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: 15-0149	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/30/2024 10:43 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/30/2024 Time: 10:43 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 DEACONESS WOMENS HOSPITAL (15-0149) 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	Christina Ryan		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	Christina Ryan			2
3	Signatory Title	CEO			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	66,029	12,455	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	66,029	12,455	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2024 10:43 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 4199 GATEWAY BLVD	PO Box:			1.00
2.00	City: NEWBURGH	State: IN	Zip Code: 47630-8940	County: WARRICK	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	DEACONESS WOMENS HOSPITAL	150149	21780	1	05/03/2001	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									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)	6		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: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2024 10:43 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.	1,773	1,520	1,260	439	9,323	177	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2024 10:43 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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 10:43 am

		V	XIX	
		1.00	2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	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.					109.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2024 10:43 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	444,058	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	Y	Y	123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0778	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: DEACONESS HEALTH SYSTEM	Contractor's Name: WPS	Contractor's Number: 08001	141.00
142.00	Street: 600 MARY ST	PO Box:		142.00
143.00	City: EVANSVILLE	State: IN	Zip Code: 47710	143.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0149	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 10:43 am

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

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

			1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act			
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)		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: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 5/30/2024 10:43 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)	Y	01/01/2023	1.00

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	05/14/2024	Y	05/14/2024	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: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II Date/Time Prepared: 5/30/2024 10:43 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?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	Y	09/30/2023	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DANIELLE	METZGER-CUNDIFF	41.00
42.00	Enter the employer/company name of the cost report preparer.	DEACONESS HEALTH SYSTEMS		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	812-450-7423	DANIELLE.METZGER-CUNDIFF@DEACONESS.C	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0149	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/30/2024 10:43 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2024 10:43 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	50	18,250	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)		50	18,250	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	24	8,760	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)		74	27,010	0.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		74				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: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2024 10:43 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)	77	221	8,562			1.00
2.00	HMO and other (see instructions)	50	11,326				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	77	221	8,562			7.00
8.00	INTENSIVE CARE UNIT	0	2,439	10,854			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		329	5,454			13.00
14.00	Total (see instructions)	77	2,989	24,870	0.00	653.19	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits	0	0	0			15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			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	653.19	27.00
28.00	Observation Bed Days		81	2,221			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	177	443			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: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2024 10:43 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	33	384	3,714	1.00
2.00	HMO and other (see instructions)			24	1,244		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	33	384	3,714	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part II Date/Time Prepared: 5/30/2024 10:43 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	54,158,611	-323,967	53,834,644	1,358,636.43	39.62	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		1,181,123	125,000	1,306,123	8,400.61	155.48	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		8,476,655	0	8,476,655	53,629.05	158.06	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)		5,033,701	387,015	5,420,716	98,231.59	55.18	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		0	0	0	0.00	0.00	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		1,757,402	0	1,757,402	9,362.50	187.71	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		2,307,162	0	2,307,162	59,946.00	38.49	14.01
14.02	Related organization salaries		1,645,351	0	1,645,351	42,815.94	38.43	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		11,276,249	0	11,276,249			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		1,465,916	0	1,465,916			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		183,894	0	183,894			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		916,176	0	916,176			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)		609,431	0	609,431			25.50
25.51	Related organization wage-related (core)		242,065	0	242,065			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part II Date/Time Prepared: 5/30/2024 10:43 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	302,207	11,001	313,208	8,609.35	36.38	26.00
27.00	Administrative & General	5.00	6,464,922	-928,669	5,536,253	98,902.39	55.98	27.00
28.00	Administrative & General under contract (see inst.)		176,573	0	176,573	375.16	470.66	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	501,610	-238	501,372	23,108.46	21.70	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,076,885	1,959	1,078,844	61,737.56	17.47	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	0	175,789	175,789	9,859.21	17.83	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	1,214,152	-437,202	776,950	31,061.73	25.01	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	0	0	0	0.00	0.00	38.00
39.00	Central Services and Supply	14.00	184,932	-1,146	183,786	5,413.49	33.95	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	80,317	0	80,317	3,156.56	25.44	41.00
42.00	Social Service	17.00	513,067	-7,609	505,458	12,696.55	39.81	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part III Date/Time Prepared: 5/30/2024 10:43 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)		45,858,529	-323,967	45,534,562	1,305,382.54	34.88	1.00
2.00	Excluded area salaries (see instructions)		5,033,701	387,015	5,420,716	98,231.59	55.18	2.00
3.00	Subtotal salaries (line 1 minus line 2)		40,824,828	-710,982	40,113,846	1,207,150.95	33.23	3.00
4.00	Subtotal other wages & related costs (see inst.)		5,709,915	0	5,709,915	112,124.44	50.92	4.00
5.00	Subtotal wage-related costs (see inst.)		12,311,639	0	12,311,639	0.00	30.69	5.00
6.00	Total (sum of lines 3 thru 5)		58,846,382	-710,982	58,135,400	1,319,275.39	44.07	6.00
7.00	Total overhead cost (see instructions)		10,514,665	-1,186,115	9,328,550	254,920.46	36.59	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part IV Date/Time Prepared: 5/30/2024 10:43 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,000,312	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)	7,694,973	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	218,613	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	34,047	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)	792,810	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	184,277	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	3,638,927	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	76,607	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	88,036	21.00
22.00	Day Care Cost and Allowances	53,607	22.00
23.00	Tuition Reimbursement	60,027	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	13,842,236	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: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part V | Date/Time Prepared: 5/30/2024 10:43 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	13,842,236	1.00
2.00	Hospital	0	13,842,236	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0149	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/30/2024 10:43 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)	0.414736	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	20,572,381	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	5,767,927	5.00
6.00	Medicaid charges	73,068,332	6.00
7.00	Medicaid cost (line 1 times line 6)	30,304,068	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	3,963,760	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)	3,963,760	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	3,418,548	546,895	3,965,443	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,417,795	546,895	1,964,690	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)	1,417,795	546,895	1,964,690	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)	0	25.01
26.00	Bad debt amount (see instructions)	1,240,731	26.00
27.00	Medicare reimbursable bad debts (see instructions)	13,315	27.00
27.01	Medicare allowable bad debts (see instructions)	20,484	27.01
28.00	Non-Medicare bad debt amount (see instructions)	1,220,247	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	513,249	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	2,477,939	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,441,699	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0149	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/30/2024 10:43 am

		1.00	
	PART II - HOSPITAL DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.414736	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		5.00
6.00	Medicaid charges		6.00
7.00	Medicaid cost (line 1 times line 6)		7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)		8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP		9.00
10.00	Stand-alone CHIP charges		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)		12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)		16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	3,418,548	546,895	3,965,443	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,417,795	546,895	1,964,690	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)	1,417,795	546,895	1,964,690	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)	0	25.01
26.00	Bad debt amount (see instructions)	1,240,731	26.00
27.00	Medicare reimbursable bad debts (see instructions)	13,315	27.00
27.01	Medicare allowable bad debts (see instructions)	20,484	27.01
28.00	Non-Medicare bad debt amount (see instructions)	1,220,247	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	513,249	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	2,477,939	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,477,939	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/30/2024 10:43 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	5,220,860	5,220,860	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	2,398,270	2,398,270	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	302,207	13,067,516	13,369,723	11,001	13,380,724	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,464,922	21,439,927	27,904,849	-5,747,062	22,157,787	5.00
7.00	00700	OPERATION OF PLANT	501,610	1,823,956	2,325,566	-152,869	2,172,697	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	1,039,525	1,039,525	8.00
9.00	00900	HOUSEKEEPING	1,076,885	1,396,842	2,473,727	-1,052,528	1,421,199	9.00
10.00	01000	DIETARY	0	0	0	328,605	328,605	10.00
11.00	01100	CAFETERIA	1,214,152	720,440	1,934,592	-848,052	1,086,540	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	184,932	71,851	256,783	-30,394	226,389	14.00
15.00	01500	PHARMACY	0	5,711,634	5,711,634	-4,383,201	1,328,433	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	80,317	150,588	230,905	0	230,905	16.00
17.00	01700	SOCIAL SERVICE	513,067	9,994	523,061	0	523,061	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,625,062	1,050,709	11,675,771	-4,859,804	6,815,967	30.00
31.00	03100	INTENSIVE CARE UNIT	9,951,139	1,938,013	11,889,152	-516,735	11,372,417	31.00
43.00	04300	NURSERY	1,165,943	189,620	1,355,563	-113,803	1,241,760	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,632,189	10,632,525	15,264,714	-10,046,608	5,218,106	50.00
51.00	05100	RECOVERY ROOM	675,466	11,882	687,348	-6,103	681,245	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	4,241,851	4,241,851	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,538,774	1,301,772	3,840,546	-809,904	3,030,642	54.00
57.00	05700	CT SCAN	0	0	0	119,903	119,903	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	126,580	126,580	58.00
60.00	06000	LABORATORY	0	3,946,941	3,946,941	-67,398	3,879,543	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	49,284	49,284	63.00
65.00	06500	RESPIRATORY THERAPY	1,618,391	660,425	2,278,816	-336,477	1,942,339	65.00
66.00	06600	PHYSICAL THERAPY	0	3,123,934	3,123,934	-191,710	2,932,224	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,430,519	4,430,519	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	496,609	496,609	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,288,440	4,288,440	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,449,075	973,253	6,422,328	-81,202	6,341,126	90.00
91.00	09100	EMERGENCY	2,130,779	486,701	2,617,480	6,000,748	8,618,228	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	49,124,910	68,708,523	117,833,433	-491,655	117,341,778	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	488,479	488,479	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,345,142	779,937	5,125,079	-6,291	5,118,788	192.00
194.00	07950	OTHER DEPARTMENTS	0	0	0	0	0	194.00
194.01	07951	WOMEN'S RESOURCES	348,966	213,960	562,926	-3,464	559,462	194.01
194.02	07952	MARKETING	267,994	283,620	551,614	17,772	569,386	194.02
194.03	07953	REPRODUCTIVE MEDICINE	0	492	492	164	656	194.03
194.04	07954	CENTER FOR HEALING ARTS	71,599	84,271	155,870	-5,005	150,865	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	54,158,611	70,070,803	124,229,414	0	124,229,414	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/30/2024 10:43 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	-86,949	5,133,911		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	2,398,270		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,624,013	16,004,737		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,771,518	19,386,269		5.00
7.00	00700	OPERATION OF PLANT	1,082,705	3,255,402		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,039,525		8.00
9.00	00900	HOUSEKEEPING	0	1,421,199		9.00
10.00	01000	DIETARY	0	328,605		10.00
11.00	01100	CAFETERIA	-330,773	755,767		11.00
13.00	01300	NURSING ADMINISTRATION	0	0		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	282,463	508,852		14.00
15.00	01500	PHARMACY	645,217	1,973,650		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	187	231,092		16.00
17.00	01700	SOCIAL SERVICE	-132	522,929		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	6,815,967		30.00
31.00	03100	INTENSIVE CARE UNIT	-3,443,698	7,928,719		31.00
43.00	04300	NURSERY	0	1,241,760		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-68,139	5,149,967		50.00
51.00	05100	RECOVERY ROOM	0	681,245		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,241,851		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-26,291	3,004,351		54.00
57.00	05700	CT SCAN	0	119,903		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	126,580		58.00
60.00	06000	LABORATORY	-12,000	3,867,543		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	49,284		63.00
65.00	06500	RESPIRATORY THERAPY	0	1,942,339		65.00
66.00	06600	PHYSICAL THERAPY	-906,002	2,026,222		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,430,519		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	496,609		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,288,440		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-4,432,566	1,908,560		90.00
91.00	09100	EMERGENCY	-5,782,035	2,836,193		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-13,225,518	104,116,260		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-220,515	267,964		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,118,788		192.00
194.00	07950	OTHER DEPARTMENTS	0	0		194.00
194.01	07951	WOMEN'S RESOURCES	-295,212	264,250		194.01
194.02	07952	MARKETING	0	569,386		194.02
194.03	07953	REPRODUCTIVE MEDICINE	0	656		194.03
194.04	07954	CENTER FOR HEALING ARTS	-14,884	135,981		194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-13,756,129	110,473,285		200.00

RECLASSIFICATIONS | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/30/2024 10:43 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - LEASEHOLD IMPROVEMENTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	619,475	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	0	2.00
3.00	OPERATION OF PLANT	7.00	0	0	3.00
4.00	CAFETERIA	11.00	0	0	4.00
5.00	PHARMACY	15.00	0	0	5.00
6.00	ADULTS & PEDIATRICS	30.00	0	0	6.00
7.00	OPERATING ROOM	50.00	0	0	7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	0	8.00
9.00	PHYSICAL THERAPY	66.00	0	0	9.00
10.00	CLINIC	90.00	0	0	10.00
11.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	0	11.00
12.00	WOMEN'S RESOURCES	194.01	0	0	12.00
	0		0	619,475	
	B - EQUIPMENT DEPRECIATION				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,266,198	1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	0	2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	0	3.00
4.00	OPERATION OF PLANT	7.00	0	0	4.00
5.00	HOUSEKEEPING	9.00	0	0	5.00
6.00	CAFETERIA	11.00	0	0	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	0	7.00
8.00	PHARMACY	15.00	0	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	0	9.00
10.00	INTENSIVE CARE UNIT	31.00	0	0	10.00
11.00	NURSERY	43.00	0	0	11.00
12.00	OPERATING ROOM	50.00	0	0	12.00
13.00	RECOVERY ROOM	51.00	0	0	13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	0	14.00
15.00	LABORATORY	60.00	0	0	15.00
16.00	RESPIRATORY THERAPY	65.00	0	0	16.00
17.00	PHYSICAL THERAPY	66.00	0	0	17.00
18.00	CLINIC	90.00	0	0	18.00
19.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	0	19.00
20.00	CENTER FOR HEALING ARTS	194.04	0	0	20.00
	0		0	1,266,198	
	C - INTEREST EXPENSE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	229,928	1.00
2.00	REPRODUCTIVE MEDICINE	194.03	0	164	2.00
3.00		0.00	0	0	3.00
	0		0	230,092	
	D - EQUIPMENT LEASES				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	802,543	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	0	2.00
3.00	OPERATION OF PLANT	7.00	0	0	3.00
4.00	HOUSEKEEPING	9.00	0	0	4.00
5.00	PHARMACY	15.00	0	0	5.00
6.00	INTENSIVE CARE UNIT	31.00	0	0	6.00
7.00	OPERATING ROOM	50.00	0	0	7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	0	8.00
9.00	RESPIRATORY THERAPY	65.00	0	0	9.00
10.00	CLINIC	90.00	0	0	10.00
11.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	0	11.00
12.00	WOMEN'S RESOURCES	194.01	0	0	12.00
13.00		0.00	0	0	13.00
	0		0	802,543	
	E - BUILDING LEASES				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,462,214	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	0	2.00
3.00	INTENSIVE CARE UNIT	31.00	0	0	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	0	4.00
5.00	PHYSICAL THERAPY	66.00	0	0	5.00
6.00	CLINIC	90.00	0	0	6.00
7.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	0	7.00
	0		0	4,462,214	
	F - DRUGS/IV SOLUTIONS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,288,440	1.00
	0		0	4,288,440	
	G - IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	496,609	1.00
	0		0	496,609	

RECLASSIFICATIONS | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/30/2024 10:43 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	H - PROPERTY INSURANCE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	67,601	1.00
2.00		0.00	0	0	2.00
	0		0	67,601	
	I - DIETARY				
1.00	DIETARY	10.00	175,789	0	1.00
2.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	261,314	0	2.00
3.00		0.00	0	0	3.00
4.00	DIETARY	10.00	0	152,816	4.00
5.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	227,165	5.00
6.00		0.00	0	0	6.00
	0		437,103	379,981	
	J - PROPERTY TAXES				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	139,171	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	32,000	2.00
3.00		0.00	0	0	3.00
	0		0	171,171	
	K - LABOR & DELIVERY				
1.00	DELIVERY ROOM & LABOR ROOM	52.00	4,079,692	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	0	162,159	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	0		4,079,692	162,159	
	M - EMERGENCY DEPARTMENT				
1.00	EMERGENCY	91.00	972,716	0	1.00
2.00		0.00	0	0	2.00
3.00	EMERGENCY	91.00	0	68,380	3.00
4.00		0.00	0	0	4.00
	0		972,716	68,380	
	N - INCENTIVE COMPENSATION				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	11,001	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	166,693	0	2.00
3.00	HOUSEKEEPING	9.00	10,285	0	3.00
4.00	CAFETERIA	11.00	15,984	0	4.00
5.00	NURSING ADMINISTRATION	13.00	0	0	5.00
6.00	ADULTS & PEDIATRICS	30.00	66,874	0	6.00
7.00	INTENSIVE CARE UNIT	31.00	37,893	0	7.00
8.00	NURSERY	43.00	6,790	0	8.00
9.00	OPERATING ROOM	50.00	34,521	0	9.00
10.00	RECOVERY ROOM	51.00	3,011	0	10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	16,376	0	11.00
12.00	RESPIRATORY THERAPY	65.00	8,054	0	12.00
13.00	CLINIC	90.00	444,976	0	13.00
14.00	PHYSICIANS' PRIVATE OFFICES	192.00	258,714	0	14.00
15.00	WOMEN'S RESOURCES	194.01	2,225	0	15.00
16.00	MARKETING	194.02	17,772	0	16.00
	0		1,101,169	0	
	O - PHYSICIAN PART A				
1.00	ADMINISTRATIVE & GENERAL	5.00	25,125	0	1.00
2.00	OPERATING ROOM	50.00	125,000	0	2.00
3.00		0.00	0	0	3.00
	0		150,125	0	
	P - DISABILITY				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	19,318	1.00
2.00	OPERATION OF PLANT	7.00	0	238	2.00
3.00	HOUSEKEEPING	9.00	0	8,326	3.00
4.00	CAFETERIA	11.00	0	16,083	4.00
5.00	NURSING ADMINISTRATION	13.00	0	0	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,146	6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	0	7.00
8.00	SOCIAL SERVICE	17.00	0	7,609	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	107,778	9.00
10.00	INTENSIVE CARE UNIT	31.00	0	77,279	10.00
11.00	NURSERY	43.00	0	231	11.00
12.00	OPERATING ROOM	50.00	0	34,073	12.00
13.00	RECOVERY ROOM	51.00	0	2,439	13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	18,498	14.00
15.00	RESPIRATORY THERAPY	65.00	0	6,605	15.00
16.00	CLINIC	90.00	0	21,459	16.00
17.00	EMERGENCY	91.00	0	0	17.00
18.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2,040	18.00
19.00	WOMEN'S RESOURCES	194.01	0	845	19.00

RECLASSIFICATIONS | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/30/2024 10:43 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
33.00		0.00	0	0		33.00
34.00		0.00	0	0		34.00
35.00		0.00	0	0		35.00
36.00		0.00	0	0		36.00
37.00		0.00	0	0		37.00
38.00		0.00	0	0		38.00
	0		0	323,967		
	Q - LAUNDRY					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	1,039,525		1.00
2.00	HOUSEKEEPING	9.00	0	0		2.00
	0		0	1,039,525		
	R - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	4,927,128		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	176,815		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	5,103,943		
	S - ANESTHESIA PART A					
1.00	EMERGENCY	91.00	0	4,959,652		1.00
2.00		0.00	0	0		2.00
	0		0	4,959,652		
	T - RADIOLOGY					
1.00	CT SCAN	57.00	95,009	0		1.00
2.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	100,300	0		2.00
3.00		0.00	0	0		3.00
4.00	CT SCAN	57.00	0	24,894		4.00
5.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	26,280		5.00
6.00		0.00	0	0		6.00
	0		195,309	51,174		
	U - BLOOD BANK					
1.00	BLOOD STORING, PROCESSING, & TRANS.	63.00	0	49,284		1.00
2.00		0.00	0	0		2.00
	0		0	49,284		
500.00	Grand Total: Increases		6,936,114	24,542,408		500.00

RECLASSIFICATIONS | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/30/2024 10:43 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - LEASEHOLD IMPROVEMENTS						
1.00		0.00	0	0	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	247,354	0		2.00
3.00	OPERATION OF PLANT	7.00	0	120,469	0		3.00
4.00	CAFETERIA	11.00	0	13,615	0		4.00
5.00	PHARMACY	15.00	0	6,420	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	233	0		6.00
7.00	OPERATING ROOM	50.00	0	2,126	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	22,790	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	85,355	0		9.00
10.00	CLINIC	90.00	0	120,130	0		10.00
11.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	442	0		11.00
12.00	WOMEN'S RESOURCES	194.01	0	541	0		12.00
	0		0	619,475			
	B - EQUIPMENT DEPRECIATION						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	0	9		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	0	0		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	257,423	0		3.00
4.00	OPERATION OF PLANT	7.00	0	26,296	0		4.00
5.00	HOUSEKEEPING	9.00	0	21,747	0		5.00
6.00	CAFETERIA	11.00	0	33,337	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	30,394	0		7.00
8.00	PHARMACY	15.00	0	2,178	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	188,643	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	210,540	0		10.00
11.00	NURSERY	43.00	0	17,455	0		11.00
12.00	OPERATING ROOM	50.00	0	155,197	0		12.00
13.00	RECOVERY ROOM	51.00	0	9,114	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	75,554	0		14.00
15.00	LABORATORY	60.00	0	18,114	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	87,284	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	11,319	0		17.00
18.00	CLINIC	90.00	0	25,697	0		18.00
19.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	90,901	0		19.00
20.00	CENTER FOR HEALING ARTS	194.04	0	5,005	0		20.00
	0		0	1,266,198			
	C - INTEREST EXPENSE						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	0	11		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	230,092	0		2.00
3.00	REPRODUCTIVE MEDICINE	194.03	0	0	0		3.00
	0		0	230,092			
	D - EQUIPMENT LEASES						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	0	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	59,733	0		2.00
3.00	OPERATION OF PLANT	7.00	0	6,104	0		3.00
4.00	HOUSEKEEPING	9.00	0	1,541	0		4.00
5.00	PHARMACY	15.00	0	86,163	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	44,234	0		6.00
7.00	OPERATING ROOM	50.00	0	238,686	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	104,549	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	61,141	0		9.00
10.00	CLINIC	90.00	0	194,584	0		10.00
11.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	660	0		11.00
12.00	WOMEN'S RESOURCES	194.01	0	5,148	0		12.00
13.00	MARKETING	194.02	0	0	0		13.00
	0		0	802,543			
	E - BUILDING LEASES						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	0	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	3,981,152	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	62,502	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	125,278	0		4.00
5.00	PHYSICAL THERAPY	66.00	0	95,036	0		5.00
6.00	CLINIC	90.00	0	175,369	0		6.00
7.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	22,877	0		7.00
	0		0	4,462,214			
	F - DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00	0	4,288,440	0		1.00
	0		0	4,288,440			
	G - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	496,609	0		1.00
	0		0	496,609			

RECLASSIFICATIONS | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/30/2024 10:43 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	H - PROPERTY INSURANCE						
1.00		0.00	0	0	12		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	67,601	0		2.00
	0		0	67,601			
	I - DIETARY						
1.00		0.00	0	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00	CAFETERIA	11.00	437,103	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00	CAFETERIA	11.00	0	379,981	0		6.00
	0		437,103	379,981			
	J - PROPERTY TAXES						
1.00		0.00	0	0	13		1.00
2.00		0.00	0	0	13		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	171,171	0		3.00
	0		0	171,171			
	K - LABOR & DELIVERY						
1.00		0.00	0	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	162,159	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	4,079,692	0	0		4.00
	0		4,079,692	162,159			
	M - EMERGENCY DEPARTMENT						
1.00		0.00	0	0	0		1.00
2.00	OPERATING ROOM	50.00	972,716	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00	OPERATING ROOM	50.00	0	68,380	0		4.00
	0		972,716	68,380			
	N - INCENTIVE COMPENSATION						
1.00		0.00	0	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00	ADMINISTRATIVE & GENERAL	5.00	1,101,169	0	0		15.00
16.00		0.00	0	0	0		16.00
	0		1,101,169	0			
	O - PHYSICIAN PART A						
1.00		0.00	0	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	150,125	0	0		3.00
	0		150,125	0			
	P - DISABILITY						
1.00		0.00	0	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00	ADMINISTRATIVE & GENERAL	5.00	19,318	0	0		20.00
21.00	OPERATION OF PLANT	7.00	238	0	0		21.00

RECLASSIFICATIONS | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/30/2024 10:43 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
22.00	HOUSEKEEPING	9.00	8,326	0	0		22.00
23.00	CAFETERIA	11.00	16,083	0	0		23.00
24.00	NURSING ADMINISTRATION	13.00	0	0	0		24.00
25.00	CENTRAL SERVICES & SUPPLY	14.00	1,146	0	0		25.00
26.00	MEDICAL RECORDS & LIBRARY	16.00	0	0	0		26.00
27.00	SOCIAL SERVICE	17.00	7,609	0	0		27.00
28.00	ADULTS & PEDIATRICS	30.00	107,778	0	0		28.00
29.00	INTENSIVE CARE UNIT	31.00	77,279	0	0		29.00
30.00	NURSERY	43.00	231	0	0		30.00
31.00	OPERATING ROOM	50.00	34,073	0	0		31.00
32.00	RECOVERY ROOM	51.00	2,439	0	0		32.00
33.00	RADIOLOGY-DIAGNOSTIC	54.00	18,498	0	0		33.00
34.00	RESPIRATORY THERAPY	65.00	6,605	0	0		34.00
35.00	CLINIC	90.00	21,459	0	0		35.00
36.00	EMERGENCY	91.00	0	0	0		36.00
37.00	PHYSICIANS' PRIVATE OFFICES	192.00	2,040	0	0		37.00
38.00	WOMEN'S RESOURCES	194.01	845	0	0		38.00
	0		323,967	0			
	Q - LAUNDRY						
1.00		0.00	0	0	0		1.00
2.00	HOUSEKEEPING	9.00	0	1,039,525	0		2.00
	0		0	1,039,525			
	R - MEDICAL SUPPLIES						
1.00		0.00	0	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	495,951	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	237,352	0		4.00
5.00	NURSERY	43.00	0	103,138	0		5.00
6.00	OPERATING ROOM	50.00	0	3,809,372	0		6.00
7.00	RECOVERY ROOM	51.00	0	0	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	251,626	0		8.00
9.00	LABORATORY	60.00	0	0	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	196,106	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	0	0		11.00
12.00	CLINIC	90.00	0	10,398	0		12.00
	0		0	5,103,943			
	S - ANESTHESIA PART A						
1.00		0.00	0	0	0		1.00
2.00	OPERATING ROOM	50.00	0	4,959,652	0		2.00
	0		0	4,959,652			
	T - RADIOLOGY						
1.00		0.00	0	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	195,309	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	51,174	0		6.00
	0		195,309	51,174			
	U - BLOOD BANK						
1.00		0.00	0	0	0		1.00
2.00	LABORATORY	60.00	0	49,284	0		2.00
	0		0	49,284			
500.00	Grand Total: Decreases		7,260,081	24,218,441			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 5/30/2024 10:43 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	6,507,085	329,434	0	329,434	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	21,055,352	2,448,501	0	2,448,501	329,247	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	27,562,437	2,777,935	0	2,777,935	329,247	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	27,562,437	2,777,935	0	2,777,935	329,247	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	6,836,519	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	23,174,606	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	30,011,125	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	30,011,125	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part II | Date/Time Prepared: 5/30/2024 10:43 am

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

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

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part III | Date/Time Prepared: 5/30/2024 10:43 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	6,836,519	0	6,836,519	0.227799	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	23,174,606	0	23,174,606	0.772201	0	2.00
3.00	Total (sum of lines 1-2)	30,011,125	0	30,011,125	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	619,475	4,462,214	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,266,198	802,543	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,885,673	5,264,757	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	-86,949	0	139,171	0	5,133,911	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	229,928	67,601	32,000	0	2,398,270	2.00
3.00	Total (sum of lines 1-2)	142,979	67,601	171,171	0	7,532,181	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/30/2024 10:43 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)	B	-86,949	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-3,641	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-13,860,557			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	8,283,435			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-273,948	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-11,756	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	COFFEE SHOP REVENUE	B	-45,069	CAFETERIA	11.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/30/2024 10:43 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	
34.00	CLASS REVENUE	B	-15,093	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	LOBBYING	B	-73,737	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	AHA DUES	A	-6,599	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	IHA DUES	A	-3,431	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	PHYSICIAN RECRUITMENT	A	-43,126	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	HENDERSON MGMT FEES	B	-204,496	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	HAF	A	-6,795,897	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	PHYSICIAN BILLING	A	-84,654	ADMINISTRATIVE & GENERAL	5.00	0	41.00
41.01	VENDING REVENUE	B	-7,837	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	41.01
41.02	COFFEE SHOP REVENUE	B	-30,046	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	41.02
41.03	CAFETERIA REVENUE	B	-182,632	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	41.03
41.04	CENTER FOR HEALING ARTS REVENUE	B	-14,884	CENTER FOR HEALING ARTS	194.04	0	41.04
41.05	WOMEN'S RESOURCES REVENUE	B	-251,536	WOMEN'S RESOURCES	194.01	0	41.05
41.06	LACTATION SERVICES REVENUE	B	-43,676	WOMEN'S RESOURCES	194.01	0	41.06
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-13,756,129				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: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 5/30/2024 10:43 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	FACILITY RENT	4,267,373	4,267,373	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	VARIOUS	2,674,400	50,387	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	VARIOUS	7,337,468	2,782,616	3.00
4.00	7.00	OPERATION OF PLANT	VARIOUS	2,378,160	1,295,455	4.00
4.01	14.00	CENTRAL SERVICES & SUPPLY	VARIOUS	282,463	0	4.01
4.02	15.00	PHARMACY	VARIOUS	1,891,972	1,246,755	4.02
4.03	16.00	MEDICAL RECORDS & LIBRARY	VARIOUS	92,659	92,472	4.03
4.04	30.00	ADULTS & PEDIATRICS	VARIOUS	4,758	4,758	4.04
4.05	31.00	INTENSIVE CARE UNIT	VARIOUS	103,700	103,700	4.05
4.06	43.00	NURSERY	VARIOUS	833	833	4.06
4.07	50.00	OPERATING ROOM	VARIOUS	5,624	5,624	4.07
4.08	51.00	RECOVERY ROOM	VARIOUS	964	964	4.08
4.09	54.00	RADIOLOGY-DIAGNOSTIC	VARIOUS	18,422	18,422	4.09
4.10	65.00	RESPIRATORY THERAPY	VARIOUS	10,019	10,019	4.10
4.11	66.00	PHYSICAL THERAPY	VARIOUS	88,716	88,716	4.11
4.12	90.00	CLINIC	VARIOUS	178,704	178,704	4.12
4.13	66.00	PHYSICAL THERAPY	THERAPY SERVICES	1,987,394	2,893,396	4.13
4.14	0.00			0	0	4.14
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			21,323,629	13,040,194	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		0.00	DEACONESS HEALT	50.00	6.00
7.00	B		0.00	DEACONESS HOSPI	50.00	7.00
8.00	A	DEACONESS HOSPI	51.00	PROGRESSIVE HEA	49.00	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: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 5/30/2024 10:43 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	0	10		1.00
2.00	2,624,013	0		2.00
3.00	4,554,852	0		3.00
4.00	1,082,705	0		4.00
4.01	282,463	0		4.01
4.02	645,217	0		4.02
4.03	187	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	-906,002	0		4.13
4.14	0	0		4.14
5.00	8,283,435			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	HEALTH SYSTEM		6.00
7.00	HOSPITAL		7.00
8.00	THERAPY SERVICE		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: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 5/30/2024 10:43 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	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	249,542	47,617	201,925	211,500	1,513	1.00
2.00	17.00	AGGREGATE-SOCIAL SERVICE	1,500	0	1,500	237,100	12	2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	3,496,645	3,421,837	74,808	237,100	459	3.00
4.00	50.00	AGGREGATE-OPERATING ROOM	125,000	0	125,000	246,400	480	4.00
5.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	51,390	3,390	48,000	271,900	192	5.00
6.00	60.00	AGGREGATE-LABORATORY	12,000	12,000	0	260,300	0	6.00
7.00	90.00	AGGREGATE-CLINIC	4,454,412	4,354,412	100,000	237,100	180	7.00
8.00	91.00	AGGREGATE-EMERGENCY	7,325,422	4,788,005	2,537,417	211,500	14,927	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			15,715,911	12,627,261	3,088,650		17,763	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	153,846	7,692	0	0	0	1.00
2.00	17.00	AGGREGATE-SOCIAL SERVICE	1,368	68	0	0	0	2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	52,322	2,616	0	0	29,200	3.00
4.00	50.00	AGGREGATE-OPERATING ROOM	56,861	2,843	0	0	0	4.00
5.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	25,099	1,255	0	0	0	5.00
6.00	60.00	AGGREGATE-LABORATORY	0	0	0	0	0	6.00
7.00	90.00	AGGREGATE-CLINIC	20,518	1,026	0	0	59,173	7.00
8.00	91.00	AGGREGATE-EMERGENCY	1,517,817	75,891	0	0	73,819	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,827,831	91,391	0	0	162,192	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	153,846	48,079	95,696		1.00
2.00	17.00	AGGREGATE-SOCIAL SERVICE	0	1,368	132	132		2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	625	52,947	21,861	3,443,698		3.00
4.00	50.00	AGGREGATE-OPERATING ROOM	0	56,861	68,139	68,139		4.00
5.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	25,099	22,901	26,291		5.00
6.00	60.00	AGGREGATE-LABORATORY	0	0	0	12,000		6.00
7.00	90.00	AGGREGATE-CLINIC	1,328	21,846	78,154	4,432,566		7.00
8.00	91.00	AGGREGATE-EMERGENCY	25,570	1,543,387	994,030	5,782,035		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			27,523	1,855,354	1,233,296	13,860,557		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/30/2024 10:43 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	5,133,911	5,133,911				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,398,270		2,398,270			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	16,004,737	89,448	0	16,094,185		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	19,386,269	649,230	367,675	1,664,779	22,067,953	5.00
7.00	00700	OPERATION OF PLANT	3,255,402	160,670	37,561	150,765	3,604,398	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,039,525	0	0	0	1,039,525	8.00
9.00	00900	HOUSEKEEPING	1,421,199	27,338	26,998	324,414	1,799,949	9.00
10.00	01000	DIETARY	328,605	50,645	12,182	52,861	444,293	10.00
11.00	01100	CAFETERIA	755,767	112,964	18,273	233,633	1,120,637	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	508,852	32,587	35,235	55,265	631,939	14.00
15.00	01500	PHARMACY	1,973,650	37,585	102,413	0	2,113,648	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	231,092	20,745	0	24,152	275,989	16.00
17.00	01700	SOCIAL SERVICE	522,929	4,913	0	151,994	679,836	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,815,967	1,059,470	128,671	1,955,925	9,960,033	30.00
31.00	03100	INTENSIVE CARE UNIT	7,928,719	396,761	295,357	2,980,534	11,601,371	31.00
43.00	04300	NURSERY	1,241,760	82,225	20,235	352,577	1,696,797	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,149,967	600,012	451,304	1,138,145	7,339,428	50.00
51.00	05100	RECOVERY ROOM	681,245	0	10,566	203,288	895,099	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,241,851	528,538	90,021	1,226,784	6,087,194	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,004,351	236,217	208,791	704,054	4,153,413	54.00
57.00	05700	CT SCAN	119,903	0	0	28,570	148,473	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	126,580	0	0	30,161	156,741	58.00
60.00	06000	LABORATORY	3,867,543	6,929	20,999	0	3,895,471	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	49,284	0	0	0	49,284	63.00
65.00	06500	RESPIRATORY THERAPY	1,942,339	13,102	172,068	487,094	2,614,603	65.00
66.00	06600	PHYSICAL THERAPY	2,026,222	153,195	13,122	0	2,192,539	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,430,519	0	0	0	4,430,519	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	496,609	0	0	0	496,609	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,288,440	0	0	0	4,288,440	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,908,560	314,788	255,369	1,765,918	4,244,635	90.00
91.00	09100	EMERGENCY	2,836,193	104,271	5,321	933,236	3,879,021	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	104,116,260	4,681,633	2,272,161	14,464,149	101,907,837	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	267,964	75,296	8,193	78,578	430,031	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,118,788	175,158	106,146	1,338,646	6,738,738	192.00
194.00	07950	OTHER DEPARTMENTS	0	0	0	0	0	194.00
194.01	07951	WOMEN'S RESOURCES	264,250	201,824	5,968	105,351	577,393	194.01
194.02	07952	MARKETING	569,386	0	0	85,931	655,317	194.02
194.03	07953	REPRODUCTIVE MEDICINE	656	0	0	0	656	194.03
194.04	07954	CENTER FOR HEALING ARTS	135,981	0	5,802	21,530	163,313	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	110,473,285	5,133,911	2,398,270	16,094,185	110,473,285	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/30/2024 10:43 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	22,067,953					5.00
7.00	00700	OPERATION OF PLANT	899,737	4,504,135				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	259,488	0	1,299,013			8.00
9.00	00900	HOUSEKEEPING	449,307	29,079	0	2,278,335		9.00
10.00	01000	DIETARY	110,905	53,869	0	27,426	636,493	10.00
11.00	01100	CAFETERIA	279,736	120,156	0	61,173	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	157,746	34,662	0	17,647	0	14.00
15.00	01500	PHARMACY	527,613	39,977	0	20,353	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	68,893	22,066	0	11,234	0	16.00
17.00	01700	SOCIAL SERVICE	169,702	5,226	0	2,661	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,486,243	1,126,916	113,566	573,736	631,333	30.00
31.00	03100	INTENSIVE CARE UNIT	2,895,995	422,018	352,310	214,857	0	31.00
43.00	04300	NURSERY	423,558	87,459	71,845	44,527	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,832,083	638,209	417,011	324,924	0	50.00
51.00	05100	RECOVERY ROOM	223,436	0	45,375	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,519,498	562,185	118,850	286,219	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,036,783	251,255	0	127,918	0	54.00
57.00	05700	CT SCAN	37,062	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	39,126	0	0	0	0	58.00
60.00	06000	LABORATORY	972,395	7,370	0	3,752	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	12,302	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	652,662	13,936	0	7,095	0	65.00
66.00	06600	PHYSICAL THERAPY	547,306	162,947	0	82,959	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,105,955	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	123,965	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,070,489	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,059,554	334,827	0	170,467	0	90.00
91.00	09100	EMERGENCY	968,289	110,909	180,056	56,466	5,160	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,929,828	4,023,066	1,299,013	2,033,414	636,493	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	107,345	80,089	0	40,775	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,682,137	186,308	0	94,853	0	192.00
194.00	07950	OTHER DEPARTMENTS	0	0	0	0	0	194.00
194.01	07951	WOMEN'S RESOURCES	144,130	214,672	0	109,293	0	194.01
194.02	07952	MARKETING	163,582	0	0	0	0	194.02
194.03	07953	REPRODUCTIVE MEDICINE	164	0	0	0	0	194.03
194.04	07954	CENTER FOR HEALING ARTS	40,767	0	0	0	0	194.04
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)	22,067,953	4,504,135	1,299,013	2,278,335	636,493	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/30/2024 10:43 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,581,702					11.00
13.00	01300	NURSING ADMINISTRATION	0	0				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,842	0	850,836			14.00
15.00	01500	PHARMACY	0	0	15,768	2,717,359		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,101	0	7	0	383,290	16.00
17.00	01700	SOCIAL SERVICE	20,745	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	307,770	0	25,360	53	21,867	30.00
31.00	03100	INTENSIVE CARE UNIT	320,013	0	46,613	133,294	51,789	31.00
43.00	04300	NURSERY	68,356	0	2,836	1,590	10,561	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	172,760	0	103,799	0	61,174	50.00
51.00	05100	RECOVERY ROOM	0	0	15	0	6,670	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	191,124	0	0	0	17,471	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	119,027	0	4,561	14,055	54,098	54.00
57.00	05700	CT SCAN	0	0	0	0	1,192	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	1,258	58.00
60.00	06000	LABORATORY	0	0	2	0	43,188	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	546	63.00
65.00	06500	RESPIRATORY THERAPY	73,457	0	18,023	36,964	12,292	65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,638	5	11,051	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	561,963	0	17,078	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	60,337	0	1,764	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,520,562	29,213	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	89,440	0	2,318	927	15,588	90.00
91.00	09100	EMERGENCY	60,534	0	0	0	26,490	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,437,169	0	844,240	2,707,450	383,290	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	23,805	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	88,080	0	6,183	9,608	0	192.00
194.00	07950	OTHER DEPARTMENTS	0	0	0	0	0	194.00
194.01	07951	WOMEN'S RESOURCES	19,725	0	350	0	0	194.01
194.02	07952	MARKETING	9,862	0	37	0	0	194.02
194.03	07953	REPRODUCTIVE MEDICINE	0	0	0	301	0	194.03
194.04	07954	CENTER FOR HEALING ARTS	3,061	0	26	0	0	194.04
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)	1,581,702	0	850,836	2,717,359	383,290	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/30/2024 10:43 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
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	878,170					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	302,328	15,549,205	0	15,549,205		30.00
31.00	03100	INTENSIVE CARE UNIT	383,259	16,421,519	0	16,421,519		31.00
43.00	04300	NURSERY	192,583	2,600,112	0	2,600,112		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	10,889,388	0	10,889,388		50.00
51.00	05100	RECOVERY ROOM	0	1,170,595	0	1,170,595		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	8,782,541	0	8,782,541		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,761,110	0	5,761,110		54.00
57.00	05700	CT SCAN	0	186,727	0	186,727		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	197,125	0	197,125		58.00
60.00	06000	LABORATORY	0	4,922,178	0	4,922,178		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	62,132	0	62,132		63.00
65.00	06500	RESPIRATORY THERAPY	0	3,429,032	0	3,429,032		65.00
66.00	06600	PHYSICAL THERAPY	0	2,999,445	0	2,999,445		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,115,515	0	6,115,515		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	682,675	0	682,675		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,908,704	0	7,908,704		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	5,917,756	0	5,917,756		90.00
91.00	09100	EMERGENCY	0	5,286,925	0	5,286,925		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	878,170	98,882,684	0	98,882,684		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	682,045	0	682,045		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	8,805,907	0	8,805,907		192.00
194.00	07950	OTHER DEPARTMENTS	0	0	0	0		194.00
194.01	07951	WOMEN'S RESOURCES	0	1,065,563	0	1,065,563		194.01
194.02	07952	MARKETING	0	828,798	0	828,798		194.02
194.03	07953	REPRODUCTIVE MEDICINE	0	1,121	0	1,121		194.03
194.04	07954	CENTER FOR HEALING ARTS	0	207,167	0	207,167		194.04
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	878,170	110,473,285	0	110,473,285		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/30/2024 10:43 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	89,448	0	89,448	89,448	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	649,230	367,675	1,016,905	9,251	5.00
7.00	00700	OPERATION OF PLANT	0	160,670	37,561	198,231	838	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	27,338	26,998	54,336	1,803	9.00
10.00	01000	DIETARY	0	50,645	12,182	62,827	294	10.00
11.00	01100	CAFETERIA	0	112,964	18,273	131,237	1,298	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	32,587	35,235	67,822	307	14.00
15.00	01500	PHARMACY	0	37,585	102,413	139,998	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	20,745	0	20,745	134	16.00
17.00	01700	SOCIAL SERVICE	0	4,913	0	4,913	845	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,059,470	128,671	1,188,141	10,869	30.00
31.00	03100	INTENSIVE CARE UNIT	0	396,761	295,357	692,118	16,574	31.00
43.00	04300	NURSERY	0	82,225	20,235	102,460	1,959	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	600,012	451,304	1,051,316	6,325	50.00
51.00	05100	RECOVERY ROOM	0	0	10,566	10,566	1,130	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	528,538	90,021	618,559	6,817	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	236,217	208,791	445,008	3,912	54.00
57.00	05700	CT SCAN	0	0	0	0	159	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	168	58.00
60.00	06000	LABORATORY	0	6,929	20,999	27,928	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	13,102	172,068	185,170	2,707	65.00
66.00	06600	PHYSICAL THERAPY	0	153,195	13,122	166,317	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	314,788	255,369	570,157	9,813	90.00
91.00	09100	EMERGENCY	0	104,271	5,321	109,592	5,186	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	4,681,633	2,272,161	6,953,794	80,389	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	75,296	8,193	83,489	437	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	175,158	106,146	281,304	7,439	192.00
194.00	07950	OTHER DEPARTMENTS	0	0	0	0	0	194.00
194.01	07951	WOMEN'S RESOURCES	0	201,824	5,968	207,792	585	194.01
194.02	07952	MARKETING	0	0	0	0	478	194.02
194.03	07953	REPRODUCTIVE MEDICINE	0	0	0	0	0	194.03
194.04	07954	CENTER FOR HEALING ARTS	0	0	5,802	5,802	120	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	5,133,911	2,398,270	7,532,181	89,448	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/30/2024 10:43 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,026,156					5.00
7.00	00700	OPERATION OF PLANT	41,836	240,905				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,066	0	12,066			8.00
9.00	00900	HOUSEKEEPING	20,892	1,555	0	78,586		9.00
10.00	01000	DIETARY	5,157	2,881	0	946	72,105	10.00
11.00	01100	CAFETERIA	13,007	6,427	0	2,110	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,335	1,854	0	609	0	14.00
15.00	01500	PHARMACY	24,533	2,138	0	702	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,203	1,180	0	387	0	16.00
17.00	01700	SOCIAL SERVICE	7,891	280	0	92	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	115,606	60,273	1,059	19,790	71,520	30.00
31.00	03100	INTENSIVE CARE UNIT	134,692	22,572	3,285	7,411	0	31.00
43.00	04300	NURSERY	19,695	4,678	670	1,536	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	85,189	34,135	3,842	11,208	0	50.00
51.00	05100	RECOVERY ROOM	10,389	0	423	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	70,654	30,069	1,108	9,872	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	48,209	13,438	0	4,412	0	54.00
57.00	05700	CT SCAN	1,723	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,819	0	0	0	0	58.00
60.00	06000	LABORATORY	45,215	394	0	129	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	572	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	30,348	745	0	245	0	65.00
66.00	06600	PHYSICAL THERAPY	25,449	8,715	0	2,861	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	51,425	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,764	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	49,776	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	49,267	17,908	0	5,880	0	90.00
91.00	09100	EMERGENCY	45,024	5,932	1,679	1,948	585	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	926,736	215,174	12,066	70,138	72,105	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,991	4,284	0	1,406	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	78,217	9,965	0	3,272	0	192.00
194.00	07950	OTHER DEPARTMENTS	0	0	0	0	0	194.00
194.01	07951	WOMEN'S RESOURCES	6,702	11,482	0	3,770	0	194.01
194.02	07952	MARKETING	7,606	0	0	0	0	194.02
194.03	07953	REPRODUCTIVE MEDICINE	8	0	0	0	0	194.03
194.04	07954	CENTER FOR HEALING ARTS	1,896	0	0	0	0	194.04
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)	1,026,156	240,905	12,066	78,586	72,105	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/30/2024 10:43 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	154,079					11.00
13.00	01300	NURSING ADMINISTRATION	0	0				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	861	0	78,788			14.00
15.00	01500	PHARMACY	0	0	1,460	168,831		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	497	0	1	0	26,147	16.00
17.00	01700	SOCIAL SERVICE	2,021	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,981	0	2,348	3	1,496	30.00
31.00	03100	INTENSIVE CARE UNIT	31,173	0	4,316	8,282	3,543	31.00
43.00	04300	NURSERY	6,659	0	263	99	722	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,829	0	9,612	0	4,113	50.00
51.00	05100	RECOVERY ROOM	0	0	1	0	456	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,618	0	0	0	1,195	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,595	0	422	873	3,701	54.00
57.00	05700	CT SCAN	0	0	0	0	82	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	86	58.00
60.00	06000	LABORATORY	0	0	0	0	2,954	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	37	63.00
65.00	06500	RESPIRATORY THERAPY	7,156	0	1,669	2,297	841	65.00
66.00	06600	PHYSICAL THERAPY	0	0	244	0	756	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	52,040	0	1,168	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	5,587	0	121	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	156,603	1,998	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	8,713	0	215	58	1,066	90.00
91.00	09100	EMERGENCY	5,897	0	0	0	1,812	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	140,000	0	78,178	168,215	26,147	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,319	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,580	0	573	597	0	192.00
194.00	07950	OTHER DEPARTMENTS	0	0	0	0	0	194.00
194.01	07951	WOMEN'S RESOURCES	1,921	0	32	0	0	194.01
194.02	07952	MARKETING	961	0	3	0	0	194.02
194.03	07953	REPRODUCTIVE MEDICINE	0	0	0	19	0	194.03
194.04	07954	CENTER FOR HEALING ARTS	298	0	2	0	0	194.04
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)	154,079	0	78,788	168,831	26,147	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/30/2024 10:43 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
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	16,042					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,523	1,506,609	0	1,506,609		30.00
31.00	03100	INTENSIVE CARE UNIT	7,001	930,967	0	930,967		31.00
43.00	04300	NURSERY	3,518	142,259	0	142,259		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,222,569	0	1,222,569		50.00
51.00	05100	RECOVERY ROOM	0	22,965	0	22,965		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	756,892	0	756,892		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	531,570	0	531,570		54.00
57.00	05700	CT SCAN	0	1,964	0	1,964		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,073	0	2,073		58.00
60.00	06000	LABORATORY	0	76,620	0	76,620		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	609	0	609		63.00
65.00	06500	RESPIRATORY THERAPY	0	231,178	0	231,178		65.00
66.00	06600	PHYSICAL THERAPY	0	204,342	0	204,342		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	104,633	0	104,633		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,472	0	11,472		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	208,377	0	208,377		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	663,077	0	663,077		90.00
91.00	09100	EMERGENCY	0	177,655	0	177,655		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,042	6,795,831	0	6,795,831		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	96,926	0	96,926		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	389,947	0	389,947		192.00
194.00	07950	OTHER DEPARTMENTS	0	0	0	0		194.00
194.01	07951	WOMEN'S RESOURCES	0	232,284	0	232,284		194.01
194.02	07952	MARKETING	0	9,048	0	9,048		194.02
194.03	07953	REPRODUCTIVE MEDICINE	0	27	0	27		194.03
194.04	07954	CENTER FOR HEALING ARTS	0	8,118	0	8,118		194.04
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	16,042	7,532,181	0	7,532,181		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/30/2024 10:43 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	122,253					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,068,739				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,130	0	53,521,436			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,460	317,155	5,536,253	-22,067,953	88,405,332	5.00
7.00	00700	OPERATION OF PLANT	3,826	32,400	501,372	0	3,604,398	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	1,039,525	8.00
9.00	00900	HOUSEKEEPING	651	23,288	1,078,844	0	1,799,949	9.00
10.00	01000	DIETARY	1,206	10,508	175,789	0	444,293	10.00
11.00	01100	CAFETERIA	2,690	15,762	776,950	0	1,120,637	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	776	30,394	183,786	0	631,939	14.00
15.00	01500	PHARMACY	895	88,341	0	0	2,113,648	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	494	0	80,317	0	275,989	16.00
17.00	01700	SOCIAL SERVICE	117	0	505,458	0	679,836	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,229	110,991	6,504,466	0	9,960,033	30.00
31.00	03100	INTENSIVE CARE UNIT	9,448	254,774	9,911,753	0	11,601,371	31.00
43.00	04300	NURSERY	1,958	17,455	1,172,502	0	1,696,797	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,288	389,294	3,784,921	0	7,339,428	50.00
51.00	05100	RECOVERY ROOM	0	9,114	676,038	0	895,099	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,586	77,652	4,079,692	0	6,087,194	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,625	180,102	2,341,343	0	4,153,413	54.00
57.00	05700	CT SCAN	0	0	95,009	0	148,473	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	100,300	0	156,741	58.00
60.00	06000	LABORATORY	165	18,114	0	0	3,895,471	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	49,284	63.00
65.00	06500	RESPIRATORY THERAPY	312	148,425	1,619,840	0	2,614,603	65.00
66.00	06600	PHYSICAL THERAPY	3,648	11,319	0	0	2,192,539	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	4,430,519	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	496,609	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	4,288,440	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,496	220,280	5,872,592	0	4,244,635	90.00
91.00	09100	EMERGENCY	2,483	4,590	3,103,495	0	3,879,021	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	111,483	1,959,958	48,100,720	-22,067,953	79,839,884	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,793	7,067	261,314	0	430,031	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,171	91,561	4,451,691	0	6,738,738	192.00
194.00	07950	OTHER DEPARTMENTS	0	0	0	0	0	194.00
194.01	07951	WOMEN'S RESOURCES	4,806	5,148	350,346	0	577,393	194.01
194.02	07952	MARKETING	0	0	285,766	0	655,317	194.02
194.03	07953	REPRODUCTIVE MEDICINE	0	0	0	0	656	194.03
194.04	07954	CENTER FOR HEALING ARTS	0	5,005	71,599	0	163,313	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,133,911	2,398,270	16,094,185		22,067,953	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	41.994151	1.159291	0.300705		0.249622	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			89,448		1,026,156	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001671		0.011607	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: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/30/2024 10:43 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (GROSS REVENUE)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	100,837					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	118,745,618				8.00
9.00	00900	HOUSEKEEPING	651	0	100,186			9.00
10.00	01000	DIETARY	1,206	0	1,206	27,015		10.00
11.00	01100	CAFETERIA	2,690	0	2,690	0	4,651	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	776	0	776	0	26	14.00
15.00	01500	PHARMACY	895	0	895	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	494	0	494	0	15	16.00
17.00	01700	SOCIAL SERVICE	117	0	117	0	61	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,229	10,381,756	25,229	26,796	905	30.00
31.00	03100	INTENSIVE CARE UNIT	9,448	32,206,807	9,448	0	941	31.00
43.00	04300	NURSERY	1,958	6,567,775	1,958	0	201	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,288	38,116,366	14,288	0	508	50.00
51.00	05100	RECOVERY ROOM	0	4,148,039	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,586	10,864,828	12,586	0	562	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,625	0	5,625	0	350	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	165	0	165	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	312	0	312	0	216	65.00
66.00	06600	PHYSICAL THERAPY	3,648	0	3,648	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,496	0	7,496	0	263	90.00
91.00	09100	EMERGENCY	2,483	16,460,047	2,483	219	178	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	90,067	118,745,618	89,416	27,015	4,226	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,793	0	1,793	0	70	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,171	0	4,171	0	259	192.00
194.00	07950	OTHER DEPARTMENTS	0	0	0	0	0	194.00
194.01	07951	WOMEN'S RESOURCES	4,806	0	4,806	0	58	194.01
194.02	07952	MARKETING	0	0	0	0	29	194.02
194.03	07953	REPRODUCTIVE MEDICINE	0	0	0	0	0	194.03
194.04	07954	CENTER FOR HEALING ARTS	0	0	0	0	9	194.04
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)	4,504,135	1,299,013	2,278,335	636,493	1,581,702	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	44.667483	0.010939	22.741052	23.560726	340.077833	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	240,905	12,066	78,586	72,105	154,079	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.389054	0.000102	0.784401	2.669073	33.128144	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: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/30/2024 10:43 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	0					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,002,939				14.00
15.00	01500	PHARMACY	0	129,782	4,438,642			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	55	0	238,423,325		16.00
17.00	01700	SOCIAL SERVICE	0	3	0	0	24,870	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	208,728	87	13,599,108	8,562	30.00
31.00	03100	INTENSIVE CARE UNIT	0	383,652	217,727	32,206,807	10,854	31.00
43.00	04300	NURSERY	0	23,343	2,597	6,567,775	5,454	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	854,333	0	38,102,350	0	50.00
51.00	05100	RECOVERY ROOM	0	127	0	4,148,039	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	10,864,828	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	37,538	22,958	33,643,297	0	54.00
57.00	05700	CT SCAN	0	0	0	741,241	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	782,523	0	58.00
60.00	06000	LABORATORY	0	19	0	26,858,140	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	339,611	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	148,341	60,378	7,644,054	0	65.00
66.00	06600	PHYSICAL THERAPY	0	21,714	8	6,872,511	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,625,318	0	10,620,591	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	496,609	0	1,097,146	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	4,117,186	18,167,081	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	19,079	1,515	9,694,159	0	90.00
91.00	09100	EMERGENCY	0	0	0	16,474,064	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	6,948,641	4,422,456	238,423,325	24,870	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	50,890	15,694	0	0	192.00
194.00	07950	OTHER DEPARTMENTS	0	0	0	0	0	194.00
194.01	07951	WOMEN'S RESOURCES	0	2,884	0	0	0	194.01
194.02	07952	MARKETING	0	306	0	0	0	194.02
194.03	07953	REPRODUCTIVE MEDICINE	0	0	492	0	0	194.03
194.04	07954	CENTER FOR HEALING ARTS	0	218	0	0	0	194.04
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)	0	850,836	2,717,359	383,290	878,170	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.121497	0.612205	0.001608	35.310414	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	78,788	168,831	26,147	16,042	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.011251	0.038037	0.000110	0.645034	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/30/2024 10:43 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,549,205		15,549,205	0	15,549,205	30.00
31.00	03100	INTENSIVE CARE UNIT	16,421,519		16,421,519	21,861	16,443,380	31.00
43.00	04300	NURSERY	2,600,112		2,600,112	0	2,600,112	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,889,388		10,889,388	68,139	10,957,527	50.00
51.00	05100	RECOVERY ROOM	1,170,595		1,170,595	0	1,170,595	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,782,541		8,782,541	0	8,782,541	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,761,110		5,761,110	22,901	5,784,011	54.00
57.00	05700	CT SCAN	186,727		186,727	0	186,727	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	197,125		197,125	0	197,125	58.00
60.00	06000	LABORATORY	4,922,178		4,922,178	0	4,922,178	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	62,132		62,132	0	62,132	63.00
65.00	06500	RESPIRATORY THERAPY	3,429,032	0	3,429,032	0	3,429,032	65.00
66.00	06600	PHYSICAL THERAPY	2,999,445	0	2,999,445	0	2,999,445	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,115,515		6,115,515	0	6,115,515	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	682,675		682,675	0	682,675	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,908,704		7,908,704	0	7,908,704	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,917,756		5,917,756	78,154	5,995,910	90.00
91.00	09100	EMERGENCY	5,286,925		5,286,925	994,030	6,280,955	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,202,704		3,202,704		3,202,704	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	102,085,388	0	102,085,388	1,185,085	103,270,473	200.00
201.00		Less Observation Beds	3,202,704		3,202,704		3,202,704	201.00
202.00		Total (see instructions)	98,882,684	0	98,882,684	1,185,085	100,067,769	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/30/2024 10:43 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,381,756		10,381,756			30.00
31.00	03100	INTENSIVE CARE UNIT	32,206,807		32,206,807			31.00
43.00	04300	NURSERY	6,567,775		6,567,775			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,720,956	26,381,394	38,102,350	0.285793	0.000000	50.00
51.00	05100	RECOVERY ROOM	207,772	3,940,267	4,148,039	0.282204	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,864,828	0	10,864,828	0.808346	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,894,782	29,748,515	33,643,297	0.171241	0.000000	54.00
57.00	05700	CT SCAN	151,091	590,150	741,241	0.251911	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	239,685	542,838	782,523	0.251910	0.000000	58.00
60.00	06000	LABORATORY	12,586,280	14,271,860	26,858,140	0.183266	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	300,044	39,567	339,611	0.182950	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	7,631,632	12,422	7,644,054	0.448588	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	540,956	6,331,555	6,872,511	0.436441	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,114,969	8,505,622	10,620,591	0.575817	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	37,281	1,059,865	1,097,146	0.622228	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,253,270	7,913,811	18,167,081	0.435332	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	280,960	9,413,199	9,694,159	0.610446	0.000000	90.00
91.00	09100	EMERGENCY	3,374,868	13,099,196	16,474,064	0.320924	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,425,483	1,791,869	3,217,352	0.995447	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	114,781,195	123,642,130	238,423,325			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	114,781,195	123,642,130	238,423,325			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/30/2024 10:43 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.287581	50.00
51.00	05100	RECOVERY ROOM	0.282204	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.808346	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171922	54.00
57.00	05700	CT SCAN	0.251911	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.251910	58.00
60.00	06000	LABORATORY	0.183266	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.182950	63.00
65.00	06500	RESPIRATORY THERAPY	0.448588	65.00
66.00	06600	PHYSICAL THERAPY	0.436441	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.575817	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.622228	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.435332	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.618507	90.00
91.00	09100	EMERGENCY	0.381263	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.995447	92.00
		OTHER REIMBURSABLE COST CENTERS		
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/30/2024 10:43 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,549,205		15,549,205	0	15,549,205	30.00
31.00	03100	INTENSIVE CARE UNIT	16,421,519		16,421,519	21,861	16,443,380	31.00
43.00	04300	NURSERY	2,600,112		2,600,112	0	2,600,112	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,889,388		10,889,388	68,139	10,957,527	50.00
51.00	05100	RECOVERY ROOM	1,170,595		1,170,595	0	1,170,595	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,782,541		8,782,541	0	8,782,541	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,761,110		5,761,110	22,901	5,784,011	54.00
57.00	05700	CT SCAN	186,727		186,727	0	186,727	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	197,125		197,125	0	197,125	58.00
60.00	06000	LABORATORY	4,922,178		4,922,178	0	4,922,178	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	62,132		62,132	0	62,132	63.00
65.00	06500	RESPIRATORY THERAPY	3,429,032	0	3,429,032	0	3,429,032	65.00
66.00	06600	PHYSICAL THERAPY	2,999,445	0	2,999,445	0	2,999,445	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,115,515		6,115,515	0	6,115,515	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	682,675		682,675	0	682,675	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,908,704		7,908,704	0	7,908,704	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,917,756		5,917,756	78,154	5,995,910	90.00
91.00	09100	EMERGENCY	5,286,925		5,286,925	994,030	6,280,955	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,202,704		3,202,704		3,202,704	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	102,085,388	0	102,085,388	1,185,085	103,270,473	200.00
201.00		Less Observation Beds	3,202,704		3,202,704		3,202,704	201.00
202.00		Total (see instructions)	98,882,684	0	98,882,684	1,185,085	100,067,769	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/30/2024 10:43 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,381,756		10,381,756			30.00
31.00	03100	INTENSIVE CARE UNIT	32,206,807		32,206,807			31.00
43.00	04300	NURSERY	6,567,775		6,567,775			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,720,956	26,381,394	38,102,350	0.285793	0.000000	50.00
51.00	05100	RECOVERY ROOM	207,772	3,940,267	4,148,039	0.282204	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,864,828	0	10,864,828	0.808346	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,894,782	29,748,515	33,643,297	0.171241	0.000000	54.00
57.00	05700	CT SCAN	151,091	590,150	741,241	0.251911	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	239,685	542,838	782,523	0.251910	0.000000	58.00
60.00	06000	LABORATORY	12,586,280	14,271,860	26,858,140	0.183266	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	300,044	39,567	339,611	0.182950	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	7,631,632	12,422	7,644,054	0.448588	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	540,956	6,331,555	6,872,511	0.436441	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,114,969	8,505,622	10,620,591	0.575817	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	37,281	1,059,865	1,097,146	0.622228	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,253,270	7,913,811	18,167,081	0.435332	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	280,960	9,413,199	9,694,159	0.610446	0.000000	90.00
91.00	09100	EMERGENCY	3,374,868	13,099,196	16,474,064	0.320924	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,425,483	1,791,869	3,217,352	0.995447	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	114,781,195	123,642,130	238,423,325			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	114,781,195	123,642,130	238,423,325			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/30/2024 10:43 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.287581		50.00
51.00	05100	RECOVERY ROOM	0.282204		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.808346		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171922		54.00
57.00	05700	CT SCAN	0.251911		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.251910		58.00
60.00	06000	LABORATORY	0.183266		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.182950		63.00
65.00	06500	RESPIRATORY THERAPY	0.448588		65.00
66.00	06600	PHYSICAL THERAPY	0.436441		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.575817		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.622228		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.435332		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000		78.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.618507		90.00
91.00	09100	EMERGENCY	0.381263		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.995447		92.00
		OTHER REIMBURSABLE COST CENTERS			
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part II | Date/Time Prepared: 5/30/2024 10:43 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,889,388	1,222,569	9,666,819	0	0	50.00
51.00	05100	RECOVERY ROOM	1,170,595	22,965	1,147,630	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,782,541	756,892	8,025,649	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,761,110	531,570	5,229,540	0	0	54.00
57.00	05700	CT SCAN	186,727	1,964	184,763	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	197,125	2,073	195,052	0	0	58.00
60.00	06000	LABORATORY	4,922,178	76,620	4,845,558	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	62,132	609	61,523	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	3,429,032	231,178	3,197,854	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,999,445	204,342	2,795,103	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,115,515	104,633	6,010,882	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	682,675	11,472	671,203	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,908,704	208,377	7,700,327	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,917,756	663,077	5,254,679	0	0	90.00
91.00	09100	EMERGENCY	5,286,925	177,655	5,109,270	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,202,704	310,320	2,892,384	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
200.00		Subtotal (sum of lines 50 thru 199)	67,514,552	4,526,316	62,988,236	0	0	200.00
201.00		Less Observation Beds	3,202,704	310,320	2,892,384	0	0	201.00
202.00		Total (line 200 minus line 201)	64,311,848	4,215,996	60,095,852	0	0	202.00

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

Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part II Date/Time Prepared: 5/30/2024 10:43 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	10,889,388	38,102,350	0.285793		50.00
51.00	05100	RECOVERY ROOM	1,170,595	4,148,039	0.282204		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,782,541	10,864,828	0.808346		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,761,110	33,643,297	0.171241		54.00
57.00	05700	CT SCAN	186,727	741,241	0.251911		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	197,125	782,523	0.251910		58.00
60.00	06000	LABORATORY	4,922,178	26,858,140	0.183266		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	62,132	339,611	0.182950		63.00
65.00	06500	RESPIRATORY THERAPY	3,429,032	7,644,054	0.448588		65.00
66.00	06600	PHYSICAL THERAPY	2,999,445	6,872,511	0.436441		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,115,515	10,620,591	0.575817		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	682,675	1,097,146	0.622228		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,908,704	18,167,081	0.435332		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000		78.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	5,917,756	9,694,159	0.610446		90.00
91.00	09100	EMERGENCY	5,286,925	16,474,064	0.320924		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,202,704	3,217,352	0.995447		92.00
		OTHER REIMBURSABLE COST CENTERS					
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0.000000		102.00
200.00		Subtotal (sum of lines 50 thru 199)	67,514,552	189,266,987			200.00
201.00		Less Observation Beds	3,202,704	0			201.00
202.00		Total (line 200 minus line 201)	64,311,848	189,266,987			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part I Date/Time Prepared: 5/30/2024 10:43 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,506,609	0	1,506,609	10,783	139.72	30.00
31.00	INTENSIVE CARE UNIT	930,967		930,967	10,854	85.77	31.00
43.00	NURSERY	142,259		142,259	5,454	26.08	43.00
200.00	Total (lines 30 through 199)	2,579,835		2,579,835	27,091		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	77	10,758	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	77	10,758	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/30/2024 10:43 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	1,222,569	38,102,350	0.032086	559,994	17,968	50.00
51.00	05100	RECOVERY ROOM	22,965	4,148,039	0.005536	45,288	251	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	756,892	10,864,828	0.069664	14,721	1,026	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	531,570	33,643,297	0.015800	7,400	117	54.00
57.00	05700	CT SCAN	1,964	741,241	0.002650	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,073	782,523	0.002649	0	0	58.00
60.00	06000	LABORATORY	76,620	26,858,140	0.002853	285,853	816	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	609	339,611	0.001793	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	231,178	7,644,054	0.030243	60	2	65.00
66.00	06600	PHYSICAL THERAPY	204,342	6,872,511	0.029733	938	28	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	104,633	10,620,591	0.009852	121,327	1,195	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,472	1,097,146	0.010456	4,453	47	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	208,377	18,167,081	0.011470	81,956	940	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	663,077	9,694,159	0.068400	1,020	70	90.00
91.00	09100	EMERGENCY	177,655	16,474,064	0.010784	1,188	13	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	310,320	3,217,352	0.096452	4,946	477	92.00
200.00		Total (lines 50 through 199)	4,526,316	189,266,987		1,129,144	22,950	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part III Date/Time Prepared: 5/30/2024 10:43 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
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	10,783	0.00	77	30.00
31.00	03100	INTENSIVE CARE UNIT		0	10,854	0.00	0	31.00
43.00	04300	NURSERY		0	5,454	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	27,091		77	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/30/2024 10:43 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/30/2024 10:43 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	38,102,350	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	4,148,039	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	10,864,828	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	33,643,297	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	741,241	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	782,523	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	26,858,140	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	339,611	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,644,054	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,872,511	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	10,620,591	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,097,146	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	18,167,081	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	9,694,159	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	16,474,064	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,217,352	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	189,266,987		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/30/2024 10:43 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	559,994	0	3,268,787	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	45,288	0	381,995	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	14,721	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	7,400	0	1,611,433	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	14,664	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	285,853	0	1,299,218	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	0	0	2,280	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	60	0	1,079	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	938	0	67,522	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	121,327	0	743,703	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	4,453	0	355,430	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	81,956	0	295,462	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	1,020	0	40,278	0	90.00
91.00	09100	EMERGENCY	0.000000	1,188	0	51,715	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	4,946	0	6,009	0	92.00
200.00		Total (lines 50 through 199)		1,129,144	0	8,139,575	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/30/2024 10:43 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	0.285793	3,268,787	0	0	934,196	50.00
51.00	05100	RECOVERY ROOM	0.282204	381,995	0	0	107,801	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.808346	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171241	1,611,433	0	0	275,943	54.00
57.00	05700	CT SCAN	0.251911	14,664	0	0	3,694	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.251910	0	0	0	0	58.00
60.00	06000	LABORATORY	0.183266	1,299,218	0	0	238,102	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.182950	2,280	0	0	417	63.00
65.00	06500	RESPIRATORY THERAPY	0.448588	1,079	0	0	484	65.00
66.00	06600	PHYSICAL THERAPY	0.436441	67,522	0	0	29,469	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.575817	743,703	0	0	428,237	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.622228	355,430	0	0	221,158	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.435332	295,462	0	5,114	128,624	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.610446	40,278	0	0	24,588	90.00
91.00	09100	EMERGENCY	0.320924	51,715	0	0	16,597	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.995447	6,009	0	0	5,982	92.00
200.00		Subtotal (see instructions)		8,139,575	0	5,114	2,415,292	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		8,139,575	0	5,114	2,415,292	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/30/2024 10:43 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
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,226		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	2,226		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	2,226		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part I Date/Time Prepared: 5/30/2024 10:43 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,506,609	0	1,506,609	10,783	139.72	30.00
31.00	INTENSIVE CARE UNIT	930,967		930,967	10,854	85.77	31.00
43.00	NURSERY	142,259		142,259	5,454	26.08	43.00
200.00	Total (lines 30 through 199)	2,579,835		2,579,835	27,091		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	221	30,878				30.00
31.00	INTENSIVE CARE UNIT	2,439	209,193				31.00
43.00	NURSERY	329	8,580				43.00
200.00	Total (lines 30 through 199)	2,989	248,651				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/30/2024 10:43 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,222,569	38,102,350	0.032086	464,872	14,916	50.00
51.00	05100	RECOVERY ROOM	22,965	4,148,039	0.005536	67,080	371	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	756,892	10,864,828	0.069664	451,917	31,482	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	531,570	33,643,297	0.015800	259,272	4,096	54.00
57.00	05700	CT SCAN	1,964	741,241	0.002650	8,239	22	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,073	782,523	0.002649	20,828	55	58.00
60.00	06000	LABORATORY	76,620	26,858,140	0.002853	1,048,265	2,991	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	609	339,611	0.001793	75,135	135	63.00
65.00	06500	RESPIRATORY THERAPY	231,178	7,644,054	0.030243	789,057	23,863	65.00
66.00	06600	PHYSICAL THERAPY	204,342	6,872,511	0.029733	45,530	1,354	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	104,633	10,620,591	0.009852	86,041	848	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,472	1,097,146	0.010456	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	208,377	18,167,081	0.011470	728,574	8,357	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	663,077	9,694,159	0.068400	13,865	948	90.00
91.00	09100	EMERGENCY	177,655	16,474,064	0.010784	68,727	741	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	310,320	3,217,352	0.096452	63,871	6,160	92.00
200.00		Total (lines 50 through 199)	4,526,316	189,266,987		4,191,273	96,339	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part III Date/Time Prepared: 5/30/2024 10:43 am

Title XIX | Hospital | PPS

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	10,783	0.00	221	30.00
31.00	03100	INTENSIVE CARE UNIT		0	10,854	0.00	2,439	31.00
43.00	04300	NURSERY		0	5,454	0.00	329	43.00
200.00		Total (lines 30 through 199)		0	27,091		2,989	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/30/2024 10:43 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/30/2024 10:43 am

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	38,102,350	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	4,148,039	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	10,864,828	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	33,643,297	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	741,241	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	782,523	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	26,858,140	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	339,611	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,644,054	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,872,511	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	10,620,591	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,097,146	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	18,167,081	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	9,694,159	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	16,474,064	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,217,352	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	189,266,987		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/30/2024 10:43 am

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	464,872	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	67,080	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	451,917	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	259,272	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	8,239	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	20,828	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	1,048,265	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	75,135	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	789,057	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	45,530	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	86,041	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	728,574	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	13,865	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	68,727	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	63,871	0	0	0	92.00
200.00		Total (lines 50 through 199)		4,191,273	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/30/2024 10:43 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.285793	0	0	331,864	0	50.00
51.00	05100	RECOVERY ROOM	0.282204	0	0	37,305	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.808346	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171241	0	0	216,326	0	54.00
57.00	05700	CT SCAN	0.251911	0	0	12,293	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.251910	0	0	11,792	0	58.00
60.00	06000	LABORATORY	0.183266	0	0	333,205	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.182950	0	0	2,381	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.448588	0	0	495	0	65.00
66.00	06600	PHYSICAL THERAPY	0.436441	0	0	124	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.575817	0	0	46,357	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.622228	0	0	44,885	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.435332	0	0	53,311	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.610446	0	0	398,057	0	90.00
91.00	09100	EMERGENCY	0.320924	0	0	238,841	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.995447	0	0	45,336	0	92.00
200.00		Subtotal (see instructions)		0	0	1,772,572	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	1,772,572	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/30/2024 10:43 am

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	94,844		50.00
51.00	05100	RECOVERY ROOM	0	10,528		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	37,044		54.00
57.00	05700	CT SCAN	0	3,097		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,971		58.00
60.00	06000	LABORATORY	0	61,065		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	436		63.00
65.00	06500	RESPIRATORY THERAPY	0	222		65.00
66.00	06600	PHYSICAL THERAPY	0	54		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	26,693		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	27,929		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	23,208		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	242,992		90.00
91.00	09100	EMERGENCY	0	76,650		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	45,130		92.00
200.00		Subtotal (see instructions)	0	652,863		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	652,863		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/30/2024 10:43 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)	10,783	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	10,783	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)	8,562	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)	77	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	15,549,205	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	15,549,205	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	15,549,205	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)	1,442.01	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	111,035	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)	111,035	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/30/2024 10:43 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	16,443,380	10,854	1,514.96	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)	354,137	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)	465,172	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)	10,758	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	22,950	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	33,708	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	431,464	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	2,221	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,442.01	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,202,704	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/30/2024 10:43 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,506,609	15,549,205	0.096893	3,202,704	310,320	90.00
91.00	Nursing Program cost	0	15,549,205	0.000000	3,202,704	0	91.00
92.00	Allied health cost	0	15,549,205	0.000000	3,202,704	0	92.00
93.00	All other Medical Education	0	15,549,205	0.000000	3,202,704	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/30/2024 10:43 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	10,783	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	10,783	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)	8,562	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)	221	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)	5,454	15.00
16.00	Nursery days (title V or XIX only)	329	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	15,549,205	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	15,549,205	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	15,549,205	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)	1,442.01	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	318,684	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)	318,684	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/30/2024 10:43 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	2,600,112	5,454	476.73	329	156,844	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	16,443,380	10,854	1,514.96	2,439	3,694,987	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)	1,614,585	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)	5,785,100	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)	248,651	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	96,339	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	344,990	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	5,440,110	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	2,221	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,442.01	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,202,704	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/30/2024 10:43 am

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,506,609	15,549,205	0.096893	3,202,704	310,320	90.00
91.00	Nursing Program cost	0	15,549,205	0.000000	3,202,704	0	91.00
92.00	Allied health cost	0	15,549,205	0.000000	3,202,704	0	92.00
93.00	All other Medical Education	0	15,549,205	0.000000	3,202,704	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/30/2024 10:43 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		102,866		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.287581	559,994	161,044	50.00
51.00	05100	RECOVERY ROOM	0.282204	45,288	12,780	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.808346	14,721	11,900	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171922	7,400	1,272	54.00
57.00	05700	CT SCAN	0.251911	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.251910	0	0	58.00
60.00	06000	LABORATORY	0.183266	285,853	52,387	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.182950	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.448588	60	27	65.00
66.00	06600	PHYSICAL THERAPY	0.436441	938	409	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.575817	121,327	69,862	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.622228	4,453	2,771	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.435332	81,956	35,678	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.618507	1,020	631	90.00
91.00	09100	EMERGENCY	0.381263	1,188	453	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.995447	4,946	4,923	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,129,144	354,137	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,129,144		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/30/2024 10:43 am

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		465,677		30.00
31.00	03100	INTENSIVE CARE UNIT		2,759,056		31.00
43.00	04300	NURSERY		272,660		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.287581	464,872	133,688	50.00
51.00	05100	RECOVERY ROOM	0.282204	67,080	18,930	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.808346	451,917	365,305	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171922	259,272	44,575	54.00
57.00	05700	CT SCAN	0.251911	8,239	2,075	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.251910	20,828	5,247	58.00
60.00	06000	LABORATORY	0.183266	1,048,265	192,111	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.182950	75,135	13,746	63.00
65.00	06500	RESPIRATORY THERAPY	0.448588	789,057	353,962	65.00
66.00	06600	PHYSICAL THERAPY	0.436441	45,530	19,871	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.575817	86,041	49,544	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.622228	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.435332	728,574	317,172	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.618507	13,865	8,576	90.00
91.00	09100	EMERGENCY	0.381263	68,727	26,203	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.995447	63,871	63,580	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,191,273	1,614,585	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		4,191,273		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0149	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/30/2024 10:43 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	275,409	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	43,101	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)	0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	0	2.04
3.00	Managed Care Simulated Payments	212,724	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	67.92	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)	8.97	30.00
31.00	Percentage of Medicaid patient days (see instructions)	57.25	31.00
32.00	Sum of lines 30 and 31	66.22	32.00
33.00	Allowable disproportionate share percentage (see instructions)	12.00	33.00
34.00	Disproportionate share adjustment (see instructions)	9,555	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0149	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/30/2024 10:43 am
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Payment Adjustment			
35.00	Total uncompensated care amount (see instructions)	6,874,403,459	5,938,006,757	35.00
35.01	Factor 3 (see instructions)	0.000047131	0.000047274	35.01
35.02	Hospital UCP, including supplemental UCP (see instructions)	323,995	280,712	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	242,330	70,561	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	312,891		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)	640,956		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)	640,956	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	24,796	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
55.01	Cellular therapy acquisition cost (see instructions)	0	55.01
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	665,752	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	665,752	61.00
62.00	Deductibles billed to program beneficiaries	46,400	62.00
63.00	Coinsurance billed to program beneficiaries	0	63.00
64.00	Allowable bad debts (see instructions)	4,586	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	2,981	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	4,586	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	622,333	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)	1,565	70.93
70.94	HRR adjustment amount (see instructions)	0	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A | Date/Time Prepared: 5/30/2024 10:43 am

Title XVIII | Hospital | PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3	0	0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		623,898	71.00
71.01	Sequestration adjustment (see instructions)		12,478	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		545,391	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)		66,029	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		470,000	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: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/30/2024 10:43 am

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	275,409	0	275,409		275,409	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	43,101	0		43,101	43,101	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	0	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	212,724	0	212,724	0	212,724	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	0.1200	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	9,555	0	8,262	1,293	9,555	11.00
11.01	Uncompensated care payments	36.00	312,891	0	242,330	70,561	312,891	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	640,956	0	526,001	114,955	640,956	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	640,956	0	526,001	114,955	640,956	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	24,796	0	21,394	3,402	24,796	16.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/30/2024 10:43 am

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	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	547,395	118,357	665,752	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	24,796	0	21,394	3,402	24,796	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	0	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	24,796	0	21,394	3,402	24,796	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: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/30/2024 10:43 am

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	275,409	275,409		275,409	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	43,101		43,101	43,101	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	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	212,724	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	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	9,555	8,262	1,293	9,555	11.00
11.01	Uncompensated care payments	36.00	312,891	242,330	70,561	312,891	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	640,956	526,001	114,955	640,956	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	640,956	526,001	114,955	640,956	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	24,796	21,394	3,402	24,796	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	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			547,395	118,357	665,752	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/30/2024 10:43 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	24,796	21,394	3,402	24,796	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	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	24,796	21,394	3,402	24,796	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	1,565	0	1,565	1,565	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	0	0	0	0	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	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0149	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/30/2024 10:43 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	2,226	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	2,415,292	2.00
3.00	OPPS or REH payments	2,034,746	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)	2,226	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	5,114	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)	5,114	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)	5,114	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	2,888	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	2,226	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)	2,034,746	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)	349,926	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,687,046	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount (see instructions)		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	1,687,046	30.00
31.00	Primary payer payments	198	31.00
32.00	Subtotal (line 30 minus line 31)	1,686,848	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)	15,898	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	10,334	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	10,645	36.00
37.00	Subtotal (see instructions)	1,697,182	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-38	38.00
39.00	OTHER ADJUSTMENTS PER PS&R SUMMARY	146	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,697,366	40.00
40.01	Sequestration adjustment (see instructions)	33,947	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	1,650,964	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)	12,455	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	10,000	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: 15-0149	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/30/2024 10:43 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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/30/2024 10:43 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		545,391		1,650,964	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)		545,391		1,650,964	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		66,029		12,455	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		611,420		1,663,419	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: 15-0149	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/30/2024 10:43 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

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0149	Period: From 01/01/2023 To 12/31/2023	Worksheet E-5 Date/Time Prepared: 5/30/2024 10:43 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: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G | Date/Time Prepared: 5/30/2024 10:43 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	16,176,482	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	39,693,603	0	0	0	4.00
5.00	Other receivable	390,997	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-21,370,066	0	0	0	6.00
7.00	Inventory	796,196	0	0	0	7.00
8.00	Prepaid expenses	1,303,452	0	0	0	8.00
9.00	Other current assets	50,000	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)	37,040,664	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	7,216,244	0	0	0	17.00
18.00	Accumulated depreciation	-4,809,252	0	0	0	18.00
19.00	Fixed equipment	541,778	0	0	0	19.00
20.00	Accumulated depreciation	-541,778	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	22,632,829	0	0	0	25.00
26.00	Accumulated depreciation	-18,310,478	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)	6,729,343	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	229,978,810	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	229,978,810	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	273,748,817	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	8,680,311	0	0	0	37.00
38.00	Salaries, wages, and fees payable	5,982,262	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,731,187	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	50,844	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	16,444,604	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	32,451,151	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	32,451,151	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	48,895,755	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	224,853,062				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)	224,853,062	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	273,748,817	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 5/30/2024 10:43 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		5,478,502		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		17,059,510				2.00
3.00	Total (sum of line 1 and line 2)		22,538,012		0		3.00
4.00	PAID IN CAPITAL	5,124,601		0		0	4.00
5.00	EQUITY - OTHER CHANGES	198,521,498		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)		203,646,099		0		10.00
11.00	Subtotal (line 3 plus line 10)		226,184,111		0		11.00
12.00	DISTRIBUTION TO MEMBERS	1,331,049		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)		1,331,049		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		224,853,062		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	PAID IN CAPITAL		0		4.00
5.00	EQUITY - OTHER CHANGES		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	DISTRIBUTION TO MEMBERS		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: 15-0149 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/30/2024 10:43 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	16,949,531		16,949,531	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	16,949,531		16,949,531	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	41,988,299		41,988,299	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)	41,988,299		41,988,299	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	58,937,830		58,937,830	17.00
18.00	Ancillary services	60,543,545	108,537,023	169,080,568	18.00
19.00	Outpatient services	5,081,311	35,539,576	40,620,887	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NON-REIMBURSABLE	0	5,557,343	5,557,343	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	124,562,686	149,633,942	274,196,628	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		124,229,414		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)		124,229,414		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0149	Period: From 01/01/2023 To 12/31/2023	Worksheet G-3 Date/Time Prepared: 5/30/2024 10:43 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	274,196,628	1.00
2.00	Less contractual allowances and discounts on patients' accounts	134,753,024	2.00
3.00	Net patient revenues (line 1 minus line 2)	139,443,604	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	124,229,414	4.00
5.00	Net income from service to patients (line 3 minus line 4)	15,214,190	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	86,949	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	551,287	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	291,549	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	193,105	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	722,430	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	1,845,320	25.00
26.00	Total (line 5 plus line 25)	17,059,510	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)	17,059,510	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0149	Period: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III Date/Time Prepared: 5/30/2024 10:43 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	24,796	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	0	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)	54.41	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	24,796	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