

Hoboken University Medical Center -TCU
Statement of Operations
FYE 12/31/23
DRAFT

FYE 12/31/23

Operating Revenues

Net Patient Service Revenue TCU

4,400,499

Operating Expenses

Salaries

1,555,685

Benefits

334,858

Supplies/Other Expenses

33,048

Allocated Expenses

2,435,860

Total Operating Expenses

4,359,451

Net Income (Loss) TCU

41,048

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: 31-0040	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/31/2024 12:06 pm
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report	Date: 5/31/2024	Time: 12:06 pm
	2. <input type="checkbox"/> Manually prepared cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.		
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> 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 HOBOKEN UNIVERSITY MEDICAL CENTER (31-0040) 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	Richard Sarli	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	Richard Sarli		2
3	Signatory Title	CFO		3
4	Date	05/31/2024 12:06:57 PM		4

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	1,014,333	434,534	0	75,131
2.00	SUBPROVIDER - IPF	0	0	0		-9,324
3.00	SUBPROVIDER - IRF	0	0	0		0
5.00	SWING BED - SNF	0	0	0		0
6.00	SWING BED - NF	0				0
7.00	SKILLED NURSING FACILITY	0	0	0		0
8.00	NURSING FACILITY	0				0
9.00	HOME HEALTH AGENCY I	0	0	0		0
10.00	RURAL HEALTH CLINIC I	0				0
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0				0
12.00	CMHC I	0				0
200.00	TOTAL	0	1,014,333	434,534	0	65,807

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: 31-0040		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 12:06 pm		
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 308 WILLOW AVENUE			PO Box:				1.00			
2.00	City: HOBOKEN			State: NJ		Zip Code: 07030		County:			
		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		HOBOKEN UNIVERSITY MEDICAL CENTER		310040	35614	1	01/01/1965	N	P	T
4.00	Subprovider - IPF		HOBOKEN PSYCH		31S040	35614	4	01/01/1965	N	P	T
5.00	Subprovider - IRF										
6.00	Subprovider - (Other)										
7.00	Swing Beds - SNF										
8.00	Swing Beds - NF										
9.00	Hospital-Based SNF		HOBOKEN SNF		315512	35614		10/23/2012	N	P	N
10.00	Hospital-Based NF										
11.00	Hospital-Based OLTC										
12.00	Hospital-Based HHA										
13.00	Separately Certified ASC										
14.00	Hospital-Based Hospice										
15.00	Hospital-Based Health Clinic - RHC										
16.00	Hospital-Based Health Clinic - FQHC										
17.00	Hospital-Based (CMHC) I										
17.10	Hospital-Based (CORF) I										
18.00	Renal Dialysis										
19.00	Other										
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2023		12/31/2023		20.00
21.00	Type of Control (see instructions)						2				21.00
						1.00	2.00	3.00			
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					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: 31-0040		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 12:06 pm	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,209	522	61	12	2,983	98	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	Y	40.00	
						V	XVIII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 412.320? (see instructions)					N	Y	N	
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	
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	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	
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.					Y	Y		
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.					Y			
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 31-0040		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 12:06 pm	
				V	XVIII	XIX	
				1.00	2.00	3.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.			N			59.00
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.			N			60.00
				Y/N	IME	Direct GME	
				1.00	2.00	3.00	
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	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	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	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: 31-0040

Period:
From 01/01/2023
To 12/31/2023Worksheet S-2
Part I
Date/Time Prepared:
5/31/2024 12:06 pm

			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.16	6.18	0.025237	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)	FAMILY MEDICINE	1350	2.39	21.17	0.101443	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)		7.00	7.08	0.497159	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)	FAMILY MEDICINE	1350	1.58	20.92	0.070222	67.00

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			1.00			
68.00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?				68.00	
			1.00	2.00	3.00	
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			Y	70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N N 0	71.00	
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N	75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00	
			1.00			
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00	
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87.00	
			Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments		
			1.00	2.00		
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.			N 0	88.00	
			Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge	
			1.00	2.00	3.00	
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.			0.00 0	89.00	
			V	XIX		
			1.00	2.00		
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	Y	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	10.00	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	Y	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00	5.80	97.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 31-0040		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 12:06 pm	
		V 1.00		XIX 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		N		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)					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)					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 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00	
				1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N		110.00	
				1.00			
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			
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				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: 31-0040	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 12:06 pm
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	1	0	0
		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		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: CARE POINT MANAGEMENT	Contractor's Name: NOVITAS		Contractor's Number: 12001
142.00	Street: 508 WILLOW AVE	PO Box:		
143.00	City: HOBOKEN	State: NJ		Zip Code: 07030-3808
				1.00
144.00	Are provider based physicians' costs included in Worksheet A?			Y
				1.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 31-0040		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 12:06 pm		
						1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N	149.00
		Part A	Part B	Title V	Title XIX			
		1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital	N	N	N	N		155.00	
156.00	Subprovider - IPF	N	N	N	N		156.00	
157.00	Subprovider - IRF	N	N	N	N		157.00	
158.00	SUBPROVIDER						158.00	
159.00	SNF	N	N	N	N		159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N		160.00	
161.00	CMHC		N	N	N		161.00	
161.10	CORF		N	N	N		161.10	
						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	
						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: 31-0040		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part II Date/Time Prepared: 5/31/2024 12:06 pm	
				Y/N	Date		
				1.00	2.00		
PART II - HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE							
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date	V/I			
		1.00	2.00	3.00			
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type	Date			
		1.00	2.00	3.00			
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	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.	Y					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.	Y					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)	Y	05/12/2024	Y	05/12/2024		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)	N		N			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

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		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.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TI NA	FORD		41.00
42.00	Enter the employer/company name of the cost report preparer.	HOBOKEN UNIVERSITY MEDICAL CENTER			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	973-951-2304	TI NA. FORD@CAREPOINTHEALTH.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

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		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	GOVERNMENT 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: 31-0040

Period:
From 01/01/2023
To 12/31/2023Worksheet S-3
Part I
Date/Time Prepared:
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Component	Worksheet A	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P	
	Line No.				Visits / Trips	
	1.00	2.00	3.00	4.00	5.00	
PART I - STATISTICAL DATA						
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	99	36,135	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		99	36,135	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	15	5,475	0.00	0	8.00
9.00 CORONARY CARE UNIT	32.00	0	0	0.00	0	9.00
10.00 BURN INTENSIVE CARE UNIT	33.00	0	0	0.00	0	10.00
11.00 SURGICAL INTENSIVE CARE UNIT	34.00	0	0	0.00	0	11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		114	41,610	0.00	0	14.00
15.00 CAH visits					0	15.00
15.10 REH hours and visits				0.00	0	15.10
16.00 SUBPROVIDER - IPF	40.00	47	17,155		0	16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	15	5,475		0	19.00
20.00 NURSING FACILITY	45.00	0	0		0	20.00
21.00 OTHER LONG TERM CARE	46.00	0	0		0	21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)	115.00					23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC	99.00				0	25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		176				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

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Date/Time Prepared:
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Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,092	369	13,214		1.00
2.00	HMO and other (see instructions)	2,709	4,142			2.00
3.00	HMO IPF Subprovider	1,519	0			3.00
4.00	HMO IRF Subprovider	0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,092	369	13,214		7.00
8.00	INTENSIVE CARE UNIT	395	50	1,180		8.00
9.00	CORONARY CARE UNIT	0	0	0		9.00
10.00	BURN INTENSIVE CARE UNIT	0	0	0		10.00
11.00	SURGICAL INTENSIVE CARE UNIT	0	0	0		11.00
12.00	OTHER SPECIAL CARE (SPECIFY)					12.00
13.00	NURSERY		258	1,943		13.00
14.00	Total (see instructions)	2,487	677	16,337	32.40	701.42
15.00	CAH visits	0	0	0		15.00
15.10	REH hours and visits	0	0	0		15.10
16.00	SUBPROVIDER - IPF	1,462	341	11,216	0.00	74.64
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY	1,670	0	3,812	0.00	18.94
20.00	NURSING FACILITY		0	0	0.00	0.00
21.00	OTHER LONG TERM CARE			0	0.00	0.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)				0.00	0.00
24.00	HOSPICE	0	0	0	0.00	0.00
24.10	HOSPICE (non-distinct part)			47		24.10
25.00	CMHC - CMHC	0	0	0	0.00	0.00
25.10	CMHC - CORF	0	0	0	0.00	0.00
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00
27.00	Total (sum of lines 14-26)				32.40	795.00
28.00	Observation Bed Days		57	3,359		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	66	765		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: 31-0040

Period:
From 01/01/2023
To 12/31/2023Worksheet S-3
Part I
Date/Time Prepared:
5/31/2024 12:06 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
	Nonpaid Workers					
	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	401	228	3,120	1.00
2.00 HMO and other (see instructions)			484	0		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	401	228	3,120	14.00
15.00 CAH visits						15.00
15.10 REH hours and visits						15.10
16.00 SUBPROVIDER - IPF	0.00	0	109	44	1,360	16.00
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY	0.00					20.00
21.00 OTHER LONG TERM CARE	0.00				0	21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)	0.00					23.00
24.00 HOSPICE	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC	0.00					25.00
25.10 CMHC - CORF	0.00					25.10
26.00 RURAL HEALTH CLINIC	0.00					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: 31-0040

Period:
From 01/01/2023
To 12/31/2023Worksheet S-3
Part II
Date/Time Prepared:
5/31/2024 12:06 pm

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 + col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	64,920,857	0	64,920,857	1,649,646.00	39.35
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	2,963,212	-381,227	2,581,985	78,664.00	32.82
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	1,552,116	3,569	1,555,685	39,392.00	39.49
10.00	Excluded area salaries (see instructions)		7,168,424	25,047	7,193,471	177,941.00	40.43
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		0	0	0	0.00	0.00
12.00	Contract Labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		471,616	0	471,616	2,208.00	213.59
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		4,923,142	0	4,923,142	101,790.00	48.37
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		10,671,290	0	10,671,290		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		1,748,016	0	1,748,016		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		549,828	0	549,828		
25.50	Home office wage-related (core)		1,029,648	0	1,029,648		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023Worksheet S-3
Part II
Date/Time Prepared:
5/31/2024 12:06 pm

		Wkst. A Line Number	Amount Reported	Recl assi fi cati on 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	395,416	0	395,416	8,973.00	44.07	26.00
27.00	Administrative & General	5.00	4,116,584	1,794	4,118,378	125,452.00	32.83	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,296,499	209	2,296,708	82,523.00	27.83	30.00
31.00	Laundry & Linen Service	8.00	128,694	0	128,694	5,675.00	22.68	31.00
32.00	Housekeeping	9.00	1,424,872	3,343	1,428,215	67,973.00	21.01	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,519,862	-573,380	946,482	44,042.00	21.49	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	573,380	573,380	26,680.00	21.49	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	3,270,066	1,691	3,271,757	59,151.00	55.31	38.00
39.00	Central Services and Supply	14.00	503,383	0	503,383	20,090.00	25.06	39.00
40.00	Pharmacy	15.00	2,646,835	0	2,646,835	51,374.00	51.52	40.00
41.00	Medical Records & Medical Records Library	16.00	792,053	0	792,053	25,369.00	31.22	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023Worksheet S-3
Part III
Date/Time Prepared:
5/31/2024 12:06 pm

	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	61,957,645	381,227	62,338,872	1,570,982.00	39.68	1.00
2.00	Excluded area salaries (see instructions)	8,720,540	28,616	8,749,156	217,333.00	40.26	2.00
3.00	Subtotal salaries (line 1 minus line 2)	53,237,105	352,611	53,589,716	1,353,649.00	39.59	3.00
4.00	Subtotal other wages & related costs (see inst.)	5,394,758	0	5,394,758	103,998.00	51.87	4.00
5.00	Subtotal wage-related costs (see inst.)	11,700,938	0	11,700,938	0.00	21.83	5.00
6.00	Total (sum of lines 3 thru 5)	70,332,801	352,611	70,685,412	1,457,647.00	48.49	6.00
7.00	Total overhead cost (see instructions)	17,094,264	7,037	17,101,301	517,302.00	33.06	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023Worksheet S-3
Part IV
Date/Time Prepared:
5/31/2024 12:06 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	922,733	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	246	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)	0	8.02
8.03	Health Insurance (Purchased)	4,083,384	8.03
9.00	Prescription Drug Plan	1,718,204	9.00
10.00	Dental, Hearing and Vision Plan	-20,934	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	131,507	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)	270,184	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	782,418	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	3,989,830	17.00
18.00	Medicare Taxes - Employers Portion Only	916,545	18.00
19.00	Unemployment Insurance	273,529	19.00
20.00	State or Federal Unemployment Taxes	46,753	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	-145,265	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	12,969,134	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: 31-0040

Period:
From 01/01/2023
To 12/31/2023Worksheet S-3
Part V
Date/Time Prepared:
5/31/2024 12:06 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	12,969,134	1.00
2.00	Hospital	0	12,969,134	2.00
3.00	SUBPROVIDER - IPF	0	0	3.00
4.00	SUBPROVIDER - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY	0	0	8.00
9.00	NURSING FACILITY	0	0	9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I	0	0	12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC	0	0	16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	RENAL DIALYSIS I	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 31-0040	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/31/2024 12:06 pm
				1.00
PART I - HOSPITAL AND HOSPITAL COMPLEX DATA				
Uncompensated and Indigent Care Cost-to-Charge Ratio				
1.00	Cost to charge ratio (see instructions)		0.057931	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		17,524,603	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		12,495,318	5.00
6.00	Medicaid charges		933,836,265	6.00
7.00	Medicaid cost (line 1 times line 6)		54,098,069	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)		24,078,148	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)		24,078,148	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)	282,823,403	0	282,823,403
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	16,384,243	0	16,384,243
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (see instructions)	16,384,243	0	16,384,243
				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)		11,272,073	26.00
27.00	Medicare reimbursable bad debts (see instructions)		0	27.00
27.01	Medicare allowable bad debts (see instructions)		0	27.01
28.00	Non-Medicare bad debt amount (see instructions)		11,272,073	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)		653,002	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)		17,037,245	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		41,115,393	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 31-0040	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/31/2024 12:06 pm
				1.00
PART II - HOSPITAL DATA				
Uncompensated and Indigent Care Cost-to-Charge Ratio				
1.00	Cost to charge ratio (see instructions)		0.055307	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)	282,823,403	0	282,823,403
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	15,642,114	0	15,642,114
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (see instructions)	15,642,114	0	15,642,114
				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)		11,272,073	26.00
27.00	Medicare reimbursable bad debts (see instructions)		0	27.00
27.01	Medicare allowable bad debts (see instructions)		0	27.01
28.00	Non-Medicare bad debt amount (see instructions)		11,272,073	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)		623,425	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)		16,265,539	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		16,265,539	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023

Worksheet A

Date/Time Prepared:
5/31/2024 12:06 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification (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		6,926,691	6,926,691	4,608,461	11,535,152	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		767,399	767,399	0	767,399	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	395,416	13,083,969	13,479,385	393,616	13,873,001	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,116,584	60,871,557	64,988,141	-5,078,283	59,909,858	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	2,296,499	6,371,870	8,668,369	209	8,668,578	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	128,694	337,964	466,658	0	466,658	8.00
9.00	00900	HOUSEKEEPING	1,424,872	1,359,754	2,784,626	3,343	2,787,969	9.00
10.00	01000	DIETARY	1,519,862	1,961,504	3,481,366	-1,267,489	2,213,877	10.00
11.00	01100	CAFETERIA	0	0	0	1,267,489	1,267,489	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	3,270,066	268,990	3,539,056	1,691	3,540,747	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	503,383	1,992,388	2,495,771	-838,303	1,657,468	14.00
15.00	01500	PHARMACY	2,646,835	3,835,478	6,482,313	-3,477,934	3,004,379	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	792,053	51,288	843,341	0	843,341	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	2,963,212	1,399,720	4,362,932	-1,715,160	2,647,772	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	1,714,909	1,714,909	22.00
23.00	02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,054,653	2,175,504	10,230,157	-1,493,101	8,737,056	30.00
31.00	03100	INTENSIVE CARE UNIT	1,951,051	435,676	2,386,727	-57,923	2,328,804	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00	04000	SUBPROVIDER - IPF	6,491,104	654,588	7,145,692	30,845	7,176,537	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	2,484,508	365,633	2,850,141	-64,304	2,785,837	43.00
44.00	04400	SKILLED NURSING FACILITY	1,552,116	34,479	1,586,595	2,138	1,588,733	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,383,186	7,823,214	11,206,400	-4,452,325	6,754,075	50.00
51.00	05100	RECOVERY ROOM	899,005	301,136	1,200,141	-34,085	1,166,056	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,677,482	748,693	3,426,175	-360,612	3,065,563	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,559,119	1,161,459	2,720,578	-169,619	2,550,959	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	123,071	35,785	158,856	0	158,856	56.00
57.00	05700	CT SCAN	582,336	77,438	659,774	-53,292	606,482	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	266,119	14,090	280,209	-2,919	277,290	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,872,793	3,054,647	4,927,440	-79,568	4,847,872	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	556,828	556,828	-74,962	481,866	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,167,720	548,365	1,716,085	-206,947	1,509,138	65.00
66.00	06600	PHYSICAL THERAPY	663,178	4,985	668,163	-2,030	666,133	66.00
67.00	06700	OCCUPATIONAL THERAPY	278,054	0	278,054	0	278,054	67.00
68.00	06800	SPEECH PATHOLOGY	78,599	0	78,599	0	78,599	68.00
69.00	06900	ELECTROCARDIOLOGY	540,657	56,214	596,871	-32,815	564,056	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	5,396,934	5,396,934	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,320,902	2,320,902	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,578,928	3,578,928	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	824,511	824,511	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
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								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	896,372	100,271	996,643	-11,238	985,405	90.00
90.01	09001	CLINIC CMHC	2,273,090	282,207	2,555,297	-109,539	2,445,758	90.01
90.02	09002	CLINIC CHEMO	0	0	0	0	0	90.02

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023

Worksheet A

Date/Time Prepared:
5/31/2024 12:06 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Recl assi fi cati ons (See A-6)	Recl assi fi ed Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
90.03	09003	CLINIC RYAN WHITE	607,966	656,089	1,264,055	-131,773	1,132,282	90.03
91.00	09100	EMERGENCY	5,783,882	3,303,776	9,087,658	-287,518	8,800,140	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	64,243,537	121,619,649	185,863,186	142,237	186,005,423	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	COMMUNITY MOBILE	0	0	0	0	0	190.01
190.02	19002	FAITH	677,320	198,232	875,552	-142,237	733,315	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	64,920,857	121,817,881	186,738,738	0	186,738,738	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023

Worksheet A

Date/Time Prepared:
5/31/2024 12:06 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-3,970,699	7,564,453	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	767,399	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	13,873,001	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-24,184,178	35,725,680	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-12,496	8,656,082	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	466,658	8.00
9.00	00900	HOUSEKEEPING	0	2,787,969	9.00
10.00	01000	DIETARY	0	2,213,877	10.00
11.00	01100	CAFETERIA	-20,099	1,247,390	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	3,540,747	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,657,468	14.00
15.00	01500	PHARMACY	0	3,004,379	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-51	843,290	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	2,647,772	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	1,714,909	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-336,794	8,400,262	30.00
31.00	03100	INTENSIVE CARE UNIT	-18,115	2,310,689	31.00
32.00	03200	CORONARY CARE UNIT	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	34.00
40.00	04000	SUBPROVIDER - IPF	-10,107	7,166,430	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
43.00	04300	NURSERY	-104,712	2,681,125	43.00
44.00	04400	SKILLED NURSING FACILITY	0	1,588,733	44.00
45.00	04500	NURSING FACILITY	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-100,382	6,653,693	50.00
51.00	05100	RECOVERY ROOM	0	1,166,056	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,065,563	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-35,301	2,515,658	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	158,856	56.00
57.00	05700	CT SCAN	0	606,482	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	277,290	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-3,718	4,844,154	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	481,866	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,509,138	65.00
66.00	06600	PHYSICAL THERAPY	0	666,133	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	278,054	67.00
68.00	06800	SPEECH PATHOLOGY	0	78,599	68.00
69.00	06900	ELECTROCARDIOLOGY	0	564,056	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,396,934	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,320,902	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,578,928	73.00
74.00	07400	RENAL DIALYSIS	0	824,511	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
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					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	-1,140	984,265	90.00
90.01	09001	CLINIC CMHC	0	2,445,758	90.01
90.02	09002	CLINIC CHEMO	0	0	90.02
90.03	09003	CLINIC RYAN WHITE	-421,852	710,430	90.03
91.00	09100	EMERGENCY	-1,189,200	7,610,940	91.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023

Worksheet A

Date/Time Prepared:
5/31/2024 12:06 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
94.00	09400	HOME PROGRAM DIALYSIS	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
99.00	09900	CMHC	0	0	99.00
99.10	09910	CORF	0	0	99.10
100.00	10000	I & R SERVICES-NOT APPRVD PRGM	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
		SPECIAL PURPOSE COST CENTERS			
105.00	10500	KIDNEY ACQUISITION	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	115.00
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-30,408,844	155,596,579	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001	COMMUNITY MOBILE	0	0	190.01
190.02	19002	FAITH	0	733,315	190.02
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	VACANT SPACE	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-30,408,844	156,329,894	200.00

RECLASSIFICATIONS

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023

Worksheet A-6

Date/Time Prepared:
5/31/2024 12:06 pm

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - SUPPLIES						
1.00	MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	71.00	0	5,396,934		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
TOTALS			0	5,396,934		
B - IMPLANTS						
1.00	IMPL. DEV. CHARGED TO PATI ENTS	72.00	0	2,320,902		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
TOTALS			0	2,320,902		
C - DRUGS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,578,928		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
TOTALS			0	3,578,928		
D - CAFETERIA						
1.00	CAFETERIA	11.00	573,380	694,109		1.00
TOTALS			573,380	694,109		
E - INTEREST						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3,528,136		1.00
TOTALS			0	3,528,136		
F - I & R ADMIN						
1.00	I & R SERVICES-OTHER PRGM COSTS APPRVD	22.00	381,227	1,333,682		1.00
TOTALS			381,227	1,333,682		
G - PROPERTY TAX						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,080,325		1.00
TOTALS			0	1,080,325		
H - MEDI CAL DIRECTORS						
1.00	ADULTS & PEDI ATRI CS	30.00	0	113,410		1.00
2.00	INTENSIVE CARE UNI T	31.00	0	36,825		2.00
3.00	SUBPROVI DER - I PF	40.00	0	17,952		3.00
4.00	OPERATING ROOM	50.00	0	165,891		4.00
5.00	RADI OLOGY-DI AGNOSTI C	54.00	0	101,969		5.00
6.00	LABORATORY	60.00	0	9,975		6.00
7.00	EMERGENCY	91.00	0	25,594		7.00
TOTALS			0	471,616		

RECLASSIFICATIONS

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023

Worksheet A-6

Date/Time Prepared:
5/31/2024 12:06 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	I - ALLOCATED FRINGES					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	393,616	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
	TOTALS		0	393,616		
	J - SITTERS					
1.00	ADMINISTRATIVE & GENERAL	5.00	1,794	0	1.00	
2.00	OPERATION OF PLANT	7.00	209	0	2.00	
3.00	HOUSEKEEPING	9.00	3,343	0	3.00	
4.00	NURSING ADMINISTRATION	13.00	1,691	0	4.00	
5.00	INTENSIVE CARE UNIT	31.00	24,086	0	5.00	
6.00	SUBPROVIDER - IPF	40.00	25,047	0	6.00	
7.00	SKILLED NURSING FACILITY	44.00	3,569	0	7.00	
8.00	RECOVERY ROOM	51.00	1,636	0	8.00	
9.00	DELIVERY ROOM & LABOR ROOM	52.00	19,338	0	9.00	
10.00	CLINIC RYAN WHITE	90.03	7,248	0	10.00	
11.00	EMERGENCY	91.00	336,186	0	11.00	
	TOTALS		424,147	0		
	K - RENAL					
1.00	RENAL DIALYSIS	74.00	0	824,511	1.00	
	TOTALS		0	824,511		
500.00	Grand Total: Increases		1,378,754	19,622,759	500.00	

RECLASSIFICATIONS

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023

Worksheet A-6

Date/Time Prepared:
5/31/2024 12:06 pm

	Decreases				Wkst. A-7 Ref.		
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00			
	A - SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	828,389	0	1.00	
2.00	PHARMACY	15.00	0	15,418	0	2.00	
3.00	I&R SERVICES-SALARY & FRINGES APPRVD	21.00	0	175	0	3.00	
4.00	ADULTS & PEDIATRICS	30.00	0	313,563	0	4.00	
5.00	INTENSIVE CARE UNIT	31.00	0	113,938	0	5.00	
6.00	SUBPROVIDER - IPF	40.00	0	11,434	0	6.00	
7.00	NURSERY	43.00	0	64,149	0	7.00	
8.00	SKILLED NURSING FACILITY	44.00	0	1,272	0	8.00	
9.00	OPERATING ROOM	50.00	0	2,303,879	0	9.00	
10.00	RECOVERY ROOM	51.00	0	31,992	0	10.00	
11.00	DELIVERY ROOM & LABOR ROOM	52.00	0	353,608	0	11.00	
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	271,588	0	12.00	
13.00	CT SCAN	57.00	0	53,292	0	13.00	
14.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	2,919	0	14.00	
15.00	LABORATORY	60.00	0	89,543	0	15.00	
16.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	74,962	0	16.00	
17.00	RESPIRATORY THERAPY	65.00	0	206,947	0	17.00	
18.00	PHYSICAL THERAPY	66.00	0	2,030	0	18.00	
19.00	ELECTROCARDIOLOGY	69.00	0	32,798	0	19.00	
20.00	CLINIC	90.00	0	11,213	0	20.00	
21.00	CLINIC CMHC	90.01	0	3	0	21.00	
22.00	CLINIC RYAN WHITE	90.03	0	3,526	0	22.00	
23.00	EMERGENCY	91.00	0	610,296	0	23.00	
	TOTALS		0	5,396,934			
	B - IMPLANTS						
1.00	OPERATING ROOM	50.00	0	2,305,557	0	1.00	
2.00	DELIVERY ROOM & LABOR ROOM	52.00	0	11,802	0	2.00	
3.00	EMERGENCY	91.00	0	3,543	0	3.00	
	TOTALS		0	2,320,902			
	C - DRUGS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	9,914	0	1.00	
2.00	PHARMACY	15.00	0	3,462,516	0	2.00	
3.00	I&R SERVICES-SALARY & FRINGES APPRVD	21.00	0	76	0	3.00	
4.00	ADULTS & PEDIATRICS	30.00	0	30,081	0	4.00	
5.00	INTENSIVE CARE UNIT	31.00	0	4,896	0	5.00	
6.00	SUBPROVIDER - IPF	40.00	0	720	0	6.00	
7.00	NURSERY	43.00	0	155	0	7.00	
8.00	SKILLED NURSING FACILITY	44.00	0	159	0	8.00	
9.00	OPERATING ROOM	50.00	0	8,780	0	9.00	
10.00	RECOVERY ROOM	51.00	0	3,729	0	10.00	
11.00	DELIVERY ROOM & LABOR ROOM	52.00	0	14,540	0	11.00	
12.00	ELECTROCARDIOLOGY	69.00	0	17	0	12.00	
13.00	CLINIC	90.00	0	25	0	13.00	
14.00	CLINIC RYAN WHITE	90.03	0	7,861	0	14.00	
15.00	EMERGENCY	91.00	0	35,459	0	15.00	
	TOTALS		0	3,578,928			
	D - CAFETERIA						
1.00	DIETARY	10.00	573,380	694,109	0	1.00	
	TOTALS		573,380	694,109			
	E - INTEREST						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,528,136	11	1.00	
	TOTALS		0	3,528,136			
	F - I&R ADMIN						
1.00	I&R SERVICES-SALARY & FRINGES APPRVD	21.00	381,227	1,333,682	0	1.00	
	TOTALS		381,227	1,333,682			
	G - PROPERTY TAX						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,080,325	9	1.00	
	TOTALS		0	1,080,325			
	H - MEDICAL DIRECTORS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	471,616	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	
	TOTALS		0	471,616			

RECLASSIFICATIONS

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023

Worksheet A-6

Date/Time Prepared:
5/31/2024 12:06 pm

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
I - ALLOCATED FRINGES						
1.00	ADULTS & PEDIATRICS	30.00	0	14,209	0	1.00
2.00	CLINIC CMHC	90.01	0	109,536	0	2.00
3.00	CLINIC RYAN WHITE	90.03	0	127,634	0	3.00
4.00	FAITH	190.02	0	142,237	0	4.00
	TOTALS		0	393,616		
J - SITTERS						
1.00	ADULTS & PEDIATRICS	30.00	424,147	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
	TOTALS		424,147	0		
K - RENAL						
1.00	ADULTS & PEDIATRICS	30.00	0	824,511	0	1.00
	TOTALS		0	824,511		
500.00	Grand Total: Decreases		1,378,754	19,622,759		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023Worksheet A-7
Part I
Date/Time Prepared:
5/31/2024 12:06 pm

		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	54,863,962	-16,332,661	0	-16,332,661	0	3.00	
4.00	Building Improvements	0	94,920	0	94,920	0	4.00	
5.00	Fixed Equipment	14,646,232	4,874,788	0	4,874,788	0	5.00	
6.00	Movable Equipment	40,432,311	-3,744,254	0	-3,744,254	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	109,942,505	-15,107,207	0	-15,107,207	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	109,942,505	-15,107,207	0	-15,107,207	0	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	38,531,301	0					3.00
4.00	Building Improvements	94,920	0					4.00
5.00	Fixed Equipment	19,521,020	0					5.00
6.00	Movable Equipment	36,688,057	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	94,835,298	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	94,835,298	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023Worksheet A-7
Part II
Date/Time Prepared:
5/31/2024 12:06 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	6,926,691	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	767,399	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	7,694,090	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of col.s. 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	6,926,691				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	767,399				2.00
3.00	Total (sum of lines 1-2)	0	7,694,090				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023Worksheet A-7
Part III
Date/Time Prepared:
5/31/2024 12:06 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	58,147,241	0	58,147,241	0.613139	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	36,688,057	0	36,688,057	0.386861	0	2.00
3.00	Total (sum of lines 1-2)	94,835,298	0	94,835,298	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital -Related Costs	Total (sum of col.s. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	4,285,421	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	767,399	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,052,820	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital -Related Costs (see instructions)	Total (2) (sum of col.s. 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	3,279,032	0	0	0	7,564,453	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	767,399	2.00
3.00	Total (sum of lines 1-2)	3,279,032	0	0	0	8,331,852	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023

Worksheet A-8

Date/Time Prepared:
5/31/2024 12:06 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00		B	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-249,104	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-180,529	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-7,845	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)	B	-612	OPERATION OF PLANT	7.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-646,267			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	-20,770,992			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-51	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-20,099	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		ORESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			OUTILIZATION REVIEW-SNF	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			OADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		OSPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC	B	-85	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023

Worksheet A-8

Date/Time Prepared:
5/31/2024 12:06 pm

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
33.01 CMHC OP YOUTH	B	-1,140	CLINIC	90.00	0	33.01
33.02 CCIS TUTOR	B	-475	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03 MAXIMUS	B	-5,220	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04 ROTHMAN ONE	A	-3,000,000	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05 ROTHMAN ONE LEASE EQUIP	A	-21,368	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06 LATE FINANCE CHARGE	A	-11,884	OPERATION OF PLANT	7.00	0	33.06
33.07 PENALTIES	A	-1,143	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08 COURTESY ADVERTISING	A	-8,867	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09 DONATION	A	-300,000	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10 MAPLE HEALTHCARE INTEREST	A	-1,317,567	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11 LOBBYING	A	-9,170	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12 MPT LEASE	A	-3,721,595	CAP REL COSTS-BLDG & FIXT	1.00	9	33.12
33.13 OTHER REVENUE	B	-29,235	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14 RENTAL INCOME	B	-105,596	ADMINISTRATIVE & GENERAL	5.00	0	33.14
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-30,408,844				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: 31-0040

Period:
From 01/01/2023
To 12/31/2023

Worksheet A-8-1

Date/Time Prepared:
5/31/2024 12:06 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	90.03	CLINIC RYAN WHITE	PHYSICIANS	0	421,852	1.00
2.00	91.00	EMERGENCY	AMBULANCE	0	1,176,621	2.00
3.00	22.00	I&R SERVICES-OTHER PRGM COST	TEACHING JHA	1,234,809	1,234,809	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES & HO A&G	9,952,006	11,202,592	4.00
4.01	90.03	CLINIC RYAN WHITE	MSO SHARED SALARY	9,680	9,680	4.01
4.02	90.03	CLINIC RYAN WHITE	MSO SHARED SALARY	6,608	6,608	4.02
4.03	90.01	CLINIC CMHC	MSO SHARED SALARY	3,630	3,630	4.03
4.04	190.02	FAITH	MSO SHARED SALARY	9,494	9,494	4.04
4.05	5.00	ADMINISTRATIVE & GENERAL	JHA SUBS	471,616	18,393,549	4.05
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			11,687,843	32,458,835	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.

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office		
	1.00	2.00	3.00	Name	Percentage of Ownership	
	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	JHA	100.00	HUMC OPCO	100.00	6.00
7.00	B	MCCABE	100.00	HUMC OPCO	100.00	7.00
8.00	B	MSO ALL ADMIN	100.00	HUMC OPCO	100.00	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: 31-0040

Period:
From 01/01/2023
To 12/31/2023

Worksheet A-8-1

Date/Time Prepared:
5/31/2024 12:06 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-421,852	0		1.00
2.00	-1,176,621	0		2.00
3.00	0	0		3.00
4.00	-1,250,586	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	-17,921,933	0		4.05
5.00	-20,770,992			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	B		6.00
7.00	B		7.00
8.00	B		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: 31-0040

Period:
From 01/01/2023
To 12/31/2023

Worksheet A-8-2

Date/Time Prepared:
5/31/2024 12:06 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	113,410	0	113,410	211,500	693	1.00
2.00	31.00	INTENSIVE CARE UNIT	36,825	0	36,825	211,500	184	2.00
3.00	40.00	SUBPROVIDER - IPF	17,952	0	17,952	181,300	90	3.00
4.00	50.00	OPERATING ROOM	165,891	0	165,891	246,400	553	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	101,969	0	101,969	271,900	510	5.00
6.00	60.00	LABORATORY	9,975	0	9,975	260,300	50	6.00
7.00	91.00	EMERGENCY	25,594	0	25,594	211,500	128	7.00
8.00	5.00	ADMINISTRATIVE & GENERAL	1,571,367	24,559	1,546,808	211,500	196,047	8.00
9.00	30.00	ADULTS & PEDIATRICS	293,850	293,850	0	0	0	9.00
10.00	43.00	NURSERY	104,712	104,712	0	0	0	10.00
200.00			2,441,545	423,121	2,018,424		198,255	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	70,466	3,523	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	18,710	936	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	7,845	392	0	0	0	3.00
4.00	50.00	OPERATING ROOM	65,509	3,275	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	66,668	3,333	0	0	0	5.00
6.00	60.00	LABORATORY	6,257	313	0	0	0	6.00
7.00	91.00	EMERGENCY	13,015	651	0	0	0	7.00
8.00	5.00	ADMINISTRATIVE & GENERAL	19,934,587	996,729	0	0	0	8.00
9.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	9.00
10.00	43.00	NURSERY	0	0	0	0	0	10.00
200.00			20,183,057	1,009,152	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	70,466	42,944	42,944		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	18,710	18,115	18,115		2.00
3.00	40.00	SUBPROVIDER - IPF	0	7,845	10,107	10,107		3.00
4.00	50.00	OPERATING ROOM	0	65,509	100,382	100,382		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	66,668	35,301	35,301		5.00
6.00	60.00	LABORATORY	0	6,257	3,718	3,718		6.00
7.00	91.00	EMERGENCY	0	13,015	12,579	12,579		7.00
8.00	5.00	ADMINISTRATIVE & GENERAL	0	19,934,587	0	24,559		8.00
9.00	30.00	ADULTS & PEDIATRICS	0	0	0	293,850		9.00
10.00	43.00	NURSERY	0	0	0	104,712		10.00
200.00			0	20,183,057	223,146	646,267		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023Worksheet B
Part I
Date/Time Prepared:
5/31/2024 12:06 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst Allocation 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	7,564,453	7,564,453			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	767,399		767,399		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	13,873,001	14,509	1,472	13,888,982	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	35,725,680	629,796	63,892	886,473	37,305,841
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00	00700	OPERATION OF PLANT	8,656,082	769,702	78,085	494,362	9,998,231
8.00	00800	LAUNDRY & LINEN SERVICE	466,658	48,264	4,896	27,701	547,519
9.00	00900	HOUSEKEEPING	2,787,969	40,713	4,130	307,420	3,140,232
10.00	01000	DIETARY	2,213,877	156,664	15,893	203,728	2,590,162
11.00	01100	CAFETERIA	1,247,390	157,227	15,950	123,419	1,543,986
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	3,540,747	38,492	3,905	704,239	4,287,383
14.00	01400	CENTRAL SERVICES & SUPPLY	1,657,468	150,713	15,290	108,352	1,931,823
15.00	01500	PHARMACY	3,004,379	106,595	10,814	569,726	3,691,514
16.00	01600	MEDICAL RECORDS & LIBRARY	843,290	124,656	12,646	170,488	1,151,080
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING PROGRAM	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	2,647,772	245,908	24,947	555,767	3,474,394
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	1,714,909	0	0	82,058	1,796,967
23.00	02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,400,262	946,382	96,011	1,642,463	11,085,118
31.00	03100	INTENSIVE CARE UNIT	2,310,689	405,059	41,092	425,144	3,181,984
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0
40.00	04000	SUBPROVIDER - IPF	7,166,430	628,316	63,741	1,402,588	9,261,075
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
43.00	04300	NURSERY	2,681,125	85,128	8,636	534,785	3,309,674
44.00	04400	SKILLED NURSING FACILITY	1,588,733	216,150	21,928	334,858	2,161,669
45.00	04500	NURSING FACILITY	0	0	0	0	0
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,653,693	784,358	79,572	728,224	8,245,847
51.00	05100	RECOVERY ROOM	1,166,056	59,219	6,008	193,861	1,425,144
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,065,563	83,499	8,471	580,485	3,738,018
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,515,658	212,449	21,553	335,597	3,085,257
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0
56.00	05600	RADIOISOTOPE	158,856	23,688	2,403	26,491	211,438
57.00	05700	CT SCAN	606,482	49,300	5,001	125,347	786,130
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	277,290	49,300	5,001	57,282	388,873
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	4,844,154	227,994	23,130	403,115	5,498,393
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	481,866	7,402	751	0	490,019
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	1,509,138	33,755	3,424	251,349	1,797,666
66.00	06600	PHYSICAL THERAPY	666,133	47,671	4,836	142,748	861,388
67.00	06700	OCCUPATIONAL THERAPY	278,054	7,254	736	59,851	345,895
68.00	06800	SPEECH PATHOLOGY	78,599	7,254	736	16,918	103,507
69.00	06900	ELECTROCARDIOLOGY	564,056	38,196	3,875	116,375	722,502
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,254	736	0	7,990
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,396,934	0	0	0	5,396,934
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,320,902	0	0	0	2,320,902
73.00	07300	DRUGS CHARGED TO PATIENTS	3,578,928	0	0	0	3,578,928
74.00	07400	RENAL DIALYSIS	824,511	26,501	2,688	0	853,700
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	984,265	94,455	9,582	192,942	1,281,244

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023Worksheet B
Part I
Date/Time Prepared:
5/31/2024 12:06 pm

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
90.01	09001	CLINIC CMHC	2,445,758	0	0	489,278	2,935,036	90.01
90.02	09002	CLINIC CHEMO	0	26,501	2,688	0	29,189	90.02
90.03	09003	CLINIC RYAN WHITE	710,430	0	0	132,424	842,854	90.03
91.00	09100	EMERGENCY	7,610,940	620,025	62,900	1,317,332	9,611,197	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	155,596,579	7,170,349	727,419	13,743,190	155,016,703	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,246	1,952	0	21,198	190.00
190.01	19001	COMMUNITY MOBILE	0	0	0	0	0	190.01
190.02	19002	FAITH	733,315	0	0	145,792	879,107	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	165,222	16,761	0	181,983	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT SPACE	0	209,636	21,267	0	230,903	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	156,329,894	7,564,453	767,399	13,888,982	156,329,894	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023Worksheet B
Part I
Date/Time Prepared:
5/31/2024 12:06 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
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	37,305,841					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	3,133,756	0	13,131,987			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	171,609	0	103,049	822,177		8.00
9.00	00900	HOUSEKEEPING	984,246	0	86,928	0	4,211,406	9.00
10.00	01000	DIETARY	811,837	0	334,498	0	108,859	10.00
11.00	01100	CAFETERIA	483,933	0	335,700	0	109,250	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,343,799	0	82,186	0	26,747	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	605,493	0	321,791	0	104,723	14.00
15.00	01500	PHARMACY	1,157,035	0	227,593	0	74,068	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	360,784	0	266,157	0	86,618	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,088,983	0	525,044	0	170,870	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	563,225	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,474,434	0	2,020,648	320,013	882,227	30.00
31.00	03100	INTENSIVE CARE UNIT	997,332	0	864,853	54,103	281,457	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00	04000	SUBPROVIDER - IPF	2,902,708	0	1,341,534	62,557	436,176	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	1,037,354	0	181,758	0	59,151	43.00
44.00	04400	SKILLED NURSING FACILITY	677,534	0	461,508	73,018	150,193	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,584,504	0	1,674,705	0	545,015	50.00
51.00	05100	RECOVERY ROOM	446,684	0	126,441	0	41,149	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,171,611	0	178,281	0	58,020	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	967,015	0	453,605	0	147,621	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	66,271	0	50,576	0	16,459	56.00
57.00	05700	CT SCAN	246,398	0	105,262	0	34,256	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	121,885	0	105,262	0	34,256	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,723,367	0	486,796	0	158,423	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	153,587	0	15,805	0	5,144	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	563,444	0	72,071	0	23,455	65.00
66.00	06600	PHYSICAL THERAPY	269,986	0	101,785	0	33,125	66.00
67.00	06700	OCCUPATIONAL THERAPY	108,414	0	15,489	0	5,041	67.00
68.00	06800	SPEECH PATHOLOGY	32,442	0	15,489	0	5,041	68.00
69.00	06900	ELECTROCARDIOLOGY	226,455	0	81,554	0	26,541	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,504	0	15,489	0	5,041	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,691,566	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	727,443	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,121,747	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	267,576	0	56,582	0	18,414	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
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								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	401,582	0	201,673	0	65,632	90.00
90.01	09001	CLINIC CMHC	919,931	0	0	0	0	90.01
90.02	09002	CLINIC CHEMO	9,149	0	56,582	0	18,414	90.02
90.03	09003	CLINIC RYAN WHITE	264,177	0	0	0	0	90.03
91.00	09100	EMERGENCY	3,012,447	0	1,323,832	312,486	430,827	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 31-0040

Period:
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,894,247	0	12,290,526	822,177	4,162,213	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,644	0	41,093	0	13,373	190.00
190.01	19001	COMMUNITY MOBILE	0	0	0	0	0	190.01
190.02	19002	FAITH	275,539	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	57,039	0	352,769	0	35,820	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT SPACE	72,372	0	447,599	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	37,305,841	0	13,131,987	822,177	4,211,406	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	3,845,356					10.00
11.00	01100	CAFETERIA	0	2,472,869				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	113,541	0	5,853,656		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	38,566	0	0	3,002,396	14.00
15.00	01500	PHARMACY	0	98,610	0	0	5,603	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	48,706	0	0	28	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	150,989	0	0	3,969	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	16,488	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,528,917	348,888	0	1,413,493	129,071	30.00
31.00	03100	INTENSIVE CARE UNIT	136,531	77,850	0	420,598	42,668	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00	04000	SUBPROVIDER - IPF	1,514,030	297,985	0	983,433	10,626	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	224,813	92,741	0	597,620	3,728	43.00
44.00	04400	SKILLED NURSING FACILITY	441,065	75,614	0	252,063	1,914	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	117,453	0	445,291	231,399	50.00
51.00	05100	RECOVERY ROOM	0	27,467	0	177,301	1,392	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	108,431	0	532,406	26,572	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	59,725	0	0	22,106	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	4,272	0	0	37	56.00
57.00	05700	CT SCAN	0	20,520	0	0	6,057	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	8,663	0	0	2,868	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	102,522	0	0	17,534	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	412	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	42,917	0	0	16,550	65.00
66.00	06600	PHYSICAL THERAPY	0	27,427	0	0	423	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	12,017	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,633	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	27,946	0	32,105	1,607	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,832,723	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	596,845	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
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								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	50,223	0	158,834	3,331	90.00
90.01	09001	CLINIC CMHC	0	129,909	0	4,327	374	90.01
90.02	09002	CLINIC CHEMO	0	0	0	0	0	90.02
90.03	09003	CLINIC RYAN WHITE	0	45,871	0	29,034	394	90.03
91.00	09100	EMERGENCY	0	280,339	0	807,151	43,662	91.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,845,356	2,429,313	0	5,853,656	3,001,893	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	COMMUNITY MOBILE	0	0	0	0	0	190.01
190.02	19002	FAITH	0	43,556	0	0	503	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,845,356	2,472,869	0	5,853,656	3,002,396	202.00

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	NONPHYSICIAN ANESTHETISTS	
			15.00	16.00	17.00	18.00	19.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	5,254,423					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,913,373				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0		18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	237,797	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	26,342	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00	04000	SUBPROVIDER - IPF	0	190,365	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	35,664	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	64,873	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	74,908	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	7,294	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	10,245	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	187,353	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	6,055	0	0	0	56.00
57.00	05700	CT SCAN	0	101,073	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	17,095	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	252,466	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	8,702	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	11,703	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	9,700	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,484	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,018	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	34,193	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	664	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8,406	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,525	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,254,423	55,289	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	563	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
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								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	27,723	0	0	0	90.00
90.01	09001	CLINIC CMHC	0	39,243	0	0	0	90.01
90.02	09002	CLINIC CHEMO	0	1,006	0	0	0	90.02

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	NONPHYSICIAN ANESTHETISTS	
			15.00	16.00	17.00	18.00	19.00	
90.03	09003	CLINIC RYAN WHITE	0	144	0	0	0	90.03
91.00	09100	EMERGENCY	0	489,480	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I & R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,254,423	1,913,373	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	COMMUNITY MOBILE	0	0	0	0	0	190.01
190.02	19002	FAITH	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,254,423	1,913,373	0	0	0	202.00

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Cost Center Description			INTERNS & RESIDENTS		PARAMED PRGM	Subtotal	
			NURSING PROGRAM	SERVICES-SALARY & FRINGES			
				Y & FRINGES	SERVICES-OTHER PRGM COSTS		
			20.00	21.00	22.00	23.00	24.00
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
6.00	00600	MAINTENANCE & REPAIRS					6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)					18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
20.00	02000	NURSING PROGRAM	0				20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD		5,414,249			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD			2,376,680		22.00
23.00	02300	PARAMED PRGM-(SPECIFY)				0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	1,840,845	808,071	0	24,089,522
31.00	03100	INTENSIVE CARE UNIT	0	108,285	47,534	0	6,239,537
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	17,000,489
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
43.00	04300	NURSERY	0	0	0	0	5,542,503
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	4,359,451
45.00	04500	NURSING FACILITY	0	0	0	0	0
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	324,855	142,601	0	14,386,578
51.00	05100	RECOVERY ROOM	0	0	0	0	2,252,872
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	812,137	356,502	0	6,992,223
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	4,922,682
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0
56.00	05600	RADIOISOTOPE	0	0	0	0	355,108
57.00	05700	CT SCAN	0	0	0	0	1,299,696
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	678,902
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	0	0	0	0	8,239,501
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	673,669
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	2,527,806
66.00	06600	PHYSICAL THERAPY	0	0	0	0	1,303,834
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	491,340
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	161,130
69.00	06900	ELECTROCARDIOLOGY	0	108,285	47,534	0	1,308,722
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	31,688
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	8,929,629
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,654,715
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	10,010,387
74.00	07400	RENAL DIALYSIS	0	0	0	0	1,196,835
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	0	2,219,842	974,438	0	5,384,522
90.01	09001	CLINIC CMHC	0	0	0	0	4,028,820
90.02	09002	CLINIC CHEMO	0	0	0	0	114,340
90.03	09003	CLINIC RYAN WHITE	0	0	0	0	1,182,474

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			INTERNS & RESIDENTS			PARAMED PRGM	Subtotal	
			NURSING PROGRAM	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS			
				20.00	21.00			
91.00	09100	EMERGENCY	0	0	0	0	16,311,421	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0			0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	5,414,249	2,376,680	0	153,670,396	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	82,308	190.00
190.01	19001	COMMUNITY MOBILE	0	0	0	0	0	190.01
190.02	19002	FAITH	0	0	0	0	1,198,705	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	627,611	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT SPACE	0	0	0	0	750,874	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	5,414,249	2,376,680	0	156,329,894	202.00

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Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			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
6.00	00600	MAINTENANCE & REPAIRS			6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)			18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING PROGRAM			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,648,916	21,440,606	30.00
31.00	03100	INTENSIVE CARE UNIT	-155,819	6,083,718	31.00
32.00	03200	CORONARY CARE UNIT	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	34.00
40.00	04000	SUBPROVIDER - IPF	0	17,000,489	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
43.00	04300	NURSERY	0	5,542,503	43.00
44.00	04400	SKILLED NURSING FACILITY	0	4,359,451	44.00
45.00	04500	NURSING FACILITY	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-467,456	13,919,122	50.00
51.00	05100	RECOVERY ROOM	0	2,252,872	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-1,168,639	5,823,584	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,922,682	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	355,108	56.00
57.00	05700	CT SCAN	0	1,299,696	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	678,902	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	8,239,501	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	673,669	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,527,806	65.00
66.00	06600	PHYSICAL THERAPY	0	1,303,834	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	491,340	67.00
68.00	06800	SPEECH PATHOLOGY	0	161,130	68.00
69.00	06900	ELECTROCARDIOLOGY	-155,819	1,152,903	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	31,688	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8,929,629	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,654,715	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,010,387	73.00
74.00	07400	RENAL DIALYSIS	0	1,196,835	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
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					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	-3,194,280	2,190,242	90.00
90.01	09001	CLINIC CMHC	0	4,028,820	90.01
90.02	09002	CLINIC CHEMO	0	114,340	90.02

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Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
90.03	09003	CLINIC RYAN WHITE	0	1,182,474	90.03
91.00	09100	EMERGENCY	0	16,311,421	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
99.00	09900	CMHC	0	0	99.00
99.10	09910	CORF	0	0	99.10
100.00	10000	I & R SERVICES-NOT APPRVD PRGM	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
SPECIAL PURPOSE COST CENTERS					
105.00	10500	KIDNEY ACQUISITION	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	115.00
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-7,790,929	145,879,467	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	82,308	190.00
190.01	19001	COMMUNITY MOBILE	0	0	190.01
190.02	19002	FAITH	0	1,198,705	190.02
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	627,611	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	VACANT SPACE	0	750,874	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.01
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	-7,790,929	148,538,965	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023Worksheet B
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			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	14,509	1,472	15,981	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	629,796	63,892	693,688	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	769,702	78,085	847,787	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	48,264	4,896	53,160	8.00
9.00	00900	HOUSEKEEPING	0	40,713	4,130	44,843	9.00
10.00	01000	DIETARY	0	156,664	15,893	172,557	10.00
11.00	01100	CAFETERIA	0	157,227	15,950	173,177	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	38,492	3,905	42,397	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	150,713	15,290	166,003	14.00
15.00	01500	PHARMACY	0	106,595	10,814	117,409	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	124,656	12,646	137,302	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	245,908	24,947	270,855	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	946,382	96,011	1,042,393	30.00
31.00	03100	INTENSIVE CARE UNIT	0	405,059	41,092	446,151	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
40.00	04000	SUBPROVIDER - IPF	0	628,316	63,741	692,057	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
43.00	04300	NURSERY	0	85,128	8,636	93,764	43.00
44.00	04400	SKILLED NURSING FACILITY	0	216,150	21,928	238,078	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	784,358	79,572	863,930	50.00
51.00	05100	RECOVERY ROOM	0	59,219	6,008	65,227	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	83,499	8,471	91,970	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	212,449	21,553	234,002	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	23,688	2,403	26,091	56.00
57.00	05700	CT SCAN	0	49,300	5,001	54,301	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	49,300	5,001	54,301	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	227,994	23,130	251,124	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	7,402	751	8,153	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	33,755	3,424	37,179	65.00
66.00	06600	PHYSICAL THERAPY	0	47,671	4,836	52,507	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,254	736	7,990	67.00
68.00	06800	SPEECH PATHOLOGY	0	7,254	736	7,990	68.00
69.00	06900	ELECTROCARDIOLOGY	0	38,196	3,875	42,071	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,254	736	7,990	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	26,501	2,688	29,189	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
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							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	94,455	9,582	104,037	90.00
90.01	09001	CLINIC CMHC	0	0	0	0	90.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-0040

Period:
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Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
90.02	09002	CLINIC CHEMO	0	26,501	2,688	29,189	0	90.02
90.03	09003	CLINIC RYAN WHITE	0	0	0	0	153	90.03
91.00	09100	EMERGENCY	0	620,025	62,900	682,925	1,518	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I & R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	7,170,349	727,419	7,897,768	15,813	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,246	1,952	21,198	0	190.00
190.01	19001	COMMUNITY MOBILE	0	0	0	0	0	190.01
190.02	19002	FAITH	0	0	0	0	168	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	165,222	16,761	181,983	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT SPACE	0	209,636	21,267	230,903	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	7,564,453	767,399	8,331,852	15,981	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
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	694,709					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	58,360	0	906,717			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,196		7,115	63,503		8.00
9.00	00900	HOUSEKEEPING	18,330	0	6,002	0	69,529	9.00
10.00	01000	DIETARY	15,119	0	23,096	0	1,797	10.00
11.00	01100	CAFETERIA	9,012	0	23,179	0	1,804	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	25,025	0	5,675	0	442	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,276	0	22,219	0	1,729	14.00
15.00	01500	PHARMACY	21,547	0	15,714	0	1,223	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,719	0	18,377	0	1,430	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	20,280	0	36,252	0	2,821	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	10,489	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	64,667	0	139,521	24,716	14,563	30.00
31.00	03100	INTENSIVE CARE UNIT	18,573	0	59,715	4,179	4,647	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00	04000	SUBPROVIDER - IPF	54,057	0	92,628	4,832	7,201	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	19,319	0	12,550	0	977	43.00
44.00	04400	SKILLED NURSING FACILITY	12,618	0	31,865	5,640	2,480	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	48,131	0	115,632	0	8,998	50.00
51.00	05100	RECOVERY ROOM	8,319	0	8,730	0	679	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	21,819	0	12,310	0	958	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,009	0	31,320	0	2,437	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	1,234	0	3,492	0	272	56.00
57.00	05700	CT SCAN	4,589	0	7,268	0	566	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,270	0	7,268	0	566	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	32,094	0	33,612	0	2,616	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,860	0	1,091	0	85	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	10,493	0	4,976	0	387	65.00
66.00	06600	PHYSICAL THERAPY	5,028	0	7,028	0	547	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,019	0	1,069	0	83	67.00
68.00	06800	SPEECH PATHOLOGY	604	0	1,069	0	83	68.00
69.00	06900	ELECTROCARDIOLOGY	4,217	0	5,631	0	438	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	47	0	1,069	0	83	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	31,502	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,547	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,890	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	4,983	0	3,907	0	304	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
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								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	7,479	0	13,925	0	1,084	90.00
90.01	09001	CLINIC CMHC	17,132	0	0	0	0	90.01
90.02	09002	CLINIC CHEMO	170	0	3,907	0	304	90.02
90.03	09003	CLINIC RYAN WHITE	4,920	0	0	0	0	90.03
91.00	09100	EMERGENCY	56,101	0	91,406	24,136	7,113	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	687,044	0	848,618	63,503	68,717	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	124	0	2,837	0	221	190.00
190.01	19001	COMMUNITY MOBILE	0	0	0	0	0	190.01
190.02	19002	FAITH	5,131	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,062	0	24,357	0	591	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT SPACE	1,348	0	30,905	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	694,709	0	906,717	63,503	69,529	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	212,804					10.00
11.00	01100	CAFETERIA	0	207,314				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	9,519	0	83,869		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,233	0	0	204,585	14.00
15.00	01500	PHARMACY	0	8,267	0	0	382	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,083	0	0	2	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	12,658	0	0	270	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	1,382	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	84,611	29,250	0	20,253	8,795	30.00
31.00	03100	INTENSIVE CARE UNIT	7,556	6,527	0	6,026	2,907	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00	04000	SUBPROVIDER - IPF	83,787	24,982	0	14,090	724	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	12,441	7,775	0	8,562	254	43.00
44.00	04400	SKILLED NURSING FACILITY	24,409	6,339	0	3,611	130	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	9,847	0	6,380	15,768	50.00
51.00	05100	RECOVERY ROOM	0	2,303	0	2,540	95	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	9,090	0	7,628	1,811	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,007	0	0	1,506	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	358	0	0	3	56.00
57.00	05700	CT SCAN	0	1,720	0	0	413	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	726	0	0	195	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	8,595	0	0	1,195	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	28	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	3,598	0	0	1,128	65.00
66.00	06600	PHYSICAL THERAPY	0	2,299	0	0	29	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,007	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	305	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,343	0	460	110	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	124,883	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	40,669	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
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								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	4,210	0	2,276	227	90.00
90.01	09001	CLINIC CMHC	0	10,891	0	62	25	90.01
90.02	09002	CLINIC CHEMO	0	0	0	0	0	90.02
90.03	09003	CLINIC RYAN WHITE	0	3,846	0	416	27	90.03
91.00	09100	EMERGENCY	0	23,502	0	11,565	2,975	91.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023Worksheet B
Part II
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5/31/2024 12:06 pm

Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	212,804	203,662	0	83,869	204,551	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	COMMUNITY MOBILE	0	0	0	0	0	190.01
190.02	19002	FAITH	0	3,652	0	0	34	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	212,804	207,314	0	83,869	204,585	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Period:
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	NONPHYSICIAN ANESTHETISTS	
			15.00	16.00	17.00	18.00	19.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	165,198					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	168,109				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0		18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	20,872	0	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,312	0	0		31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0		32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0		34.00
40.00	04000	SUBPROVIDER - IPF	0	16,709	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0		41.00
43.00	04300	NURSERY	0	3,130	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	5,694	0	0		44.00
45.00	04500	NURSING FACILITY	0	0	0	0		45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0		46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	6,575	0	0		50.00
51.00	05100	RECOVERY ROOM	0	640	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	899	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	16,445	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0		55.00
56.00	05600	RADIOISOTOPE	0	531	0	0		56.00
57.00	05700	CT SCAN	0	8,872	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,500	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	0	22,160	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0		60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0		61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0		62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	764	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	1,027	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	851	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	394	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	89	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,001	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	58	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	738	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	836	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	165,198	4,853	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	49	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0		75.00
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								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
90.00	09000	CLINIC	0	2,433	0	0		90.00
90.01	09001	CLINIC CMHC	0	3,444	0	0		90.01
90.02	09002	CLINIC CHEMO	0	88	0	0		90.02

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023Worksheet B
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	NONPHYSICIAN ANESTHETISTS	
			15.00	16.00	17.00	18.00	19.00	
90.03	09003	CLINIC RYAN WHITE	0	13	0	0		90.03
91.00	09100	EMERGENCY	0	43,132	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0		94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0		97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0		98.00
99.00	09900	CMHC	0	0	0	0		99.00
99.10	09910	CORF	0	0	0	0		99.10
100.00	10000	I & R SERVICES-NOT APPRVD PRGM	0	0	0	0		100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0		102.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0		105.00
106.00	10600	HEART ACQUISITION	0	0	0	0		106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0		107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0		108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0		111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0		115.00
116.00	11600	HOSPICE	0	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	165,198	168,109	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
190.01	19001	COMMUNITY MOBILE	0	0	0	0		190.01
190.02	19002	FAITH	0	0	0	0		190.02
191.00	19100	RESEARCH	0	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	VACANT SPACE	0	0	0	0		194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.01
200.00		Cross Foot Adjustments						0200.00
201.00		Negative Cost Centers	0	0	0	0		0201.00
202.00		TOTAL (sum lines 118 through 201)	165,198	168,109	0	0	0	0202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-0040

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Cost Center Description		INTERNS & RESIDENTS		PARAMED PRGM	Subtotal	
		NURSING PROGRAM	SERVICES-SALARY & FRINGES			
			PRGM COSTS			
		20.00	21.00	22.00	23.00	24.00
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
6.00	00600	MAINTENANCE & REPAIRS				6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)				18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
20.00	02000	NURSING PROGRAM	0			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	343,776			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		11,966		22.00
23.00	02300	PARAMED PRGM-(SPECIFY)		0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS			1,451,513	30.00
31.00	03100	INTENSIVE CARE UNIT			559,083	31.00
32.00	03200	CORONARY CARE UNIT			0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT			0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT			0	34.00
40.00	04000	SUBPROVIDER - IPF			992,683	40.00
41.00	04100	SUBPROVIDER - IRF			0	41.00
43.00	04300	NURSERY			159,388	43.00
44.00	04400	SKILLED NURSING FACILITY			331,250	44.00
45.00	04500	NURSING FACILITY			0	45.00
46.00	04600	OTHER LONG TERM CARE			0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM			1,076,100	50.00
51.00	05100	RECOVERY ROOM			88,756	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM			147,154	52.00
53.00	05300	ANESTHESIOLOGY			0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC			309,113	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC			0	55.00
56.00	05600	RADIOISOTOPE			32,012	56.00
57.00	05700	CT SCAN			77,873	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)			66,892	58.00
59.00	05900	CARDIAC CATHETERIZATION			0	59.00
60.00	06000	LABORATORY			351,860	60.00
60.01	06001	BLOOD LABORATORY			0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY			0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS			0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.			12,981	63.00
64.00	06400	INTRAVENOUS THERAPY			0	64.00
65.00	06500	RESPIRATORY THERAPY			59,078	65.00
66.00	06600	PHYSICAL THERAPY			68,453	66.00
67.00	06700	OCCUPATIONAL THERAPY			12,631	67.00
68.00	06800	SPEECH PATHOLOGY			10,159	68.00
69.00	06900	ELECTROCARDIOLOGY			58,405	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY			9,247	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS			157,123	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS			55,052	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS			190,941	73.00
74.00	07400	RENAL DIALYSIS			38,432	74.00
75.00	07500	ASC (NON-DISTINCT PART)			0	75.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION			0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY			0	78.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC			0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			0	89.00
90.00	09000	CLINIC			135,893	90.00
90.01	09001	CLINIC CMHC			32,118	90.01
90.02	09002	CLINIC CHEMO			33,658	90.02
90.03	09003	CLINIC RYAN WHITE			9,375	90.03

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023Worksheet B
Part II
Date/Time Prepared:
5/31/2024 12:06 pm

Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	
			NURSING PROGRAM	SERVICES-SALARY & FRINGES			
				PRGM COSTS			
			20.00	21.00	22.00	23.00	24.00
91.00	09100	EMERGENCY					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				944,373	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS				0	94.00
95.00	09500	AMBULANCE SERVICES				0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED				0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD				0	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS				0	98.00
99.00	09900	CMHC				0	99.00
99.10	09910	CORF				0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM				0	100.00
101.00	10100	HOME HEALTH AGENCY				0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM				0	102.00
SPECIAL PURPOSE COST CENTERS							
105.00	10500	KIDNEY ACQUISITION				0	105.00
106.00	10600	HEART ACQUISITION				0	106.00
107.00	10700	LIVER ACQUISITION				0	107.00
108.00	10800	LUNG ACQUISITION				0	108.00
109.00	10900	PANCREAS ACQUISITION				0	109.00
110.00	11000	INTESTINAL ACQUISITION				0	110.00
111.00	11100	ISLET ACQUISITION				0	111.00
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)				0	115.00
116.00	11600	HOSPICE				0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	7,471,596	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				24,380	190.00
190.01	19001	COMMUNITY MOBILE				0	190.01
190.02	19002	FAITH				8,985	190.02
191.00	19100	RESEARCH				0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES				207,993	192.00
193.00	19300	NONPAID WORKERS				0	193.00
194.00	07950	VACANT SPACE				263,156	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS				0	194.01
200.00		Cross Foot Adjustments	0	343,776	11,966	0	355,742
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	343,776	11,966	0	8,331,852

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023Worksheet B
Part II
Date/Time Prepared:
5/31/2024 12:06 pm

Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			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
6.00	00600	MAINTENANCE & REPAIRS			6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)			18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING PROGRAM			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	1,451,513	30.00
31.00	03100	INTENSIVE CARE UNIT	0	559,083	31.00
32.00	03200	CORONARY CARE UNIT	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	34.00
40.00	04000	SUBPROVIDER - IPF	0	992,683	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
43.00	04300	NURSERY	0	159,388	43.00
44.00	04400	SKILLED NURSING FACILITY	0	331,250	44.00
45.00	04500	NURSING FACILITY	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,076,100	50.00
51.00	05100	RECOVERY ROOM	0	88,756	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	147,154	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	309,113	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	32,012	56.00
57.00	05700	CT SCAN	0	77,873	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	66,892	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	351,860	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	12,981	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	59,078	65.00
66.00	06600	PHYSICAL THERAPY	0	68,453	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	12,631	67.00
68.00	06800	SPEECH PATHOLOGY	0	10,159	68.00
69.00	06900	ELECTROCARDIOLOGY	0	58,405	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	9,247	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	157,123	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	55,052	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	190,941	73.00
74.00	07400	RENAL DIALYSIS	0	38,432	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
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					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	135,893	90.00
90.01	09001	CLINIC CMHC	0	32,118	90.01
90.02	09002	CLINIC CHEMO	0	33,658	90.02

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
90.03	09003	CLINIC RYAN WHITE	0	9,375	90.03
91.00	09100	EMERGENCY	0	944,373	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
99.00	09900	CMHC	0	0	99.00
99.10	09910	CORF	0	0	99.10
100.00	10000	I & R SERVICES-NOT APPRVD PRGM	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
SPECIAL PURPOSE COST CENTERS					
105.00	10500	KIDNEY ACQUISITION	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	115.00
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	7,471,596	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	24,380	190.00
190.01	19001	COMMUNITY MOBILE	0	0	190.01
190.02	19002	FAITH	0	8,985	190.02
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	207,993	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	VACANT SPACE	0	263,156	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.01
200.00		Cross Foot Adjustments	0	355,742	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	8,331,852	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023

Worksheet B-1

Date/Time Prepared:
5/31/2024 12:06 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	255,473					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		255,473				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	490	490	64,525,442			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	21,270	21,270	4,118,378	-37,305,841	119,024,053	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	25,995	25,995	2,296,708	0	9,998,231	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,630	1,630	128,694	0	547,519	8.00
9.00	00900	HOUSEKEEPING	1,375	1,375	1,428,215	0	3,140,232	9.00
10.00	01000	DIETARY	5,291	5,291	946,482	0	2,590,162	10.00
11.00	01100	CAFETERIA	5,310	5,310	573,380	0	1,543,986	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,300	1,300	3,271,757	0	4,287,383	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,090	5,090	503,383	0	1,931,823	14.00
15.00	01500	PHARMACY	3,600	3,600	2,646,835	0	3,691,514	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,210	4,210	792,053	0	1,151,080	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	8,305	8,305	2,581,985	0	3,474,394	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	381,227	0	1,796,967	22.00
23.00	02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	31,962	31,962	7,630,507	0	11,085,118	30.00
31.00	03100	INTENSIVE CARE UNIT	13,680	13,680	1,975,137	0	3,181,984	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00	04000	SUBPROVIDER - IPF	21,220	21,220	6,516,151	0	9,261,075	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	2,875	2,875	2,484,508	0	3,309,674	43.00
44.00	04400	SKILLED NURSING FACILITY	7,300	7,300	1,555,685	0	2,161,669	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	26,490	26,490	3,383,186	0	8,245,847	50.00
51.00	05100	RECOVERY ROOM	2,000	2,000	900,641	0	1,425,144	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,820	2,820	2,696,820	0	3,738,018	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,175	7,175	1,559,119	0	3,085,257	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	800	800	123,071	0	211,438	56.00
57.00	05700	CT SCAN	1,665	1,665	582,336	0	786,130	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,665	1,665	266,119	0	388,873	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	7,700	7,700	1,872,793	0	5,498,393	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	250	250	0	0	490,019	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,140	1,140	1,167,720	0	1,797,666	65.00
66.00	06600	PHYSICAL THERAPY	1,610	1,610	663,178	0	861,388	66.00
67.00	06700	OCCUPATIONAL THERAPY	245	245	278,054	0	345,895	67.00
68.00	06800	SPEECH PATHOLOGY	245	245	78,599	0	103,507	68.00
69.00	06900	ELECTROCARDIOLOGY	1,290	1,290	540,657	0	722,502	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	245	245	0	0	7,990	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	5,396,934	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2,320,902	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,578,928	73.00
74.00	07400	RENAL DIALYSIS	895	895	0	0	853,700	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
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								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	3,190	3,190	896,372	0	1,281,244	90.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023

Worksheet B-1

Date/Time Prepared:
5/31/2024 12:06 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
90.01	09001	CLINIC CMHC	0	0	2,273,090	0	2,935,036	90.01
90.02	09002	CLINIC CHEMO	895	895	0	0	29,189	90.02
90.03	09003	CLINIC RYAN WHITE	0	0	615,214	0	842,854	90.03
91.00	09100	EMERGENCY	20,940	20,940	6,120,068	0	9,611,197	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	242,163	242,163	63,848,122	-37,305,841	117,710,862	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	650	650	0	0	21,198	190.00
190.01	19001	COMMUNITY MOBILE	0	0	0	0	0	190.01
190.02	19002	FAITH	0	0	677,320	0	879,107	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,580	5,580	0	0	181,983	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT SPACE	7,080	7,080	0	0	230,903	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	7,564,453	767,399	13,888,982		37,305,841	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	29.609599	3.003836	0.215248		0.313431	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			15,981		694,709	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000248		0.005837	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: 31-0040

Period:
From 01/01/2023
To 12/31/2023

Worksheet B-1

Date/Time Prepared:
5/31/2024 12:06 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			6.00	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						5.00
6.00	00600	MAINTENANCE & REPAIRS	233,713					6.00
7.00	00700	OPERATION OF PLANT	25,995	207,718				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,630	1,630	516,451			8.00
9.00	00900	HOUSEKEEPING	1,375	1,375	0	204,692		9.00
10.00	01000	DIETARY	5,291	5,291	0	5,291	99,703	10.00
11.00	01100	CAFETERIA	5,310	5,310	0	5,310	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,300	1,300	0	1,300	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,090	5,090	0	5,090	0	14.00
15.00	01500	PHARMACY	3,600	3,600	0	3,600	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,210	4,210	0	4,210	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	8,305	8,305	0	8,305	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	31,962	31,962	201,017	42,880	39,642	30.00
31.00	03100	INTENSIVE CARE UNIT	13,680	13,680	33,985	13,680	3,540	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00	04000	SUBPROVIDER - IPF	21,220	21,220	39,295	21,200	39,256	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	2,875	2,875	0	2,875	5,829	43.00
44.00	04400	SKILLED NURSING FACILITY	7,300	7,300	45,866	7,300	11,436	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	26,490	26,490	0	26,490	0	50.00
51.00	05100	RECOVERY ROOM	2,000	2,000	0	2,000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,820	2,820	0	2,820	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,175	7,175	0	7,175	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	800	800	0	800	0	56.00
57.00	05700	CT SCAN	1,665	1,665	0	1,665	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,665	1,665	0	1,665	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	7,700	7,700	0	7,700	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	250	250	0	250	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,140	1,140	0	1,140	0	65.00
66.00	06600	PHYSICAL THERAPY	1,610	1,610	0	1,610	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	245	245	0	245	0	67.00
68.00	06800	SPEECH PATHOLOGY	245	245	0	245	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,290	1,290	0	1,290	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	245	245	0	245	0	70.00
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
74.00	07400	RENAL DIALYSIS	895	895	0	895	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
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								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	3,190	3,190	0	3,190	0	90.00
90.01	09001	CLINIC CMHC	0	0	0	0	0	90.01
90.02	09002	CLINIC CHEMO	895	895	0	895	0	90.02
90.03	09003	CLINIC RYAN WHITE	0	0	0	0	0	90.03

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023

Worksheet B-1

Date/Time Prepared:
5/31/2024 12:06 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
91.00	09100	EMERGENCY	20,940	20,940	196,288	20,940	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	220,403	194,408	516,451	202,301	99,703	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	650	650	0	650	0	190.00
190.01	19001	COMMUNITY MOBILE	0	0	0	0	0	190.01
190.02	19002	FAITH	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,580	5,580	0	1,741	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT SPACE	7,080	7,080	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	13,131,987	822,177	4,211,406	3,845,356	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	63.220265	1.591975	20.574356	38.568107	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	906,717	63,503	69,529	212,804	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	4.365134	0.122960	0.339676	2.134379	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: 31-0040

Period:
From 01/01/2023
To 12/31/2023

Worksheet B-1

Date/Time Prepared:
5/31/2024 12:06 pm

Cost Center Description			CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	61,941					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	2,844	0	419,361			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	966	0	0	11,675,150		14.00
15.00	01500	PHARMACY	2,470	0	0	21,786	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,220	0	0	107	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	3,782	0	0	15,434	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	413	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,739	0	101,264	501,906	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,950	0	30,132	165,919	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00	04000	SUBPROVIDER - IPF	7,464	0	70,454	41,321	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	2,323	0	42,814	14,497	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,894	0	18,058	7,444	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,942	0	31,901	899,823	0	50.00
51.00	05100	RECOVERY ROOM	688	0	12,702	5,413	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,716	0	38,142	103,330	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,496	0	0	85,960	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	107	0	0	144	0	56.00
57.00	05700	CT SCAN	514	0	0	23,554	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	217	0	0	11,154	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,568	0	0	68,183	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	1,601	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,075	0	0	64,356	0	65.00
66.00	06600	PHYSICAL THERAPY	687	0	0	1,643	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	301	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	91	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	700	0	2,300	6,249	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	7,126,747	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,320,901	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	100	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
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								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	1,258	0	11,379	12,953	0	90.00
90.01	09001	CLINIC CMHC	3,254	0	310	1,453	0	90.01
90.02	09002	CLINIC CHEMO	0	0	0	0	0	90.02

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023

Worksheet B-1

Date/Time Prepared:
5/31/2024 12:06 pm

Cost Center Description			CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
90.03	09003	CLINIC RYAN WHITE	1,149	0	2,080	1,532	0	90.03
91.00	09100	EMERGENCY	7,022	0	57,825	169,785	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I & R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	60,850	0	419,361	11,673,195	100	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	COMMUNITY MOBILE	0	0	0	0	0	190.01
190.02	19002	FAITH	1,091	0	0	1,955	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,472,869	0	5,853,656	3,002,396	5,254,423	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	39.922975	0.000000	13.958513	0.257161	52,544.230000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	207,314	0	83,869	204,585	165,198	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.346959	0.000000	0.199992	0.017523	1,651.980000	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: 31-0040

Period:
From 01/01/2023
To 12/31/2023

Worksheet B-1

Date/Time Prepared:
5/31/2024 12:06 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE (SPECIFY) (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING PROGRAM (ASSIGNED TIME)	
			16.00	17.00	18.00	19.00	20.00	
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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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	1,999,295,612					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0			18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING PROGRAM	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	248,481,922	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	27,526,000	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00	04000	SUBPROVIDER - IPF	198,918,000	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	37,266,109	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	67,788,000	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	78,273,526	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	7,621,975	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,705,521	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	195,770,880	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	6,326,622	0	0	0	0	56.00
57.00	05700	CT SCAN	105,614,588	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	17,862,931	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	263,809,722	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	9,093,101	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	12,229,077	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	10,135,980	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,685,325	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,063,509	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	35,729,863	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	694,044	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,783,649	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,952,507	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	57,773,475	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	588,366	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
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								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	28,968,842	0	0	0	0	90.00
90.01	09001	CLINIC CMHC	41,005,850	0	0	0	0	90.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023

Worksheet B-1

Date/Time Prepared:
5/31/2024 12:06 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE (SPECIFY) (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING PROGRAM (ASSIGNED TIME)	
			16.00	17.00	18.00	19.00	20.00	
90.02	09002	CLINIC CHEMO	1,051,240	0	0	0	0	90.02
90.03	09003	CLINIC RYAN WHITE	150,858	0	0	0	0	90.03
91.00	09100	EMERGENCY	511,424,130	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,999,295,612	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	COMMUNITY MOBILE	0	0	0	0	0	190.01
190.02	19002	FAITH	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,913,373	0	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000957	0.000000	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	168,109	0	0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000084	0.000000	0.000000	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					0.000000	207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023

Worksheet B-1

Date/Time Prepared:
5/31/2024 12:06 pm

Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM (ASSIGNED TIME)		
			SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)			
			21.00	22.00			
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
6.00	00600	MAINTENANCE & REPAIRS					6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)					18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
20.00	02000	NURSING PROGRAM					20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	100				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		100			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	34	34	0		30.00
31.00	03100	INTENSIVE CARE UNIT	2	2	0		31.00
32.00	03200	CORONARY CARE UNIT	0	0	0		32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0		34.00
40.00	04000	SUBPROVIDER - IPF	0	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0		41.00
43.00	04300	NURSERY	0	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		44.00
45.00	04500	NURSING FACILITY	0	0	0		45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0		46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6	6	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15	15	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY					61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	2	2	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0		78.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	41	41	0		90.00
90.01	09001	CLINIC CMHC	0	0	0		90.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023

Worksheet B-1

Date/Time Prepared:
5/31/2024 12:06 pm

Cost Center Description			INTERNS & RESIDENTS		PARAMED PRGM (ASSIGNED TIME)		
			SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)			
			21.00	22.00			
90.02	09002	CLINIC CHEMO	0	0	0		90.02
90.03	09003	CLINIC RYAN WHITE	0	0	0		90.03
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0		94.00
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0		97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
99.00	09900	CMHC	0	0	0		99.00
99.10	09910	CORF	0	0	0		99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0		100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0		102.00
SPECIAL PURPOSE COST CENTERS							
105.00	10500	KIDNEY ACQUISITION	0	0	0		105.00
106.00	10600	HEART ACQUISITION	0	0	0		106.00
107.00	10700	LIVER ACQUISITION	0	0	0		107.00
108.00	10800	LUNG ACQUISITION	0	0	0		108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0		115.00
116.00	11600	HOSPICE			0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	100	0		118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
190.01	19001	COMMUNITY MOBILE	0	0	0		190.01
190.02	19002	FAITH	0	0	0		190.02
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	VACANT SPACE	0	0	0		194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,414,249	2,376,680	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	54,142.490000	23,766.800000	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	343,776	11,966	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3,437.760000	119.660000	0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023Worksheet C
Part I
Date/Time Prepared:
5/31/2024 12:06 pm

				Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs		Total Costs	
						RCE	Disallowance		
					1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	21,440,606		21,440,606	42,944		21,483,550	30.00
31.00	03100	INTENSIVE CARE UNIT	6,083,718		6,083,718	18,115		6,101,833	31.00
32.00	03200	CORONARY CARE UNIT	0		0	0		0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0	0		0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0	0		0	34.00
40.00	04000	SUBPROVIDER - IPF	17,000,489		17,000,489	10,107		17,010,596	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0		0	41.00
43.00	04300	NURSERY	5,542,503		5,542,503	0		5,542,503	43.00
44.00	04400	SKILLED NURSING FACILITY	4,359,451		4,359,451	0		4,359,451	44.00
45.00	04500	NURSING FACILITY	0		0	0		0	45.00
46.00	04600	OTHER LONG TERM CARE	0		0	0		0	46.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	13,919,122		13,919,122	100,382		14,019,504	50.00
51.00	05100	RECOVERY ROOM	2,252,872		2,252,872	0		2,252,872	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,823,584		5,823,584	0		5,823,584	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0		0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,922,682		4,922,682	35,301		4,957,983	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0		0	55.00
56.00	05600	RADIOISOTOPE	355,108		355,108	0		355,108	56.00
57.00	05700	CT SCAN	1,299,696		1,299,696	0		1,299,696	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	678,902		678,902	0		678,902	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0		0	59.00
60.00	06000	LABORATORY	8,239,501		8,239,501	3,718		8,243,219	60.00
60.01	06001	BLOOD LABORATORY	0		0	0		0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0	0		0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0		0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	673,669		673,669	0		673,669	63.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0		0	64.00
65.00	06500	RESPIRATORY THERAPY	2,527,806	0	2,527,806	0		2,527,806	65.00
66.00	06600	PHYSICAL THERAPY	1,303,834	0	1,303,834	0		1,303,834	66.00
67.00	06700	OCCUPATIONAL THERAPY	491,340	0	491,340	0		491,340	67.00
68.00	06800	SPEECH PATHOLOGY	161,130	0	161,130	0		161,130	68.00
69.00	06900	ELECTROCARDIOLOGY	1,152,903		1,152,903	0		1,152,903	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	31,688		31,688	0		31,688	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,929,629		8,929,629	0		8,929,629	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,654,715		3,654,715	0		3,654,715	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,010,387		10,010,387	0		10,010,387	73.00
74.00	07400	RENAL DIALYSIS	1,196,835		1,196,835	0		1,196,835	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0		0	75.00
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									
88.00	08800	RURAL HEALTH CLINIC	0		0	0		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0		0	89.00
90.00	09000	CLINIC	2,190,242		2,190,242	0		2,190,242	90.00
90.01	09001	CLINIC CMHC	4,028,820		4,028,820	0		4,028,820	90.01
90.02	09002	CLINIC CHEMO	114,340		114,340	0		114,340	90.02
90.03	09003	CLINIC RYAN WHITE	1,182,474		1,182,474	0		1,182,474	90.03
91.00	09100	EMERGENCY	16,311,421		16,311,421	12,579		16,324,000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,354,272		4,354,272	0		4,354,272	92.00
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS	0		0	0		0	94.00
95.00	09500	AMBULANCE SERVICES	0		0	0		0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0		0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0		0	0		0	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0		0	98.00
99.00	09900	CMHC	0		0	0		0	99.00
99.10	09910	CORF	0		0	0		0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0		0	0		0	100.00
101.00	10100	HOME HEALTH AGENCY	0		0	0		0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0	0		0	102.00
SPECIAL PURPOSE COST CENTERS									
105.00	10500	KIDNEY ACQUISITION	0		0	0		0	105.00
106.00	10600	HEART ACQUISITION	0		0	0		0	106.00
107.00	10700	LIVER ACQUISITION	0		0	0		0	107.00
108.00	10800	LUNG ACQUISITION	0		0	0		0	108.00
109.00	10900	PANCREAS ACQUISITION	0		0	0		0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0	0		0	110.00
111.00	11100	ISLET ACQUISITION	0		0	0		0	111.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023Worksheet C
Part I
Date/Time Prepared:
5/31/2024 12:06 pm

					Title XVIII		Hospital		PPS	
Cost Center Description					Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
							Total Costs	RCE Disallowance	Total Costs	
					1.00	2.00	3.00	4.00	5.00	
113.00	11300	INTEREST EXPENSE								113.00
114.00	11400	UTILIZATION REVIEW-SNF								114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D. P.)			0		0		0	115.00
116.00	11600	HOSPICE			0		0		0	116.00
200.00		Subtotal (see instructions)			150,233,739	0	150,233,739	223,146	150,456,885	200.00
201.00		Less Observation Beds			4,354,272		4,354,272		4,354,272	201.00
202.00		Total (see instructions)			145,879,467	0	145,879,467	223,146	146,102,613	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023Worksheet C
Part I
Date/Time Prepared:
5/31/2024 12:06 pm

			Title XVIII		Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00	9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	248,481,922		248,481,922		30.00
31.00	03100	INTENSIVE CARE UNIT	27,526,000		27,526,000		31.00
32.00	03200	CORONARY CARE UNIT	0		0		32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0		34.00
40.00	04000	SUBPROVIDER - IPF	198,918,000		198,918,000		40.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
43.00	04300	NURSERY	37,266,109		37,266,109		43.00
44.00	04400	SKILLED NURSING FACILITY	67,788,000		67,788,000		44.00
45.00	04500	NURSING FACILITY	0		0		45.00
46.00	04600	OTHER LONG TERM CARE	0		0		46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	18,242,873	60,030,653	78,273,526	0.177827	0.000000
51.00	05100	RECOVERY ROOM	1,895,260	5,726,715	7,621,975	0.295576	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,653,927	51,594	10,705,521	0.543980	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	38,341,244	157,429,636	195,770,880	0.025145	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000
56.00	05600	RADIOISOTOPE	884,619	5,442,003	6,326,622	0.056129	0.000000
57.00	05700	CT SCAN	20,791,201	84,823,387	105,614,588	0.012306	0.000000
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5,224,500	12,638,431	17,862,931	0.038006	0.000000
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000
60.00	06000	LABORATORY	112,775,587	151,034,135	263,809,722	0.031233	0.000000
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000	0.000000
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	5,521,567	3,571,534	9,093,101	0.074086	0.000000
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000
65.00	06500	RESPIRATORY THERAPY	9,885,434	2,343,643	12,229,077	0.206705	0.000000
66.00	06600	PHYSICAL THERAPY	6,244,536	3,891,445	10,135,981	0.128634	0.000000
67.00	06700	OCCUPATIONAL THERAPY	3,875,025	810,300	4,685,325	0.104868	0.000000
68.00	06800	SPEECH PATHOLOGY	788,496	275,013	1,063,509	0.151508	0.000000
69.00	06900	ELECTROCARDIOLOGY	10,044,058	25,685,805	35,729,863	0.032267	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	548,371	145,672	694,043	0.045657	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,253,222	5,530,427	8,783,649	1.016620	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,038,305	6,914,202	9,952,507	0.367216	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	28,425,980	29,347,494	57,773,474	0.173270	0.000000
74.00	07400	RENAL DIALYSIS	588,366	0	588,366	2.034168	0.000000
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	54,780	28,914,063	28,968,843	0.075607	0.000000
90.01	09001	CLINIC CMHC	0	41,005,850	41,005,850	0.098250	0.000000
90.02	09002	CLINIC CHEMO	0	1,051,240	1,051,240	0.108767	0.000000
90.03	09003	CLINIC RYAN WHITE	0	150,859	150,859	7.838273	0.000000
91.00	09100	EMERGENCY	55,104,494	456,319,636	511,424,130	0.031894	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	162,955,140	355,886,821	518,841,961	0.008392	0.000000
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	0.000000
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	0.000000
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000
99.00	09900	CMHC	0	0	0		99.00
99.10	09910	CORF	0	0	0		99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0		100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0		102.00
SPECIAL PURPOSE COST CENTERS							
105.00	10500	KIDNEY ACQUISITION	0	0	0		105.00
106.00	10600	HEART ACQUISITION	0	0	0		106.00
107.00	10700	LIVER ACQUISITION	0	0	0		107.00
108.00	10800	LUNG ACQUISITION	0	0	0		108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
113.00	11300	INTEREST EXPENSE					113.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 31-0040		Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/31/2024 12:06 pm	
			Title XVIII		Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
114.00	11400	UTILIZATION REVIEW-SNF					114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0		115.00
116.00	11600	HOSPICE	0	0	0		116.00
200.00		Subtotal (see instructions)	1,079,117,016	1,439,020,558	2,518,137,574		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	1,079,117,016	1,439,020,558	2,518,137,574		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 31-0040	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/31/2024 12:06 pm
Cost Center Description			PPS Inpatient Ratio 11.00	Title XVIII	Hospital
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
32.00	03200	CORONARY CARE UNIT			32.00
33.00	03300	BURN INTENSIVE CARE UNIT			33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT			34.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
46.00	04600	OTHER LONG TERM CARE			46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.179109		50.00
51.00	05100	RECOVERY ROOM	0.295576		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.543980		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.025325		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600	RADIOISOTOPE	0.056129		56.00
57.00	05700	CT SCAN	0.012306		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.038006		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.031247		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000		61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.074086		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.206705		65.00
66.00	06600	PHYSICAL THERAPY	0.128634		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.104868		67.00
68.00	06800	SPEECH PATHOLOGY	0.151508		68.00
69.00	06900	ELECTROCARDIOLOGY	0.032267		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.045657		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.016620		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.367216		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.173270		73.00
74.00	07400	RENAL DIALYSIS	2.034168		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
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					
88.00	08800	RURAL HEALTH CLINIC			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000	CLINIC	0.075607		90.00
90.01	09001	CLINIC CMHC	0.098250		90.01
90.02	09002	CLINIC CHEMO	0.108767		90.02
90.03	09003	CLINIC RYAN WHITE	7.838273		90.03
91.00	09100	EMERGENCY	0.031919		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.008392		92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0.000000		94.00
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000		97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
99.00	09900	CMHC			99.00
99.10	09910	CORF			99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM			100.00
101.00	10100	HOME HEALTH AGENCY			101.00
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
SPECIAL PURPOSE COST CENTERS					
105.00	10500	KIDNEY ACQUISITION			105.00
106.00	10600	HEART ACQUISITION			106.00
107.00	10700	LIVER ACQUISITION			107.00
108.00	10800	LUNG ACQUISITION			108.00
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)			115.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 31-0040	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/31/2024 12:06 pm
			Title XVIII	Hospital	PPS
Cost Center Description		PPS Inpatient Ratio			
		11.00			
116.00	11600	HOSPICE			
200.00		Subtotal (see instructions)			
201.00		Less Observation Beds			
202.00		Total (see instructions)			

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023Worksheet C
Part I
Date/Time Prepared:
5/31/2024 12:06 pm

			Title XIX		Hospital		TEFRA	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE		Total Costs
						Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	21,440,606		21,440,606	42,944	21,483,550	30.00
31.00	03100	INTENSIVE CARE UNIT	6,083,718		6,083,718	18,115	6,101,833	31.00
32.00	03200	CORONARY CARE UNIT	0		0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.00
40.00	04000	SUBPROVIDER - IPF	17,000,489		17,000,489	10,107	17,010,596	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
43.00	04300	NURSERY	5,542,503		5,542,503	0	5,542,503	43.00
44.00	04400	SKILLED NURSING FACILITY	4,359,451		4,359,451	0	4,359,451	44.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	13,919,122		13,919,122	100,382	14,019,504	50.00
51.00	05100	RECOVERY ROOM	2,252,872		2,252,872	0	2,252,872	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,823,584		5,823,584	0	5,823,584	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,922,682		4,922,682	35,301	4,957,983	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
56.00	05600	RADIOISOTOPE	355,108		355,108	0	355,108	56.00
57.00	05700	CT SCAN	1,299,696		1,299,696	0	1,299,696	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	678,902		678,902	0	678,902	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	8,239,501		8,239,501	3,718	8,243,219	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	673,669		673,669	0	673,669	63.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,527,806	0	2,527,806	0	2,527,806	65.00
66.00	06600	PHYSICAL THERAPY	1,303,834	0	1,303,834	0	1,303,834	66.00
67.00	06700	OCCUPATIONAL THERAPY	491,340	0	491,340	0	491,340	67.00
68.00	06800	SPEECH PATHOLOGY	161,130	0	161,130	0	161,130	68.00
69.00	06900	ELECTROCARDIOLOGY	1,152,903		1,152,903	0	1,152,903	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	31,688		31,688	0	31,688	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,929,629		8,929,629	0	8,929,629	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,654,715		3,654,715	0	3,654,715	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,010,387		10,010,387	0	10,010,387	73.00
74.00	07400	RENAL DIALYSIS	1,196,835		1,196,835	0	1,196,835	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
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								
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	2,190,242		2,190,242	0	2,190,242	90.00
90.01	09001	CLINIC CMHC	4,028,820		4,028,820	0	4,028,820	90.01
90.02	09002	CLINIC CHEMO	114,340		114,340	0	114,340	90.02
90.03	09003	CLINIC RYAN WHITE	1,182,474		1,182,474	0	1,182,474	90.03
91.00	09100	EMERGENCY	16,311,421		16,311,421	12,579	16,324,000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,345,572		4,345,572	0	4,345,572	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0		0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0		0	0	0	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
99.00	09900	CMHC	0		0	0	0	99.00
99.10	09910	CORF	0		0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0		0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0		0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	0		0	0	0	105.00
106.00	10600	HEART ACQUISITION	0		0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0		0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0		0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0		0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0		0	0	0	111.00

COMPUTATION OF RATIO OF COSTS TO CHARGES					Provider CCN: 31-0040		Period: From 01/01/2023 To 12/31/2023		Worksheet C Part I Date/Time Prepared: 5/31/2024 12: 06 pm	
					Title XIX		Hospital		TEFRA	
Cost Center Description					Total Cost (from Wkst. B, Part I, col . 26)	Therapy Limit Adj .	Costs			
							Total Costs	RCE		Total Costs
								Disal lowance		
					1. 00	2. 00	3. 00	4. 00		5. 00
113. 00	11300	INTEREST EXPENSE								113. 00
114. 00	11400	UTI LI ZATION REVI EW-SNF								114. 00
115. 00	11500	AMBULATORY SURGI CAL CENTER (D. P.)			0		0			0 115. 00
116. 00	11600	HOSPICE			0		0			0 116. 00
200. 00		Subtotal (see instructions)			150, 225, 039	0	150, 225, 039	223, 146	150, 448, 185	200. 00
201. 00		Less Observation Beds			4, 345, 572		4, 345, 572		4, 345, 572	201. 00
202. 00		Total (see instructions)			145, 879, 467	0	145, 879, 467	223, 146	146, 102, 613	202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023Worksheet C
Part I
Date/Time Prepared:
5/31/2024 12:06 pm

			Title XIX		Hospital	TEFRA	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00	9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	248,481,922		248,481,922		30.00
31.00	03100	INTENSIVE CARE UNIT	27,526,000		27,526,000		31.00
32.00	03200	CORONARY CARE UNIT	0		0		32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0		34.00
40.00	04000	SUBPROVIDER - IPF	198,918,000		198,918,000		40.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
43.00	04300	NURSERY	37,266,109		37,266,109		43.00
44.00	04400	SKILLED NURSING FACILITY	67,788,000		67,788,000		44.00
45.00	04500	NURSING FACILITY	0		0		45.00
46.00	04600	OTHER LONG TERM CARE	0		0		46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	18,242,873	60,030,653	78,273,526	0.177827	0.177827
51.00	05100	RECOVERY ROOM	1,895,260	5,726,715	7,621,975	0.295576	0.295576
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,653,927	51,594	10,705,521	0.543980	0.543980
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	38,341,244	157,429,636	195,770,880	0.025145	0.025145
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000
56.00	05600	RADIOISOTOPE	884,619	5,442,003	6,326,622	0.056129	0.056129
57.00	05700	CT SCAN	20,791,201	84,823,387	105,614,588	0.012306	0.012306
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5,224,500	12,638,431	17,862,931	0.038006	0.038006
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000
60.00	06000	LABORATORY	112,775,587	151,034,135	263,809,722	0.031233	0.031233
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000	0.000000
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	5,521,567	3,571,534	9,093,101	0.074086	0.074086
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000
65.00	06500	RESPIRATORY THERAPY	9,885,434	2,343,643	12,229,077	0.206705	0.206705
66.00	06600	PHYSICAL THERAPY	6,244,536	3,891,445	10,135,981	0.128634	0.128634
67.00	06700	OCCUPATIONAL THERAPY	3,875,025	810,300	4,685,325	0.104868	0.104868
68.00	06800	SPEECH PATHOLOGY	788,496	275,013	1,063,509	0.151508	0.151508
69.00	06900	ELECTROCARDIOLOGY	10,044,058	25,685,805	35,729,863	0.032267	0.032267
70.00	07000	ELECTROENCEPHALOGRAPHY	548,371	145,672	694,043	0.045657	0.045657
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,253,222	5,530,427	8,783,649	1.016620	1.016620
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,038,305	6,914,202	9,952,507	0.367216	0.367216
73.00	07300	DRUGS CHARGED TO PATIENTS	28,425,980	29,347,494	57,773,474	0.173270	0.173270
74.00	07400	RENAL DIALYSIS	588,366	0	588,366	2.034168	2.034168
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000
90.00	09000	CLINIC	54,780	28,914,063	28,968,843	0.075607	0.075607
90.01	09001	CLINIC CMHC	0	41,005,850	41,005,850	0.098250	0.098250
90.02	09002	CLINIC CHEMO	0	1,051,240	1,051,240	0.108767	0.108767
90.03	09003	CLINIC RYAN WHITE	0	150,859	150,859	7.838273	7.838273
91.00	09100	EMERGENCY	55,104,494	456,319,636	511,424,130	0.031894	0.031894
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	162,955,140	355,886,821	518,841,961	0.008376	0.008376
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	0.000000
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	0.000000
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000
99.00	09900	CMHC	0	0	0	0.000000	0.000000
99.10	09910	CORF	0	0	0	0.000000	0.000000
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0.000000	0.000000
101.00	10100	HOME HEALTH AGENCY	0	0	0	0.000000	0.000000
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0.000000	0.000000
SPECIAL PURPOSE COST CENTERS							
105.00	10500	KIDNEY ACQUISITION	0	0	0	0.000000	0.000000
106.00	10600	HEART ACQUISITION	0	0	0	0.000000	0.000000
107.00	10700	LIVER ACQUISITION	0	0	0	0.000000	0.000000
108.00	10800	LUNG ACQUISITION	0	0	0	0.000000	0.000000
109.00	10900	PANCREAS ACQUISITION	0	0	0	0.000000	0.000000
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0.000000	0.000000
111.00	11100	ISLET ACQUISITION	0	0	0	0.000000	0.000000
113.00	11300	INTEREST EXPENSE	0	0	0	0.000000	0.000000

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023Worksheet C
Part I
Date/Time Prepared:
5/31/2024 12:06 pm

			Title XIX			Hospital	TEFRA	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00		10.00	
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0			115.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	1,079,117,016	1,439,020,558	2,518,137,574			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	1,079,117,016	1,439,020,558	2,518,137,574			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023Worksheet C
Part I
Date/Time Prepared:
5/31/2024 12:06 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	TEFRA
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
32.00	03200	CORONARY CARE UNIT				32.00
33.00	03300	BURN INTENSIVE CARE UNIT				33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT				34.00
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
44.00	04400	SKILLED NURSING FACILITY				44.00
45.00	04500	NURSING FACILITY				45.00
46.00	04600	OTHER LONG TERM CARE				46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000			55.00
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
60.01	06001	BLOOD LABORATORY	0.000000			60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000			61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000			63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000			75.00
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						
88.00	08800	RURAL HEALTH CLINIC	0.000000			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89.00
90.00	09000	CLINIC	0.000000			90.00
90.01	09001	CLINIC CMHC	0.000000			90.01
90.02	09002	CLINIC CHEMO	0.000000			90.02
90.03	09003	CLINIC RYAN WHITE	0.000000			90.03
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0.000000			94.00
95.00	09500	AMBULANCE SERVICES	0.000000			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000			96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000			97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000			98.00
99.00	09900	CMHC				99.00
99.10	09910	CORF				99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM				100.00
101.00	10100	HOME HEALTH AGENCY				101.00
102.00	10200	OPIOID TREATMENT PROGRAM				102.00
SPECIAL PURPOSE COST CENTERS						
105.00	10500	KIDNEY ACQUISITION	0.000000			105.00
106.00	10600	HEART ACQUISITION	0.000000			106.00
107.00	10700	LIVER ACQUISITION	0.000000			107.00
108.00	10800	LUNG ACQUISITION	0.000000			108.00
109.00	10900	PANCREAS ACQUISITION	0.000000			109.00
110.00	11000	INTESTINAL ACQUISITION	0.000000			110.00
111.00	11100	ISLET ACQUISITION	0.000000			111.00
113.00	11300	INTEREST EXPENSE				113.00
114.00	11400	UTILIZATION REVIEW-SNF				114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)				115.00

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 31-0040	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/31/2024 12:06 pm	
				Title XIX	Hospital	TEFRA	
Cost Center Description			PPS Inpatient Ratio				
			11.00				
116.00	11600	HOSPICE					116.00
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: 31-0040

Period:
From 01/01/2023
To 12/31/2023Worksheet C
Part II
Date/Time Prepared:
5/31/2024 12:06 pm

			Title XIX			Hospital		TEFRA	
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	13,919,122	1,076,100	12,843,022	107,610	744,895	50.00	
51.00	05100	RECOVERY ROOM	2,252,872	88,756	2,164,116	8,876	125,519	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,823,584	147,154	5,676,430	14,715	329,233	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,922,682	309,113	4,613,569	30,911	267,587	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00	
56.00	05600	RADIOISOTOPE	355,108	32,012	323,096	3,201	18,740	56.00	
57.00	05700	CT SCAN	1,299,696	77,873	1,221,823	7,787	70,866	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	678,902	66,892	612,010	6,689	35,497	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00	
60.00	06000	LABORATORY	8,239,501	351,860	7,887,641	35,186	457,483	60.00	
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01	
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	673,669	12,981	660,688	1,298	38,320	63.00	
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	2,527,806	59,078	2,468,728	5,908	143,186	65.00	
66.00	06600	PHYSICAL THERAPY	1,303,834	68,453	1,235,381	6,845	71,652	66.00	
67.00	06700	OCCUPATIONAL THERAPY	491,340	12,631	478,709	1,263	27,765	67.00	
68.00	06800	SPEECH PATHOLOGY	161,130	10,159	150,971	1,016	8,756	68.00	
69.00	06900	ELECTROCARDIOLOGY	1,152,903	58,405	1,094,498	5,841	63,481	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	31,688	9,247	22,441	925	1,302	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,929,629	157,123	8,772,506	15,712	508,805	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,654,715	55,052	3,599,663	5,505	208,780	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	10,010,387	190,941	9,819,446	19,094	569,528	73.00	
74.00	07400	RENAL DIALYSIS	1,196,835	38,432	1,158,403	3,843	67,187	74.00	
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00	
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									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00	
90.00	09000	CLINIC	2,190,242	135,893	2,054,349	13,589	119,152	90.00	
90.01	09001	CLINIC CMHC	4,028,820	32,118	3,996,702	3,212	231,809	90.01	
90.02	09002	CLINIC CHEMO	114,340	33,658	80,682	3,366	4,680	90.02	
90.03	09003	CLINIC RYAN WHITE	1,182,474	9,375	1,173,099	938	68,040	90.03	
91.00	09100	EMERGENCY	16,311,421	944,373	15,367,048	94,437	891,289	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,345,572	294,191	4,051,381	29,419	234,980	92.00	
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00	
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00	
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00	
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00	
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00	
99.00	09900	CMHC	0	0	0	0	0	99.00	
99.10	09910	CORF	0	0	0	0	0	99.10	
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00	
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00	
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00	
SPECIAL PURPOSE COST CENTERS									
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00	
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00	
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00	
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00	
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00	
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00	
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00	
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00	
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00	
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00	
116.00	11600	HOSPICE	0	0	0	0	0	116.00	
200.00		Subtotal (sum of lines 50 thru 199)	95,798,272	4,271,870	91,526,402	427,186	5,308,532	200.00	
201.00		Less Observation Beds	4,345,572	294,191	4,051,381	29,419	234,980	201.00	
202.00		Total (line 200 minus line 201)	91,452,700	3,977,679	87,475,021	397,767	5,073,552	202.00	

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

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023Worksheet C
Part II
Date/Time Prepared:
5/31/2024 12:06 pm

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)	Hospital	TEFRA
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	13,066,617	78,273,526	0.166935		50.00
51.00	05100 RECOVERY ROOM	2,118,477	7,621,975	0.277943		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	5,479,636	10,705,521	0.511851		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,624,184	195,770,880	0.023620		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0.000000		55.00
56.00	05600 RADIOISOTOPE	333,167	6,326,622	0.052661		56.00
57.00	05700 CT SCAN	1,221,043	105,614,588	0.011561		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	636,716	17,862,931	0.035645		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000		59.00
60.00	06000 LABORATORY	7,746,832	263,809,722	0.029365		60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000		60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000		61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000		62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	634,051	9,093,101	0.069729		63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	2,378,712	12,229,077	0.194513		65.00
66.00	06600 PHYSICAL THERAPY	1,225,337	10,135,981	0.120890		66.00
67.00	06700 OCCUPATIONAL THERAPY	462,312	4,685,325	0.098672		67.00
68.00	06800 SPEECH PATHOLOGY	151,358	1,063,509	0.142319		68.00
69.00	06900 ELECTROCARDIOLOGY	1,083,581	35,729,863	0.030327		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	29,461	694,043	0.042448		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8,405,112	8,783,649	0.956904		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3,440,430	9,952,507	0.345685		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	9,421,765	57,773,474	0.163081		73.00
74.00	07400 RENAL DIALYSIS	1,125,805	588,366	1.913443		74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0.000000		75.00
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						
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000		89.00
90.00	09000 CLINIC	2,057,501	28,968,843	0.071025		90.00
90.01	09001 CLINIC CMHC	3,793,799	41,005,850	0.092518		90.01
90.02	09002 CLINIC CHEMO	106,294	1,051,240	0.101113		90.02
90.03	09003 CLINIC RYAN WHITE	1,113,496	150,859	7.381038		90.03
91.00	09100 EMERGENCY	15,325,695	511,424,130	0.029967		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	4,081,173	518,841,961	0.007866		92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0.000000		94.00
95.00	09500 AMBULANCE SERVICES	0	0	0.000000		95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000		96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000		97.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000		98.00
99.00	09900 CMHC	0	0	0.000000		99.00
99.10	09910 CORF	0	0	0.000000		99.10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0.000000		100.00
101.00	10100 HOME HEALTH AGENCY	0	0	0.000000		101.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0.000000		102.00
SPECIAL PURPOSE COST CENTERS						
105.00	10500 KIDNEY ACQUISITION	0	0	0.000000		105.00
106.00	10600 HEART ACQUISITION	0	0	0.000000		106.00
107.00	10700 LIVER ACQUISITION	0	0	0.000000		107.00
108.00	10800 LUNG ACQUISITION	0	0	0.000000		108.00
109.00	10900 PANCREAS ACQUISITION	0	0	0.000000		109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0.000000		110.00
111.00	11100 ISLET ACQUISITION	0	0	0.000000		111.00
113.00	11300 INTEREST EXPENSE	0	0	0.000000		113.00
114.00	11400 UTILIZATION REVIEW-SNF	0	0	0.000000		114.00
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0.000000		115.00
116.00	11600 HOSPICE	0	0	0.000000		116.00
200.00	Subtotal (sum of lines 50 thru 199)	90,062,554	1,938,157,543			200.00
201.00	Less Observation Beds	4,081,173	0			201.00
202.00	Total (line 200 minus line 201)	85,981,381	1,938,157,543			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part I
Date/Time Prepared:
5/31/2024 12:06 pm

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)	PPS
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	1,451,513	0	1,451,513	16,573	87.58	30.00	
31.00	INTENSIVE CARE UNIT	559,083		559,083	1,180	473.80	31.00	
32.00	CORONARY CARE UNIT	0		0	0	0.00	32.00	
33.00	BURN INTENSIVE CARE UNIT	0		0	0	0.00	33.00	
34.00	SURGICAL INTENSIVE CARE UNIT	0		0	0	0.00	34.00	
40.00	SUBPROVIDER - IPF	992,683	0	992,683	11,216	88.51	40.00	
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00	
43.00	NURSERY	159,388		159,388	1,943	82.03	43.00	
44.00	SKILLED NURSING FACILITY	331,250		331,250	3,812	86.90	44.00	
45.00	NURSING FACILITY	0		0	0	0.00	45.00	
200.00	Total (lines 30 through 199)	3,493,917		3,493,917	34,724		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	2,092	183,217					30.00
31.00	INTENSIVE CARE UNIT	395	187,151					31.00
32.00	CORONARY CARE UNIT	0	0					32.00
33.00	BURN INTENSIVE CARE UNIT	0	0					33.00
34.00	SURGICAL INTENSIVE CARE UNIT	0	0					34.00
40.00	SUBPROVIDER - IPF	1,462	129,402					40.00
41.00	SUBPROVIDER - IRF	0	0					41.00
43.00	NURSERY	0	0					43.00
44.00	SKILLED NURSING FACILITY	1,670	145,123					44.00
45.00	NURSING FACILITY	0	0					45.00
200.00	Total (lines 30 through 199)	5,619	644,893					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part II
Date/Time Prepared:
5/31/2024 12:06 pm

Cost Center Description		Title XVIII			Hospital		PPS	
		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	1,076,100	78,273,526	0.013748	3,200,375	43,999	50.00
51.00	05100	RECOVERY ROOM	88,756	7,621,975	0.011645	268,691	3,129	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	147,154	10,705,521	0.013746	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	309,113	195,770,880	0.001579	8,182,136	12,920	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00	05600	RADIOISOTOPE	32,012	6,326,622	0.005060	203,396	1,029	56.00
57.00	05700	CT SCAN	77,873	105,614,588	0.000737	5,833,000	4,299	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	66,892	17,862,931	0.003745	1,255,500	4,702	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	351,860	263,809,722	0.001334	19,589,518	26,132	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	12,981	9,093,101	0.001428	311,703	445	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	59,078	12,229,077	0.004831	2,251,223	10,876	65.00
66.00	06600	PHYSICAL THERAPY	68,453	10,135,981	0.006753	1,325,725	8,953	66.00
67.00	06700	OCCUPATIONAL THERAPY	12,631	4,685,325	0.002696	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	10,159	1,063,509	0.009552	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	58,405	35,729,863	0.001635	3,752,114	6,135	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	9,247	694,043	0.013323	91,325	1,217	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	157,123	8,783,649	0.017888	357,554	6,396	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	55,052	9,952,507	0.005531	682,696	3,776	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	190,941	57,773,474	0.003305	5,014,656	16,573	73.00
74.00	07400	RENAL DIALYSIS	38,432	588,366	0.065320	271,272	17,719	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
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								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	135,893	28,968,843	0.004691	0	0	90.00
90.01	09001	CLINIC CMHC	32,118	41,005,850	0.000783	0	0	90.01
90.02	09002	CLINIC CHEMO	33,658	1,051,240	0.032017	0	0	90.02
90.03	09003	CLINIC RYAN WHITE	9,375	150,859	0.062144	0	0	90.03
91.00	09100	EMERGENCY	944,373	511,424,130	0.001847	7,727,369	14,272	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	294,192	518,841,961	0.000567	26,766,802	15,177	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	0	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00		Total (lines 50 through 199)	4,271,871	1,938,157,543		87,085,055	197,749	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part III
Date/Time Prepared:
5/31/2024 12:06 pm

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	
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00	
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00	
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00	
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	16,573	0.00	2,092	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	1,180	0.00	395	31.00	
32.00	03200	CORONARY CARE UNIT		0	0	0.00	0	32.00	
33.00	03300	BURN INTENSIVE CARE UNIT		0	0	0.00	0	33.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	0	0.00	0	34.00	
40.00	04000	SUBPROVIDER - IPF	0	0	11,216	0.00	1,462	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0	41.00	
43.00	04300	NURSERY		0	1,943	0.00	0	43.00	
44.00	04400	SKILLED NURSING FACILITY		0	3,812	0.00	1,670	44.00	
45.00	04500	NURSING FACILITY		0	0	0.00	0	45.00	
200.00		Total (lines 30 through 199)		0	34,724		5,619	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
32.00	03200	CORONARY CARE UNIT	0						32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0						33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0						34.00
40.00	04000	SUBPROVIDER - IPF	0						40.00
41.00	04100	SUBPROVIDER - IRF	0						41.00
43.00	04300	NURSERY	0						43.00
44.00	04400	SKILLED NURSING FACILITY	0						44.00
45.00	04500	NURSING FACILITY	0						45.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 31-0040		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part IV Date/Time Prepared: 5/31/2024 12:06 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	0	75.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
90.01	09001	CLINIC CMHC	0	0	0	0	0	0	90.01
90.02	09002	CLINIC CHEMO	0	0	0	0	0	0	90.02
90.03	09003	CLINIC RYAN WHITE	0	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	0	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	0	98.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 31-0040		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part IV Date/Time Prepared: 5/31/2024 12:06 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	78,273,526	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	7,621,975	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	10,705,521	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	195,770,880	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE		0	0	0	6,326,622	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	105,614,588	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	17,862,931	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	263,809,722	0.000000	60.00
60.01	06001	BLOOD LABORATORY		0	0	0	0	0.000000	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY		0	0	0	0	0.000000	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0	0	0.000000	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0	0	0	9,093,101	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	12,229,077	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	10,135,981	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	4,685,325	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	1,063,509	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	35,729,863	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	694,043	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	8,783,649	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	9,952,507	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	57,773,474	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	588,366	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)		0	0	0	0	0.000000	75.00
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									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	0	0.000000	89.00
90.00	09000	CLINIC		0	0	0	28,968,843	0.000000	90.00
90.01	09001	CLINIC CMHC		0	0	0	41,005,850	0.000000	90.01
90.02	09002	CLINIC CHEMO		0	0	0	1,051,240	0.000000	90.02
90.03	09003	CLINIC RYAN WHITE		0	0	0	150,859	0.000000	90.03
91.00	09100	EMERGENCY		0	0	0	511,424,130	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	518,841,961	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS		0	0	0	0	0.000000	94.00
95.00	09500	AMBULANCE SERVICES		0	0	0	0	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED		0	0	0	0	0.000000	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD		0	0	0	0	0.000000	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS		0	0	0	0	0.000000	98.00
200.00		Total (lines 50 through 199)		0	0	0	1,938,157,543		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part IV
Date/Time Prepared:
5/31/2024 12:06 pm

				Title XVIII		Hospital		PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			9.00	10.00	11.00	12.00	13.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	3,200,375	0	2,897,010	0	50.00	
51.00	05100	RECOVERY ROOM	0.000000	268,691	0	511,658	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	8,182,136	0	8,017,348	0	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00	
56.00	05600	RADIOISOTOPE	0.000000	203,396	0	842,386	0	56.00	
57.00	05700	CT SCAN	0.000000	5,833,000	0	7,536,921	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	1,255,500	0	1,350,000	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00	
60.00	06000	LABORATORY	0.000000	19,589,518	0	7,605,559	0	60.00	
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01	
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	0	0	61.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0	62.00	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	311,703	0	59,391	0	63.00	
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0.000000	2,251,223	0	186,227	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.000000	1,325,725	0	185,639	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.000000	3,752,114	0	4,791,381	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	91,325	0	34,776	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	357,554	0	336,336	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	682,696	0	1,468,709	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	5,014,656	0	6,941,717	0	73.00	
74.00	07400	RENAL DIALYSIS	0.000000	271,272	0	0	0	74.00	
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00	
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								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00	
90.00	09000	CLINIC	0.000000	0	0	364,704	0	90.00	
90.01	09001	CLINIC CMHC	0.000000	0	0	0	0	90.01	
90.02	09002	CLINIC CHEMO	0.000000	0	0	230,325	0	90.02	
90.03	09003	CLINIC RYAN WHITE	0.000000	0	0	0	0	90.03	
91.00	09100	EMERGENCY	0.000000	7,727,369	0	21,526,253	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	26,766,802	0	51,546,496	0	92.00	
	OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	94.00	
95.00	09500	AMBULANCE SERVICES	0.000000	0	0	0	0	95.00	
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00	
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00	
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00	
200.00	Total (lines 50 through 199)			87,085,055	0	116,432,836	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part V
Date/Time Prepared:
5/31/2024 12:06 pm

			Title XVIII		Hospital		PPS	
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		PPS Services (see inst.)	
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.177827	2,897,010	0	0	515,167	50.00
51.00	05100	RECOVERY ROOM	0.295576	511,658	0	0	151,234	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.543980	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.025145	8,017,348	0	0	201,596	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.056129	842,386	0	0	47,282	56.00
57.00	05700	CT SCAN	0.012306	7,536,921	0	0	92,749	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.038006	1,350,000	0	0	51,308	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.031233	7,605,559	0	0	237,544	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.074086	59,391	0	0	4,400	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.206705	186,227	0	0	38,494	65.00
66.00	06600	PHYSICAL THERAPY	0.128634	185,639	0	0	23,879	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.104868	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.151508	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.032267	4,791,381	0	0	154,603	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.045657	34,776	0	0	1,588	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.016620	336,336	0	0	341,926	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.367216	1,468,709	35,868	0	539,333	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.173270	6,941,717	0	38,985	1,202,791	73.00
74.00	07400	RENAL DIALYSIS	2.034168	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
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								
88.00	08800	RURAL HEALTH CLINIC						88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER						89.00
90.00	09000	CLINIC	0.075607	364,704	0	0	27,574	90.00
90.01	09001	CLINIC CMHC	0.098250	0	0	0	0	90.01
90.02	09002	CLINIC CHEMO	0.108767	230,325	0	0	25,052	90.02
90.03	09003	CLINIC RYAN WHITE	7.838273	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.031894	21,526,253	0	0	686,558	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.008392	51,546,496	0	0	432,578	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0.000000		0	0		94.00
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Subtotal (see instructions)		116,432,836	35,868	38,985	4,775,656	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		116,432,836	35,868	38,985	4,775,656	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 31-0040		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part V Date/Time Prepared: 5/31/2024 12:06 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	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
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0					55.00
56.00	05600	RADIOISOTOPE	0	0					56.00
57.00	05700	CT SCAN	0	0					57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0					58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0					59.00
60.00	06000	LABORATORY	0	0					60.00
60.01	06001	BLOOD LABORATORY	0	0					60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0						61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0					62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0					63.00
64.00	06400	INTRAVENOUS THERAPY	0	0					64.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0					67.00
68.00	06800	SPEECH PATHOLOGY	0	0					68.00
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0					70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,171	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,755					73.00
74.00	07400	RENAL DIALYSIS	0	0					74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0					75.00
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									
88.00	08800	RURAL HEALTH CLINIC							88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER							89.00
90.00	09000	CLINIC	0	0					90.00
90.01	09001	CLINIC CMHC	0	0					90.01
90.02	09002	CLINIC CHEMO	0	0					90.02
90.03	09003	CLINIC RYAN WHITE	0	0					90.03
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0					92.00
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS	0	0					94.00
95.00	09500	AMBULANCE SERVICES	0						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0					96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0					97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0					98.00
200.00		Subtotal (see instructions)	13,171	6,755					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	13,171	6,755					202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 31-0040

Period:

Worksheet D

Component CCN: 31-S040

From 01/01/2023
To 12/31/2023Part II
Date/Time Prepared:
5/31/2024 12:06 pm

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	1,076,100	78,273,526	0.013748	0	0	50.00
51.00	05100 RECOVERY ROOM	88,756	7,621,975	0.011645	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	147,154	10,705,521	0.013746	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	309,113	195,770,880	0.001579	651,671	1,029	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00	05600 RADIOISOTOPE	32,012	6,326,622	0.005060	0	0	56.00
57.00	05700 CT SCAN	77,873	105,614,588	0.000737	256,500	189	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	66,892	17,862,931	0.003745	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	351,860	263,809,722	0.001334	3,219,249	4,294	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	12,981	9,093,101	0.001428	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	59,078	12,229,077	0.004831	26,659	129	65.00
66.00	06600 PHYSICAL THERAPY	68,453	10,135,981	0.006753	197,499	1,334	66.00
67.00	06700 OCCUPATIONAL THERAPY	12,631	4,685,325	0.002696	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	10,159	1,063,509	0.009552	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	58,405	35,729,863	0.001635	199,650	326	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	9,247	694,043	0.013323	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	157,123	8,783,649	0.017888	732	13	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	55,052	9,952,507	0.005531	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	190,941	57,773,474	0.003305	651,261	2,152	73.00
74.00	07400 RENAL DIALYSIS	38,432	588,366	0.065320	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
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							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000 CLINIC	135,893	28,968,843	0.004691	0	0	90.00
90.01	09001 CLINIC CMHC	32,118	41,005,850	0.000783	0	0	90.01
90.02	09002 CLINIC CHEMO	33,658	1,051,240	0.032017	0	0	90.02
90.03	09003 CLINIC RYAN WHITE	9,375	150,859	0.062144	0	0	90.03
91.00	09100 EMERGENCY	944,373	511,424,130	0.001847	2,999,243	5,540	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	518,841,961	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	0	97.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00	Total (lines 50 through 199)	3,977,679	1,938,157,543		8,202,464	15,006	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 31-0040 Component CCN: 31-S040		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part IV Date/Time Prepared: 5/31/2024 12:06 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	0	75.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
90.01	09001	CLINIC CMHC	0	0	0	0	0	0	90.01
90.02	09002	CLINIC CHEMO	0	0	0	0	0	0	90.02
90.03	09003	CLINIC RYAN WHITE	0	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	0	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	0	98.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 31-0040 Component CCN: 31-S040		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part IV Date/Time Prepared: 5/31/2024 12:06 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of col.s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col.s. 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	0	78,273,526	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	7,621,975	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	10,705,521	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	195,770,880	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	6,326,622	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	105,614,588	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	17,862,931	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	0	263,809,722	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	0.000000	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	0.000000	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	0.000000	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	9,093,101	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	12,229,077	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	10,135,981	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	4,685,325	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	1,063,509	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	35,729,863	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	694,043	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	8,783,649	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	9,952,507	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	57,773,474	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	588,366	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	0.000000	75.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	0	28,968,843	0.000000	90.00
90.01	09001	CLINIC CMHC	0	0	0	0	41,005,850	0.000000	90.01
90.02	09002	CLINIC CHEMO	0	0	0	0	1,051,240	0.000000	90.02
90.03	09003	CLINIC RYAN WHITE	0	0	0	0	150,859	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	0	511,424,130	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	518,841,961	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	0.000000	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	0.000000	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	0.000000	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	0.000000	98.00
200.00		Total (lines 50 through 199)	0	0	0	0	1,938,157,543		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 31-0040 Component CCN: 31-S040		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part IV Date/Time Prepared: 5/31/2024 12:06 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			9.00						
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00	
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	651,671	0	0	0	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00	
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00	
57.00	05700	CT SCAN	0.000000	256,500	0	0	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00	
60.00	06000	LABORATORY	0.000000	3,219,249	0	0	0	60.00	
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01	
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0	62.00	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00	
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0.000000	26,659	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.000000	197,499	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.000000	199,650	0	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	732	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	651,261	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00	
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00	
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									
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00	
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00	
90.01	09001	CLINIC CMHC	0.000000	0	0	0	0	90.01	
90.02	09002	CLINIC CHEMO	0.000000	0	0	0	0	90.02	
90.03	09003	CLINIC RYAN WHITE	0.000000	0	0	0	0	90.03	
91.00	09100	EMERGENCY	0.000000	2,999,243	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	94.00	
95.00	09500	AMBULANCE SERVICES						95.00	
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00	
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00	
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00	
200.00		Total (lines 50 through 199)		8,202,464	0	0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 31-0040 Component CCN: 31-5512		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part IV Date/Time Prepared: 5/31/2024 12:06 pm	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	0	75.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
90.01	09001	CLINIC CMHC	0	0	0	0	0	0	90.01
90.02	09002	CLINIC CHEMO	0	0	0	0	0	0	90.02
90.03	09003	CLINIC RYAN WHITE	0	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	0	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	0	98.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 31-0040 Component CCN: 31-5512		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part IV Date/Time Prepared: 5/31/2024 12:06 pm	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of col.s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col.s. 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	0	78,273,526	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	7,621,975	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	10,705,521	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	195,770,880	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	6,326,622	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	105,614,588	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	17,862,931	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	0	263,809,722	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	0.000000	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	0.000000	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	0.000000	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	9,093,101	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	12,229,077	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	10,135,981	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	4,685,325	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	1,063,509	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	35,729,863	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	694,043	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	8,783,649	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	9,952,507	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	57,773,474	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	588,366	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	0.000000	75.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	0	28,968,843	0.000000	90.00
90.01	09001	CLINIC CMHC	0	0	0	0	41,005,850	0.000000	90.01
90.02	09002	CLINIC CHEMO	0	0	0	0	1,051,240	0.000000	90.02
90.03	09003	CLINIC RYAN WHITE	0	0	0	0	150,859	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	0	511,424,130	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	518,841,961	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	0.000000	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	0.000000	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	0.000000	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	0.000000	98.00
200.00		Total (lines 50 through 199)	0	0	0	0	1,938,157,543		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 31-0040 Component CCN: 31-5512		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part IV Date/Time Prepared: 5/31/2024 12:06 pm	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			9.00						
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00	
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	769,794	0	0	0	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00	
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00	
57.00	05700	CT SCAN	0.000000	76,000	0	0	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	13,500	0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00	
60.00	06000	LABORATORY	0.000000	3,659,490	0	0	0	60.00	
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01	
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0	62.00	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	5,780	0	0	0	63.00	
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0.000000	552,000	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.000000	2,838,708	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.000000	117,497	0	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	5,080	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	3,200	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,159,030	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00	
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00	
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									
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00	
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00	
90.01	09001	CLINIC CMHC	0.000000	0	0	0	0	90.01	
90.02	09002	CLINIC CHEMO	0.000000	0	0	0	0	90.02	
90.03	09003	CLINIC RYAN WHITE	0.000000	0	0	0	0	90.03	
91.00	09100	EMERGENCY	0.000000	555	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	94.00	
95.00	09500	AMBULANCE SERVICES						95.00	
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00	
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00	
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00	
200.00		Total (lines 50 through 199)		9,200,634	0	0	0	200.00	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part I
Date/Time Prepared:
5/31/2024 12:06 pm

			Title XIX		Hospital	TEFRA		
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	1,451,513	0	1,451,513	16,573	87.58	30.00	
31.00	INTENSIVE CARE UNIT	559,083		559,083	1,180	473.80	31.00	
32.00	CORONARY CARE UNIT	0		0	0	0.00	32.00	
33.00	BURN INTENSIVE CARE UNIT	0		0	0	0.00	33.00	
34.00	SURGICAL INTENSIVE CARE UNIT	0		0	0	0.00	34.00	
40.00	SUBPROVIDER - IPF	992,683	0	992,683	11,216	88.51	40.00	
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00	
43.00	NURSERY	159,388		159,388	1,943	82.03	43.00	
44.00	SKILLED NURSING FACILITY	331,250		331,250	3,812	86.90	44.00	
45.00	NURSING FACILITY	0		0	0	0.00	45.00	
200.00	Total (lines 30 through 199)	3,493,917		3,493,917	34,724		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	369	32,317					30.00
31.00	INTENSIVE CARE UNIT	50	23,690					
32.00	CORONARY CARE UNIT	0	0					32.00
33.00	BURN INTENSIVE CARE UNIT	0	0					
34.00	SURGICAL INTENSIVE CARE UNIT	0	0					34.00
40.00	SUBPROVIDER - IPF	341	30,182					
41.00	SUBPROVIDER - IRF	0	0					41.00
43.00	NURSERY	258	21,164					
44.00	SKILLED NURSING FACILITY	0	0					44.00
45.00	NURSING FACILITY	0	0					
200.00	Total (lines 30 through 199)	1,018	107,353					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part II
Date/Time Prepared:
5/31/2024 12:06 pm

Cost Center Description		Title XIX		Hospital		TEFRA	
		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	1,076,100	78,273,526	0.013748	1,105,432	15,197	50.00
51.00	05100 RECOVERY ROOM	88,756	7,621,975	0.011645	139,514	1,625	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	147,154	10,705,521	0.013746	667,359	9,174	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	309,113	195,770,880	0.001579	1,277,925	2,018	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00	05600 RADIOISOTOPE	32,012	6,326,622	0.005060	61,512	311	56.00
57.00	05700 CT SCAN	77,873	105,614,588	0.000737	883,500	651	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	66,892	17,862,931	0.003745	297,000	1,112	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	351,860	263,809,722	0.001334	4,093,776	5,461	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	12,981	9,093,101	0.001428	60,770	87	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	59,078	12,229,077	0.004831	116,607	563	65.00
66.00	06600 PHYSICAL THERAPY	68,453	10,135,981	0.006753	57,416	388	66.00
67.00	06700 OCCUPATIONAL THERAPY	12,631	4,685,325	0.002696	12,735	34	67.00
68.00	06800 SPEECH PATHOLOGY	10,159	1,063,509	0.009552	167,743	1,602	68.00
69.00	06900 ELECTROCARDIOLOGY	58,405	35,729,863	0.001635	328,371	537	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	9,247	694,043	0.013323	38,737	516	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	157,123	8,783,649	0.017888	139,601	2,497	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	55,052	9,952,507	0.005531	15,511	86	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	190,941	57,773,474	0.003305	1,047,596	3,462	73.00
74.00	07400 RENAL DIALYSIS	38,432	588,366	0.065320	19,600	1,280	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
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							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000 CLINIC	135,893	28,968,843	0.004691	5,029	24	90.00
90.01	09001 CLINIC CMHC	32,118	41,005,850	0.000783	0	0	90.01
90.02	09002 CLINIC CHEMO	33,658	1,051,240	0.032017	0	0	90.02
90.03	09003 CLINIC RYAN WHITE	9,375	150,859	0.062144	0	0	90.03
91.00	09100 EMERGENCY	944,373	511,424,130	0.001847	1,818,330	3,358	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	294,191	518,841,961	0.000567	2,848,739	1,615	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	0	97.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00	Total (lines 50 through 199)	4,271,870	1,938,157,543		15,202,803	51,598	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 31-0040		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part III Date/Time Prepared: 5/31/2024 12:06 pm	
					Title XIX		Hospital		TEFRA	
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		
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00		
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00		
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00		
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00		
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00		
43.00	04300	NURSERY	0	0	0	0	0	43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00		
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00		
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	16,573	0.00	369	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	1,180	0.00	50	31.00		
32.00	03200	CORONARY CARE UNIT	0	0	0	0.00	0	32.00		
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0.00	0	33.00		
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0.00	0	34.00		
40.00	04000	SUBPROVIDER - IPF	0	0	11,216	0.00	341	40.00		
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0	41.00		
43.00	04300	NURSERY	0	0	1,943	0.00	258	43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	3,812	0.00	0	44.00		
45.00	04500	NURSING FACILITY	0	0	0	0.00	0	45.00		
200.00	Total (lines 30 through 199)		0	0	34,724		1,018	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	
32.00	03200	CORONARY CARE UNIT	0						32.00	
33.00	03300	BURN INTENSIVE CARE UNIT	0						33.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0						34.00	
40.00	04000	SUBPROVIDER - IPF	0						40.00	
41.00	04100	SUBPROVIDER - IRF	0						41.00	
43.00	04300	NURSERY	0						43.00	
44.00	04400	SKILLED NURSING FACILITY	0						44.00	
45.00	04500	NURSING FACILITY	0						45.00	
200.00	Total (lines 30 through 199)		0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 31-0040		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part IV Date/Time Prepared: 5/31/2024 12:06 pm	
				Title XIX		Hospital		TEFRA	
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
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY		0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY		0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)		0	0	0	0	0	75.00
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									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	0	0	89.00
90.00	09000	CLINIC		0	0	0	0	0	90.00
90.01	09001	CLINIC CMHC		0	0	0	0	0	90.01
90.02	09002	CLINIC CHEMO		0	0	0	0	0	90.02
90.03	09003	CLINIC RYAN WHITE		0	0	0	0	0	90.03
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS		0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES		0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED		0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD		0	0	0	0	0	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS		0	0	0	0	0	98.00
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: 31-0040

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part IV
Date/Time Prepared:
5/31/2024 12:06 pm

Cost Center Description			Title XIX		Hospital		TEFRA	
			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	78,273,526	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	7,621,975	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	10,705,521	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	195,770,880	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	6,326,622	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	105,614,588	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	17,862,931	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	263,809,722	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0.000000	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0.000000	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	9,093,101	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	12,229,077	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	10,135,981	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	4,685,325	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,063,509	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	35,729,863	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	694,043	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	8,783,649	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	9,952,507	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	57,773,474	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	588,366	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
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								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	28,968,843	0.000000	90.00
90.01	09001	CLINIC CMHC	0	0	0	41,005,850	0.000000	90.01
90.02	09002	CLINIC CHEMO	0	0	0	1,051,240	0.000000	90.02
90.03	09003	CLINIC RYAN WHITE	0	0	0	150,859	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	511,424,130	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	518,841,961	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0.000000	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0.000000	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0.000000	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0.000000	98.00
200.00		Total (lines 50 through 199)	0	0	0	1,938,157,543		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 31-0040		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part IV Date/Time Prepared: 5/31/2024 12:06 pm	
				Title XIX		Hospital		TEFRA	
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		1,105,432	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000		139,514	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		667,359	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000		0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		1,277,925	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000		61,512	0	0	0	56.00
57.00	05700	CT SCAN	0.000000		883,500	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		297,000	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000		4,093,776	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000		0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000		0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		60,770	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		116,607	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000		57,416	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		12,735	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		167,743	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		328,371	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		38,737	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		139,601	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		15,511	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		1,047,596	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000		19,600	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		0	0	0	0	75.00
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									
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	0	0	0	89.00
90.00	09000	CLINIC	0.000000		5,029	0	0	0	90.00
90.01	09001	CLINIC CMHC	0.000000		0	0	0	0	90.01
90.02	09002	CLINIC CHEMO	0.000000		0	0	0	0	90.02
90.03	09003	CLINIC RYAN WHITE	0.000000		0	0	0	0	90.03
91.00	09100	EMERGENCY	0.000000		1,818,330	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		2,848,739	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS	0.000000		0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0.000000		0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000		0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000		0	0	0	0	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000		0	0	0	0	98.00
200.00		Total (lines 50 through 199)			15,202,803	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023Worksheet D
Part V
Date/Time Prepared:
5/31/2024 12:06 pm

			Title XIX		Hospital		TEFRA	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.166935	0	0	125,353	0	50.00
51.00	05100	RECOVERY ROOM	0.277943	0	0	16,247	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.511851	0	0	10,100	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.023620	0	0	5,906,569	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.052661	0	0	13,536	0	56.00
57.00	05700	CT SCAN	0.011561	0	0	779,000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.035645	0	0	94,500	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.029365	0	0	14,420	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.069729	0	0	4,955	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.194513	0	0	1,006	0	65.00
66.00	06600	PHYSICAL THERAPY	0.120890	0	0	37,300	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.098672	0	0	8,213	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.142319	0	0	203	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.030327	0	0	236,417	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.042448	0	0	5,322	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.956904	0	0	67,477	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.345685	0	0	23,708	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.163081	0	0	632,569	0	73.00
74.00	07400	RENAL DIALYSIS	1.913443	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
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								
88.00	08800	RURAL HEALTH CLINIC						88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER						89.00
90.00	09000	CLINIC	0.071025	0	0	167,825	0	90.00
90.01	09001	CLINIC CMHC	0.092518	0	0	0	0	90.01
90.02	09002	CLINIC CHEMO	0.101113	0	0	0	0	90.02
90.03	09003	CLINIC RYAN WHITE	7.381038	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.029967	0	0	8,088,848	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.007866	0	0	5,370,123	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0.000000		0	0		94.00
95.00	09500	AMBULANCE SERVICES	0.000000	0	0			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Subtotal (see instructions)		0	0	21,603,691	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	21,603,691	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 31-0040		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part V Date/Time Prepared: 5/31/2024 12:06 pm	
				Title XIX		Hospital		TEFRA	
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	20,926				50.00	
51.00	05100	RECOVERY ROOM	0	4,516				51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,170				52.00	
53.00	05300	ANESTHESIOLOGY	0	0				53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	139,513				54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0				55.00	
56.00	05600	RADIOISOTOPE	0	713				56.00	
57.00	05700	CT SCAN	0	9,006				57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,368				58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0				59.00	
60.00	06000	LABORATORY	0	423				60.00	
60.01	06001	BLOOD LABORATORY	0	0				60.01	
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0					61.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.00	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	346				63.00	
64.00	06400	INTRAVENOUS THERAPY	0	0				64.00	
65.00	06500	RESPIRATORY THERAPY	0	196				65.00	
66.00	06600	PHYSICAL THERAPY	0	4,509				66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	810				67.00	
68.00	06800	SPEECH PATHOLOGY	0	29				68.00	
69.00	06900	ELECTROCARDIOLOGY	0	7,170				69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	226				70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	64,569				71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,195				72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	103,160				73.00	
74.00	07400	RENAL DIALYSIS	0	0				74.00	
75.00	07500	ASC (NON-DISTINCT PART)	0	0				75.00	
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									
88.00	08800	RURAL HEALTH CLINIC						88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER						89.00	
90.00	09000	CLINIC	0	11,920				90.00	
90.01	09001	CLINIC CMHC	0	0				90.01	
90.02	09002	CLINIC CHEMO	0	0				90.02	
90.03	09003	CLINIC RYAN WHITE	0	0				90.03	
91.00	09100	EMERGENCY	0	242,399				91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	42,241				92.00	
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS	0	0				94.00	
95.00	09500	AMBULANCE SERVICES	0					95.00	
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0				96.00	
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0				97.00	
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0				98.00	
200.00		Subtotal (see instructions)	0	669,405				200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0					201.00	
202.00		Net Charges (line 200 - line 201)	0	669,405				202.00	

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 31-0040	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Prepared: 5/31/2024 12:06 pm	
				Component CCN: 31-S040			
				Title XIX	Subprovider - IPF	TEFRA	
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	1,076,100	78,273,526	0.013748	0	50.00
51.00	05100	RECOVERY ROOM	88,756	7,621,975	0.011645	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	147,154	10,705,521	0.013746	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	309,113	195,770,880	0.001579	80,244	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	55.00
56.00	05600	RADIOISOTOPE	32,012	6,326,622	0.005060	0	56.00
57.00	05700	CT SCAN	77,873	105,614,588	0.000737	28,500	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	66,892	17,862,931	0.003745	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	59.00
60.00	06000	LABORATORY	351,860	263,809,722	0.001334	706,856	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	12,981	9,093,101	0.001428	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	59,078	12,229,077	0.004831	0	65.00
66.00	06600	PHYSICAL THERAPY	68,453	10,135,981	0.006753	3,128	66.00
67.00	06700	OCCUPATIONAL THERAPY	12,631	4,685,325	0.002696	0	67.00
68.00	06800	SPEECH PATHOLOGY	10,159	1,063,509	0.009552	0	68.00
69.00	06900	ELECTROCARDIOLOGY	58,405	35,729,863	0.001635	22,550	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	9,247	694,043	0.013323	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	157,123	8,783,649	0.017888	69	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	55,052	9,952,507	0.005531	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	190,941	57,773,474	0.003305	68,974	73.00
74.00	07400	RENAL DIALYSIS	38,432	588,366	0.065320	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	75.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	78.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	89.00
90.00	09000	CLINIC	135,893	28,968,843	0.004691	529	90.00
90.01	09001	CLINIC CMHC	32,118	41,005,850	0.000783	0	90.01
90.02	09002	CLINIC CHEMO	33,658	1,051,240	0.032017	0	90.02
90.03	09003	CLINIC RYAN WHITE	9,375	150,859	0.062144	0	90.03
91.00	09100	EMERGENCY	944,373	511,424,130	0.001847	518,106	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	518,841,961	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0.000000	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	98.00
200.00		Total (lines 50 through 199)	3,977,679	1,938,157,543		1,428,956	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 31-0040 Component CCN: 31-S040		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part IV Date/Time Prepared: 5/31/2024 12:06 pm	
				Title XIX		Subprovider - IPF		TEFRA	
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	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	0	75.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
90.01	09001	CLINIC CMHC	0	0	0	0	0	0	90.01
90.02	09002	CLINIC CHEMO	0	0	0	0	0	0	90.02
90.03	09003	CLINIC RYAN WHITE	0	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	0	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	0	98.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 31-0040 Component CCN: 31-S040		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part IV Date/Time Prepared: 5/31/2024 12:06 pm	
				Title XIX		Subprovider - IPF		TEFRA	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of col.s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col.s. 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	0	78,273,526	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	7,621,975	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	10,705,521	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	195,770,880	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	6,326,622	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	105,614,588	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	17,862,931	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	0	263,809,722	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	0.000000	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	0.000000	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	0.000000	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	9,093,101	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	12,229,077	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	10,135,981	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	4,685,325	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	1,063,509	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	35,729,863	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	694,043	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	8,783,649	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	9,952,507	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	57,773,474	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	588,366	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	0.000000	75.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	0	28,968,843	0.000000	90.00
90.01	09001	CLINIC CMHC	0	0	0	0	41,005,850	0.000000	90.01
90.02	09002	CLINIC CHEMO	0	0	0	0	1,051,240	0.000000	90.02
90.03	09003	CLINIC RYAN WHITE	0	0	0	0	150,859	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	0	511,424,130	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	518,841,961	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	0.000000	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	0.000000	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	0.000000	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	0.000000	98.00
200.00		Total (lines 50 through 199)	0	0	0	0	1,938,157,543		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 31-0040 Component CCN: 31-S040		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part IV Date/Time Prepared: 5/31/2024 12:06 pm	
				Title XIX		Subprovider - IPF		TEFRA	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00	
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	80,244	0	0	0	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00	
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00	
57.00	05700	CT SCAN	0.000000	28,500	0	0	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00	
60.00	06000	LABORATORY	0.000000	706,856	0	0	0	60.00	
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01	
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0	62.00	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00	
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.000000	3,128	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.000000	22,550	0	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	69	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	68,974	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00	
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00	
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									
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00	
90.00	09000	CLINIC	0.000000	529	0	0	0	90.00	
90.01	09001	CLINIC CMHC	0.000000	0	0	0	0	90.01	
90.02	09002	CLINIC CHEMO	0.000000	0	0	0	0	90.02	
90.03	09003	CLINIC RYAN WHITE	0.000000	0	0	0	0	90.03	
91.00	09100	EMERGENCY	0.000000	518,106	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	94.00	
95.00	09500	AMBULANCE SERVICES						95.00	
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00	
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00	
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00	
200.00		Total (lines 50 through 199)		1,428,956	0	0	0	200.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 31-0040	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/31/2024 12:06 pm
		Title XVIII	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		16,573	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		16,573	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)		13,214	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		2,092	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)		21,483,550	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)		21,483,550	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)		21,483,550	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)		1,296.30	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,711,860	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,711,860	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023

Worksheet D-1

Date/Time Prepared:

5/31/2024 12:06 pm

		Title XVIII		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	42.00
	Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT	6,101,833	1,180	5,171.04	395	2,042,561
44.00	CORONARY CARE UNIT	0	0	0.00	0	44.00
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	45.00
46.00	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	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)					4,893,253
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					9,647,674
	PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					370,368
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					197,749
52.00	Total Program excludable cost (sum of lines 50 and 51)					568,117
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					9,079,557
	TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
55.01	Permanent adjustment amount per discharge					0.00
55.02	Adjustment amount per discharge (contractor use only)					0.00
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
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
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
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
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
	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
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					0
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
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
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)					3,359
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,296.30
89.00	Observation bed cost (line 87 x line 88) (see instructions)					4,354,272

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023

Worksheet D-1

Date/Time Prepared:
5/31/2024 12:06 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		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	1,451,513	21,483,550	0.067564	4,354,272	294,192	90.00
91.00	Nursing Program cost	0	21,483,550	0.000000	4,354,272	0	91.00
92.00	Allied health cost	0	21,483,550	0.000000	4,354,272	0	92.00
93.00	All other Medical Education	0	21,483,550	0.000000	4,354,272	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 31-0040 Component CCN: 31-S040	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/31/2024 12:06 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		11,216	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		11,216	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		11,216	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,462	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)		17,010,596	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)		17,010,596	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)		17,010,596	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)		1,516.64	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,217,328	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,217,328	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 31-0040	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1	
				Component CCN: 31-S040		Date/Time Prepared: 5/31/2024 12:06 pm	
				Title XVIII		Subprovider - IPF	PPS
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT	0	0	0.00	0	0	44.00
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	45.00
46.00	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	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)					366,931	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					2,584,259	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)					129,402	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					15,006	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					144,408	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,439,851	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)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions						66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 31-0040 Component CCN: 31-S040		Period: From 01/01/2023 To 12/31/2023		Worksheet D-1 Date/Time Prepared: 5/31/2024 12:06 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description									
								1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)							0	89.00
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)			
		1.00	2.00	3.00	4.00	5.00			
COMPUTATION OF OBSERVATION BED PASS THROUGH COST									
90.00	Capital-related cost	992,683	17,010,596	0.058357	0	0	0	90.00	
91.00	Nursing Program cost	0	17,010,596	0.000000	0	0	0	91.00	
92.00	Allied health cost	0	17,010,596	0.000000	0	0	0	92.00	
93.00	All other Medical Education	0	17,010,596	0.000000	0	0	0	93.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 31-0040 Component CCN: 31-5512	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/31/2024 12:06 pm
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,812	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,812	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		3,812	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,670	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)		4,359,451	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)		4,359,451	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)		4,359,451	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 31-0040	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1	
				Component CCN: 31-5512		Date/Time Prepared: 5/31/2024 12:06 pm	
				Title XVIII		Skilled Nursing Facility	PPS
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)						48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)						49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
55.01	Permanent adjustment amount per discharge						55.01
55.02	Adjustment amount per discharge (contractor use only)						55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)						59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)						60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions						66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						4,359,451 70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						1,143.61 71.00
72.00	Program routine service cost (line 9 x line 71)						1,909,829 72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						0 73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						1,909,829 74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						0 75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						0.00 76.00
77.00	Program capital-related costs (line 9 x line 76)						0 77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						0 78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						0 79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						0 80.00
81.00	Inpatient routine service cost per diem limitation						0.00 81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						0 82.00
83.00	Reasonable inpatient routine service costs (see instructions)						1,909,829 83.00
84.00	Program inpatient ancillary services (see instructions)						825,947 84.00
85.00	Utilization review - physician compensation (see instructions)						0 85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						2,735,776 86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)						0 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00 88.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 31-0040 Component CCN: 31-5512		Period: From 01/01/2023 To 12/31/2023		Worksheet D-1 Date/Time Prepared: 5/31/2024 12:06 pm	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description								1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)						0	89.00	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)			
		1.00	2.00	3.00	4.00	5.00			
COMPUTATION OF OBSERVATION BED PASS THROUGH COST									
90.00	Capital-related cost	0	0	0.000000	0	0		90.00	
91.00	Nursing Program cost	0	0	0.000000	0	0		91.00	
92.00	Allied health cost	0	0	0.000000	0	0		92.00	
93.00	All other Medical Education	0	0	0.000000	0	0		93.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 31-0040	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/31/2024 12:06 pm
		Title XIX	Hospital	TEFRA
Cost Center Description				
PART I - ALL PROVIDER COMPONENTS				1.00
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		16,573	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		16,573	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)		13,214	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)		369	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)		1,943	15.00
16.00	Nursery days (title V or XIX only)		258	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)		21,440,606	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)		21,440,606	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)		21,440,606	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)		1,293.71	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		477,379	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)		477,379	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023

Worksheet D-1

Date/Time Prepared:
5/31/2024 12:06 pm

		Title XIX		Hospital		TEFRA	
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)	5,542,503	1,943	2,852.55	258	735,958	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	6,083,718	1,180	5,155.69	50	257,785	43.00
44.00	CORONARY CARE UNIT	0	0	0.00	0	0	44.00
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	45.00
46.00	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	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)					1,312,794	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					2,783,916	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)					77,171	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					51,598	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					128,769	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,655,147	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					228	54.00
55.00	Target amount per discharge					4,988.61	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)					1,137,403	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					-1,517,744	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)					113,740	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					1,379,912	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					3,359	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,293.71	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					4,345,572	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023

Worksheet D-1

Date/Time Prepared:
5/31/2024 12:06 pm

Cost Center Description		Title XIX		Hospital	TEFRA	
		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	1,451,513	21,440,606	0.067699	4,345,572	294,191
91.00	Nursing Program cost	0	21,440,606	0.000000	4,345,572	0
92.00	Allied health cost	0	21,440,606	0.000000	4,345,572	0
93.00	All other Medical Education	0	21,440,606	0.000000	4,345,572	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 31-0040 Component CCN: 31-S040	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/31/2024 12:06 pm
		Title XIX	Subprovider - IPF	TEFRA
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)		11,216	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		11,216	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		11,216	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)		341	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)		1,943	15.00
16.00	Nursery days (title V or XIX only)		258	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)		17,000,489	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)		17,000,489	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)		17,000,489	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)		1,515.74	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		516,867	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)		516,867	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 31-0040	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1	
				Component CCN: 31-S040		Date/Time Prepared: 5/31/2024 12:06 pm	
				Title XIX		Subprovider - IPF	TEFRA
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)		(col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT	0	0	0.00	0	0	44.00
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	45.00
46.00	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	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)					54,161	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)					571,028	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)					30,182	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,337	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					32,519	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					538,509	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					44	54.00
55.00	Target amount per discharge					32,584.46	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)					1,433,716	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					895,207	57.00
58.00	Bonus payment (see instructions)					28,674	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)					599,702	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 31-0040 Component CCN: 31-S040		Period: From 01/01/2023 To 12/31/2023		Worksheet D-1 Date/Time Prepared: 5/31/2024 12:06 pm	
				Title XIX		Subprovider - IPF		TEFRA	
Cost Center Description									
								1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)						0		89.00
Cost Center Description			Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
			1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST									
90.00	Capital-related cost		992,683	17,000,489	0.058391	0	0	90.00	
91.00	Nursing Program cost		0	17,000,489	0.000000	0	0	91.00	
92.00	Allied health cost		0	17,000,489	0.000000	0	0	92.00	
93.00	All other Medical Education		0	17,000,489	0.000000	0	0	93.00	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 31-0040	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 5/31/2024 12:06 pm	
			Title XVIII	Hospital	PPS	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		37,778,000		30.00
31.00	03100	INTENSIVE CARE UNIT		7,900,000		31.00
32.00	03200	CORONARY CARE UNIT		0		32.00
33.00	03300	BURN INTENSIVE CARE UNIT		0		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0		34.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.179109	3,200,375	573,216	50.00
51.00	05100	RECOVERY ROOM	0.295576	268,691	79,419	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.543980	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.025325	8,182,136	207,213	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
56.00	05600	RADIOISOTOPE	0.056129	203,396	11,416	56.00
57.00	05700	CT SCAN	0.012306	5,833,000	71,781	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.038006	1,255,500	47,717	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.031247	19,589,518	612,114	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.074086	311,703	23,093	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.206705	2,251,223	465,339	65.00
66.00	06600	PHYSICAL THERAPY	0.128634	1,325,725	170,533	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.104868	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.151508	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.032267	3,752,114	121,069	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.045657	91,325	4,170	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.016620	357,554	363,497	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.367216	682,696	250,697	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.173270	5,014,656	868,889	73.00
74.00	07400	RENAL DIALYSIS	2.034168	271,272	551,813	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
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						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.075607	0	0	90.00
90.01	09001	CLINIC CMHC	0.098250	0	0	90.01
90.02	09002	CLINIC CHEMO	0.108767	0	0	90.02
90.03	09003	CLINIC RYAN WHITE	7.838273	0	0	90.03
91.00	09100	EMERGENCY	0.031919	7,727,369	246,650	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.008392	26,766,802	224,627	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	94.00
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		87,085,055	4,893,253	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)		87,085,055		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 31-0040	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3	
		Component CCN: 31-S040		Date/Time Prepared: 5/31/2024 12:06 pm	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
32.00	03200 CORONARY CARE UNIT				32.00
33.00	03300 BURN INTENSIVE CARE UNIT				33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT				34.00
40.00	04000 SUBPROVIDER - IPF		26,316,000		40.00
41.00	04100 SUBPROVIDER - IRF				41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.179109	0	0	50.00
51.00	05100 RECOVERY ROOM	0.295576	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.543980	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.025325	651,671	16,504	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
56.00	05600 RADIOISOTOPE	0.056129	0	0	56.00
57.00	05700 CT SCAN	0.012306	256,500	3,156	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.038006	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.031247	3,219,249	100,592	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.074086	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.206705	26,659	5,511	65.00
66.00	06600 PHYSICAL THERAPY	0.128634	197,499	25,405	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.104868	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.151508	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.032267	199,650	6,442	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.045657	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.016620	732	744	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.367216	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.173270	651,261	112,844	73.00
74.00	07400 RENAL DIALYSIS	2.034168	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
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					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000 CLINIC	0.075607	0	0	90.00
90.01	09001 CLINIC CMHC	0.098250	0	0	90.01
90.02	09002 CLINIC CHEMO	0.108767	0	0	90.02
90.03	09003 CLINIC RYAN WHITE	7.838273	0	0	90.03
91.00	09100 EMERGENCY	0.031919	2,999,243	95,733	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.008392	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400 HOME PROGRAM DIALYSIS	0.000000	0	0	94.00
95.00	09500 AMBULANCE SERVICES		0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		8,202,464	366,931	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		8,202,464		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 31-0040	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3	
		Component CCN: 31-5512		Date/Time Prepared: 5/31/2024 12:06 pm	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
32.00	03200 CORONARY CARE UNIT				32.00
33.00	03300 BURN INTENSIVE CARE UNIT				33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT				34.00
40.00	04000 SUBPROVIDER - IPF				40.00
41.00	04100 SUBPROVIDER - IRF				41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.179109	0	0	50.00
51.00	05100 RECOVERY ROOM	0.295576	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.543980	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.025325	769,794	19,495	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
56.00	05600 RADIOISOTOPE	0.056129	0	0	56.00
57.00	05700 CT SCAN	0.012306	76,000	935	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.038006	13,500	513	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.031247	3,659,490	114,348	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.074086	5,780	428	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.206705	552,000	114,101	65.00
66.00	06600 PHYSICAL THERAPY	0.128634	2,838,708	365,154	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.104868	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.151508	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.032267	117,497	3,791	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.045657	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.016620	5,080	5,164	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.367216	3,200	1,175	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.173270	1,159,030	200,825	73.00
74.00	07400 RENAL DIALYSIS	2.034168	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
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					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000 CLINIC	0.075607	0	0	90.00
90.01	09001 CLINIC CMHC	0.098250	0	0	90.01
90.02	09002 CLINIC CHEMO	0.108767	0	0	90.02
90.03	09003 CLINIC RYAN WHITE	7.838273	0	0	90.03
91.00	09100 EMERGENCY	0.031919	555	18	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.008392	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400 HOME PROGRAM DIALYSIS	0.000000	0	0	94.00
95.00	09500 AMBULANCE SERVICES		0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		9,200,634	825,947	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		9,200,634		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 31-0040	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 5/31/2024 12:06 pm
			Title XIX	Hospital	TEFRA
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		9,066,000	30.00
31.00	03100	INTENSIVE CARE UNIT		1,000,000	31.00
32.00	03200	CORONARY CARE UNIT		0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT		0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	34.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		4,644,000	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.177827	1,105,432	196,576 50.00
51.00	05100	RECOVERY ROOM	0.295576	139,514	41,237 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.543980	667,359	363,030 52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.025145	1,277,925	32,133 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0 55.00
56.00	05600	RADIOISOTOPE	0.056129	61,512	3,453 56.00
57.00	05700	CT SCAN	0.012306	883,500	10,872 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.038006	297,000	11,288 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0 59.00
60.00	06000	LABORATORY	0.031233	4,093,776	127,861 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0 60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0 61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0 62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.074086	60,770	4,502 63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0.206705	116,607	24,103 65.00
66.00	06600	PHYSICAL THERAPY	0.128634	57,416	7,386 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.104868	12,735	1,335 67.00
68.00	06800	SPEECH PATHOLOGY	0.151508	167,743	25,414 68.00
69.00	06900	ELECTROCARDIOLOGY	0.032267	328,371	10,596 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.045657	38,737	1,769 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.016620	139,601	141,921 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.367216	15,511	5,696 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.173270	1,047,596	181,517 73.00
74.00	07400	RENAL DIALYSIS	2.034168	19,600	39,870 74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0 75.00
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					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0 89.00
90.00	09000	CLINIC	0.075607	5,029	380 90.00
90.01	09001	CLINIC CMHC	0.098250	0	0 90.01
90.02	09002	CLINIC CHEMO	0.108767	0	0 90.02
90.03	09003	CLINIC RYAN WHITE	7.838273	0	0 90.03
91.00	09100	EMERGENCY	0.031894	1,818,330	57,994 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.008376	2,848,739	23,861 92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0 94.00
95.00	09500	AMBULANCE SERVICES			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0 96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0 97.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0 98.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		15,202,803	1,312,794 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		15,202,803	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 31-0040 Component CCN: 31-S040	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 5/31/2024 12:06 pm	
		Title XIX	Subprovider - IPF	TEFRA	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
32.00	03200 CORONARY CARE UNIT				32.00
33.00	03300 BURN INTENSIVE CARE UNIT				33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT				34.00
40.00	04000 SUBPROVIDER - IPF		6,138,000		40.00
41.00	04100 SUBPROVIDER - IRF				41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.177827	0	0	50.00
51.00	05100 RECOVERY ROOM	0.295576	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.543980	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.025145	80,244	2,018	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
56.00	05600 RADIOISOTOPE	0.056129	0	0	56.00
57.00	05700 CT SCAN	0.012306	28,500	351	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.038006	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.031233	706,856	22,077	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.074086	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.206705	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.128634	3,128	402	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.104868	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.151508	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.032267	22,550	728	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.045657	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.016620	69	70	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.367216	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.173270	68,974	11,951	73.00
74.00	07400 RENAL DIALYSIS	2.034168	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
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					
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000 CLINIC	0.075607	529	40	90.00
90.01	09001 CLINIC CMHC	0.098250	0	0	90.01
90.02	09002 CLINIC CHEMO	0.108767	0	0	90.02
90.03	09003 CLINIC RYAN WHITE	7.838273	0	0	90.03
91.00	09100 EMERGENCY	0.031894	518,106	16,524	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.008376	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400 HOME PROGRAM DIALYSIS	0.000000	0	0	94.00
95.00	09500 AMBULANCE SERVICES		0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,428,956	54,161	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		1,428,956		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 31-0040	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/31/2024 12:06 pm
		Title XVIII	Hospital	PPS
				1.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		4,193,410	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		1,088,363	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)		64,017	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		30,475	2.04
3.00	Managed Care Simulated Payments		5,367,372	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		104.67	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)		21.40	5.00
5.01	FTE cap adjustment for qualifying 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)		21.40	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		26.07	10.00
11.00	FTE count for residents in dental and podiatric programs.		11.00	11.00
12.00	Current year allowable FTE (see instructions)		32.40	12.00
13.00	Total allowable FTE count for the prior year.		32.84	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.		31.96	14.00
15.00	Sum of lines 12 through 14 divided by 3.		32.40	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		32.40	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.309544	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.312789	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.309544	21.00
22.00	IME payment adjustment (see instructions)		822,906	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		836,242	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)		4.67	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)		822,906	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		836,242	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		18.67	30.00
31.00	Percentage of Medicaid patient days (see instructions)		28.56	31.00
32.00	Sum of lines 30 and 31		47.23	32.00
33.00	Allowable disproportionate share percentage (see instructions)		28.18	33.00
34.00	Disproportionate share adjustment (see instructions)		372,101	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 31-0040	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/31/2024 12:06 pm	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Payment Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)		0.000000000	0.000000000	35.01
35.02	Hospital UCP, including supplemental UCP (see instructions)		3,441,069	2,645,975	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)		2,573,730	665,108	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)		3,238,838		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)		9,810,110		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			10,646,352	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			535,628	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).			1,378,615	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			8,094	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 instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			12,568,689	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			12,568,689	61.00
62.00	Deductibles billed to program beneficiaries			396,492	62.00
63.00	Coinurance billed to program beneficiaries			94,400	63.00
64.00	Allowable bad debts (see instructions)			0	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			0	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			12,077,797	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)			0	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)			-12,170	70.93
70.94	HRR adjustment amount (see instructions)			-28,786	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 31-0040	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/31/2024 12:06 pm	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96	
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97	
70.98	Low Volume Payment-3	0	0	70.98	
70.99	HAC adjustment amount (see instructions)		18,360	70.99	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		12,018,481	71.00	
71.01	Sequestration adjustment (see instructions)		240,370	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		10,763,778	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)		1,014,333	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		225,358	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	100.00	
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00	
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00	
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	103.00	
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		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	
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00	
213.00	Low-volume adjustment (see instructions)			213.00	
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 31-0040	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/31/2024 12:06 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		19,926	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		4,775,656	2.00
3.00	OPPS or REH payments		3,151,621	3.00
4.00	Outlier payment (see instructions)		521,942	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)		19,926	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		74,853	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)		74,853	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 charge basis 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)		74,853	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		54,927	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)		19,926	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)		3,673,563	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)		612,785	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)		3,080,704	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		423,472	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)		3,504,176	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		3,504,176	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		3,504,176	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	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)		3,504,176	40.00
40.01	Sequestration adjustment (see instructions)		70,084	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00	Interim payments		2,999,558	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)		434,534	43.00
43.01	Balance due provider/program-PARHM (see instructions)			43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 31-0040	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/31/2024 12:06 pm	
		Title XVIII	Hospital	PPS	
				1.00	
94.00	Total (sum of lines 91 and 93)			0	94.00
				1.00	
200.00	MEDICARE PART B ANCILLARY COSTS Part B Combined Billed Days			0	200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023Worksheet E-1
Part I
Date/Time Prepared:
5/31/2024 12:06 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		10,668,241		2,999,558	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	08/23/2023	95,537		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)		95,537		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)		10,763,778		2,999,558	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		1,014,333		434,534	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		11,778,111		3,434,092	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 31-0040

Period:

Worksheet E-1

Component CCN: 31-S040

From 01/01/2023

Part I

To 12/31/2023

Date/Time Prepared:

5/31/2024 12:06 pm

Title XVIII

Subprovider -

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				0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1,751,829		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,751,829		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,751,829		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

 Provider CCN: 31-0040
 Component CCN: 31-5512

 Period:
 From 01/01/2023
 To 12/31/2023

 Worksheet E-1
 Part I
 Date/Time Prepared:
 5/31/2024 12:06 pm

		Title XVIII		Skilled Nursing Facility		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider				0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1,387,149		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,387,149		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,387,149		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023Worksheet E-1
Part II
Date/Time Prepared:
5/31/2024 12:06 pm

Title XVIII

Hospital

PPS

1.00

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 31-0040 Component CCN: 31-S040	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part II Date/Time Prepared: 5/31/2024 12:06 pm
		Title XVIII	Subprovider - IPF	PPS
		1.00		
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		1,942,975	1.00
2.00	Net IPF PPS Outlier Payments		11,718	2.00
3.00	Net IPF PPS ECT Payments		0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		30.728767	9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1)\}$.		0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		1,954,693	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		0	14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00
16.00	Subtotal (see instructions)		1,954,693	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		1,954,693	18.00
19.00	Deductibles		94,312	19.00
20.00	Subtotal (line 18 minus line 19)		1,860,381	20.00
21.00	Coinurance		72,800	21.00
22.00	Subtotal (line 20 minus line 21)		1,787,581	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	25.00
26.00	Subtotal (sum of lines 22 and 24)		1,787,581	26.00
27.00	Direct graduate medical education payments (see instructions)		0	27.00
28.00	Other pass through costs (see instructions)		0	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	30.50
30.98	Recovery of accelerated depreciation.		0	30.98
30.99	Demonstration payment adjustment amount before sequestration		0	30.99
31.00	Total amount payable to the provider (see instructions)		1,787,581	31.00
31.01	Sequestration adjustment (see instructions)		35,752	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	31.02
32.00	Interim payments		1,751,829	32.00
33.00	Tentative settlement (for contractor use only)		0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)		0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		11,718	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00
FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)				
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.		0.000000	99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)		0.000000	99.01

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 31-0040 Component CCN: 31-5512	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VI Date/Time Prepared: 5/31/2024 12:06 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES			
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)			
1.00	Resource Utilization Group Payment (RUGS)			1,470,242 1.00
2.00	Routine service other pass through costs			0 2.00
3.00	Ancillary service other pass through costs			0 3.00
4.00	Subtotal (sum of lines 1 through 3)			1,470,242 4.00
	COMPUTATION OF NET COST OF COVERED SERVICES			
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible			0 6.00
7.00	Coinsurance			54,784 7.00
8.00	Allowable bad debts (see instructions)			0 8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0 9.00
10.00	Adjusted reimbursable bad debts (see instructions)			0 10.00
11.00	Utilization review			0 11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)			1,415,458 12.00
13.00	Inpatient primary payer payments			0 13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 14.50
14.98	Recovery of accelerated depreciation.			0 14.98
14.99	Demonstration payment adjustment amount before sequestration			0 14.99
15.00	Subtotal (see instructions)			1,415,458 15.00
15.01	Sequestration adjustment (see instructions)			28,309 15.01
15.02	Demonstration payment adjustment amount after sequestration			0 15.02
15.75	Sequestration for non-claims based amounts (see instructions)			0 15.75
16.00	Interim payments			1,387,149 16.00
17.00	Tentative settlement (for contractor use only)			0 17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)			0 18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2			0 19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 31-0040	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/31/2024 12:06 pm	
		Title XIX	Hospital	TEFRA	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services	1,379,912			1.00
2.00	Medical and other services			669,405	2.00
3.00	Organ acquisition (certified transplant programs only)	0			3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	1,379,912		669,405	4.00
5.00	Inpatient primary payer payments	0			5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	1,379,912		669,405	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges	14,710,000			8.00
9.00	Ancillary service charges	15,202,803		21,603,691	9.00
10.00	Organ acquisition charges, net of revenue	0			10.00
11.00	Incentive from target amount computation	0			11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	29,912,803		21,603,691	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0		0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0		0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000		0.000000	15.00
16.00	Total customary charges (see instructions)	29,912,803		21,603,691	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	28,532,891		20,934,286	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0		0	18.00
19.00	Interns and Residents (see instructions)	0		0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	1,379,912		669,405	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments	0		0	22.00
23.00	Outlier payments	0		0	23.00
24.00	Program capital payments	0			24.00
25.00	Capital exception payments (see instructions)	0			25.00
26.00	Routine and Ancillary service other pass through costs	0		0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0		0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	1,379,912		669,405	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)	0		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	1,379,912		669,405	31.00
32.00	Deductibles	0		0	32.00
33.00	Coinurance	0		0	33.00
34.00	Allowable bad debts (see instructions)	0		0	34.00
35.00	Utilization review	0			35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	1,379,912		669,405	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		0	37.00
38.00	Subtotal (line 36 ± line 37)	1,379,912		669,405	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0			39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	1,379,912		669,405	40.00
41.00	Interim payments	1,291,625		682,561	41.00
42.00	Balance due provider/program (line 40 minus line 41)	88,287		-13,156	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0		0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 31-0040 Component CCN: 31-S040	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/31/2024 12:06 pm
		Title XIX	Subprovider - IPF	TEFRA
		Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	599,702		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	599,702	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	599,702	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	6,138,000		8.00
9.00	Ancillary service charges	1,428,956	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	28,674		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	7,595,630	0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	7,595,630	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	6,995,928	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	599,702	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	599,702	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	599,702	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	599,702	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	599,702	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	599,702	0	40.00
41.00	Interim payments	609,026	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-9,324	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 31-0040		Period: From 01/01/2023 To 12/31/2023		Worksheet E-4 Date/Time Prepared: 5/31/2024 12:06 pm	
		Title XVIII		Hospital		PPS	
						1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT							
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			21.40	1.00		
1.01	FTE cap adjustment under §131 of the CAA 2021 (see instructions)			0.00	1.01		
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00		
2.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)			0.00	2.26		
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			1.92	3.00		
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01		
3.02	Adjustment (increase or decrease) to the hospital's rural track FTE limitation(s) for rural track programs with a rural track Medicare GME affiliation agreement in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)			0.00	3.02		
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00		
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01		
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02		
4.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)			0.00	4.21		
5.00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lines 2.26 through 2.49, minus lines 3 and 3.01, plus or minus line 3.02, plus or minus line 4, plus lines 4.01 through 4.27)			19.48	5.00		
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			26.07	6.00		
7.00	Enter the lesser of line 5 or line 6			19.48	7.00		
		Primary Care	Other	Total			
		1.00	2.00	3.00			
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	21.57	4.24	25.81	8.00		
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6. For cost reporting periods beginning on or after October 1, 2022, or if Worksheet S-2, Part I, line 68, is "Y", see instructions.	16.28	3.20	19.48	9.00		
10.00	Weighted dental and podiatric resident FTE count for the current year		11.00		10.00		
10.01	Unweighted dental and podiatric resident FTE count for the current year		11.00		10.01		
11.00	Total weighted FTE count	16.28	14.20		11.00		
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	17.27	13.65		12.00		
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	17.27	14.24		13.00		
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	16.94	14.03		14.00		
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00		
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01		
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00		
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01		
17.00	Adjusted rolling average FTE count	16.94	14.03		17.00		
18.00	Per resident amount	195,619.29	185,234.21		18.00		
18.01	Per resident amount under §131 of the CAA 2021	0.00	0.00		18.01		
19.00	Approved amount for resident costs	3,313,791	2,598,836	5,912,627	19.00		
				1.00			
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00		
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			6.59	21.00		
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00		
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00		
24.00	Multiply line 22 time line 23			0	24.00		
25.00	Total direct GME amount (sum of lines 19 and 24)			5,912,627	25.00		

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 31-0040	Period: From 01/01/2023 To 12/31/2023	Worksheet E-4 Date/Time Prepared: 5/31/2024 12:06 pm	
		Title XVIII	Hospital	PPS	
		Inpatient Part A	Managed Care	Total	
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	3,949	4,228		26.00
27.00	Total Inpatient Days (see instructions)	26,375	26,375		27.00
28.00	Ratio of inpatient days to total inpatient days	0.149725	0.160303		28.00
29.00	Program direct GME amount	885,268	947,812	1,833,080	29.00
29.01	Percent reduction for MA DGME		3.27		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		30,993	30,993	30.00
31.00	Net Program direct GME amount			1,802,087	31.00
				1.00	
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS)					
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			588,366	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY					
Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)			15,612,004	37.00
38.00	Organ acquisition and HSCT acquisition costs (see instructions)			0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)			0	39.00
40.00	Primary payer payments (see instructions)			0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			15,612,004	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			4,795,582	42.00
43.00	Primary payer payments (see instructions)			0	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			4,795,582	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			20,407,586	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.765010	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.234990	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			1,802,087	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			1,378,615	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			423,472	50.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT		Provider CCN: 31-0040	Period: From 01/01/2023 To 12/31/2023	Worksheet E-5 Date/Time Prepared: 5/31/2024 12:06 pm
		Title XVIII		PPS
				1.00
TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)			0 1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2			0 2.00
3.00	Operating outlier reconciliation adjustment amount (see instructions)			0 3.00
4.00	Capital outlier reconciliation adjustment amount (see instructions)			0 4.00
5.00	The rate used to calculate the time value of money (see instructions)			0.00 5.00
6.00	Time value of money for operating expenses (see instructions)			0 6.00
7.00	Time value of money for capital related expenses (see instructions)			0 7.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023

Worksheet G

Date/Time Prepared:
5/31/2024 12:06 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	998,000	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	45,587,000	0	0	0	4.00
5.00	Other receivable	214,000	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,934,000	0	0	0	7.00
8.00	Prepaid expenses	1,212,000	0	0	0	8.00
9.00	Other current assets	38,156,000	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)	89,101,000	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	58,147,262	0	0	0	15.00
16.00	Accumulated depreciation	-51,716,879	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	36,688,057	0	0	0	23.00
24.00	Accumulated depreciation	-32,538,440	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	10,580,000	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	28,567,000	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	28,567,000	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	128,248,000	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	39,202,000	0	0	0	37.00
38.00	Salaries, wages, and fees payable	7,100,000	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	32,045,000	0	0	0	40.00
41.00	Deferred income	5,488,000	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	13,331,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	97,166,000	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	11,453,000	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	6,715,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	18,168,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	115,334,000	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	12,914,000				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)	12,914,000	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	128,248,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023

Worksheet G-1

Date/Time Prepared:
5/31/2024 12:06 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		26,648,000		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-13,734,000				2.00
3.00	Total (sum of line 1 and line 2)		12,914,000		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		12,914,000		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		12,914,000		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023Worksheet G-2
Parts I & II
Date/Time Prepared:
5/31/2024 12:06 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	285,748,031		285,748,031	1.00
2.00	SUBPROVIDER - IPF	198,918,000		198,918,000	2.00
3.00	SUBPROVIDER - IRF	0		0	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	67,788,000		67,788,000	7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE	0		0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	552,454,031		552,454,031	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	27,526,000		27,526,000	11.00
12.00	CORONARY CARE UNIT	0		0	12.00
13.00	BURN INTENSIVE CARE UNIT	0		0	13.00
14.00	SURGICAL INTENSIVE CARE UNIT	0		0	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	27,526,000		27,526,000	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	579,980,031		579,980,031	17.00
18.00	Ancillary services	499,136,985	555,692,089	1,054,829,074	18.00
19.00	Outpatient services	0	883,328,469	883,328,469	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC		0	0	24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	25.00
26.00	HOSPICE	0	0	0	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	1,079,117,016	1,439,020,558	2,518,137,574	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		186,738,738		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)		186,738,738		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 31-0040

Period:
From 01/01/2023
To 12/31/2023

Worksheet G-3

Date/Time Prepared:
5/31/2024 12:06 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	2,518,137,574	1.00
2.00	Less contractual allowances and discounts on patients' accounts	2,384,731,836	2.00
3.00	Net patient revenues (line 1 minus line 2)	133,405,738	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	186,738,738	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-53,333,000	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	6,338,658	24.00
24.01	STATE SUBSIDIES	21,526,396	24.01
24.02	COVID PHE FUNDING	11,733,946	24.02
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	39,599,000	25.00
26.00	Total (line 5 plus line 25)	-13,734,000	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)	-13,734,000	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 31-0040	Period: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III Date/Time Prepared: 5/31/2024 12:06 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		397,189	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		773	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)		41.53	3.00
4.00	Number of interns & residents (see instructions)		32.40	4.00
5.00	Indirect medical education percentage (see instructions)		24.63	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)		97,828	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		18.67	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		28.56	8.00
9.00	Sum of lines 7 and 8		47.23	9.00
10.00	Allowable disproportionate share percentage (see instructions)		10.03	10.00
11.00	Disproportionate share adjustment (see instructions)		39,838	11.00
12.00	Total prospective capital payments (see instructions)		535,628	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