	0	5,857,963		41.00
43.00	04300	NURSERY	0	0	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	16,316,999	0	16,316,999		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,516,414	0	5,516,414		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,296,444	0	2,296,444		55.00
57.00	05700	CT SCAN	0	914,520	0	914,520		57.00
57.01	03630	ULTRA SOUND	0	692,921	0	692,921		57.01
58.00	05800	MRI	0	655,042	0	655,042		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,865,388	0	1,865,388		59.00
60.00	06000	LABORATORY	0	14,009,209	0	14,009,209		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	839,852	0	839,852		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	2,651,975	0	2,651,975		65.00
66.00	06600	PHYSICAL THERAPY	0	8,605,835	0	8,605,835		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,955,752	0	1,955,752		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	11,569,936	0	11,569,936		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	13,440,009	0	13,440,009		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	437,492	29,220,289	0	29,220,289		73.00
74.00	07400	RENAL DIALYSIS	0	502,171	0	502,171		74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0		76.00
76.01	03140	CARDIAC REHAB	0	2,616,877	0	2,616,877		76.01
76.02	03070	WOMEN'S CENTER	0	1,835,410	0	1,835,410		76.02
76.03	03330	ENDOSCOPY	0	0	0	0		76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	832,657	0	832,657		90.00
90.01	09001	OUTPATIENT	0	1,892,931	0	1,892,931		90.01
90.02	09002	NEUROPSYCHOLOGY	0	553,000	0	553,000		90.02
91.00	09100	EMERGENCY	0	23,823,060	0	23,823,060		91.00
91.01	09101	SHORT STAY	0	0	0	0		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	116,976	0	116,976		95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	437,492	190,013,760	0	190,013,760		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	942,657	0	942,657		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	29,053,344	0	29,053,344		192.00
192.01	19201	FOUNDATION	0	351,477	0	351,477		192.01
192.02	19202	CLINICS	0	1,383,095	0	1,383,095		192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	-995	0	-995		192.03
192.04	19207	WESTFIELD SCHOOLS	0	2,125,558	0	2,125,558		192.04
192.05	19203	PRACTICE MANAGEMENT	0	1,485,406	0	1,485,406		192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	311,915	0	311,915		192.06
192.07	19208	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.07

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/29/2024 9:54 am

		Cost Center Description	PARAMED ED PRGM PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.00	24.00	25.00	26.00		
192.08	19205	RIVERVIEW MEDICAL ARTS	0	4,382	0	4,382		192.08
192.09	19209	BEHAVIOR CARE	0	278,597	0	278,597		192.09
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	PHYSICIAN SERVICES-LYONS	0	0	0	0		193.01
193.02	19302	UNIVERSITY HS ATHLETICS	0	100,327	0	100,327		193.02
193.03	19303	OB/GYN SPEC NEMUNAITI	0	55,388	0	55,388		193.03
193.04	19304	OB/GYN SPEC GATHERS	0	18,221	0	18,221		193.04
193.05	19305	OB SPECIALISTS DAVENPORT	0	133,054	0	133,054		193.05
193.06	19306	RETAIL PHARMACY	0	7,332,776	0	7,332,776		193.06
194.00	07950	WORKMED	0	781,113	0	781,113		194.00
194.01	07951	MEALS ON WHEELS	0	561,511	0	561,511		194.01
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	437,492	234,931,586	0	234,931,586		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/29/2024 9:54 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	91,727	91,727	91,727		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	1,979,689	1,979,689	8,673	1,988,362	5.00
7.00	00700	OPERATION OF PLANT	0	8,982,148	8,982,148	2,252	185,155	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	61,447	61,447	82	20,079	8.00
9.00	00900	HOUSEKEEPING	0	49,707	49,707	1,150	26,607	9.00
10.00	01000	DIETARY	0	535,623	535,623	304	12,857	10.00
11.00	01100	CAFETERIA	0	0	0	882	17,006	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	622	8,499	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	178,471	178,471	774	93,959	14.00
15.00	01500	PHARMACY	0	315,850	315,850	2,436	238,222	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	97,597	97,597	704	17,101	16.00
17.00	01700	SOCIAL SERVICE	0	157,439	157,439	718	13,744	17.00
23.00	02300	PARAMED ED PRGM PHARMACY	0	6,546	6,546	279	3,586	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	4,077,585	4,077,585	8,640	179,341	30.00
31.00	03100	INTENSIVE CARE UNIT	0	601,715	601,715	2,176	39,384	31.00
41.00	04100	SUBPROVIDER - IRF	0	627,054	627,054	1,388	32,814	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,135,144	2,135,144	4,803	107,850	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	566,030	566,030	1,969	36,825	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	303,054	303,054	500	15,451	55.00
57.00	05700	CT SCAN	0	0	0	446	6,564	57.00
57.01	03630	ULTRA SOUND	0	0	0	435	5,744	57.01
58.00	05800	MRI	0	0	0	331	4,410	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	99,667	99,667	891	13,809	59.00
60.00	06000	LABORATORY	0	612,358	612,358	3,593	108,444	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	104,312	104,312	0	5,858	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	62,165	62,165	1,459	21,227	65.00
66.00	06600	PHYSICAL THERAPY	0	198,404	198,404	4,828	68,078	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	338,908	338,908	632	12,053	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	113,748	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	36,530	36,530	0	3,812	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0	464,505	464,505	823	16,206	76.01
76.02	03070	WOMEN'S CENTER	0	389,248	389,248	475	10,531	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL 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	101,820	101,820	341	5,696	90.00
90.01	09001	OUTPATIENT	0	148,275	148,275	526	13,405	90.01
90.02	09002	NEUROPSYCHOLOGY	0	71,709	71,709	343	3,736	90.02
91.00	09100	EMERGENCY	0	895,394	895,394	8,383	173,967	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	11,529	11,529	37	834	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	24,301,650	24,301,650	61,895	1,636,602	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	250,391	250,391	94	4,890	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,897,845	1,897,845	23,914	221,373	192.00
192.01	19201	FOUNDATION	0	0	0	226	2,909	192.01
192.02	19202	CLINICS	0	0	0	1,122	11,698	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	0	0	0	0	192.03
192.04	19207	WESTFIELD SCHOOLS	0	0	0	1,307	17,989	192.04
192.05	19203	PRACTICE MANAGEMENT	0	0	0	660	12,564	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	2,640	192.06

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/29/2024 9:54 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
192.07	19208	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.07
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	37	192.08
192.09	19209	BEHAVIOR CARE	0	0	0	464	2,358	192.09
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	PHYSICIAN SERVICES-LYONS	0	0	0	0	0	193.01
193.02	19302	UNIVERSITY HS ATHLETICS	0	0	0	65	849	193.02
193.03	19303	OB/GYN SPEC NEMUNAITI	0	0	0	238	469	193.03
193.04	19304	OB/GYN SPEC GATHERS	0	0	0	52	154	193.04
193.05	19305	OB SPECIALISTS DAVENPORT	0	0	0	647	1,126	193.05
193.06	19306	RETAIL PHARMACY	0	51,227	51,227	550	61,446	193.06
194.00	07950	WORKMED	0	0	0	335	6,611	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	158	4,647	194.01
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	26,501,113	26,501,113	91,727	1,988,362	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/29/2024 9:54 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	9,169,555					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	36,474	118,082				8.00
9.00	00900	HOUSEKEEPING	29,505	0	106,969			9.00
10.00	01000	DIETARY	317,942	0	11,306	878,032		10.00
11.00	01100	CAFETERIA	0	0	0	0	17,888	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	182	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	105,939	957	4,977	0	409	14.00
15.00	01500	PHARMACY	187,486	0	3,238	0	841	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	57,933	0	0	0	388	16.00
17.00	01700	SOCIAL SERVICE	93,455	0	645	0	280	17.00
23.00	02300	PARAMED ED PRGM PHARMACY	3,886	0	0	0	40	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,420,426	39,906	65,596	615,150	2,905	30.00
31.00	03100	INTENSIVE CARE UNIT	357,174	9,303	0	66,893	692	31.00
41.00	04100	SUBPROVIDER - IRF	372,215	9,947	0	195,989	543	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,267,406	12,357	2,326	0	1,984	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	335,991	7,455	4,036	0	776	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	179,891	1,030	0	0	179	55.00
57.00	05700	CT SCAN	0	0	4,036	0	158	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	126	57.01
58.00	05800	MRI	0	0	4,036	0	113	58.00
59.00	05900	CARDIAC CATHETERIZATION	59,161	3,285	0	0	216	59.00
60.00	06000	LABORATORY	363,491	0	4,977	0	1,595	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	61,919	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	36,901	0	0	0	497	65.00
66.00	06600	PHYSICAL THERAPY	117,771	1,074	1,722	0	1,842	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	201,174	1,093	0	0	258	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	21,684	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	275,727	94	0	0	376	76.01
76.02	03070	WOMEN'S CENTER	231,055	635	0	0	237	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL 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	60,440	172	0	0	106	90.00
90.01	09001	OUTPATIENT	88,015	3,459	0	0	241	90.01
90.02	09002	NEUROPSYCHOLOGY	42,566	0	0	0	89	90.02
91.00	09100	EMERGENCY	531,499	17,185	0	0	2,545	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	6,844	0	0	0	19	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,863,970	107,952	106,895	878,032	17,637	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	148,630	0	74	0	71	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,126,547	10,043	0	0	0	192.00
192.01	19201	FOUNDATION	0	0	0	0	69	192.01
192.02	19202	CLINICS	0	45	0	0	0	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	0	0	0	0	192.03
192.04	19207	WESTFIELD SCHOOLS	0	0	0	0	0	192.04
192.05	19203	PRACTICE MANAGEMENT	0	42	0	0	0	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	0	192.06
192.07	19208	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.07
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	0	192.08
192.09	19209	BEHAVIOR CARE	0	0	0	0	0	192.09
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/29/2024 9:54 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
193.01	19301	PHYSICIAN SERVICES-LYONS	0	0	0	0	0	193.01
193.02	19302	UNIVERSITY HS ATHLETICS	0	0	0	0	0	193.02
193.03	19303	OB/GYN SPEC NEMUNAITI	0	0	0	0	0	193.03
193.04	19304	OB/GYN SPEC GATHERS	0	0	0	0	0	193.04
193.05	19305	OB SPECIALISTS DAVENPORT	0	0	0	0	0	193.05
193.06	19306	RETAIL PHARMACY	30,408	0	0	0	0	193.06
194.00	07950	WORKMED	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	111	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	9,169,555	118,082	106,969	878,032	17,888	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/29/2024 9:54 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	9,303					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	385,486				14.00
15.00	01500	PHARMACY	0	0	748,073			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	173,723		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	266,281	17.00
23.00	02300	PARAMED ED PRGM PHARMACY	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,042	0	0	97,529	226,706	30.00
31.00	03100	INTENSIVE CARE UNIT	963	0	0	0	17,534	31.00
41.00	04100	SUBPROVIDER - IRF	756	0	0	0	22,041	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	0	57.01
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	385,486	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	748,073	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0	0	0	0	0	76.01
76.02	03070	WOMEN'S CENTER	0	0	0	0	0	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT	0	0	0	0	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	3,542	0	0	76,194	0	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,303	385,486	748,073	173,723	266,281	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FOUNDATION	0	0	0	0	0	192.01
192.02	19202	CLINICS	0	0	0	0	0	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	0	0	0	0	192.03
192.04	19207	WESTFIELD SCHOOLS	0	0	0	0	0	192.04
192.05	19203	PRACTICE MANAGEMENT	0	0	0	0	0	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	0	192.06
192.07	19208	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.07
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	0	192.08
192.09	19209	BEHAVIOR CARE	0	0	0	0	0	192.09

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/29/2024 9:54 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	PHYSICIAN SERVICES-LYONS	0	0	0	0	0	193.01
193.02	19302	UNIVERSITY HS ATHLETICS	0	0	0	0	0	193.02
193.03	19303	OB/GYN SPEC NEMUNAITI	0	0	0	0	0	193.03
193.04	19304	OB/GYN SPEC GATHERS	0	0	0	0	0	193.04
193.05	19305	OB SPECIALISTS DAVENPORT	0	0	0	0	0	193.05
193.06	19306	RETAIL PHARMACY	0	0	0	0	0	193.06
194.00	07950	WORKMED	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	9,303	385,486	748,073	173,723	266,281	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/29/2024 9:54 am

		Cost Center Description	PARAMED ED PRGM PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
23.00	02300	PARAMED ED PRGM PHARMACY	14,337					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		7,737,826	0	7,737,826		30.00
31.00	03100	INTENSIVE CARE UNIT		1,095,834	0	1,095,834		31.00
41.00	04100	SUBPROVIDER - IRF		1,262,747	0	1,262,747		41.00
43.00	04300	NURSERY		0	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		3,531,870	0	3,531,870		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		953,082	0	953,082		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		500,105	0	500,105		55.00
57.00	05700	CT SCAN		11,204	0	11,204		57.00
57.01	03630	ULTRA SOUND		6,305	0	6,305		57.01
58.00	05800	MRI		8,890	0	8,890		58.00
59.00	05900	CARDIAC CATHETERIZATION		177,029	0	177,029		59.00
60.00	06000	LABORATORY		1,094,458	0	1,094,458		60.00
60.01	06001	BLOOD LABORATORY		0	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		172,089	0	172,089		63.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY		122,249	0	122,249		65.00
66.00	06600	PHYSICAL THERAPY		393,719	0	393,719		66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY		554,118	0	554,118		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		385,486	0	385,486		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		113,748	0	113,748		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		748,073	0	748,073		73.00
74.00	07400	RENAL DIALYSIS		62,026	0	62,026		74.00
76.00	03020	OTHER ANCILLARY		0	0	0		76.00
76.01	03140	CARDIAC REHAB		757,731	0	757,731		76.01
76.02	03070	WOMEN'S CENTER		632,181	0	632,181		76.02
76.03	03330	ENDOSCOPY		0	0	0		76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION		0	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY		0	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC		168,575	0	168,575		90.00
90.01	09001	OUTPATIENT		253,921	0	253,921		90.01
90.02	09002	NEUROPSYCHOLOGY		118,443	0	118,443		90.02
91.00	09100	EMERGENCY		1,708,709	0	1,708,709		91.00
91.01	09101	SHORT STAY		0	0	0		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES		19,263	0	19,263		95.00
102.00	10200	OPIOID TREATMENT PROGRAM		0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	22,589,681	0	22,589,681		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		404,150	0	404,150		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		3,279,722	0	3,279,722		192.00
192.01	19201	FOUNDATION		3,204	0	3,204		192.01
192.02	19202	CLINICS		12,865	0	12,865		192.02
192.03	19206	HOME HEALTH PARTNERSHIP		0	0	0		192.03
192.04	19207	WESTFIELD SCHOOLS		19,296	0	19,296		192.04
192.05	19203	PRACTICE MANAGEMENT		13,266	0	13,266		192.05
192.06	19204	MOB - NOBLESVILLE SQUARE		2,640	0	2,640		192.06
192.07	19208	PHYSICIANS' PRIVATE OFFICES		0	0	0		192.07

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/29/2024 9:54 am

		Cost Center Description	PARAMED ED PRGM PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.00	24.00	25.00	26.00		
192.08	19205	RIVERVIEW MEDICAL ARTS		37	0	37		192.08
192.09	19209	BEHAVIOR CARE		2,822	0	2,822		192.09
193.00	19300	NONPAID WORKERS		0	0	0		193.00
193.01	19301	PHYSICIAN SERVICES-LYONS		0	0	0		193.01
193.02	19302	UNIVERSITY HS ATHLETICS		914	0	914		193.02
193.03	19303	OB/GYN SPEC NEMUNAITI		707	0	707		193.03
193.04	19304	OB/GYN SPEC GATHERS		206	0	206		193.04
193.05	19305	OB SPECIALISTS DAVENPORT		1,773	0	1,773		193.05
193.06	19306	RETAIL PHARMACY		143,631	0	143,631		193.06
194.00	07950	WORKMED		6,946	0	6,946		194.00
194.01	07951	MEALS ON WHEELS		4,916	0	4,916		194.01
200.00		Cross Foot Adjustments	14,337	14,337	0	14,337		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	14,337	26,501,113	0	26,501,113		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 9:54 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	627,519					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,172	98,643,252				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	46,877	9,325,758	-34,333,990	200,598,591		5.00
7.00	00700	OPERATION OF PLANT	212,688	2,421,372	0	18,679,921	365,782	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,455	88,318	0	2,025,728	1,455	8.00
9.00	00900	HOUSEKEEPING	1,177	1,237,066	0	2,684,280	1,177	9.00
10.00	01000	DIETARY	12,683	327,290	0	1,297,118	12,683	10.00
11.00	01100	CAFETERIA	0	948,638	0	1,715,652	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	669,154	0	857,435	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,226	832,549	0	9,479,307	4,226	14.00
15.00	01500	PHARMACY	7,479	2,619,002	0	24,030,733	7,479	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,311	756,733	0	1,725,272	2,311	16.00
17.00	01700	SOCIAL SERVICE	3,728	771,926	0	1,386,627	3,728	17.00
23.00	02300	PARAMED ED PRGM PHARMACY	155	300,384	0	361,780	155	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	96,553	9,290,412	0	18,093,368	96,553	30.00
31.00	03100	INTENSIVE CARE UNIT	14,248	2,339,935	0	3,973,327	14,248	31.00
41.00	04100	SUBPROVIDER - IRF	14,848	1,492,395	0	3,310,581	14,848	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	50,558	5,164,236	0	10,880,755	50,558	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,403	2,117,479	0	3,715,195	13,403	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	7,176	537,595	0	1,558,858	7,176	55.00
57.00	05700	CT SCAN	0	479,645	0	662,191	0	57.00
57.01	03630	ULTRA SOUND	0	467,341	0	579,530	0	57.01
58.00	05800	MRI	0	355,549	0	444,884	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,360	958,007	0	1,393,128	2,360	59.00
60.00	06000	LABORATORY	14,500	3,863,261	0	10,940,706	14,500	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,470	0	0	590,973	2,470	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,472	1,569,230	0	2,141,577	1,472	65.00
66.00	06600	PHYSICAL THERAPY	4,698	5,191,389	0	6,868,262	4,698	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	8,025	679,619	0	1,215,974	8,025	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11,475,829	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	865	0	0	384,607	865	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	10,999	884,715	0	1,635,004	10,999	76.01
76.02	03070	WOMEN'S CENTER	9,217	510,314	0	1,062,499	9,217	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL 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	2,411	366,797	0	574,620	2,411	90.00
90.01	09001	OUTPATIENT	3,511	565,673	0	1,352,388	3,511	90.01
90.02	09002	NEUROPSYCHOLOGY	1,698	368,798	0	376,893	1,698	90.02
91.00	09100	EMERGENCY	21,202	9,014,207	0	17,551,152	21,202	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	273	39,644	0	84,115	273	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	575,438	66,554,431	-34,333,990	165,110,269	313,701	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,929	100,965	0	493,366	5,929	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	44,939	25,723,761	0	22,333,794	44,939	192.00
192.01	19201	FOUNDATION	0	243,547	0	293,474	0	192.01
192.02	19202	CLINICS	0	1,206,666	0	1,180,159	0	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	0	995	0	0	192.03
192.04	19207	WESTFIELD SCHOOLS	0	1,405,880	0	1,814,920	0	192.04
192.05	19203	PRACTICE MANAGEMENT	0	709,933	0	1,267,580	0	192.05

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 9:54 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	266,330	0	192.06
192.07	19208	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.07
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	3,742	0	192.08
192.09	19209	BEHAVIOR CARE	0	498,561	0	237,882	0	192.09
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	PHYSICIAN SERVICES-LYONS	0	0	0	0	0	193.01
193.02	19302	UNIVERSITY HS ATHLETICS	0	69,430	0	85,665	0	193.02
193.03	19303	OB/GYN SPEC NEMUNAITI	0	256,252	0	47,293	0	193.03
193.04	19304	OB/GYN SPEC GATHERS	0	56,259	0	15,558	0	193.04
193.05	19305	OB SPECIALISTS DAVENPORT	0	695,609	0	113,609	0	193.05
193.06	19306	RETAIL PHARMACY	1,213	591,222	0	6,199,187	1,213	193.06
194.00	07950	WORKMED	0	360,555	0	666,958	0	194.00
194.01	07951	MEALS ON WHEELS	0	170,181	0	468,805	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	26,501,113	14,776,563		34,333,990	21,877,139	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	42.231571	0.149798		0.171158	59.809228	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		91,727		1,988,362	9,169,555	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000930		0.009912	25.068360	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: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 9:54 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (HOURS OF SERVIC)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HR)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	67,867					8.00
9.00	00900	HOUSEKEEPING	0	26,028				9.00
10.00	01000	DIETARY	0	2,751	64,790			10.00
11.00	01100	CAFETERIA	0	0	0	1,237,234		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	12,615	462,356	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	550	1,211	0	28,289	0	14.00
15.00	01500	PHARMACY	0	788	0	58,161	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	26,826	0	16.00
17.00	01700	SOCIAL SERVICE	0	157	0	19,370	0	17.00
23.00	02300	PARAMED ED PRGM PHARMACY	0	0	0	2,783	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,936	15,961	45,392	200,931	200,931	30.00
31.00	03100	INTENSIVE CARE UNIT	5,347	0	4,936	47,863	47,863	31.00
41.00	04100	SUBPROVIDER - IRF	5,717	0	14,462	37,549	37,549	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,102	566	0	137,199	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,285	982	0	53,669	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	592	0	0	12,395	0	55.00
57.00	05700	CT SCAN	0	982	0	10,915	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	8,744	0	57.01
58.00	05800	MRI	0	982	0	7,850	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,888	0	0	14,929	0	59.00
60.00	06000	LABORATORY	0	1,211	0	110,305	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	34,366	0	65.00
66.00	06600	PHYSICAL THERAPY	617	419	0	127,418	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	628	0	0	17,812	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	54	0	0	26,003	0	76.01
76.02	03070	WOMEN'S CENTER	365	0	0	16,359	0	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL 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	99	0	0	7,326	0	90.00
90.01	09001	OUTPATIENT	1,988	0	0	16,648	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0	0	0	6,184	0	90.02
91.00	09100	EMERGENCY	9,877	0	0	176,013	176,013	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	1,315	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	62,045	26,010	64,790	1,219,837	462,356	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18	0	4,935	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,772	0	0	0	0	192.00
192.01	19201	FOUNDATION	0	0	0	4,786	0	192.01
192.02	19202	CLINICS	26	0	0	0	0	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	0	0	0	0	192.03
192.04	19207	WESTFIELD SCHOOLS	0	0	0	0	0	192.04
192.05	19203	PRACTICE MANAGEMENT	24	0	0	0	0	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	0	192.06
192.07	19208	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.07

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 9:54 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (HOURS OF SERVIC)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HR)	
			8.00	9.00	10.00	11.00	13.00	
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	0	192.08
192.09	19209	BEHAVIOR CARE	0	0	0	0	0	192.09
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	PHYSICIAN SERVICES-LYONS	0	0	0	0	0	193.01
193.02	19302	UNIVERSITY HS ATHLETICS	0	0	0	0	0	193.02
193.03	19303	OB/GYN SPEC NEMUNAITI	0	0	0	0	0	193.03
193.04	19304	OB/GYN SPEC GATHERS	0	0	0	0	0	193.04
193.05	19305	OB SPECIALISTS DAVENPORT	0	0	0	0	0	193.05
193.06	19306	RETAIL PHARMACY	0	0	0	0	0	193.06
194.00	07950	WORKMED	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	7,676	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,459,470	3,214,111	2,617,402	2,009,300	1,024,679	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	36.239557	123.486668	40.398240	1.624026	2.216212	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	118,082	106,969	878,032	17,888	9,303	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.739903	4.109766	13.551968	0.014458	0.020121	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: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 9:54 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	PARAMED ED PRGM PHARMACY (ASSIGNED TIME)	
			14.00	15.00	16.00	17.00	23.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	100					14.00
15.00	01500	PHARMACY	0	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	342			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	4,313		17.00
23.00	02300	PARAMED ED PRGM PHARMACY	0	0	0	0	100	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	192	3,672	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	284	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	357	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	0	57.01
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	100	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	100	0	0	100	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0	0	0	0	0	76.01
76.02	03070	WOMEN'S CENTER	0	0	0	0	0	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT	0	0	0	0	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	150	0	0	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	100	342	4,313	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FOUNDATION	0	0	0	0	0	192.01
192.02	19202	CLINICS	0	0	0	0	0	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	0	0	0	0	192.03
192.04	19207	WESTFIELD SCHOOLS	0	0	0	0	0	192.04
192.05	19203	PRACTICE MANAGEMENT	0	0	0	0	0	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	0	192.06
192.07	19208	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.07

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 9:54 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	PARAMED ED PRGM PHARMACY (ASSIGNED TIME)	
			14.00	15.00	16.00	17.00	23.00	
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	0	192.08
192.09	19209	BEHAVIOR CARE	0	0	0	0	0	192.09
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	PHYSICIAN SERVICES-LYONS	0	0	0	0	0	193.01
193.02	19302	UNIVERSITY HS ATHLETICS	0	0	0	0	0	193.02
193.03	19303	OB/GYN SPEC NEMUNAITI	0	0	0	0	0	193.03
193.04	19304	OB/GYN SPEC GATHERS	0	0	0	0	0	193.04
193.05	19305	OB SPECIALISTS DAVENPORT	0	0	0	0	0	193.05
193.06	19306	RETAIL PHARMACY	0	0	0	0	0	193.06
194.00	07950	WORKMED	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	11,569,936	28,782,797	2,202,351	1,897,772	437,492	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	115,699.36000	287,827.97000	6,439.622807	440.012057	4,374.920000	203.00
			0	0				
204.00		Cost to be allocated (per Wkst. B, Part II)	385,486	748,073	173,723	266,281	14,337	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3,854.860000	7,480.730000	507.961988	61.739161	143.370000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 9:54 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,224,626		35,224,626	0	35,224,626	30.00
31.00	03100	INTENSIVE CARE UNIT	6,207,504		6,207,504	0	6,207,504	31.00
41.00	04100	SUBPROVIDER - IRF	5,857,963		5,857,963	0	5,857,963	41.00
43.00	04300	NURSERY	0		0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,316,999		16,316,999	0	16,316,999	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,516,414		5,516,414	0	5,516,414	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,296,444		2,296,444	0	2,296,444	55.00
57.00	05700	CT SCAN	914,520		914,520	0	914,520	57.00
57.01	03630	ULTRA SOUND	692,921		692,921	0	692,921	57.01
58.00	05800	MRI	655,042		655,042	0	655,042	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,865,388		1,865,388	0	1,865,388	59.00
60.00	06000	LABORATORY	14,009,209		14,009,209	0	14,009,209	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	839,852		839,852	0	839,852	63.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,651,975	0	2,651,975	0	2,651,975	65.00
66.00	06600	PHYSICAL THERAPY	8,605,835	0	8,605,835	0	8,605,835	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	1,955,752		1,955,752	0	1,955,752	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,569,936		11,569,936	0	11,569,936	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,440,009		13,440,009	0	13,440,009	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,220,289		29,220,289	0	29,220,289	73.00
74.00	07400	RENAL DIALYSIS	502,171		502,171	0	502,171	74.00
76.00	03020	OTHER ANCILLARY	0		0	0	0	76.00
76.01	03140	CARDIAC REHAB	2,616,877		2,616,877	0	2,616,877	76.01
76.02	03070	WOMEN'S CENTER	1,835,410		1,835,410	0	1,835,410	76.02
76.03	03330	ENDOSCOPY	0		0	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL 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	832,657		832,657	0	832,657	90.00
90.01	09001	OUTPATIENT	1,892,931		1,892,931	0	1,892,931	90.01
90.02	09002	NEUROPSYCHOLOGY	553,000		553,000	0	553,000	90.02
91.00	09100	EMERGENCY	23,823,060		23,823,060	0	23,823,060	91.00
91.01	09101	SHORT STAY	0		0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	8,291,733		8,291,733		8,291,733	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	116,976		116,976	0	116,976	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	198,305,493	0	198,305,493	0	198,305,493	200.00
201.00		Less Observation Beds	8,291,733		8,291,733		8,291,733	201.00
202.00		Total (see instructions)	190,013,760	0	190,013,760	0	190,013,760	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I | Date/Time Prepared: 5/29/2024 9:54 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	34,809,069		34,809,069			30.00
31.00	03100	INTENSIVE CARE UNIT	9,765,619		9,765,619			31.00
41.00	04100	SUBPROVIDER - IRF	6,110,163		6,110,163			41.00
43.00	04300	NURSERY	0		0			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,638,683	101,114,633	119,753,316	0.136255	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,006,007	14,986,359	16,992,366	0.324641	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	122,071	10,769,794	10,891,865	0.210840	0.000000	55.00
57.00	05700	CT SCAN	4,232,844	22,842,363	27,075,207	0.033777	0.000000	57.00
57.01	03630	ULTRA SOUND	1,016,798	8,617,333	9,634,131	0.071924	0.000000	57.01
58.00	05800	MRI	847,823	8,975,107	9,822,930	0.066685	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	10,911,431	20,546,597	31,458,028	0.059298	0.000000	59.00
60.00	06000	LABORATORY	17,564,490	54,358,056	71,922,546	0.194782	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,212,156	728,449	1,940,605	0.432778	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	6,146,090	2,460,265	8,606,355	0.308141	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	7,333,404	22,772,511	30,105,915	0.285852	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	3,045,955	9,959,403	13,005,358	0.150380	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,091,684	36,182,738	53,274,422	0.217176	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,949,511	24,069,974	31,019,485	0.433276	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,194,923	81,856,679	98,051,602	0.298009	0.000000	73.00
74.00	07400	RENAL DIALYSIS	883,231	35,224	918,455	0.546756	0.000000	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03140	CARDIAC REHAB	540,063	18,378,264	18,918,327	0.138325	0.000000	76.01
76.02	03070	WOMEN'S CENTER	26,297	9,397,564	9,423,861	0.194762	0.000000	76.02
76.03	03330	ENDOSCOPY	0	0	0	0.000000	0.000000	76.03
77.00	07700	ALLOGENEIC STEM CELL 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	30,000	6,170,853	6,200,853	0.134281	0.000000	90.00
90.01	09001	OUTPATIENT	291,991	7,466,720	7,758,711	0.243975	0.000000	90.01
90.02	09002	NEUROPSYCHOLOGY	0	2,623,085	2,623,085	0.210820	0.000000	90.02
91.00	09100	EMERGENCY	5,452,740	85,178,806	90,631,546	0.262856	0.000000	91.00
91.01	09101	SHORT STAY	0	0	0	0.000000	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,020,430	7,754,119	9,774,549	0.848298	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	173,243,473	557,244,896	730,488,369			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	173,243,473	557,244,896	730,488,369			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 9:54 am

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		Cost Center Description	PPS Inpatient Ratio
			11.00
		INPATIENT ROUTINE SERVICE COST CENTERS	
30.00	03000	ADULTS & PEDIATRICS	
31.00	03100	INTENSIVE CARE UNIT	
41.00	04100	SUBPROVIDER - IRF	
43.00	04300	NURSERY	
44.00	04400	SKILLED NURSING FACILITY	
		ANCILLARY SERVICE COST CENTERS	
50.00	05000	OPERATING ROOM	0.136255
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.324641
55.00	05500	RADIOLOGY-THERAPEUTIC	0.210840
57.00	05700	CT SCAN	0.033777
57.01	03630	ULTRA SOUND	0.071924
58.00	05800	MRI	0.066685
59.00	05900	CARDIAC CATHETERIZATION	0.059298
60.00	06000	LABORATORY	0.194782
60.01	06001	BLOOD LABORATORY	0.000000
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.432778
64.00	06400	INTRAVENOUS THERAPY	0.000000
65.00	06500	RESPIRATORY THERAPY	0.308141
66.00	06600	PHYSICAL THERAPY	0.285852
67.00	06700	OCCUPATIONAL THERAPY	0.000000
68.00	06800	SPEECH PATHOLOGY	0.000000
69.00	06900	ELECTROCARDIOLOGY	0.150380
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.217176
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.433276
73.00	07300	DRUGS CHARGED TO PATIENTS	0.298009
74.00	07400	RENAL DIALYSIS	0.546756
76.00	03020	OTHER ANCILLARY	0.000000
76.01	03140	CARDIAC REHAB	0.138325
76.02	03070	WOMEN'S CENTER	0.194762
76.03	03330	ENDOSCOPY	0.000000
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000
		OUTPATIENT SERVICE COST CENTERS	
90.00	09000	CLINIC	0.134281
90.01	09001	OUTPATIENT	0.243975
90.02	09002	NEUROPSYCHOLOGY	0.210820
91.00	09100	EMERGENCY	0.262856
91.01	09101	SHORT STAY	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.848298
		OTHER REIMBURSABLE COST CENTERS	
95.00	09500	AMBULANCE SERVICES	0.000000
102.00	10200	OPIOID TREATMENT PROGRAM	
200.00		Subtotal (see instructions)	
201.00		Less Observation Beds	
202.00		Total (see instructions)	

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 9:54 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,224,626		35,224,626	0	35,224,626	30.00
31.00	03100	INTENSIVE CARE UNIT	6,207,504		6,207,504	0	6,207,504	31.00
41.00	04100	SUBPROVIDER - IRF	5,857,963		5,857,963	0	5,857,963	41.00
43.00	04300	NURSERY	0		0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,316,999		16,316,999	0	16,316,999	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,516,414		5,516,414	0	5,516,414	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,296,444		2,296,444	0	2,296,444	55.00
57.00	05700	CT SCAN	914,520		914,520	0	914,520	57.00
57.01	03630	ULTRA SOUND	692,921		692,921	0	692,921	57.01
58.00	05800	MRI	655,042		655,042	0	655,042	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,865,388		1,865,388	0	1,865,388	59.00
60.00	06000	LABORATORY	14,009,209		14,009,209	0	14,009,209	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	839,852		839,852	0	839,852	63.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,651,975	0	2,651,975	0	2,651,975	65.00
66.00	06600	PHYSICAL THERAPY	8,605,835	0	8,605,835	0	8,605,835	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	1,955,752		1,955,752	0	1,955,752	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,569,936		11,569,936	0	11,569,936	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,440,009		13,440,009	0	13,440,009	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,220,289		29,220,289	0	29,220,289	73.00
74.00	07400	RENAL DIALYSIS	502,171		502,171	0	502,171	74.00
76.00	03020	OTHER ANCILLARY	0		0	0	0	76.00
76.01	03140	CARDIAC REHAB	2,616,877		2,616,877	0	2,616,877	76.01
76.02	03070	WOMEN'S CENTER	1,835,410		1,835,410	0	1,835,410	76.02
76.03	03330	ENDOSCOPY	0		0	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL 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	832,657		832,657	0	832,657	90.00
90.01	09001	OUTPATIENT	1,892,931		1,892,931	0	1,892,931	90.01
90.02	09002	NEUROPSYCHOLOGY	553,000		553,000	0	553,000	90.02
91.00	09100	EMERGENCY	23,823,060		23,823,060	0	23,823,060	91.00
91.01	09101	SHORT STAY	0		0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	8,291,733		8,291,733		8,291,733	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	116,976		116,976	0	116,976	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	198,305,493	0	198,305,493	0	198,305,493	200.00
201.00		Less Observation Beds	8,291,733		8,291,733		8,291,733	201.00
202.00		Total (see instructions)	190,013,760	0	190,013,760	0	190,013,760	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 9:54 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	34,809,069		34,809,069			30.00
31.00	03100	INTENSIVE CARE UNIT	9,765,619		9,765,619			31.00
41.00	04100	SUBPROVIDER - IRF	6,110,163		6,110,163			41.00
43.00	04300	NURSERY	0		0			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,638,683	101,114,633	119,753,316	0.136255	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,006,007	14,986,359	16,992,366	0.324641	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	122,071	10,769,794	10,891,865	0.210840	0.000000	55.00
57.00	05700	CT SCAN	4,232,844	22,842,363	27,075,207	0.033777	0.000000	57.00
57.01	03630	ULTRA SOUND	1,016,798	8,617,333	9,634,131	0.071924	0.000000	57.01
58.00	05800	MRI	847,823	8,975,107	9,822,930	0.066685	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	10,911,431	20,546,597	31,458,028	0.059298	0.000000	59.00
60.00	06000	LABORATORY	17,564,490	54,358,056	71,922,546	0.194782	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,212,156	728,449	1,940,605	0.432778	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	6,146,090	2,460,265	8,606,355	0.308141	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	7,333,404	22,772,511	30,105,915	0.285852	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	3,045,955	9,959,403	13,005,358	0.150380	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,091,684	36,182,738	53,274,422	0.217176	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,949,511	24,069,974	31,019,485	0.433276	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,194,923	81,856,679	98,051,602	0.298009	0.000000	73.00
74.00	07400	RENAL DIALYSIS	883,231	35,224	918,455	0.546756	0.000000	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03140	CARDIAC REHAB	540,063	18,378,264	18,918,327	0.138325	0.000000	76.01
76.02	03070	WOMEN'S CENTER	26,297	9,397,564	9,423,861	0.194762	0.000000	76.02
76.03	03330	ENDOSCOPY	0	0	0	0.000000	0.000000	76.03
77.00	07700	ALLOGENEIC STEM CELL 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	30,000	6,170,853	6,200,853	0.134281	0.000000	90.00
90.01	09001	OUTPATIENT	291,991	7,466,720	7,758,711	0.243975	0.000000	90.01
90.02	09002	NEUROPSYCHOLOGY	0	2,623,085	2,623,085	0.210820	0.000000	90.02
91.00	09100	EMERGENCY	5,452,740	85,178,806	90,631,546	0.262856	0.000000	91.00
91.01	09101	SHORT STAY	0	0	0	0.000000	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,020,430	7,754,119	9,774,549	0.848298	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	173,243,473	557,244,896	730,488,369			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	173,243,473	557,244,896	730,488,369			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 9:54 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
57.00	05700	CT SCAN	0.000000		57.00
57.01	03630	ULTRA SOUND	0.000000		57.01
58.00	05800	MRI	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03020	OTHER ANCILLARY	0.000000		76.00
76.01	03140	CARDIAC REHAB	0.000000		76.01
76.02	03070	WOMEN'S CENTER	0.000000		76.02
76.03	03330	ENDOSCOPY	0.000000		76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000		78.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	OUTPATIENT	0.000000		90.01
90.02	09002	NEUROPSYCHOLOGY	0.000000		90.02
91.00	09100	EMERGENCY	0.000000		91.00
91.01	09101	SHORT STAY	0.000000		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part I Date/Time Prepared: 5/29/2024 9:54 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	7,737,826	0	7,737,826	15,544	497.80	30.00
31.00	INTENSIVE CARE UNIT	1,095,834		1,095,834	2,507	437.11	31.00
41.00	SUBPROVIDER - IRF	1,262,747	0	1,262,747	3,870	326.29	41.00
43.00	NURSERY	0		0	0	0.00	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	10,096,407		10,096,407	21,921		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	2,885	1,436,153	30.00
31.00	INTENSIVE CARE UNIT	610	266,637	31.00
41.00	SUBPROVIDER - IRF	2,200	717,838	41.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30 through 199)	5,695	2,420,628	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/29/2024 9:54 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,531,870	119,753,316	0.029493	5,129,214	151,276	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	953,082	16,992,366	0.056089	633,059	35,508	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	500,105	10,891,865	0.045915	2,295	105	55.00
57.00	05700	CT SCAN	11,204	27,075,207	0.000414	1,178,816	488	57.00
57.01	03630	ULTRA SOUND	6,305	9,634,131	0.000654	286,712	188	57.01
58.00	05800	MRI	8,890	9,822,930	0.000905	159,456	144	58.00
59.00	05900	CARDIAC CATHETERIZATION	177,029	31,458,028	0.005627	3,072,342	17,288	59.00
60.00	06000	LABORATORY	1,094,458	71,922,546	0.015217	4,608,672	70,130	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	172,089	1,940,605	0.088678	200,095	17,744	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	122,249	8,606,355	0.014205	1,867,771	26,532	65.00
66.00	06600	PHYSICAL THERAPY	393,719	30,105,915	0.013078	894,012	11,692	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	554,118	13,005,358	0.042607	778,210	33,157	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	385,486	53,274,422	0.007236	4,056,722	29,354	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	113,748	31,019,485	0.003667	2,051,656	7,523	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	748,073	98,051,602	0.007629	4,244,864	32,384	73.00
74.00	07400	RENAL DIALYSIS	62,026	918,455	0.067533	306,257	20,682	74.00
76.00	03020	OTHER ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03140	CARDIAC REHAB	757,731	18,918,327	0.040053	170,344	6,823	76.01
76.02	03070	WOMEN'S CENTER	632,181	9,423,861	0.067083	0	0	76.02
76.03	03330	ENDOSCOPY	0	0	0.000000	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL 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	168,575	6,200,853	0.027186	25,025	680	90.00
90.01	09001	OUTPATIENT	253,921	7,758,711	0.032727	60,636	1,984	90.01
90.02	09002	NEUROPSYCHOLOGY	118,443	2,623,085	0.045154	0	0	90.02
91.00	09100	EMERGENCY	1,708,709	90,631,546	0.018853	1,672,367	31,529	91.00
91.01	09101	SHORT STAY	0	0	0.000000	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,821,453	9,774,549	0.186347	564,260	105,148	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	14,295,464	679,803,518		31,962,785	600,359	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part III Date/Time Prepared: 5/29/2024 9:54 am

Title XVIII | Hospital | PPS

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	15,544	0.00	2,885	30.00
31.00	03100	INTENSIVE CARE UNIT		0	2,507	0.00	610	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	3,870	0.00	2,200	41.00
43.00	04300	NURSERY		0	0	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00
200.00		Total (lines 30 through 199)		0	21,921		5,695	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/29/2024 9:54 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	0	57.01
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	437,492	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0	0	0	0	0	76.01
76.02	03070	WOMEN'S CENTER	0	0	0	0	0	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT	0	0	0	0	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	437,492	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/29/2024 9:54 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	119,753,316	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	16,992,366	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	10,891,865	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	27,075,207	0.000000	57.00
57.01	03630	ULTRA SOUND	0	0	0	9,634,131	0.000000	57.01
58.00	05800	MRI	0	0	0	9,822,930	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	31,458,028	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	71,922,546	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	1,940,605	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,606,355	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	30,105,915	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	13,005,358	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	53,274,422	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	31,019,485	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	437,492	437,492	98,051,602	0.004462	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	918,455	0.000000	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03140	CARDIAC REHAB	0	0	0	18,918,327	0.000000	76.01
76.02	03070	WOMEN'S CENTER	0	0	0	9,423,861	0.000000	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0.000000	76.03
77.00	07700	ALLOGENEIC STEM CELL 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	6,200,853	0.000000	90.00
90.01	09001	OUTPATIENT	0	0	0	7,758,711	0.000000	90.01
90.02	09002	NEUROPSYCHOLOGY	0	0	0	2,623,085	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	90,631,546	0.000000	91.00
91.01	09101	SHORT STAY	0	0	0	0	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	9,774,549	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	437,492	437,492	679,803,518		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/29/2024 9:54 am

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	5,129,214	0	15,914,836	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	633,059	0	2,814,749	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	2,295	0	2,880,332	0	55.00
57.00	05700	CT SCAN	0.000000	1,178,816	0	4,425,324	0	57.00
57.01	03630	ULTRA SOUND	0.000000	286,712	0	1,949,096	0	57.01
58.00	05800	MRI	0.000000	159,456	0	1,685,199	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	3,072,342	0	5,746,945	0	59.00
60.00	06000	LABORATORY	0.000000	4,608,672	0	3,941,487	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	200,095	0	54,644	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,867,771	0	4,096	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	894,012	0	161,498	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	778,210	0	1,673,895	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	4,056,722	0	6,495,229	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	2,051,656	0	5,200,994	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.004462	4,244,864	18,941	27,516,329	122,778	73.00
74.00	07400	RENAL DIALYSIS	0.000000	306,257	0	1,818	0	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0.000000	170,344	0	6,133,131	0	76.01
76.02	03070	WOMEN'S CENTER	0.000000	0	0	428,427	0	76.02
76.03	03330	ENDOSCOPY	0.000000	0	0	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL 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	25,025	0	2,014,842	0	90.00
90.01	09001	OUTPATIENT	0.000000	60,636	0	2,739,234	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0.000000	0	0	890,767	0	90.02
91.00	09100	EMERGENCY	0.000000	1,672,367	0	6,239,423	0	91.00
91.01	09101	SHORT STAY	0.000000	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	564,260	0	745,181	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		31,962,785	18,941	99,657,476	122,778	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/29/2024 9:54 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.136255	15,914,836	0	0	2,168,476	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.324641	2,814,749	0	0	913,783	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.210840	2,880,332	0	0	607,289	55.00
57.00	05700	CT SCAN	0.033777	4,425,324	0	0	149,474	57.00
57.01	03630	ULTRA SOUND	0.071924	1,949,096	0	0	140,187	57.01
58.00	05800	MRI	0.066685	1,685,199	0	0	112,377	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.059298	5,746,945	0	0	340,782	59.00
60.00	06000	LABORATORY	0.194782	3,941,487	1,347	0	767,731	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.432778	54,644	0	0	23,649	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.308141	4,096	0	0	1,262	65.00
66.00	06600	PHYSICAL THERAPY	0.285852	161,498	0	0	46,165	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	0.150380	1,673,895	0	0	251,720	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.217176	6,495,229	736	0	1,410,608	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.433276	5,200,994	0	0	2,253,466	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.298009	27,516,329	0	10,575	8,200,114	73.00
74.00	07400	RENAL DIALYSIS	0.546756	1,818	0	0	994	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0.138325	6,133,131	0	0	848,365	76.01
76.02	03070	WOMEN'S CENTER	0.194762	428,427	0	0	83,441	76.02
76.03	03330	ENDOSCOPY	0.000000	0	0	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL 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	0.134281	2,014,842	0	0	270,555	90.00
90.01	09001	OUTPATIENT	0.243975	2,739,234	0	0	668,305	90.01
90.02	09002	NEUROPSYCHOLOGY	0.210820	890,767	0	0	187,791	90.02
91.00	09100	EMERGENCY	0.262856	6,239,423	0	0	1,640,070	91.00
91.01	09101	SHORT STAY	0.000000	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.848298	745,181	0	0	632,136	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		99,657,476	2,083	10,575	21,718,740	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		99,657,476	2,083	10,575	21,718,740	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/29/2024 9:54 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00	05700	CT SCAN	0	0		57.00
57.01	03630	ULTRA SOUND	0	0		57.01
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	262	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	160	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,151		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	OTHER ANCILLARY	0	0		76.00
76.01	03140	CARDIAC REHAB	0	0		76.01
76.02	03070	WOMEN'S CENTER	0	0		76.02
76.03	03330	ENDOSCOPY	0	0		76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OUTPATIENT	0	0		90.01
90.02	09002	NEUROPSYCHOLOGY	0	0		90.02
91.00	09100	EMERGENCY	0	0		91.00
91.01	09101	SHORT STAY	0	0		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	422	3,151		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	422	3,151		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II | Date/Time Prepared: 5/29/2024 9:54 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,531,870	119,753,316	0.029493	487,812	14,387	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	953,082	16,992,366	0.056089	59,668	3,347	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	500,105	10,891,865	0.045915	0	0	55.00
57.00	05700	CT SCAN	11,204	27,075,207	0.000414	62,552	26	57.00
57.01	03630	ULTRA SOUND	6,305	9,634,131	0.000654	26,715	17	57.01
58.00	05800	MRI	8,890	9,822,930	0.000905	16,351	15	58.00
59.00	05900	CARDIAC CATHETERIZATION	177,029	31,458,028	0.005627	188,071	1,058	59.00
60.00	06000	LABORATORY	1,094,458	71,922,546	0.015217	601,221	9,149	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	172,089	1,940,605	0.088678	28,216	2,502	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	122,249	8,606,355	0.014205	303,646	4,313	65.00
66.00	06600	PHYSICAL THERAPY	393,719	30,105,915	0.013078	2,738,945	35,820	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	554,118	13,005,358	0.042607	25,614	1,091	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	385,486	53,274,422	0.007236	744,589	5,388	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	113,748	31,019,485	0.003667	273,854	1,004	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	748,073	98,051,602	0.007629	687,066	5,242	73.00
74.00	07400	RENAL DIALYSIS	62,026	918,455	0.067533	53,699	3,626	74.00
76.00	03020	OTHER ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03140	CARDIAC REHAB	757,731	18,918,327	0.040053	11,484	460	76.01
76.02	03070	WOMEN'S CENTER	632,181	9,423,861	0.067083	0	0	76.02
76.03	03330	ENDOSCOPY	0	0	0.000000	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL 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	168,575	6,200,853	0.027186	3,036	83	90.00
90.01	09001	OUTPATIENT	253,921	7,758,711	0.032727	17,681	579	90.01
90.02	09002	NEUROPSYCHOLOGY	118,443	2,623,085	0.045154	0	0	90.02
91.00	09100	EMERGENCY	1,708,709	90,631,546	0.018853	43,205	815	91.00
91.01	09101	SHORT STAY	0	0	0.000000	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	9,774,549	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	12,474,011	679,803,518		6,373,425	88,922	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/29/2024 9:54 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	0	57.01
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	437,492	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0	0	0	0	0	76.01
76.02	03070	WOMEN'S CENTER	0	0	0	0	0	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT	0	0	0	0	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	437,492	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/29/2024 9:54 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	119,753,316	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	16,992,366	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	10,891,865	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	27,075,207	0.000000	57.00
57.01	03630	ULTRA SOUND	0	0	0	9,634,131	0.000000	57.01
58.00	05800	MRI	0	0	0	9,822,930	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	31,458,028	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	71,922,546	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	1,940,605	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,606,355	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	30,105,915	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	13,005,358	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	53,274,422	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	31,019,485	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	437,492	437,492	98,051,602	0.004462	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	918,455	0.000000	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03140	CARDIAC REHAB	0	0	0	18,918,327	0.000000	76.01
76.02	03070	WOMEN'S CENTER	0	0	0	9,423,861	0.000000	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0.000000	76.03
77.00	07700	ALLOGENEIC STEM CELL 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	6,200,853	0.000000	90.00
90.01	09001	OUTPATIENT	0	0	0	7,758,711	0.000000	90.01
90.02	09002	NEUROPSYCHOLOGY	0	0	0	2,623,085	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	90,631,546	0.000000	91.00
91.01	09101	SHORT STAY	0	0	0	0	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	9,774,549	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	437,492	437,492	679,803,518		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/29/2024 9:54 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	487,812	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	59,668	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
57.00	05700	CT SCAN	0.000000	62,552	0	0	0	57.00
57.01	03630	ULTRA SOUND	0.000000	26,715	0	0	0	57.01
58.00	05800	MRI	0.000000	16,351	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	188,071	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	601,221	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	28,216	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	303,646	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	2,738,945	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	25,614	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	744,589	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	273,854	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.004462	687,066	3,066	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	53,699	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0.000000	11,484	0	0	0	76.01
76.02	03070	WOMEN'S CENTER	0.000000	0	0	0	0	76.02
76.03	03330	ENDOSCOPY	0.000000	0	0	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL 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	3,036	0	0	0	90.00
90.01	09001	OUTPATIENT	0.000000	17,681	0	0	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	43,205	0	408	0	91.00
91.01	09101	SHORT STAY	0.000000	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		6,373,425	3,066	408	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V | Date/Time Prepared: 5/29/2024 9:54 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.136255	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.324641	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.210840	0	0	0	0	55.00
57.00	05700	CT SCAN	0.033777	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0.071924	0	0	0	0	57.01
58.00	05800	MRI	0.066685	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.059298	0	0	0	0	59.00
60.00	06000	LABORATORY	0.194782	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.432778	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.308141	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.285852	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	0.150380	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.217176	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.433276	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.298009	0	0	987	0	73.00
74.00	07400	RENAL DIALYSIS	0.546756	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0.138325	0	0	0	0	76.01
76.02	03070	WOMEN'S CENTER	0.194762	0	0	0	0	76.02
76.03	03330	ENDOSCOPY	0.000000	0	0	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL 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	0.134281	0	0	0	0	90.00
90.01	09001	OUTPATIENT	0.243975	0	0	0	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0.210820	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.262856	408	0	0	107	91.00
91.01	09101	SHORT STAY	0.000000	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.848298	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		408	0	987	107	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		408	0	987	107	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V | Date/Time Prepared: 5/29/2024 9:54 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00	05700	CT SCAN	0	0		57.00
57.01	03630	ULTRA SOUND	0	0		57.01
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	294		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	OTHER ANCILLARY	0	0		76.00
76.01	03140	CARDIAC REHAB	0	0		76.01
76.02	03070	WOMEN'S CENTER	0	0		76.02
76.03	03330	ENDOSCOPY	0	0		76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OUTPATIENT	0	0		90.01
90.02	09002	NEUROPSYCHOLOGY	0	0		90.02
91.00	09100	EMERGENCY	0	0		91.00
91.01	09101	SHORT STAY	0	0		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	294		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	294		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 9:54 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	15,544	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,544	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)	11,885	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	2,885	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	35,224,626	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	35,224,626	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)	35,224,626	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)	2,266.12	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	6,537,756	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)	6,537,756	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 9:54 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	6,207,504	2,507	2,476.07	610	1,510,403	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	7,252,921	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)	15,301,080	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)	1,702,790	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	619,300	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,322,090	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	12,978,990	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)	3,659	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,266.12	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0059	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/29/2024 9:54 am
	Title XVIII	Hospital	PPS

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	8,291,733	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	7,737,826	35,224,626	0.219671	8,291,733	1,821,453	90.00
91.00	Nursing Program cost	0	35,224,626	0.000000	8,291,733	0	91.00
92.00	Allied health cost	0	35,224,626	0.000000	8,291,733	0	92.00
93.00	All other Medical Education	0	35,224,626	0.000000	8,291,733	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0059 Component CCN: 15-T059	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/29/2024 9:54 am
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,870	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,870	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)	3,870	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	2,200	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,857,963	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,857,963	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)	5,857,963	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,513.69	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,330,118	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3,330,118	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 9:54 am

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	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)	1,643,924	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)	4,974,042	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)	717,838	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	91,988	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	809,826	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	4,164,216	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0059 Component CCN: 15-T059	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/29/2024 9:54 am
	Title XVIII	Subprovider - IRF	PPS

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

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,262,747	5,857,963	0.215561	0	0	90.00
91.00	Nursing Program cost	0	5,857,963	0.000000	0	0	91.00
92.00	Allied health cost	0	5,857,963	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,857,963	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 9:54 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	15,544	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,544	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)	11,885	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	391	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	35,224,626	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	35,224,626	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)	35,224,626	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)	2,266.12	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	886,053	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)	886,053	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 9:54 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	6,207,504	2,507	2,476.07	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	471,375	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	1,357,428	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	3,659	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,266.12	88.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 9:54 am

Title XIX | Hospital | Cost

	Cost Center Description						
						1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					8,291,733	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	7,737,826	35,224,626	0.219671	8,291,733	1,821,453	90.00
91.00	Nursing Program cost	0	35,224,626	0.000000	8,291,733	0	91.00
92.00	Allied health cost	0	35,224,626	0.000000	8,291,733	0	92.00
93.00	All other Medical Education	0	35,224,626	0.000000	8,291,733	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0059 Component CCN: 15-T059	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/29/2024 9:54 am
	Title XIX	Subprovider - IRF	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,870	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,870	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)	3,870	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	7	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,857,963	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,857,963	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)	5,857,963	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,513.69	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	10,596	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)	10,596	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 9:54 am

Title XIX | Subprovider - IRF | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	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)	2,448	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	13,044	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0059 Component CCN: 15-T059	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/29/2024 9:54 am
	Title XIX	Subprovider - IRF	Cost

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

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,262,747	5,857,963	0.215561	0	0	90.00
91.00	Nursing Program cost	0	5,857,963	0.000000	0	0	91.00
92.00	Allied health cost	0	5,857,963	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,857,963	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/29/2024 9:54 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		6,041,512		30.00
31.00	03100	INTENSIVE CARE UNIT		2,395,359		31.00
41.00	04100	SUBPROVIDER - IRF		411,066		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.136255	5,129,214	698,881	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.324641	633,059	205,517	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.210840	2,295	484	55.00
57.00	05700	CT SCAN	0.033777	1,178,816	39,817	57.00
57.01	03630	ULTRA SOUND	0.071924	286,712	20,621	57.01
58.00	05800	MRI	0.066685	159,456	10,633	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.059298	3,072,342	182,184	59.00
60.00	06000	LABORATORY	0.194782	4,608,672	897,686	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.432778	200,095	86,597	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.308141	1,867,771	575,537	65.00
66.00	06600	PHYSICAL THERAPY	0.285852	894,012	255,555	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.150380	778,210	117,027	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.217176	4,056,722	881,023	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.433276	2,051,656	888,933	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.298009	4,244,864	1,265,008	73.00
74.00	07400	RENAL DIALYSIS	0.546756	306,257	167,448	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	0	76.00
76.01	03140	CARDIAC REHAB	0.138325	170,344	23,563	76.01
76.02	03070	WOMEN'S CENTER	0.194762	0	0	76.02
76.03	03330	ENDOSCOPY	0.000000	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL 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	0.134281	25,025	3,360	90.00
90.01	09001	OUTPATIENT	0.243975	60,636	14,794	90.01
90.02	09002	NEUROPSYCHOLOGY	0.210820	0	0	90.02
91.00	09100	EMERGENCY	0.262856	1,672,367	439,592	91.00
91.01	09101	SHORT STAY	0.000000	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.848298	564,260	478,661	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		31,962,785	7,252,921	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)		31,962,785		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/29/2024 9:54 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
41.00	04100	SUBPROVIDER - IRF		3,538,829		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.136255	487,812	66,467	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.324641	59,668	19,371	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.210840	0	0	55.00
57.00	05700	CT SCAN	0.033777	62,552	2,113	57.00
57.01	03630	ULTRA SOUND	0.071924	26,715	1,921	57.01
58.00	05800	MRI	0.066685	16,351	1,090	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.059298	188,071	11,152	59.00
60.00	06000	LABORATORY	0.194782	601,221	117,107	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.432778	28,216	12,211	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.308141	303,646	93,566	65.00
66.00	06600	PHYSICAL THERAPY	0.285852	2,738,945	782,933	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.150380	25,614	3,852	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.217176	744,589	161,707	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.433276	273,854	118,654	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.298009	687,066	204,752	73.00
74.00	07400	RENAL DIALYSIS	0.546756	53,699	29,360	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	0	76.00
76.01	03140	CARDIAC REHAB	0.138325	11,484	1,589	76.01
76.02	03070	WOMEN'S CENTER	0.194762	0	0	76.02
76.03	03330	ENDOSCOPY	0.000000	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL 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	0.134281	3,036	408	90.00
90.01	09001	OUTPATIENT	0.243975	17,681	4,314	90.01
90.02	09002	NEUROPSYCHOLOGY	0.210820	0	0	90.02
91.00	09100	EMERGENCY	0.262856	43,205	11,357	91.00
91.01	09101	SHORT STAY	0.000000	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.848298	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		6,373,425	1,643,924	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)		6,373,425		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/29/2024 9:54 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,278,615		30.00
31.00	03100	INTENSIVE CARE UNIT		143,290		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.136255	510,399	69,544	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.324641	25,472	8,269	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.210840	0	0	55.00
57.00	05700	CT SCAN	0.033777	59,289	2,003	57.00
57.01	03630	ULTRA SOUND	0.071924	20,265	1,458	57.01
58.00	05800	MRI	0.066685	6,039	403	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.059298	89,386	5,300	59.00
60.00	06000	LABORATORY	0.194782	403,707	78,635	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.432778	66,102	28,607	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.308141	54,531	16,803	65.00
66.00	06600	PHYSICAL THERAPY	0.285852	89,098	25,469	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.150380	31,647	4,759	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.217176	333,689	72,469	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.433276	40,002	17,332	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.298009	341,087	101,647	73.00
74.00	07400	RENAL DIALYSIS	0.546756	15,073	8,241	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	0	76.00
76.01	03140	CARDIAC REHAB	0.138325	2,353	325	76.01
76.02	03070	WOMEN'S CENTER	0.194762	0	0	76.02
76.03	03330	ENDOSCOPY	0.000000	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL 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	0.134281	0	0	90.00
90.01	09001	OUTPATIENT	0.243975	23,625	5,764	90.01
90.02	09002	NEUROPSYCHOLOGY	0.210820	0	0	90.02
91.00	09100	EMERGENCY	0.262856	75,841	19,935	91.00
91.01	09101	SHORT STAY	0.000000	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.848298	5,201	4,412	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,192,806	471,375	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)		2,192,806		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/29/2024 9:54 am

Title XIX | Subprovider - IRF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
41.00	04100	SUBPROVIDER - IRF		94,755		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.136255	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.324641	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.210840	0	0	55.00
57.00	05700	CT SCAN	0.033777	0	0	57.00
57.01	03630	ULTRA SOUND	0.071924	0	0	57.01
58.00	05800	MRI	0.066685	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.059298	0	0	59.00
60.00	06000	LABORATORY	0.194782	540	105	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.432778	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.308141	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.285852	1,068	305	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.150380	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.217176	9,384	2,038	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.433276	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.298009	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.546756	0	0	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	0	76.00
76.01	03140	CARDIAC REHAB	0.138325	0	0	76.01
76.02	03070	WOMEN'S CENTER	0.194762	0	0	76.02
76.03	03330	ENDOSCOPY	0.000000	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL 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	0.134281	0	0	90.00
90.01	09001	OUTPATIENT	0.243975	0	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0.210820	0	0	90.02
91.00	09100	EMERGENCY	0.262856	0	0	91.00
91.01	09101	SHORT STAY	0.000000	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.848298	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		10,992	2,448	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)		10,992		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/29/2024 9:54 am
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		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	6,041,312	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	2,195,072	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	253,734	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	152,326	2.04
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	110.63	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
5.01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)	0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)	0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	1.19	30.00
31.00	Percentage of Medicaid patient days (see instructions)	19.09	31.00
32.00	Sum of lines 30 and 31	20.28	32.00
33.00	Allowable disproportionate share percentage (see instructions)	5.95	33.00

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			1.00	
34.00	Disproportionate share adjustment (see instructions)		122,517	34.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Payment Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital UCP, including supplemental UCP (see instructions)	1,468,768	1,299,466	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	1,098,558	326,642	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	1,425,200		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	10,190,161		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	10,190,161	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	737,629	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	54,720	53.00
54.00	Special add-on payments for new technologies	19,567	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
55.01	Cellular therapy acquisition cost (see instructions)	0	55.01
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	18,941	58.00
59.00	Total (sum of amounts on lines 49 through 58)	11,021,018	59.00
60.00	Primary payer payments	10,522	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	11,010,496	61.00
62.00	Deductibles billed to program beneficiaries	1,020,316	62.00
63.00	Coinsurance billed to program beneficiaries	9,200	63.00
64.00	Allowable bad debts (see instructions)	38,624	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	25,106	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	23,120	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	10,006,086	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)	0	70.75
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	-16,819	70.93
70.94	HRR adjustment amount (see instructions)	-81,373	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A | Date/Time Prepared: 5/29/2024 9:54 am

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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3	0	0	70.98
70.99	HAC adjustment amount (see instructions)		28,959	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		9,878,935	71.00
71.01	Sequestration adjustment (see instructions)		197,579	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		9,227,926	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		453,430	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		267,424	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/29/2024 9:54 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	6,041,312	0	6,041,312		6,041,312	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,195,072	0		2,195,072	2,195,072	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	253,734	0	253,734		253,734	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	152,326	0		152,326	152,326	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0595	0.0595	0.0595	0.0595		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	122,517	0	89,865	32,652	122,517	11.00
11.01	Uncompensated care payments	36.00	1,425,200	0	1,098,558	326,642	1,425,200	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	10,190,161	0	7,483,469	2,706,692	10,190,161	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	10,190,161	0	7,483,469	2,706,692	10,190,161	15.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/29/2024 9:54 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	737,629	0	529,609	208,020	737,629	16.00
17.00	Special add-on payments for new technologies	54.00	19,567	0	19,567	0	19,567	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	8,032,645	2,914,712	10,947,357	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	625,552	0	456,123	169,429	625,552	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	85,804	0	54,329	31,475	85,804	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0420	0.0420	0.0420	0.0420		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	26,273	0	19,157	7,116	26,273	25.00
26.00	Total prospective capital payments (see instructions)	12.00	737,629	0	529,609	208,020	737,629	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/29/2024 9:54 am

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	6,041,312	6,041,312		6,041,312	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,195,072		2,195,072	2,195,072	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	253,734	253,734		253,734	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	152,326		152,326	152,326	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0595	0.0595	0.0595		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	122,517	89,865	32,652	122,517	11.00
11.01	Uncompensated care payments	36.00	1,425,200	1,098,558	326,642	1,425,200	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	10,190,161	7,483,469	2,706,692	10,190,161	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	10,190,161	7,483,469	2,706,692	10,190,161	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	737,629	529,609	208,020	737,629	16.00
17.00	Special add-on payments for new technologies	54.00	19,567	19,567	0	19,567	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			8,032,645	2,914,712	10,947,357	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/29/2024 9:54 am

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	625,552	456,123	169,429	625,552	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	85,804	54,329	31,475	85,804	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0420	0.0420	0.0420		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	26,273	19,157	7,116	26,273	25.00
26.00	Total prospective capital payments (see instructions)	12.00	737,629	529,609	208,020	737,629	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-16,819	0	-16,819	-16,819	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-81,373	-79,397	-1,976	-81,373	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	28,959	28,959	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/29/2024 9:54 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,573	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	21,595,962	2.00
3.00	OPPS or REH payments	17,977,956	3.00
4.00	Outlier payment (see instructions)	106,735	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	122,778	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	3,573	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	12,658	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)	12,658	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)	12,658	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	9,085	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)	3,573	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)	18,207,469	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	197	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,238,444	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)	14,972,401	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)	14,972,401	30.00
31.00	Primary payer payments	1,840	31.00
32.00	Subtotal (line 30 minus line 31)	14,970,561	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)	194,145	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	126,194	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	183,787	36.00
37.00	Subtotal (see instructions)	15,096,755	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)	15,096,755	40.00
40.01	Sequestration adjustment (see instructions)	301,935	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	14,678,274	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)	116,546	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/29/2024 9:54 am
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059 Component CCN: 15-T059	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/29/2024 9:54 am
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	294	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	107	2.00
3.00	OPPS or REH payments	125	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)	294	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	987	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)	987	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)	987	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	693	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)	294	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)	125	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	419	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)	419	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	419	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	419	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)	419	40.00
40.01	Sequestration adjustment (see instructions)	8	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	529	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)	-118	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059 Component CCN: 15-T059	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/29/2024 9:54 am
	Title XVIII	Subprovider - IRF	PPS

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2024 9:54 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		9,160,358		14,550,454	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	12/31/2023	67,568	12/31/2023	127,820	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)		67,568		127,820	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)		9,227,926		14,678,274	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		453,430		116,546	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		9,681,356		14,794,820	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: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2024 9:54 am

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,558,064		529	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,558,064		529	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		59,062		118	6.02
7.00	Total Medicare program liability (see instructions)		4,499,002		411	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: 15-0059	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/29/2024 9:54 am
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059 Component CCN: 15-T059	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part III Date/Time Prepared: 5/29/2024 9:54 am
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	4,287,027	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0053	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	63,448	3.00
4.00	Outlier Payments	315,326	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	10.602740	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	4,665,801	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	4,665,801	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	4,665,801	19.00
20.00	Deductibles	73,512	20.00
21.00	Subtotal (line 19 minus line 20)	4,592,289	21.00
22.00	Coinsurance	16,800	22.00
23.00	Subtotal (line 21 minus line 22)	4,575,489	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	18,866	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	12,263	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	18,866	26.00
27.00	Subtotal (sum of lines 23 and 25)	4,587,752	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	3,066	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.98	Recovery of accelerated depreciation.	0	31.98
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	4,590,818	32.00
32.01	Sequestration adjustment (see instructions)	91,816	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	4,558,064	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	-59,062	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	315,326	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)		
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0.000000	99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0.000000	99.01

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/29/2024 9:54 am
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	1,357,428		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	1,357,428	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	1,357,428	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	1,421,905		8.00
9.00	Ancillary service charges	2,192,806	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	3,614,711	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	3,614,711	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	2,257,283	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	1,357,428	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	1,357,428	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	1,357,428	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	1,357,428	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	1,357,428	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	1,357,428	0	40.00
41.00	Interim payments	1,472,383	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-114,955	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059 Component CCN: 15-T059	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/29/2024 9:54 am
	Title XIX	Subprovider - IRF	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	13,044		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	13,044	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	13,044	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	94,755		8.00
9.00	Ancillary service charges	10,992	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	105,747	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	105,747	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	92,703	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	13,044	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	13,044	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	13,044	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	13,044	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	13,044	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	13,044	0	40.00
41.00	Interim payments	43,356	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-30,312	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0059	Period: From 01/01/2023 To 12/31/2023	Worksheet E-5 Date/Time Prepared: 5/29/2024 9:54 am
	Title XVIII		PPS

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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G | Date/Time Prepared: 5/29/2024 9:54 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	7,774,333	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	121,853,926	0	0	0	4.00
5.00	Other receivable	15,059,550	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-81,181,875	0	0	0	6.00
7.00	Inventory	8,054,723	0	0	0	7.00
8.00	Prepaid expenses	4,191,860	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)	75,752,517	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	16,050,414	0	0	0	12.00
13.00	Land improvements	3,469,338	0	0	0	13.00
14.00	Accumulated depreciation	-4,342,210	0	0	0	14.00
15.00	Buildings	166,960,514	0	0	0	15.00
16.00	Accumulated depreciation	-92,128,227	0	0	0	16.00
17.00	Leasehold improvements	36,505,309	0	0	0	17.00
18.00	Accumulated depreciation	-9,370,141	0	0	0	18.00
19.00	Fixed equipment	63,091,129	0	0	0	19.00
20.00	Accumulated depreciation	-39,390,704	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	127,818,612	0	0	0	23.00
24.00	Accumulated depreciation	-107,853,414	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)	160,810,620	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	48,658,235	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	79,827	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	48,738,062	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	285,301,199	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	10,537,281	0	0	0	37.00
38.00	Salaries, wages, and fees payable	10,756,379	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	21,364,063	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	149,303,743	0	0	0	43.00
44.00	Other current liabilities	4,969,189	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	196,930,655	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	41,827,629	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	18,074,605	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	59,902,234	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	256,832,889	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	28,468,310				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)	28,468,310	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	285,301,199	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 5/29/2024 9:54 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		52,004,289		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-23,535,995				2.00
3.00	Total (sum of line 1 and line 2)		28,468,294		0		3.00
4.00	ROUNDING	16		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		16		0		10.00
11.00	Subtotal (line 3 plus line 10)		28,468,310		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		28,468,310		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	ROUNDING		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/29/2024 9:54 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	48,085,794		48,085,794	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	6,848,837		6,848,837	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	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)	54,934,631		54,934,631	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	11,946,986		11,946,986	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)	11,946,986		11,946,986	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	66,881,617		66,881,617	17.00
18.00	Ancillary services	107,814,880	440,999,577	548,814,457	18.00
19.00	Outpatient services	6,958,257	107,834,038	114,792,295	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN PRACTICE	0	66,374,427	66,374,427	27.00
27.01	PROF FEES	0	37,510,927	37,510,927	27.01
27.02	DSH REVENUE	0	3,225,419	3,225,419	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	181,654,754	655,944,388	837,599,142	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		295,078,964		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)		295,078,964		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0059 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-3 | Date/Time Prepared: 5/29/2024 9:54 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	837,599,142	1.00
2.00	Less contractual allowances and discounts on patients' accounts	586,760,992	2.00
3.00	Net patient revenues (line 1 minus line 2)	250,838,150	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	295,078,964	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-44,240,814	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	4,884,956	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	15,760,978	24.00
24.01	OTHER OPERATING REVENUE	58,885	24.01
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	20,704,819	25.00
26.00	Total (line 5 plus line 25)	-23,535,995	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)	-23,535,995	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0059	Period: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III Date/Time Prepared: 5/29/2024 9:54 am
	Title XVIII	Hospital	PPS

			1.00	
	PART I - FULLY PROSPECTIVE METHOD			
	CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier		625,552	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		85,804	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		40.13	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		1.19	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		19.09	8.00
9.00	Sum of lines 7 and 8		20.28	9.00
10.00	Allowable disproportionate share percentage (see instructions)		4.20	10.00
11.00	Disproportionate share adjustment (see instructions)		26,273	11.00
12.00	Total prospective capital payments (see instructions)		737,629	12.00
			1.00	
	PART II - PAYMENT UNDER REASONABLE COST			
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
			1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00