

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: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/20/2024 2:35 pm
--	-----------------------	---------------------------------------	---

PART I - COST REPORT STATUS

Provider use only 1. Electronically prepared cost report use only 2. Manually prepared cost report 3. If this is an amended report enter the number of times the provider resubmitted this cost report 4. Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only 5. 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. Initial Report for this Provider CCN 9. Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Date: 5/20/2024 Time: 2:35 pm

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY MEDICAL CENTER (31-0041) 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 Henwood	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 Henwood		2
3	Signatory Title	VP CORPORATE REIMBURSEMENT		3
4	Date	(Dated when report is electronic)		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	-3,385,599	2,357,720	0	-2,207,305	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	1,045	-868		0	7.00
200.00	TOTAL	0	-3,384,554	2,356,852	0	-2,207,305	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 31-0041		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/20/2024 2:35 pm				
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 99 ROUTE 37S	PO Box:						1.00		
2.00	City: TOMS RIVER	State: NJ	Zip Code: 08755-6423	County: OCEAN				2.00		
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	COMMUNITY MEDICAL CENTER	310041	35154	1	07/01/1967	N	P	T	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	COMMUNITY MEDICAL CENTER	315490	35154		02/10/2005	N	P	O	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2023	12/31/2023		20.00	
21.00	Type of Control (see instructions)					2			21.00	
						1.00	2.00	3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.				N	N		22.00		
22.01	Did this hospital receive interim UCPS, including supplemental UCPS, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				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)				N	N		22.03		
22.04	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		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.				1	Y		23.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 31-0041		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/20/2024 2:35 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.	1,290	905	61	134	10,355	210	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	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	
						Beginni ng:	Endi ng:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00	
						V	XVII I	XI X	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 412.320? (see instructions)					N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR 412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teachi ng Hospi tal s									
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 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		56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.					Y			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 31-0041		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/20/2024 2:35 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.	Y	Y			60.00	
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1		60.01	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00		61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00		61.20
							1.00
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 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) Teaching Hospitals that Claim Residents in Nonprovider Settings					0.00	62.01
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: 31-0041		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/20/2024 2:35 pm		
			Unweighted FTEs Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))			
			1.00	2.00	3.00			
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.								
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		64.00	
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))		
		1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00	
			Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))			
			1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010								
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.62	39.39	0.015496		66.00	
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	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)	INTERNAL MEDICINE	1400	0.38	28.35	0.013227	67.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/20/2024 2:35 pm	
			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.			N	70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0
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
			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
			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
			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
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
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
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
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	Y
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	10.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	Y
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00	5.80

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/20/2024 2:35 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.	N	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	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.				109.00
				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00
				1.00	2.00
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.		N		111.00
				1.00	2.00
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: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/20/2024 2:35 pm
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	4,256,575	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
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y	121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.		N	122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.		Y	N
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	H53560
		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: RWJBARNABAS HEALTH	Contractor's Name: NOVITAS SOLUTIONS		Contractor's Number: 12001
142.00	Street: 95 OLD SHORT HILLS ROAD	PO Box:		
143.00	City: WEST ORANGE	State: NJ	Zip Code:	07052
			1.00	
144.00	Are provider based physicians' costs included in Worksheet A?		Y	144.00
		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N	146.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 31-0041		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/20/2024 2:35 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	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	N	157.00	
158.00	SUBPROVIDER						158.00	
159.00	SNF	N	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00	
161.00	CMHC		N	N	N	N	161.00	
1.00								
Multi campus								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00
1.00								
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00
		Beginning	Ending					
		1.00	2.00					
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							170.00
		1.00	2.00					
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, 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	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 31-0041		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part II Date/Time Prepared: 5/20/2024 2:35 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	04/30/2022			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N			Legal Oper.		
		1.00			2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.				Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.				N		13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.				N		14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.				N		15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/03/2023	Y	04/03/2023		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 31-0041

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

Worksheet S-2
Part II
Date/Time Prepared:
5/20/2024 2:35 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			N	N	21.00
					1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)						
Capital Related Cost						
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions					22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.					23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions					24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.					25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.					26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.					27.00
Interest Expense						
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.					28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions					29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.					30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					31.00
Purchased Services						
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.					32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
Provider-Based Physicians						
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.					34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.					35.00
				Y/N	Date	
				1.00	2.00	
Home Office Costs						
36.00	Were home office costs claimed on the cost report?					36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					40.00
				1.00	2.00	
Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RI CHARD		HENWOOD		41.00
42.00	Enter the employer/company name of the cost report preparer.	RWJBARNABAS HEALTH				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	732-923-8074		RI CH. HENWOOD@RWJBH. ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 31-0041

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

Worksheet S-2
Part II
Date/Time Prepared:
5/20/2024 2:35 pm

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	VP OF CORPORATE 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: 31-0041

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

Worksheet S-3
Part I
Date/Time Prepared:
5/20/2024 2:35 pm

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	235	85,775	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)		235	85,775	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	163	59,495	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT	34.00	12	4,380	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)		410	149,650	0.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	25	9,125		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		435				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 31-0041

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

Worksheet S-3
Part I
Date/Time Prepared:
5/20/2024 2:35 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	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)	46,606	565	65,794		1.00
2.00	HMO and other (see instructions)	35,524	12,002			2.00
3.00	HMO IPF Subprovider	0	0			3.00
4.00	HMO IRF Subprovider	0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	46,606	565	65,794		7.00
8.00	INTENSIVE CARE UNIT	2,974	574	48,180		8.00
9.00	CORONARY CARE UNIT					9.00
10.00	BURN INTENSIVE CARE UNIT					10.00
11.00	SURGICAL INTENSIVE CARE UNIT	1,541	0	3,566		11.00
12.00	OTHER SPECIAL CARE (SPECIFY)					12.00
13.00	NURSERY		1,829	3,946		13.00
14.00	Total (see instructions)	51,121	2,968	121,486	68.74	1,986.05
15.00	CAH visits	0	0	0		15.00
15.10	REH hours and visits	0	0	0		15.10
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF					17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY	3,680	0	5,975	0.00	34.26
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE					21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE					24.00
24.10	HOSPICE (non-distinct part)			0		24.10
25.00	CMHC - CMHC					25.00
26.00	RURAL HEALTH CLINIC					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00
27.00	Total (sum of lines 14-26)				68.74	2,020.31
28.00	Observation Bed Days		0	371		28.00
29.00	Ambulance Trips	0				29.00
30.00	Employee discount days (see instruction)			1,221		30.00
31.00	Employee discount days - IRF			0		31.00
32.00	Labor & delivery days (see instructions)	0	10	1,027		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: 31-0041

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

Worksheet S-3
Part I
Date/Time Prepared:
5/20/2024 2:35 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
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	8,344	276	23,416	1.00
2.00	HMO and other (see instructions)			5,541	3,528		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	8,344	276	23,416	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 31-0041

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

Worksheet S-3
Part II
Date/Time Prepared:
5/20/2024 2:35 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	187,928,710	-3,835,139	184,093,571	4,202,261.02	43.81
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		76,708	0	76,708	359.00	213.67
4.01	Physicians - Part A - Teaching		286,791	0	286,791	1,094.00	262.15
5.00	Physician and Non-Physician-Part B		1,189,300	0	1,189,300	2,080.00	571.78
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	0	5,721,009	5,721,009	159,262.00	35.92
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	3,487,887	-65,790	3,422,097	71,263.48	48.02
10.00	Excluded area salaries (see instructions)		387,769	414,656	802,425	21,771.06	36.86
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		6,993,017	0	6,993,017	59,819.00	116.90
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		0	0	0	0.00	0.00
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		31,916,903	0	31,916,903	448,369.27	71.18
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)		49,385,102	0	49,385,102		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		260,318	0	260,318		
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		1,237	0	1,237		
22.01	Physician Part A - Teaching		3,770	0	3,770		
23.00	Physician Part B		47,324	0	47,324		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		548,865	0	548,865		
25.50	Home office wage-related (core)		5,923,545	0	5,923,545		
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: 31-0041

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

Worksheet S-3
Part II
Date/Time Prepared:
5/20/2024 2:35 pm

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)	0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	695,755	0	695,755	17,889.40	38.89	26.00
27.00	Administrative & General	13,808,060	-2,604,781	11,203,279	212,828.37	52.64	27.00
28.00	Administrative & General under contract (see inst.)	2,430,831	0	2,430,831	9,798.00	248.09	28.00
29.00	Maintenance & Repairs	184,550	0	184,550	4,170.29	44.25	29.00
30.00	Operation of Plant	4,119,192	0	4,119,192	141,551.32	29.10	30.00
31.00	Laundry & Linen Service	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	3,614,617	0	3,614,617	182,230.12	19.84	32.00
33.00	Housekeeping under contract (see instructions)	0	0	0	0.00	0.00	33.00
34.00	Dietary	3,550,061	-1,424,832	2,125,229	94,035.51	22.60	34.00
35.00	Dietary under contract (see instructions)	0	0	0	0.00	0.00	35.00
36.00	Cafeteria	0	1,424,832	1,424,832	60,147.00	23.69	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	4,388,809	-8,624	4,380,185	68,942.59	63.53	38.00
39.00	Central Services and Supply	2,060,682	0	2,060,682	74,557.25	27.64	39.00
40.00	Pharmacy	6,212,705	-61,090	6,151,615	126,378.44	48.68	40.00
41.00	Medical Records & Medical Records Library	1,284,573	-37,283	1,247,290	40,455.54	30.83	41.00
42.00	Social Service	3,014,899	-535	3,014,364	62,625.83	48.13	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 31-0041

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

Worksheet S-3
Part III
Date/Time Prepared:
5/20/2024 2:35 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on 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)	188,883,450	-9,556,148	179,327,302	4,049,623.02	44.28	1.00
2.00	Excluded area salaries (see instructions)	3,875,656	348,866	4,224,522	93,034.54	45.41	2.00
3.00	Subtotal salaries (line 1 minus line 2)	185,007,794	-9,905,014	175,102,780	3,956,588.48	44.26	3.00
4.00	Subtotal other wages & related costs (see inst.)	38,909,920	0	38,909,920	508,188.27	76.57	4.00
5.00	Subtotal wage-related costs (see inst.)	55,309,884	0	55,309,884	0.00	31.59	5.00
6.00	Total (sum of lines 3 thru 5)	279,227,598	-9,905,014	269,322,584	4,464,776.75	60.32	6.00
7.00	Total overhead cost (see instructions)	45,364,734	-2,712,313	42,652,421	1,095,609.66	38.93	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part IV Date/Time Prepared: 5/20/2024 2:35 pm
-----------------------------	-----------------------	---	--

			Amount Reported	
			1.00	
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		7,654,715	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		304,253	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		740,640	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		1,868,710	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		22,660,694	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		413,736	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		116,116	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)		796,176	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		225,491	14.00
15.00	'Workers' Compensation Insurance		1,376,029	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		11,452,240	17.00
18.00	Medicare Taxes - Employers Portion Only		1,968,665	18.00
19.00	Unemployment Insurance		265,170	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		403,981	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		50,246,616	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: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part V Date/Time Prepared: 5/20/2024 2:35 pm
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	6,993,017	50,246,616	1.00
2.00	Hospital	6,993,017	50,246,616	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY	0	0	8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/20/2024 2:35 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)			0.178216	1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			41,128,401	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			N	4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			3,296,836	5.00	
6.00	Medicaid charges			321,415,593	6.00	
7.00	Medicaid cost (line 1 times line 6)			57,281,401	7.00	
8.00	Difference between net revenue and costs for Medicaid program (see instructions)			12,856,164	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)			129,636	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			3,718,058	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)			662,617	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)			532,981	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)			13,389,145	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)	59,929,636	873,201	60,802,837	20.00	
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	10,680,420	873,201	11,553,621	21.00	
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00	
23.00	Cost of charity care (see instructions)	10,680,420	873,201	11,553,621	23.00	
				1.00		
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00	
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00	
25.01	Charges for insured patients' liability (see instructions)			0	25.01	
26.00	Bad debt amount (see instructions)			22,649,391	26.00	
27.00	Medicare reimbursable bad debts (see instructions)			1,227,629	27.00	
27.01	Medicare allowable bad debts (see instructions)			1,888,661	27.01	
28.00	Non-Medicare bad debt amount (see instructions)			20,760,730	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)			4,360,926	29.00	
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)			15,914,547	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			29,303,692	31.00	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/20/2024 2:35 pm
---	-----------------------	---	--

				1.00	
PART II - HOSPITAL DATA					
Uncompensated and Indigent Care Cost-to-Charge Ratio					
1.00	Cost to charge ratio (see instructions)			0.176515	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)	59,929,636	848,781	60,778,417	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	10,578,480	848,781	11,427,261	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (see instructions)	10,578,480	848,781	11,427,261	23.00
				1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
25.01	Charges for insured patients' liability (see instructions)			0	25.01
26.00	Bad debt amount (see instructions)			22,631,422	26.00
27.00	Medicare reimbursable bad debts (see instructions)			1,227,629	27.00
27.01	Medicare allowable bad debts (see instructions)			1,888,661	27.01
28.00	Non-Medicare bad debt amount (see instructions)			20,742,761	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)			4,322,440	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)			15,749,701	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			15,749,701	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 31-0041		Period: From 01/01/2023 To 12/31/2023		Worksheet A	
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassified (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		11,111,968	11,111,968	2,698,092	13,810,060	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		9,350,753	9,350,753	2,238,141	11,588,894	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	695,755	30,451,424	31,147,179	2,758,710	33,905,889	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,808,060	117,953,944	131,762,004	-2,016,463	129,745,541	5.00
6.00	00600	MAINTENANCE & REPAIRS	184,550	517,619	702,169	-3,125	699,044	6.00
7.00	00700	OPERATION OF PLANT	4,119,192	8,919,747	13,038,939	-2,145	13,036,794	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	1,219,806	1,219,806	8.00
9.00	00900	HOUSEKEEPING	3,614,617	1,871,181	5,485,798	-86,371	5,399,427	9.00
10.00	01000	DIETARY	3,550,061	3,548,778	7,098,839	-2,860,376	4,238,463	10.00
11.00	01100	CAFETERIA	0	0	0	2,834,675	2,834,675	11.00
13.00	01300	NURSING ADMINISTRATION	4,388,809	469,675	4,858,484	-5,362	4,853,122	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,060,682	2,927,237	4,987,919	-863,638	4,124,281	14.00
15.00	01500	PHARMACY	6,212,705	42,420,665	48,633,370	-42,314,506	6,318,864	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,284,573	438,405	1,722,978	0	1,722,978	16.00
17.00	01700	SOCIAL SERVICE	3,014,899	1,627,691	4,642,590	-67,060	4,575,530	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	5,721,009	5,721,009	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	8,002,429	3,224,551	11,226,980	-7,077,639	4,149,341	22.00
23.00	02300	PARAMED PRGM-(SPECIFY)	145,626	36,366	181,992	61,090	243,082	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	36,403,561	8,985,683	45,389,244	-4,028,116	41,361,128	30.00
31.00	03100	INTENSIVE CARE UNIT	26,167,945	3,727,737	29,895,682	-1,960,283	27,935,399	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	3,396,175	760,622	4,156,797	-308,134	3,848,663	34.00
43.00	04300	NURSERY	1,085,622	3,608	1,089,230	2,147,491	3,236,721	43.00
44.00	04400	SKILLED NURSING FACILITY	3,487,887	1,565,110	5,052,997	-975,094	4,077,903	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	10,547,721	26,444,649	36,992,370	-23,170,681	13,821,689	50.00
51.00	05100	RECOVERY ROOM	1,689,446	107,252	1,796,698	-78,477	1,718,221	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,730,136	533,562	4,263,698	-631,550	3,632,148	52.00
52.01	03190	OP INFUSION	1,773,232	259,491	2,032,723	-215,237	1,817,486	52.01
53.00	05300	ANESTHESIOLOGY	104,849	1,549,226	1,654,075	-547,124	1,106,951	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,149,373	5,797,183	12,946,556	-2,547,602	10,398,954	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,730,885	2,418,289	6,149,174	661,146	6,810,320	55.00
56.00	05600	RADIOISOTOPE	553,685	927,599	1,481,284	50,414	1,531,698	56.00
57.00	05700	CT SCAN	2,112,862	979,724	3,092,586	-126,398	2,966,188	57.00
58.00	05800	MRI	866,659	247,218	1,113,877	-26,765	1,087,112	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,572,256	7,230,706	10,802,962	-6,596,461	4,206,501	59.00
60.00	06000	LABORATORY	30,084	19,143,087	19,173,171	125,680	19,298,851	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	3,588,477	1,287,671	4,876,148	-471,610	4,404,538	65.00
66.00	06600	PHYSICAL THERAPY	2,226,821	111,046	2,337,867	273,153	2,611,020	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,186,702	1,536	1,188,238	0	1,188,238	67.00
68.00	06800	SPEECH PATHOLOGY	339,797	2,210	342,007	0	342,007	68.00
69.00	06900	ELECTROCARDIOLOGY	2,431,549	1,396,670	3,828,219	-37,773	3,790,446	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,265,661	525,260	1,790,921	-35,322	1,755,599	70.00
70.01	07001	SLEEP LAB	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	20,617,901	20,617,901	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	18,871,711	18,871,711	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	44,840,108	44,840,108	73.00
76.97	07697	CARDIAC REHABILITATION	622,329	28,100	650,429	-4,309	646,120	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	314,307	314,307	-16,016	298,291	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CART-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	177,999	1,158,041	1,336,040	-497,424	838,616	90.00
91.00	09100	EMERGENCY	14,491,324	8,928,990	23,420,314	-2,469,794	20,950,520	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	3,871,572	800,523	4,672,095	-283,139	4,388,956	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	1,120,361	1,120,361	0	1,120,361	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		4,794,960	4,794,960	-4,794,960	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	187,686,567	336,020,425	523,706,992	173	523,707,165	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	MISCELLANEOUS	0	0	0	0	0	194.00
194.01	07951	PUBLIC RELATIONS	0	384	384	0	384	194.01
194.03	07952	LIGHTHOUSE	46,922	160	47,082	0	47,082	194.03
194.04	07953	KIDS & FAMILY	0	0	0	0	0	194.04
194.05	07954	OTHER NON REIMBURABLE	194,375	55,989	250,364	-173	250,191	194.05
194.06	07955	GRANTS/TRIALS	846	512	1,358	0	1,358	194.06

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 31-0041		Period: From 01/01/2023 To 12/31/2023		Worksheet A Date/Time Prepared: 5/20/2024 2:35 pm	
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
194.07	07956	RETAIL PHARMACY	0	0	0	0	0	194.07
200.00		TOTAL (SUM OF LINES 118 through 199)	187,928,710	336,077,470	524,006,180	0	524,006,180	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 31-0041

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

Worksheet A
Date/Time Prepared:
5/20/2024 2: 35 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	-837,233	12,972,827	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-704,534	10,884,360	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,813,043	35,718,932	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-26,682,713	103,062,828	5.00
6.00	00600	MAINTENANCE & REPAIRS	-17,946	681,098	6.00
7.00	00700	OPERATION OF PLANT	-115,734	12,921,060	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,219,806	8.00
9.00	00900	HOUSEKEEPING	-671	5,398,756	9.00
10.00	01000	DIETARY	-21,122	4,217,341	10.00
11.00	01100	CAFETERIA	-1,380,090	1,454,585	11.00
13.00	01300	NURSING ADMINISTRATION	-70,301	4,782,821	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-210,333	3,913,948	14.00
15.00	01500	PHARMACY	-1,989	6,316,875	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-682	1,722,296	16.00
17.00	01700	SOCIAL SERVICE	-29,629	4,545,901	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	5,721,009	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	-39,739	4,109,602	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	-685	242,397	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-3,094,693	38,266,435	30.00
31.00	03100	INTENSIVE CARE UNIT	-59,708	27,875,691	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	-437	3,848,226	34.00
43.00	04300	NURSERY	-474	3,236,247	43.00
44.00	04400	SKILLED NURSING FACILITY	-7,590	4,070,313	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-131,417	13,690,272	50.00
51.00	05100	RECOVERY ROOM	-1,114	1,717,107	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-4,835	3,627,313	52.00
52.01	03190	OP INFUSION	-6,102	1,811,384	52.01
53.00	05300	ANESTHESIOLOGY	-986,955	119,996	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-2,006,158	8,392,796	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-292,234	6,518,086	55.00
56.00	05600	RADIOISOTOPE	-209	1,531,489	56.00
57.00	05700	CT SCAN	-2,653	2,963,535	57.00
58.00	05800	MRI	-8,557	1,078,555	58.00
59.00	05900	CARDIAC CATHETERIZATION	-89,231	4,117,270	59.00
60.00	06000	LABORATORY	-877,154	18,421,697	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	-62,542	4,341,996	65.00
66.00	06600	PHYSICAL THERAPY	-22,184	2,588,836	66.00
67.00	06700	OCCUPATIONAL THERAPY	-1,443	1,186,795	67.00
68.00	06800	SPEECH PATHOLOGY	-1,723	340,284	68.00
69.00	06900	ELECTROCARDIOLOGY	-17,384	3,773,062	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-406,769	1,348,830	70.00
70.01	07001	SLEEP LAB	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-864	20,617,037	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	-1,294	18,870,417	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-2,825	44,837,283	73.00
76.97	07697	CARDIAC REHABILITATION	-5,734	640,386	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	298,291	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	78.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-28,274	810,342	90.00
91.00	09100	EMERGENCY	-2,550,006	18,400,514	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	-10,807	4,378,149	92.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	20,156	1,140,517	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-38,961,572	484,745,593	118.00
NONREIMBURSABLE COST CENTERS					
194.00	07950	MISCELLANEOUS	0	0	194.00
194.01	07951	PUBLIC RELATIONS	0	384	194.01
194.03	07952	LIGHTHOUSE	0	47,082	194.03
194.04	07953	KIDS & FAMILY	0	0	194.04
194.05	07954	OTHER NON REIMBURABLE	0	250,191	194.05
194.06	07955	GRANTS/TRIALS	0	1,358	194.06
194.07	07956	RETAIL PHARMACY	0	0	194.07
200.00		TOTAL (SUM OF LINES 118 through 199)	-38,961,572	485,044,608	200.00

RECLASSIFICATIONS

Provider CCN: 31-0041

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

Worksheet A-6

Date/Time Prepared:
5/20/2024 2:35 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - MEDICAL SURGICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	20,617,901	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	208	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
0			0	20,618,109	
B - IMPLANTABLES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	18,871,711	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
0			0	18,871,711	
C - DRUGS AND IV SOLUTIONS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	44,840,108	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	52,160	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

RECLASSIFICATIONS

Provider CCN: 31-0041

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

Worksheet A-6

Date/Time Prepared:
5/20/2024 2:35 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
	0		0	44,892,268	
D - BLOOD					
1.00	LABORATORY	60.00	0	125,191	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	26	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
	0		0	125,217	
E - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,603,830	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,191,130	2.00
	0		0	4,794,960	
F - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	94,262	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	47,011	2.00
	0		0	141,273	
G - RADIOLOGY RNS					
1.00	RADIOLOGY-THERAPEUTIC	55.00	594,234	4,203	1.00
2.00	RADIOISOTOPE	56.00	61,274	433	2.00
	0		655,508	4,636	
H - DIETARY					
1.00	CAFETERIA	11.00	1,424,832	1,409,843	1.00
	0		1,424,832	1,409,843	
J - LINEN					
1.00	LAUNDRY & LINEN SERVICE	8.00		1,219,806	1.00
2.00	PHARMACY	15.00		34	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
	0		0	1,219,840	
K - MOTHER BABY					
1.00	NURSERY	43.00	1,923,024	225,234	1.00
	0		1,923,024	225,234	
M - MALPRACTICE					
1.00	SKILLED NURSING FACILITY	44.00	0	10,817	1.00
2.00	RADIOLOGY-THERAPEUTIC	55.00	0	53,704	2.00
3.00	CARDIAC CATHETERIZATION	59.00	0	13,327	3.00
4.00	RESPIRATORY THERAPY	65.00	0	19,072	4.00
5.00	ELECTROCARDIOLOGY	69.00	0	18,174	5.00
	0		0	115,094	

RECLASSIFICATIONS

Provider CCN: 31-0041

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

Worksheet A-6
Date/Time Prepared:
5/20/2024 2:35 pm

		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
N - BENEFITS DIRECTLY ASSIGNED						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,764,269	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
	0		0	2,764,269		
O - TRANSPORT						
1.00	ADULTS & PEDIATRICS	30.00	323,583	3,974	1.00	
2.00	INTENSIVE CARE UNIT	31.00	240,671	2,956	2.00	
3.00	SURGICAL INTENSIVE CARE UNIT	34.00	18,407	226	3.00	
4.00	OPERATING ROOM	50.00	16,131	198	4.00	
5.00	DELIVERY ROOM & LABOR ROOM	52.00	8,223	101	5.00	
6.00	RADIOLOGY-THERAPEUTIC	55.00	40,033	492	6.00	
7.00	CARDIAC CATHETERIZATION	59.00	5,063	62	7.00	
8.00	PHYSICAL THERAPY	66.00	306,510	3,764	8.00	
9.00	ELECTROCARDIOLOGY	69.00	237,688	2,919	9.00	
10.00	ELECTROENCEPHALOGRAPHY	70.00	8,811	108	10.00	
11.00	EMERGENCY	91.00	88,996	1,093	11.00	
	0		1,294,116	15,893		
R - PHARMACY RESIDENTS						
1.00	PARAMED ED PRGM-(SPECFY)	23.00	61,090	0	1.00	
	0		61,090	0		
W - WAGE INDEX						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,310,665	1.00	
2.00	NURSING ADMINISTRATION	13.00	0	8,624	2.00	
3.00	MEDICAL RECORDS & LIBRARY	16.00	0	37,283	3.00	
4.00	SOCIAL SERVICE	17.00	0	535	4.00	
5.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00	0	1,697,984	5.00	
6.00	ADULTS & PEDIATRICS	30.00	0	348,062	6.00	
7.00	INTENSIVE CARE UNIT	31.00	0	49,963	7.00	
8.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	93,260	8.00	
9.00	SKILLED NURSING FACILITY	44.00	0	65,790	9.00	
10.00	OPERATING ROOM	50.00	0	9,425	10.00	
11.00	DELIVERY ROOM & LABOR ROOM	52.00	0	53,689	11.00	
12.00	OP INFUSION	52.01	0	60,466	12.00	
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	32,393	13.00	
14.00	RADIOLOGY-THERAPEUTIC	55.00	0	89,476	14.00	
15.00	CT SCAN	57.00	0	204	15.00	
16.00	CARDIAC CATHETERIZATION	59.00	0	44,586	16.00	
17.00	RESPIRATORY THERAPY	65.00	0	14,185	17.00	
18.00	PHYSICAL THERAPY	66.00	0	1,876	18.00	
19.00	CARDIAC REHABILITATION	76.97	0	857	19.00	
20.00	EMERGENCY	91.00	0	239,298	20.00	
21.00	OTHER NON REIMBURABLE	194.05	353,566	0	21.00	
22.00	LABORATORY	60.00	0	30,084	22.00	
	0		353,566	4,188,705		
X - OB SUPPORT						
1.00	ADULTS & PEDIATRICS	30.00	210,274	3,788	1.00	
	0		210,274	3,788		
Y - INTERN & RESIDENT SALARY RECLASS						
1.00	I&R SERVICES-SALARY & FRINGES APPRVD	21.00	5,721,009	0	1.00	
	0		5,721,009	0		
Z - COVID-19- CONTRACT LABOR						
1.00	ADULTS & PEDIATRICS	30.00	0	2,672	1.00	
	0		0	2,672		
AA - CONTRACT LABOR						
1.00	ADULTS & PEDIATRICS	30.00	0	67,454	1.00	
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	460	2.00	
3.00	LABORATORY	60.00	0	2,193	3.00	
	TOTALS		0	70,107		
AB - HBP TEACH PART A						
1.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00	5,909	0	1.00	
	TOTALS		5,909	0		
AC - RESIDENT MALPRACTICE						
1.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00	0	439,735	1.00	
	TOTALS		0	439,735		
500.00	Grand Total: Increases		11,649,328	99,903,354	500.00	

RECLASSIFICATIONS

Provider CCN: 31-0041

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

Worksheet A-6
Date/Time Prepared:
5/20/2024 2:35 pm

Decreases							
Cost Center	Line #	Salary	Other	Wkst.	A-7 Ref.		
6.00	7.00	8.00	9.00	10.00			
A - MEDICAL SURGICAL SUPPLIES							
1.00	MAINTENANCE & REPAIRS	6.00	0	3,125	0		1.00
2.00	OPERATION OF PLANT	7.00	0	1,951	0		2.00
3.00	HOUSEKEEPING	9.00	0	65,961	0		3.00
4.00	DIETARY	10.00	0	4,107	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	4,995	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	830,525	0		6.00
7.00	PHARMACY	15.00	0	55,509	0		7.00
8.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00	0	758	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	1,621,694	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	1,564,168	0		10.00
11.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	162,122	0		11.00
12.00	NURSERY	43.00	0	767	0		12.00
13.00	SKILLED NURSING FACILITY	44.00	0	88,210	0		13.00
14.00	OPERATING ROOM	50.00	0	9,309,584	0		14.00
15.00	RECOVERY ROOM	51.00	0	55,085	0		15.00
16.00	DELIVERY ROOM & LABOR ROOM	52.00	0	342,413	0		16.00
17.00	OP INFUSION	52.01	0	70,033	0		17.00
18.00	ANESTHESIOLOGY	53.00	0	513,707	0		18.00
19.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,079,220	0		19.00
20.00	RADIOLOGY-THERAPEUTIC	55.00	0	31,311	0		20.00
21.00	RADIOISOTOPE	56.00	0	807	0		21.00
22.00	CT SCAN	57.00	0	121,985	0		22.00
23.00	MRI	58.00	0	14,865	0		23.00
24.00	CARDIAC CATHETERIZATION	59.00	0	2,014,261	0		24.00
25.00	RESPIRATORY THERAPY	65.00	0	408,811	0		25.00
26.00	PHYSICAL THERAPY	66.00	0	26,923	0		26.00
27.00	ELECTROCARDIOLOGY	69.00	0	123,163	0		27.00
28.00	ELECTROENCEPHALOGRAPHY	70.00	0	36,715	0		28.00
29.00	CARDIAC REHABILITATION	76.97	0	4,309	0		29.00
30.00	CLINIC	90.00	0	305,314	0		30.00
31.00	EMERGENCY	91.00	0	1,581,101	0		31.00
32.00	OBSERVATION BEDS-DISTINCT O	92.01	0	174,610	0		32.00
			0	20,618,109			
B - IMPLANTABLES							
1.00	CENTRAL SERVICES & SUPPLY	14.00		8,299	0		1.00
2.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00		10,150	0		2.00
3.00	ADULTS & PEDIATRICS	30.00		372	0		3.00
4.00	INTENSIVE CARE UNIT	31.00		3,448	0		4.00
5.00	SURGICAL INTENSIVE CARE UNIT	34.00		3,432	0		5.00
6.00	OPERATING ROOM	50.00		13,400,828	0		6.00
7.00	RECOVERY ROOM	51.00		495	0		7.00
8.00	ANESTHESIOLOGY	53.00		5,201	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00		687,282	0		9.00
10.00	CARDIAC CATHETERIZATION	59.00		4,557,111	0		10.00
11.00	ELECTROCARDIOLOGY	69.00		6,336	0		11.00
12.00	ELECTROENCEPHALOGRAPHY	70.00		62	0		12.00
13.00	CLINIC	90.00		186,746	0		13.00
14.00	EMERGENCY	91.00		1,949	0		14.00
			0	18,871,711			
C - DRUGS AND IV SOLUTIONS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		5,559	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00		2,732	0		2.00
3.00	PHARMACY	15.00		42,197,941	0		3.00
4.00	ADULTS & PEDIATRICS	30.00		498,659	0		4.00
5.00	INTENSIVE CARE UNIT	31.00		398,300	0		5.00
6.00	SURGICAL INTENSIVE CARE UNIT	34.00		131,312	0		6.00
7.00	SKILLED NURSING FACILITY	44.00		5,789	0		7.00
8.00	OPERATING ROOM	50.00		342,469	0		8.00
9.00	RECOVERY ROOM	51.00		9,054	0		9.00
10.00	DELIVERY ROOM & LABOR ROOM	52.00		40,813	0		10.00
11.00	OP INFUSION	52.01		87,785	0		11.00
12.00	ANESTHESIOLOGY	53.00		28,216	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00		77,342	0		13.00
14.00	RADIOLOGY-THERAPEUTIC	55.00		183	0		14.00
15.00	RADIOISOTOPE	56.00		535	0		15.00
16.00	CT SCAN	57.00		4,413	0		16.00
17.00	MRI	58.00		2,746	0		17.00
18.00	CARDIAC CATHETERIZATION	59.00		33,252	0		18.00
19.00	RESPIRATORY THERAPY	65.00		81,871	0		19.00
20.00	ELECTROCARDIOLOGY	69.00		149,156	0		20.00
21.00	ELECTROENCEPHALOGRAPHY	70.00		308	0		21.00

RECLASSIFICATIONS

Provider CCN: 31-0041

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

Worksheet A-6
Date/Time Prepared:
5/20/2024 2:35 pm

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
22.00	CLINIC	90.00		4,318	0	22.00
23.00	EMERGENCY	91.00		717,965	0	23.00
24.00	OBSERVATION BEDS-DISTINCT	92.01		71,550	0	24.00
	0		0	44,892,268		
D - BLOOD						
1.00	NURSING ADMINISTRATION	13.00		26	0	1.00
2.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00		809	0	2.00
3.00	ADULTS & PEDIATRICS	30.00		3,255	0	3.00
4.00	INTENSIVE CARE UNIT	31.00		3,760	0	4.00
5.00	SURGICAL INTENSIVE CARE UNIT	34.00		6,130	0	5.00
6.00	OPERATING ROOM	50.00		64,398	0	6.00
7.00	OP INFUSION	52.01		45,232	0	7.00
8.00	LABORATORY	60.00		1,554	0	8.00
9.00	EMERGENCY	91.00		53	0	9.00
	0		0	125,217		
E - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	4,794,960	11	1.00
2.00		0.00	0	0	11	2.00
	0		0	4,794,960		
F - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	141,273	12	1.00
2.00		0.00	0	0	12	2.00
	0		0	141,273		
G - RADIOLOGY RNS						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	655,508	4,636	0	1.00
2.00		0.00	0	0	0	2.00
	0		655,508	4,636		
H - DIETARY						
1.00	DIETARY	10.00	1,424,832	1,409,843	0	1.00
	0		1,424,832	1,409,843		
J - LINEN						
1.00	ADMINISTRATIVE & GENERAL	5.00		10,616	0	1.00
2.00	OPERATION OF PLANT	7.00		194	0	2.00
3.00	HOUSEKEEPING	9.00		20,410	0	3.00
4.00	DIETARY	10.00		21,594	0	4.00
5.00	NURSING ADMINISTRATION	13.00		341	0	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00		22,082	0	6.00
7.00	SOCIAL SERVICE	17.00		26	0	7.00
8.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00		2,802	0	8.00
9.00	ADULTS & PEDIATRICS	30.00		316,684	0	9.00
10.00	INTENSIVE CARE UNIT	31.00		234,234	0	10.00
11.00	SURGICAL INTENSIVE CARE UNIT	34.00		23,771	0	11.00
12.00	SKILLED NURSING FACILITY	44.00		20,369	0	12.00
13.00	OPERATING ROOM	50.00		69,731	0	13.00
14.00	RECOVERY ROOM	51.00		13,843	0	14.00
15.00	DELIVERY ROOM & LABOR ROOM	52.00		42,586	0	15.00
16.00	OP INFUSION	52.01		12,187	0	16.00
17.00	RADIOLOGY-DIAGNOSTIC	54.00		44,100	0	17.00
18.00	RADIOLOGY-THERAPEUTIC	55.00		26	0	18.00
19.00	RADIOISOTOPE	56.00		9,951	0	19.00
20.00	MRI	58.00		9,154	0	20.00
21.00	CARDIAC CATHETERIZATION	59.00		10,289	0	21.00
22.00	LABORATORY	60.00		150	0	22.00
23.00	PHYSICAL THERAPY	66.00		10,198	0	23.00
24.00	ELECTROCARDIOLOGY	69.00		10,388	0	24.00
25.00	ELECTROCARDIOLOGY	69.00		1,602	0	25.00
26.00	ELECTROENCEPHALOGRAPHY	70.00		2,381	0	26.00
27.00	ELECTROENCEPHALOGRAPHY	70.00		4,775	0	27.00
28.00	HYPERBARIC OXYGEN THERAPY	76.98		16,016	0	28.00
29.00	CLINIC	90.00		1,046	0	29.00
30.00	EMERGENCY	91.00		251,315	0	30.00
31.00	OBSERVATION BEDS-DISTINCT	92.01		36,979	0	31.00
	0		0	1,219,840		
K - MOTHER BABY						
1.00	ADULTS & PEDIATRICS	30.00	1,923,024	225,234	0	1.00
	0		1,923,024	225,234		
M - MALPRACTICE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	115,094	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

RECLASSIFICATIONS

Provider CCN: 31-0041

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

Worksheet A-6
Date/Time Prepared:
5/20/2024 2:35 pm

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	0		0	115,094		
N - BENEFITS DIRECTLY ASSIGNED						
1.00	ADMINISTRATIVE & GENERAL	5.00		46,359	0	1.00
2.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00		1,787,755	0	2.00
3.00	ADULTS & PEDIATRICS	30.00		50,939	0	3.00
4.00	SKILLED NURSING FACILITY	44.00		871,543	0	4.00
5.00	EMERGENCY	91.00		7,500	0	5.00
6.00	OTHER NON REIMBURABLE	194.05		173	0	6.00
	0		0	2,764,269		
Q - TRANSPORT						
1.00	ADMINISTRATIVE & GENERAL	5.00	1,294,116	15,893	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
	0		1,294,116	15,893		
R - PHARMACY RESIDENTS						
1.00	PHARMACY	15.00	61,090	0	0	1.00
	0		61,090	0		
W - WAGE INDEX						
1.00	ADMINISTRATIVE & GENERAL	5.00	1,310,665	0	0	1.00
2.00	NURSING ADMINISTRATION	13.00	8,624	0	0	2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	37,283	0	0	3.00
4.00	SOCIAL SERVICE	17.00	535	0	0	4.00
5.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00	1,697,984	0	0	5.00
6.00	ADULTS & PEDIATRICS	30.00	348,062	0	0	6.00
7.00	INTENSIVE CARE UNIT	31.00	49,963	0	0	7.00
8.00	SURGICAL INTENSIVE CARE UNIT	34.00	93,260	0	0	8.00
9.00	SKILLED NURSING FACILITY	44.00	65,790	0	0	9.00
10.00	OPERATING ROOM	50.00	9,425	0	0	10.00
11.00	DELIVERY ROOM & LABOR ROOM	52.00	53,689	0	0	11.00
12.00	OP INFUSION	52.01	60,466	0	0	12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	32,393	0	0	13.00
14.00	RADIOLOGY-THERAPEUTIC	55.00	89,476	0	0	14.00
15.00	CT SCAN	57.00	204	0	0	15.00
16.00	CARDIAC CATHETERIZATION	59.00	44,586	0	0	16.00
17.00	RESPIRATORY THERAPY	65.00	14,185	0	0	17.00
18.00	PHYSICAL THERAPY	66.00	1,876	0	0	18.00
19.00	CARDIAC REHABILITATION	76.97	857	0	0	19.00
20.00	EMERGENCY	91.00	239,298	0	0	20.00
21.00	OTHER NON REIMBURABLE	194.05	0	353,566	0	21.00
22.00	LABORATORY	60.00	30,084	0	0	22.00
	0		4,188,705	353,566		
X - OB SUPPORT						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	210,274	3,788	0	1.00
	0		210,274	3,788		
Y - INTERN & RESIDENT SALARY RECLASS						
1.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00	5,721,009	0	0	1.00
	0		5,721,009	0		
Z - COVID-19- CONTRACT LABOR						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,672	0	1.00
	0		0	2,672		
AA - CONTRACT LABOR						
1.00	SOCIAL SERVICE	17.00	0	67,034	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	3,073	0	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		0	70,107		
AB - HBP TEACH PART A						
1.00	ELECTROCARDIOLOGY	69.00	5,909	0	0	1.00
	TOTALS		5,909	0		
AC - RESIDENT MALPRACTICE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	439,735	0	1.00
	TOTALS		0	439,735		
500.00	Grand Total: Decreases		15,484,467	96,068,215		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 31-0041

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

Worksheet A-7
Part I
Date/Time Prepared:
5/20/2024 2:35 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	198,713	0	0	0	1.00
2.00	Land Improvements	3,070,534	0	0	0	2.00
3.00	Buildings and Fixtures	289,229,993	28,367,966	0	28,367,966	3.00
4.00	Building Improvements	17,860,652	0	0	0	4.00
5.00	Fixed Equipment	78,755,860	0	0	0	5.00
6.00	Movable Equipment	200,390,619	7,725,241	0	7,725,241	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	589,506,371	36,093,207	0	36,093,207	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	589,506,371	36,093,207	0	36,093,207	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	198,713	0			1.00
2.00	Land Improvements	3,070,534	1,628,159			2.00
3.00	Buildings and Fixtures	317,597,959	57,244,879			3.00
4.00	Building Improvements	17,860,652	5,183,612			4.00
5.00	Fixed Equipment	78,755,860	67,348,630			5.00
6.00	Movable Equipment	208,109,529	98,378,455			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	625,593,247	229,783,735			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	625,593,247	229,783,735			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 31-0041

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

Worksheet A-7
Part II
Date/Time Prepared:
5/20/2024 2:35 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	11,111,968	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	9,350,753	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	20,462,721	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	11,111,968				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	9,350,753				2.00
3.00	Total (sum of lines 1-2)	0	20,462,721				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 31-0041

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

Worksheet A-7
Part III
Date/Time Prepared:
5/20/2024 2:35 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	417,483,717	0	417,483,717	0.667341	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	208,109,528	0	208,109,528	0.332659	0	2.00
3.00	Total (sum of lines 1-2)	625,593,245	0	625,593,245	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	11,111,968	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	9,350,753	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	20,462,721	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	1,766,597	94,262	0	0	12,972,827	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,486,596	47,011	0	0	10,884,360	2.00
3.00	Total (sum of lines 1-2)	3,253,193	141,273	0	0	23,857,187	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 31-0041

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

Worksheet A-8

Date/Time Prepared:
5/20/2024 2:35 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	2.00	3.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-837,233	CAP REL COSTS-BLDG & FIXT		1.00	11 1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-704,534	CAP REL COSTS-MVBLE EQUIP		2.00	11 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)	B	-59,710	ADMINISTRATIVE & GENERAL		5.00	0 7.00
8.00 Television and radio service (chapter 21)	B	-38,235	OPERATION OF PLANT		7.00	0 8.00
9.00 Parking lot (chapter 21)		0			0.00	0 9.00
10.00 Provider-based physician adjustment	A-8-2	-19,034,584				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	13,359,097				0 12.00
13.00 Laundry and linen service		0			0.00	0 13.00
14.00 Cafeteria-employees and guests	B	-1,380,090	CAFETERIA		11.00	0 14.00
15.00 Rental of quarters to employee and others		0			0.00	0 15.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00	0 16.00
17.00 Sale of drugs to other than patients		0			0.00	0 17.00
18.00 Sale of medical records and abstracts		0			0.00	0 18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)		0			0.00	0 19.00
20.00 Vending machines	B	-35,388	OPERATION OF PLANT		7.00	0 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	0 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	0 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY		65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY		66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***		114.00	25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT		1.00	0 26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP		2.00	0 27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***		19.00	28.00
29.00 Physicians' assistant		0			0.00	0 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY		67.00	30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS		30.00	30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY		68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	0 32.00
33.00 MED & DENTAL STAFF OTHER REV	B	-170,050	CENTRAL SERVICES & SUPPLY		14.00	0 33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 31-0041

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

Worksheet A-8

Date/Time Prepared:
5/20/2024 2:35 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #	Wkst. A-7 Ref.
			Cost Center			
			1.00	2.00		
33.01 GARNISHEE SERVICE CHARGE REV	B	-3,778	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.01
33.02 OUTREACH LAB	B	-313,402	LABORATORY		60.00	0 33.02
33.03 OTHER MISCELLANEOUS REVENUE	B	-57,079	ADMINISTRATIVE & GENERAL		5.00	0 33.03
33.04 OTHER MISCELLANEOUS REVENUE	B	-14,000	ADULTS & PEDIATRICS		30.00	0 33.04
33.05 OTHER MISCELLANEOUS REVENUE	B	-1,340	I&R SERVICES-OTHER PRGM. COSTS APPRVD		22.00	0 33.05
33.06 OTHER MISCELLANEOUS REVENUE	B	-100,800	OPERATING ROOM		50.00	0 33.06
33.07 OTHER MISCELLANEOUS REVENUE	B	-315,955	LABORATORY		60.00	0 33.07
33.08 EMPLOYEE - HEALTH PAYMENTS	B	-10,708	ADULTS & PEDIATRICS		30.00	0 33.08
33.09 EMPLOYEE - HEALTH PAYMENTS	B	-4,023	INTENSIVE CARE UNIT		31.00	0 33.09
33.10 EMPLOYEE - HEALTH PAYMENTS	B	-377	SURGICAL INTENSIVE CARE UNIT		34.00	0 33.10
33.11 EMPLOYEE - HEALTH PAYMENTS	B	-324	SKILLED NURSING FACILITY		44.00	0 33.11
33.12 EMPLOYEE - HEALTH PAYMENTS	B	-5,762	OPERATING ROOM		50.00	0 33.12
33.13 EMPLOYEE - HEALTH PAYMENTS	B	-1,114	RECOVERY ROOM		51.00	0 33.13
33.14 EMPLOYEE - HEALTH PAYMENTS	B	-2,650	DELIVERY ROOM & LABOR ROOM		52.00	0 33.14
33.15 EMPLOYEE - HEALTH PAYMENTS	B	-730	OP INFUSION		52.01	0 33.15
33.16 EMPLOYEE - HEALTH PAYMENTS	B	-1,094	ANESTHESIOLOGY		53.00	0 33.16
33.17 EMPLOYEE - HEALTH PAYMENTS	B	-5,376	RADIOLOGY-DIAGNOSTIC		54.00	0 33.17
33.18 EMPLOYEE - HEALTH PAYMENTS	B	-2,604	RADIOLOGY-THERAPEUTIC		55.00	0 33.18
33.19 EMPLOYEE - HEALTH PAYMENTS	B	-209	RADIOISOTOPE		56.00	0 33.19
33.20 EMPLOYEE - HEALTH PAYMENTS	B	-2,653	CT SCAN		57.00	0 33.20
33.21 EMPLOYEE - HEALTH PAYMENTS	B	-2,608	MRI		58.00	0 33.21
33.22 EMPLOYEE - HEALTH PAYMENTS	B	-1,548	CARDIAC CATHETERIZATION		59.00	0 33.22
33.23 EMPLOYEE - HEALTH PAYMENTS	B	-9,386	LABORATORY		60.00	0 33.23
33.24 EMPLOYEE - HEALTH PAYMENTS	B	-337	RESPIRATORY THERAPY		65.00	0 33.24
33.25 EMPLOYEE - HEALTH PAYMENTS	B	-571	PHYSICAL THERAPY		66.00	0 33.25
33.26 EMPLOYEE - HEALTH PAYMENTS	B	-302	OCCUPATIONAL THERAPY		67.00	0 33.26
33.27 EMPLOYEE - HEALTH PAYMENTS	B	-54	SPEECH PATHOLOGY		68.00	0 33.27
33.28 EMPLOYEE - HEALTH PAYMENTS	B	-2,772	ELECTROCARDIOLOGY		69.00	0 33.28
33.29 EMPLOYEE - HEALTH PAYMENTS	B	-548	ELECTROENCEPHALOGRAPHY		70.00	0 33.29
33.30 EMPLOYEE - HEALTH PAYMENTS	B	-864	MEDICAL SUPPLIES CHARGED TO PATIENT		71.00	0 33.30
33.31 EMPLOYEE - HEALTH PAYMENTS	B	-1,294	IMPL. DEV. CHARGED TO PATIENTS		72.00	0 33.31
33.32 EMPLOYEE - HEALTH PAYMENTS	B	-2,825	DRUGS CHARGED TO PATIENTS		73.00	0 33.32
33.33 EMPLOYEE - HEALTH PAYMENTS	B	-137	CARDIAC REHABILITATION		76.97	0 33.33
33.34 EMPLOYEE - HEALTH PAYMENTS	B	-72	CLINIC		90.00	0 33.34
33.35 EMPLOYEE - HEALTH PAYMENTS	B	-9,798	EMERGENCY		91.00	0 33.35
33.36 EMPLOYEE - HEALTH PAYMENTS	B	-112	OBSERVATION BEDS-DISTINCT		92.01	0 33.36
33.37 EMPLOYEE - HEALTH PAYMENTS	B	-2,095	OBSERVATION BEDS-DISTINCT		92.01	0 33.37
33.38 RENTAL INCOME	B	-249,166	ADMINISTRATIVE & GENERAL		5.00	0 33.38
33.39 RENTAL INCOME	B	-27,008	RADIOLOGY-DIAGNOSTIC		54.00	0 33.39
33.40 RENTAL INCOME	B	-21,576	PHYSICAL THERAPY		66.00	0 33.40
33.41 FOUNDATION SUBSIDY	B	-51,183	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.41
33.42 FOUNDATION SUBSIDY	B	-236,258	ADMINISTRATIVE & GENERAL		5.00	0 33.42
33.43 FOUNDATION SUBSIDY	B	-17,946	MAINTENANCE & REPAIRS		6.00	0 33.43
33.44 FOUNDATION SUBSIDY	B	-39,246	OPERATION OF PLANT		7.00	0 33.44
33.45 FOUNDATION SUBSIDY	B	-8,672	DIETARY		10.00	0 33.45
33.46 FOUNDATION SUBSIDY	B	-68,976	NURSING ADMINISTRATION		13.00	0 33.46
33.47 FOUNDATION SUBSIDY	B	-40,283	CENTRAL SERVICES & SUPPLY		14.00	0 33.47
33.48 FOUNDATION SUBSIDY	B	-150	SOCIAL SERVICE		17.00	0 33.48
33.49 FOUNDATION SUBSIDY	B	-30,909	I&R SERVICES-OTHER PRGM. COSTS APPRVD		22.00	0 33.49
33.50 FOUNDATION SUBSIDY	B	-99,070	ADULTS & PEDIATRICS		30.00	0 33.50
33.51 FOUNDATION SUBSIDY	B	-52,150	INTENSIVE CARE UNIT		31.00	0 33.51
33.52 FOUNDATION SUBSIDY	B	-474	NURSERY		43.00	0 33.52
33.53 FOUNDATION SUBSIDY	B	-6,829	SKILLED NURSING FACILITY		44.00	0 33.53
33.54 FOUNDATION SUBSIDY	B	-1,633	OPERATING ROOM		50.00	0 33.54
33.55 FOUNDATION SUBSIDY	B	-2,185	DELIVERY ROOM & LABOR ROOM		52.00	0 33.55
33.56 FOUNDATION SUBSIDY	B	-5,372	OP INFUSION		52.01	0 33.56
33.57 FOUNDATION SUBSIDY	B	-3,253	RADIOLOGY-DIAGNOSTIC		54.00	0 33.57
33.58 FOUNDATION SUBSIDY	B	-61,635	RADIOLOGY-THERAPEUTIC		55.00	0 33.58
33.59 FOUNDATION SUBSIDY	B	-5,949	MRI		58.00	0 33.59
33.60 FOUNDATION SUBSIDY	B	-670	CARDIAC CATHETERIZATION		59.00	0 33.60
33.61 FOUNDATION SUBSIDY	B	-200	RESPIRATORY THERAPY		65.00	0 33.61
33.62 FOUNDATION SUBSIDY	B	-1,141	OCCUPATIONAL THERAPY		67.00	0 33.62
33.63 FOUNDATION SUBSIDY	B	-1,669	SPEECH PATHOLOGY		68.00	0 33.63
33.64 FOUNDATION SUBSIDY	B	-350	ELECTROCARDIOLOGY		69.00	0 33.64
33.65 FOUNDATION SUBSIDY	B	-239,915	ELECTROENCEPHALOGRAPHY		70.00	0 33.65

ADJUSTMENTS TO EXPENSES

Provider CCN: 31-0041

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

Worksheet A-8

Date/Time Prepared:
5/20/2024 2:35 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	2.00	3.00	
33.66 FOUNDATION SUBSIDY	B	-5,597	CARDIAC REHABILITATION	76.97	0	33.66
33.67 FOUNDATION SUBSIDY	B	-28,202	CLINIC	90.00	0	33.67
33.68 FOUNDATION SUBSIDY	B	-2,905	EMERGENCY	91.00	0	33.68
33.69 FOUNDATION SUBSIDY	B	-8,285	OBSERVATION BEDS-DISTINCT	92.01	0	33.69
33.70 INTERCOMPANY RENTAL INCOME	B	-1,303,801	ADMINISTRATIVE & GENERAL	5.00	0	33.70
33.71 INTERCOMPANY RENTAL INCOME	B	-237,966	RADIOLOGY-DIAGNOSTIC	54.00	0	33.71
33.72 NON ALLOWABLE ENTERTAINMENT	A	-706	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.72
33.73 NON ALLOWABLE ENTERTAINMENT	A	-13,264	ADMINISTRATIVE & GENERAL	5.00	0	33.73
33.74 NON ALLOWABLE ENTERTAINMENT	A	-2,865	OPERATION OF PLANT	7.00	0	33.74
33.75 NON ALLOWABLE ENTERTAINMENT	A	-671	HOUSEKEEPING	9.00	0	33.75
33.76 NON ALLOWABLE ENTERTAINMENT	A	-1,101	DIETARY	10.00	0	33.76
33.77 NON ALLOWABLE ENTERTAINMENT	A	-1,325	NURSING ADMINISTRATION	13.00	0	33.77
33.78 NON ALLOWABLE ENTERTAINMENT	A	-1,989	PHARMACY	15.00	0	33.78
33.79 NON ALLOWABLE ENTERTAINMENT	A	-682	MEDICAL RECORDS & LIBRARY	16.00	0	33.79
33.80 NON ALLOWABLE ENTERTAINMENT	A	-3,287	SOCIAL SERVICE	17.00	0	33.80
33.81 NON ALLOWABLE ENTERTAINMENT	A	-7,490	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00	0	33.81
33.82 NON ALLOWABLE ENTERTAINMENT	A	-685	PARAMEDICAL PRGM-(SPECIFY)	23.00	0	33.82
33.83 NON ALLOWABLE ENTERTAINMENT	A	-4,062	ADULTS & PEDIATRICS	30.00	0	33.83
33.84 NON ALLOWABLE ENTERTAINMENT	A	-3,535	INTENSIVE CARE UNIT	31.00	0	33.84
33.85 NON ALLOWABLE ENTERTAINMENT	A	-60	SURGICAL INTENSIVE CARE UNIT	34.00	0	33.85
33.86 NON ALLOWABLE ENTERTAINMENT	A	-437	SKILLED NURSING FACILITY	44.00	0	33.86
33.87 NON ALLOWABLE ENTERTAINMENT	A	-422	OPERATING ROOM	50.00	0	33.87
33.88 NON ALLOWABLE ENTERTAINMENT	A	-657	RADIOLOGY-DIAGNOSTIC	54.00	0	33.88
33.89 NON ALLOWABLE ENTERTAINMENT	A	-352	RADIOLOGY-THERAPEUTIC	55.00	0	33.89
33.90 NON ALLOWABLE ENTERTAINMENT	A	-37	PHYSICAL THERAPY	66.00	0	33.90
33.91 NON ALLOWABLE ENTERTAINMENT	A	-2,007	ELECTROENCEPHALOGRAPHY	70.00	0	33.91
33.92 NON ALLOWABLE ENTERTAINMENT	A	-1,259	EMERGENCY	91.00	0	33.92
33.93 NON ALLOWABLE ENTERTAINMENT	A	-315	OBSERVATION BEDS-DISTINCT	92.01	0	33.93
33.94 COMMUNITY BENEFIT	A	-26,192	SOCIAL SERVICE	17.00	0	33.94
33.95 FQHC	A	-1,150,000	ADMINISTRATIVE & GENERAL	5.00	0	33.95
33.96 LOBBYING EXPENSE	A	-21,700	ADMINISTRATIVE & GENERAL	5.00	0	33.96
33.97 BHMG/MMG	A	-26,785,383	ADMINISTRATIVE & GENERAL	5.00	0	33.97
33.98 NURSE PRACTITIONERS (INCLUDES FRINGES)	A	-147,798	ADMINISTRATIVE & GENERAL	5.00	0	33.98
33.99 HBP	A	-11,349	DIETARY	10.00	0	33.99
34.00 PENSION ADMINISTRATION COSTS	A	1,868,710	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.00
34.01 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.01
34.02 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.02
34.03 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.03
34.04 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.04
34.05 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.05
34.06 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.06
34.07 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.07
34.08 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.08
34.09 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.09
34.10 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.10
34.11 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.11
34.12 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.12
34.13 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.13
34.14 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.14
34.15 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.15
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-38,961,572				50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 31-0041

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

Worksheet A-8

Date/Time Prepared:
5/20/2024 2:35 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	2.00	3.00	4.00	5.00

(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: 31-0041

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

Worksheet A-8-1

Date/Time Prepared:
5/20/2024 2:35 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	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	78,627,579	65,288,638	1.00
2.00	0.00			0	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	COMMUNITY MEDICAL CENTER AUX	11,031	11,031	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	COMMUNITY MEDICAL CENTER FOU	100,826	100,826	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	SAINT BARNABAS CORPORATION	585,253	585,253	3.02
3.03	95.00	AMBULANCE SERVICES	AMBULANCE ADD ON	20,156	0	3.03
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			79,344,845	65,985,748	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	
			Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				

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

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

6.00	A		0.00	RWJ BARNABAS HEALTH	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 31-0041

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

Worksheet A-8-1

Date/Time Prepared:
5/20/2024 2:35 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	13,338,941	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
3.01	0	0		3.01
3.02	0	0		3.02
3.03	20,156	0		3.03
4.00	0	0		4.00
5.00	13,359,097			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	HEALTHCARE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 31-0041

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

Worksheet A-8-2

Date/Time Prepared:
5/20/2024 2:35 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	10,008,744	9,986,307	22,437	211,500	103	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	2,966,853	2,966,853	0	0	0	2.00
3.00	50.00	AGGREGATE-OPERATING ROOM	22,800	22,800	0	0	0	3.00
4.00	53.00	AGGREGATE-ANESTHESIOLOGY	985,861	985,861	0	0	0	4.00
5.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	1,731,898	1,731,898	0	0	0	5.00
6.00	55.00	AGGREGATE-RADIOLOGY-THERAPEUTIC	227,643	227,643	0	0	0	6.00
7.00	59.00	AGGREGATE-CARDIAC CATHETERIZATION	87,013	87,013	0	0	0	7.00
8.00	60.00	AGGREGATE-LABORATORY	238,411	238,411	0	0	0	8.00
9.00	65.00	AGGREGATE-RESPIRATORY THERAPY	62,005	62,005	0	0	0	9.00
10.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	53,179	0	53,179	211,500	204	10.00
11.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY	164,299	164,299	0	0	0	11.00
12.00	91.00	AGGREGATE-EMERGENCY	2,536,044	2,536,044	0	0	0	12.00
200.00			19,084,750	19,009,134	75,616		307	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	10,473	524	0	0	346,246	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	3.00
4.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	55.00	AGGREGATE-RADIOLOGY-THERAPEUTIC	0	0	0	0	53,704	6.00
7.00	59.00	AGGREGATE-CARDIAC CATHETERIZATION	0	0	0	0	13,327	7.00
8.00	60.00	AGGREGATE-LABORATORY	0	0	0	0	0	8.00
9.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	0	19,072	9.00
10.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	20,743	1,037	0	0	18,174	10.00
11.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY	0	0	0	0	0	11.00
12.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	12.00
200.00			31,216	1,561	0	0	450,523	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	776	11,249	11,188	9,997,495		1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	2,966,853		2.00
3.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	22,800		3.00
4.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	985,861		4.00
5.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	1,731,898		5.00
6.00	55.00	AGGREGATE-RADIOLOGY-THERAPEUTIC	0	0	0	227,643		6.00
7.00	59.00	AGGREGATE-CARDIAC CATHETERIZATION	0	0	0	87,013		7.00
8.00	60.00	AGGREGATE-LABORATORY	0	0	0	238,411		8.00
9.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	62,005		9.00
10.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	18,174	38,917	14,262	14,262		10.00
11.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY	0	0	0	164,299		11.00
12.00	91.00	AGGREGATE-EMERGENCY	0	0	0	2,536,044		12.00
200.00			18,950	50,166	25,450	19,034,584		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 31-0041

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

Worksheet B
Part I
Date/Time Prepared:
5/20/2024 2: 35 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			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	12,972,827	12,972,827			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	10,884,360		10,884,360		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	35,718,932	133,929	0	35,852,861	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	103,062,828	667,065	4,854,781	2,190,151	110,774,825
6.00 00600	MAINTENANCE & REPAIRS	681,098	41,222	3,707	36,078	762,105
7.00 00700	OPERATION OF PLANT	12,921,060	206,160	712,781	805,269	14,645,270
8.00 00800	LAUNDRY & LINEN SERVICE	1,219,806	0	0	0	1,219,806
9.00 00900	HOUSEKEEPING	5,398,756	151,280	9,625	706,629	6,266,290
10.00 01000	DIETARY	4,217,341	268,601	60,134	415,465	4,961,541
11.00 01100	CAFETERIA	1,454,585	223,537	3,861	278,543	1,960,526
13.00 01300	NURSING ADMINISTRATION	4,782,821	109,339	574,103	856,291	6,322,554
14.00 01400	CENTRAL SERVICES & SUPPLY	3,913,948	513,851	269,636	402,847	5,100,282
15.00 01500	PHARMACY	6,316,875	134,152	135,800	1,202,592	7,789,419
16.00 01600	MEDICAL RECORDS & LIBRARY	1,722,296	198,947	0	243,835	2,165,078
17.00 01700	SOCIAL SERVICE	4,545,901	0	0	589,284	5,135,185
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	5,721,009	0	0	1,118,411	6,839,420
22.00 02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	4,109,602	0	0	115,212	4,224,814
23.00 02300	PARAMED PRGM-(SPECIFY)	242,397	0	0	40,411	282,808
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	38,266,435	2,772,195	77,161	6,777,048	47,892,839
31.00 03100	INTENSIVE CARE UNIT	27,875,691	1,526,582	79,341	5,152,906	34,634,520
34.00 03400	SURGICAL INTENSIVE CARE UNIT	3,848,226	117,717	7,272	649,292	4,622,507
43.00 04300	NURSERY	3,236,247	165,558	6,638	588,166	3,996,609
44.00 04400	SKILLED NURSING FACILITY	4,070,313	213,968	995	668,993	4,954,269
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	13,690,272	844,223	1,383,905	2,063,306	17,981,706
51.00 05100	RECOVERY ROOM	1,717,107	120,469	5,801	330,273	2,173,650
52.00 05200	DELIVERY ROOM & LABOR ROOM	3,627,313	387,929	46,617	679,217	4,741,076
52.01 03190	OP INFUSION	1,811,384	207,226	0	334,832	2,353,442
53.00 05300	ANESTHESIOLOGY	119,996	24,788	4,930	20,497	170,211
54.00 05400	RADIOLOGY-DIAGNOSTIC	8,392,796	537,796	584,330	1,263,166	10,778,088
55.00 05500	RADIOLOGY-THERAPEUTIC	6,518,086	359,522	566,312	835,860	8,279,780
56.00 05600	RADIOISOTOPE	1,531,489	12,394	36,816	120,220	1,700,919
57.00 05700	CT SCAN	2,963,535	18,591	0	413,008	3,395,134
58.00 05800	MRI	1,078,555	73,521	155,494	169,425	1,476,995
59.00 05900	CARDIAC CATHETERIZATION	4,117,270	523,172	281,829	690,621	5,612,892
60.00 06000	LABORATORY	18,421,697	329,827	311,485	0	19,063,009
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	4,341,996	46,651	251,229	698,745	5,338,621
66.00 06600	PHYSICAL THERAPY	2,588,836	132,739	16,517	494,879	3,232,971
67.00 06700	OCCUPATIONAL THERAPY	1,186,795	6,643	0	231,991	1,425,429
68.00 06800	SPEECH PATHOLOGY	340,284	20,772	0	66,428	427,484
69.00 06900	ELECTROCARDIOLOGY	3,773,062	110,182	92,517	520,659	4,496,420
70.00 07000	ELECTROENCEPHALOGRAPHY	1,348,830	230,031	126,851	249,149	1,954,861
70.01 07001	SLEEP LAB	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20,617,037	0	0	0	20,617,037
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	18,870,417	0	0	0	18,870,417
73.00 07300	DRUGS CHARGED TO PATIENTS	44,837,283	0	0	0	44,837,283
76.97 07697	CARDIAC REHABILITATION	640,386	60,631	1,872	121,493	824,382
76.98 07698	HYPERBARIC OXYGEN THERAPY	298,291	64,448	0	0	362,739
77.00 07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0
78.00 07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	810,342	0	0	34,797	845,139
91.00 09100	EMERGENCY	18,400,514	1,417,169	176,482	2,803,555	22,797,720
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
92.01 09201	OBSERVATION BEDS-DISTINCT	4,378,149	0	0	756,861	5,135,010
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	1,140,517	0	0	0	1,140,517
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	484,745,593	12,972,827	10,838,822	35,736,405	484,583,599
NONREIMBURSABLE COST CENTERS						
194.00 07950	MISCELLANEOUS	0	0	0	0	0
194.01 07951	PUBLIC RELATIONS	384	0	0	0	384
194.03 07952	LIGHTHOUSE	47,082	0	0	9,173	56,255
194.04 07953	KIDS & FAMILY	0	0	0	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 31-0041

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

Worksheet B
Part I
Date/Time Prepared:
5/20/2024 2:35 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	
194.05 07954 OTHER NON REIMBURABLE	250,191	0	45,538	107,118	402,847	194.05
194.06 07955 GRANTS/TRIALS	1,358	0	0	165	1,523	194.06
194.07 07956 RETAIL PHARMACY	0	0	0	0	0	194.07
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)	485,044,608	12,972,827	10,884,360	35,852,861	485,044,608	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Prepared: 5/20/2024 2:35 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	110,774,825			5.00		
6.00	00600	MAINTENANCE & REPAIRS	225,565	987,670		6.00		
7.00	00700	OPERATION OF PLANT	4,334,648	16,785	18,996,703	7.00		
8.00	00800	LAUNDRY & LINEN SERVICE	361,033	0	0	1,580,839	8.00	
9.00	00900	HOUSEKEEPING	1,854,671	12,317	241,002	0	8,374,280	9.00
10.00	01000	DIETARY	1,468,497	21,869	427,905	15,806	0	10.00
11.00	01100	CAFETERIA	580,269	18,200	356,113	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,871,324	8,902	174,187	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,509,561	41,838	818,611	18,531	0	14.00
15.00	01500	PHARMACY	2,305,481	10,923	213,715	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	640,811	16,198	316,940	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,519,892	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	2,024,304	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	1,250,444	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	83,704	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14,175,084	225,713	4,416,350	423,826	3,191,243	30.00
31.00	03100	INTENSIVE CARE UNIT	10,250,987	124,294	2,431,980	314,537	1,683,053	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,368,151	9,585	187,534	28,363	0	34.00
43.00	04300	NURSERY	1,182,900	13,480	263,748	0	153,005	43.00
44.00	04400	SKILLED NURSING FACILITY	1,466,345	17,421	340,871	28,418	153,005	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,322,153	68,736	1,344,922	97,288	218,578	50.00
51.00	05100	RECOVERY ROOM	643,348	9,809	191,917	19,313	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,403,245	31,585	618,006	50,392	153,005	52.00
52.01	03190	OP INFUSION	696,562	16,872	330,130	17,003	109,289	52.01
53.00	05300	ANESTHESIOLOGY	50,378	2,018	39,489	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,190,055	43,787	856,757	61,528	153,005	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,450,616	29,272	572,751	0	0	55.00
56.00	05600	RADIOISOTOPE	503,431	1,009	19,745	13,685	0	56.00
57.00	05700	CT SCAN	1,004,878	1,514	29,617	0	0	57.00
58.00	05800	MRI	437,155	5,986	117,125	12,771	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,661,281	42,596	833,459	14,355	218,578	59.00
60.00	06000	LABORATORY	5,642,193	26,854	525,443	2,627	51,912	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,580,104	3,798	74,319	0	0	65.00
66.00	06600	PHYSICAL THERAPY	956,882	10,808	211,465	14,228	51,912	66.00
67.00	06700	OCCUPATIONAL THERAPY	421,893	541	10,583	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	126,525	1,691	33,092	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,330,832	8,971	175,529	0	51,912	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	578,592	18,729	366,460	24,306	218,578	70.00
70.01	07001	SLEEP LAB	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,102,148	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,585,191	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,270,760	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	243,997	4,937	96,591	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	107,362	5,247	102,672	22,345	0	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	250,141	0	0	0	131,147	90.00
91.00	09100	EMERGENCY	6,747,578	115,385	2,257,675	401,517	1,683,053	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	1,519,840	0	0	0	153,005	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	337,566	0	0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	110,638,377	987,670	18,996,703	1,580,839	8,374,280	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	MISCELLANEOUS	0	0	0	0	0	194.00
194.01	07951	PUBLIC RELATIONS	114	0	0	0	0	194.01
194.03	07952	LIGHTHOUSE	16,650	0	0	0	0	194.03
194.04	07953	KIDS & FAMILY	0	0	0	0	0	194.04
194.05	07954	OTHER NON REIMBURSABLE	119,233	0	0	0	0	194.05
194.06	07955	GRANTS/TRIALS	451	0	0	0	0	194.06
194.07	07956	RETAIL PHARMACY	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 31-0041			Period: From 01/01/2023 To 12/31/2023		Worksheet B Part I Date/Time Prepared: 5/20/2024 2:35 pm	
Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
202.00	TOTAL (sum lines 118 through 201)	110,774,825	987,670	18,996,703	1,580,839	8,374,280	202.00	

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 31-0041		Period: From 01/01/2023 To 12/31/2023		Worksheet B Part I Date/Time Prepared: 5/20/2024 2:35 pm	
Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	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	6,895,618					10.00
11.00	01100	CAFETERIA	0	2,915,108				11.00
13.00	01300	NURSING ADMINISTRATION	0	57,604	8,434,571			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	62,278	0	7,551,101		14.00
15.00	01500	PHARMACY	0	105,581	0	2,649	10,427,768	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	33,798	83,048	33,176	0	16.00
17.00	01700	SOCIAL SERVICE	0	52,321	193,699	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	133,054	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	7,872	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	5,022	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,702,341	666,782	2,862,932	36,033	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,662,059	460,119	1,970,071	32,452	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	197,399	49,715	257,646	4,906	0	34.00
43.00	04300	NURSERY	0	40,627	84,698	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	333,819	59,533	151,823	2,133	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	185,671	683,052	33,499	0	50.00
51.00	05100	RECOVERY ROOM	0	21,808	138,494	130	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	54,146	268,123	7,095	0	52.00
52.01	03190	OP INFUSION	0	31,834	112,759	1,446	0	52.01
53.00	05300	ANESTHESIOLOGY	0	3,840	0	23	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	120,404	82,119	8,174	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	61,722	57,439	224	0	55.00
56.00	05600	RADIOISOTOPE	0	7,767	0	33	0	56.00
57.00	05700	CT SCAN	0	31,313	0	0	0	57.00
58.00	05800	MRI	0	13,849	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	48,238	221,770	6,597	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORAGE, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	59,550	0	873	0	65.00
66.00	06600	PHYSICAL THERAPY	0	51,435	0	104	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	18,593	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	5,491	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	55,554	74,193	657	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	23,320	23,183	9,076	0	70.00
70.01	07001	SLEEP LAB	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,830,706	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,506,270	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	10,427,768	73.00
76.97	07697	CARDIAC REHABILITATION	0	8,966	46,568	68	0	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	3,632	8,967	684	0	90.00
91.00	09100	EMERGENCY	0	290,887	819,467	30,604	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0	69,629	294,456	3,489	0	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,895,618	2,901,955	8,434,507	7,551,101	10,427,768	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	MISCELLANEOUS	0	0	0	0	0	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0	0	194.01
194.03	07952	LIGHTHOUSE	0	0	0	0	0	194.03
194.04	07953	KIDS & FAMILY	0	712	0	0	0	194.04
194.05	07954	OTHER NON REIMBURABLE	0	12,424	0	0	0	194.05
194.06	07955	GRANTS/TRIALS	0	17	64	0	0	194.06
194.07	07956	RETAIL PHARMACY	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 31-0041

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

Worksheet B
Part I
Date/Time Prepared:
5/20/2024 2:35 pm

Cost Center Description		DI ETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	6,895,618	2,915,108	8,434,571	7,551,101	10,427,768	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 31-0041

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

Worksheet B
Part I
Date/Time Prepared:
5/20/2024 2:35 pm

Line	Code	Cost Center Description	INTERNS & RESIDENTS				PARAMED PRGM	Total
			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM. COSTS		
			16.00	17.00	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	
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	3,289,049				16.00	
17.00	01700	SOCIAL SERVICE	0	6,901,097			17.00	
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	8,996,778		21.00	
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	5,483,130	22.00	
23.00	02300	PARAMED PRGM-(SPECFY)	0	0	0	0	371,534	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,099,874	1,852,948	4,326,571	2,636,850	0	
31.00	03100	INTENSIVE CARE UNIT	105,757	1,020,373	744,159	453,532	0	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	116,333	78,683	0	0	0	
43.00	04300	NURSERY	338,423	110,659	0	0	0	
44.00	04400	SKILLED NURSING FACILITY	0	143,017	0	0	0	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	317,272	564,282	540,239	329,251	0	
51.00	05100	RECOVERY ROOM	0	80,522	0	0	0	
52.00	05200	DELIVERY ROOM & LABOR ROOM	169,212	259,293	0	0	0	
52.01	03190	OP INFUSION	0	138,511	61,209	37,304	0	
53.00	05300	ANESTHESIOLOGY	0	16,568	164,001	99,951	0	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	359,465	67,530	41,156	0	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	240,306	0	0	0	
56.00	05600	RADIOISOTOPE	0	8,284	0	0	0	
57.00	05700	CT SCAN	0	12,426	0	0	0	
58.00	05800	MRI	0	49,141	0	0	0	
59.00	05900	CARDIAC CATHETERIZATION	0	349,690	0	0	0	
60.00	06000	LABORATORY	0	220,457	34,597	21,085	0	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	
65.00	06500	RESPIRATORY THERAPY	0	31,181	140,050	85,354	0	
66.00	06600	PHYSICAL THERAPY	0	88,723	0	0	0	
67.00	06700	OCCUPATIONAL THERAPY	0	4,440	0	0	0	
68.00	06800	SPEECH PATHOLOGY	0	13,884	0	0	0	
69.00	06900	ELECTROCARDIOLOGY	0	73,646	90,816	55,348	0	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	153,754	0	0	0	
70.01	07001	SLEEP LAB	0	0	0	0	0	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	371,534	
76.97	07697	CARDIAC REHABILITATION	0	40,526	0	0	0	
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	43,077	0	0	0	
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	264,393	0	767,113	467,521	0	
91.00	09100	EMERGENCY	877,785	947,241	2,060,493	1,255,778	0	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	
92.01	09201	OBSERVATION BEDS-DISTINCT	0	0	0	0	0	
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE					113.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,289,049	6,901,097	8,996,778	5,483,130	371,534	
NONREIMBURSABLE COST CENTERS								
194.00	07950	MISCELLANEOUS	0	0	0	0	0	
194.01	07951	PUBLIC RELATIONS	0	0	0	0	0	
194.03	07952	LIGHTHOUSE	0	0	0	0	0	
194.04	07953	KIDS & FAMILY	0	0	0	0	0	
194.05	07954	OTHER NON REIMBURABLE	0	0	0	0	0	
194.06	07955	GRANTS/TRIALS	0	0	0	0	0	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 31-0041

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

Worksheet B
Part I
Date/Time Prepared:
5/20/2024 2:35 pm

Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		PARAMED PRGM	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM. COSTS		
			16.00	17.00		
194.07 07956 RETAIL PHARMACY	0	0	0	0	0	0 194.07
200.00 Cross Foot Adjustments			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)	3,289,049	6,901,097	8,996,778	5,483,130	371,534	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 31-0041

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

Worksheet B
Part I
Date/Time Prepared:
5/20/2024 2:35 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
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
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
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	87,509,386	-6,963,421	80,545,965	30.00
31.00	03100	INTENSIVE CARE UNIT	56,887,893	-1,197,691	55,690,202	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	6,920,822	0	6,920,822	34.00
43.00	04300	NURSERY	6,184,149	0	6,184,149	43.00
44.00	04400	SKILLED NURSING FACILITY	7,650,654	0	7,650,654	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,686,649	-869,490	26,817,159	50.00
51.00	05100	RECOVERY ROOM	3,278,991	0	3,278,991	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,755,178	0	7,755,178	52.00
52.01	03190	OP INFUSION	3,906,361	-98,513	3,807,848	52.01
53.00	05300	ANESTHESIOLOGY	546,479	-263,952	282,527	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,762,068	-108,686	15,653,382	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	11,692,110	0	11,692,110	55.00
56.00	05600	RADIOISOTOPE	2,254,873	0	2,254,873	56.00
57.00	05700	CT SCAN	4,474,882	0	4,474,882	57.00
58.00	05800	MRI	2,113,022	0	2,113,022	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,009,456	0	9,009,456	59.00
60.00	06000	LABORATORY	25,588,177	-55,682	25,532,495	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	7,313,850	-225,404	7,088,446	65.00
66.00	06600	PHYSICAL THERAPY	4,618,528	0	4,618,528	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,881,479	0	1,881,479	67.00
68.00	06800	SPEECH PATHOLOGY	608,167	0	608,167	68.00
69.00	06900	ELECTROCARDIOLOGY	6,413,878	-146,164	6,267,714	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,370,859	0	3,370,859	70.00
70.01	07001	SLEEP LAB	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	30,549,891	0	30,549,891	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,961,878	0	27,961,878	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	68,907,345	0	68,907,345	73.00
76.97	07697	CARDIAC REHABILITATION	1,266,035	0	1,266,035	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	643,442	0	643,442	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,738,737	-1,234,634	1,504,103	90.00
91.00	09100	EMERGENCY	40,285,183	-3,316,271	36,968,912	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	7,175,429	0	7,175,429	92.01
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,478,083	0	1,478,083	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	484,433,934	-14,479,908	469,954,026	118.00
NONREIMBURSABLE COST CENTERS						
194.00	07950	MISCELLANEOUS	0	0	0	194.00
194.01	07951	PUBLIC RELATIONS	498	0	498	194.01
194.03	07952	LIGHTHOUSE	72,905	0	72,905	194.03
194.04	07953	KIDS & FAMILY	712	0	712	194.04
194.05	07954	OTHER NON REIMBURABLE	534,504	0	534,504	194.05
194.06	07955	GRANTS/TRIALS	2,055	0	2,055	194.06

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 31-0041

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

Worksheet B
Part I
Date/Time Prepared:
5/20/2024 2:35 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
194.07	07956	RETAIL PHARMACY	0	0	0	194.07
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	485,044,608	-14,479,908	470,564,700	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-0041

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

Worksheet B
Part II
Date/Time Prepared:
5/20/2024 2: 35 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
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	133,929	0	133,929	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	667,065	4,854,781	5,521,846	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	41,222	3,707	44,929	6.00
7.00 00700	OPERATION OF PLANT	0	206,160	712,781	918,941	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	151,280	9,625	160,905	9.00
10.00 01000	DIETARY	0	268,601	60,134	328,735	10.00
11.00 01100	CAFETERIA	0	223,537	3,861	227,398	11.00
13.00 01300	NURSING ADMINISTRATION	0	109,339	574,103	683,442	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	513,851	269,636	783,487	14.00
15.00 01500	PHARMACY	0	134,152	135,800	269,952	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	198,947	0	198,947	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	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	2,772,195	77,161	2,849,356	30.00
31.00 03100	INTENSIVE CARE UNIT	0	1,526,582	79,341	1,605,923	31.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	117,717	7,272	124,989	34.00
43.00 04300	NURSERY	0	165,558	6,638	172,196	43.00
44.00 04400	SKILLED NURSING FACILITY	0	213,968	995	214,963	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	844,223	1,383,905	2,228,128	50.00
51.00 05100	RECOVERY ROOM	0	120,469	5,801	126,270	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	387,929	46,617	434,546	52.00
52.01 03190	OP INFUSION	0	207,226	0	207,226	52.01
53.00 05300	ANESTHESIOLOGY	0	24,788	4,930	29,718	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	537,796	584,330	1,122,126	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	359,522	566,312	925,834	55.00
56.00 05600	RADIOISOTOPE	0	12,394	36,816	49,210	56.00
57.00 05700	CT SCAN	0	18,591	0	18,591	57.00
58.00 05800	MRI	0	73,521	155,494	229,015	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	523,172	281,829	805,001	59.00
60.00 06000	LABORATORY	0	329,827	311,485	641,312	60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00 06500	RESPIRATORY THERAPY	0	46,651	251,229	297,880	65.00
66.00 06600	PHYSICAL THERAPY	0	132,739	16,517	149,256	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	6,643	0	6,643	67.00
68.00 06800	SPEECH PATHOLOGY	0	20,772	0	20,772	68.00
69.00 06900	ELECTROCARDIOLOGY	0	110,182	92,517	202,699	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	230,031	126,851	356,882	70.00
70.01 07001	SLEEP LAB	0	0	0	0	70.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.97 07697	CARDIAC REHABILITATION	0	60,631	1,872	62,503	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	64,448	0	64,448	76.98
77.00 07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	77.00
78.00 07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	1,417,169	176,482	1,593,651	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
92.01 09201	OBSERVATION BEDS-DISTINCT	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	12,972,827	10,838,822	23,811,649	118.00
NONREIMBURSABLE COST CENTERS						
194.00 07950	MISCELLANEOUS	0	0	0	0	194.00
194.01 07951	PUBLIC RELATIONS	0	0	0	0	194.01
194.03 07952	LIGHTHOUSE	0	0	0	0	194.03
194.04 07953	KIDS & FAMILY	0	0	0	0	194.04
194.05 07954	OTHER NON REIMBURABLE	0	0	45,538	45,538	194.05

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-0041

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

Worksheet B
Part II
Date/Time Prepared:
5/20/2024 2:35 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
	0			2A	4.00	
194.06 07955 GRANTS/TRIALS	0	0	0	0		194.06
194.07 07956 RETAIL PHARMACY	0	0	0	0		194.07
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0	0	0		201.00
202.00 TOTAL (sum lines 118 through 201)	0	12,972,827	10,884,360	23,857,187	133,929	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 5/20/2024 2:35 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	5,530,024				5.00
6.00	00600	MAINTENANCE & REPAIRS	11,261	56,325			6.00
7.00	00700	OPERATION OF PLANT	216,399	957	1,139,304		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	18,024	0	0	18,024	8.00
9.00	00900	HOUSEKEEPING	92,591	702	14,454	0	271,291
10.00	01000	DIETARY	73,312	1,247	25,663	180	0
11.00	01100	CAFETERIA	28,969	1,038	21,357	0	0
13.00	01300	NURSING ADMINISTRATION	93,422	508	10,447	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	75,362	2,386	49,095	211	0
15.00	01500	PHARMACY	115,096	623	12,817	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	31,991	924	19,008	0	0
17.00	01700	SOCIAL SERVICE	75,877	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	101,059	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	62,426	0	0	0	0
23.00	02300	PARAMED ED PRGM-(SPECIFY)	4,179	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	707,479	12,873	264,867	4,832	103,379
31.00	03100	INTENSIVE CARE UNIT	511,760	7,088	145,855	3,586	54,524
34.00	03400	SURGICAL INTENSIVE CARE UNIT	68,302	547	11,247	323	0
43.00	04300	NURSERY	59,054	769	15,818	0	4,957
44.00	04400	SKILLED NURSING FACILITY	73,204	994	20,443	324	4,957
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	265,698	3,920	80,660	1,109	7,081
51.00	05100	RECOVERY ROOM	32,118	559	11,510	220	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	70,054	1,801	37,064	575	4,957
52.01	03190	OP INFUSION	34,774	962	19,799	194	3,541
53.00	05300	ANESTHESIOLOGY	2,515	115	2,368	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	159,257	2,497	51,383	702	4,957
55.00	05500	RADIOLOGY-THERAPEUTIC	122,342	1,669	34,350	0	0
56.00	05600	RADIOISOTOPE	25,133	58	1,184	156	0
57.00	05700	CT SCAN	50,166	86	1,776	0	0
58.00	05800	MRI	21,824	341	7,024	146	0
59.00	05900	CARDIAC CATHETERIZATION	82,936	2,429	49,986	164	7,081
60.00	06000	LABORATORY	281,675	1,531	31,513	30	1,682
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	78,883	217	4,457	0	0
66.00	06600	PHYSICAL THERAPY	47,770	616	12,682	162	1,682
67.00	06700	OCCUPATIONAL THERAPY	21,062	31	635	0	0
68.00	06800	SPEECH PATHOLOGY	6,317	96	1,985	0	0
69.00	06900	ELECTROCARDIOLOGY	66,439	512	10,527	0	1,682
70.00	07000	ELECTROENCEPHALOGRAPHY	28,885	1,068	21,978	277	7,081
70.01	07001	SLEEP LAB	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	304,637	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	278,829	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	662,516	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	12,181	282	5,793	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	5,360	299	6,158	255	0
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	12,488	0	0	0	4,249
91.00	09100	EMERGENCY	336,859	6,580	135,401	4,578	54,524
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
92.01	09201	OBSERVATION BEDS-DISTINCT	75,875	0	0	0	4,957
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	16,852	0	0	0	0
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,523,212	56,325	1,139,304	18,024	271,291
NONREIMBURSABLE COST CENTERS							
194.00	07950	MISCELLANEOUS	0	0	0	0	0
194.01	07951	PUBLIC RELATIONS	6	0	0	0	0
194.03	07952	LIGHTHOUSE	831	0	0	0	0
194.04	07953	KIDS & FAMILY	0	0	0	0	0
194.05	07954	OTHER NON REIMBURABLE	5,952	0	0	0	0
194.06	07955	GRANTS/TRIALS	23	0	0	0	0
194.07	07956	RETAIL PHARMACY	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 31-0041			Period: From 01/01/2023 To 12/31/2023		Worksheet B Part II Date/Time Prepared: 5/20/2024 2:35 pm	
Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
202.00	TOTAL (sum lines 118 through 201)	5,530,024	56,325	1,139,304	18,024	271,291	202.00	

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-0041

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

Worksheet B
Part II
Date/Time Prepared:
5/20/2024 2:35 pm

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY		
		10.00	11.00	13.00	14.00	15.00		
GENERAL SERVICE COST CENTERS								
1.00	00100						1.00	
2.00	00200						2.00	
4.00	00400						4.00	
5.00	00500						5.00	
6.00	00600						6.00	
7.00	00700						7.00	
8.00	00800						8.00	
9.00	00900						9.00	
10.00	01000	430,688					10.00	
11.00	01100	0	279,802				11.00	
13.00	01300	0	5,529	796,546			13.00	
14.00	01400	0	5,978	0	918,023		14.00	
15.00	01500	0	10,134	0	322	413,435	15.00	
16.00	01600	0	3,244	7,843	4,033	0	16.00	
17.00	01700	0	5,022	18,293	0	0	17.00	
21.00	02100	0	12,771	0	0	0	21.00	
22.00	02200	0	756	0	0	0	22.00	
23.00	02300	0	482	0	0	0	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	231,242	63,997	270,342	4,381	0	30.00	
31.00	03100	166,267	44,164	186,060	3,945	0	31.00	
34.00	03400	12,329	4,772	24,333	597	0	34.00	
43.00	04300	0	3,900	7,999	0	0	43.00	
44.00	04400	20,850	5,714	14,339	259	0	44.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	0	17,821	64,510	4,073	0	50.00	
51.00	05100	0	2,093	13,080	16	0	51.00	
52.00	05200	0	5,197	25,322	863	0	52.00	
52.01	03190	0	3,056	10,649	176	0	52.01	
53.00	05300	0	369	0	3	0	53.00	
54.00	05400	0	11,557	7,756	994	0	54.00	
55.00	05500	0	5,924	5,425	27	0	55.00	
56.00	05600	0	746	0	4	0	56.00	
57.00	05700	0	3,006	0	0	0	57.00	
58.00	05800	0	1,329	0	0	0	58.00	
59.00	05900	0	4,630	20,945	802	0	59.00	
60.00	06000	0	0	0	0	0	60.00	
63.00	06300	0	0	0	0	0	63.00	
65.00	06500	0	5,716	0	106	0	65.00	
66.00	06600	0	4,937	0	13	0	66.00	
67.00	06700	0	1,785	0	0	0	67.00	
68.00	06800	0	527	0	0	0	68.00	
69.00	06900	0	5,332	7,007	80	0	69.00	
70.00	07000	0	2,238	2,190	1,103	0	70.00	
70.01	07001	0	0	0	0	0	70.01	
71.00	07100	0	0	0	465,716	0	71.00	
72.00	07200	0	0	0	426,274	0	72.00	
73.00	07300	0	0	0	0	413,435	73.00	
76.97	07697	0	861	4,398	8	0	76.97	
76.98	07698	0	0	0	0	0	76.98	
77.00	07700	0	0	0	0	0	77.00	
78.00	07800	0	0	0	0	0	78.00	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	0	349	847	83	0	90.00	
91.00	09100	0	27,920	77,393	3,721	0	91.00	
92.00	09200	0	6,683	27,809	424	0	92.00	
92.01	09201	0	6,683	27,809	424	0	92.01	
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	0	0	0	0	0	95.00	
102.00	10200	0	0	0	0	0	102.00	
SPECIAL PURPOSE COST CENTERS								
113.00	11300	0	0	0	0	0	113.00	
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		430,688	278,539	796,540	918,023	413,435	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	0	0	0	0	0	194.00	
194.01	07951	0	0	0	0	0	194.01	
194.03	07952	0	0	0	0	0	194.03	
194.04	07953	0	68	0	0	0	194.04	
194.05	07954	0	1,193	0	0	0	194.05	
194.06	07955	0	2	6	0	0	194.06	
194.07	07956	0	0	0	0	0	194.07	
200.00	Cross Foot Adjustments						200.00	

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-0041

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

Worksheet B
Part II
Date/Time Prepared:
5/20/2024 2:35 pm

Cost Center Description		DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	430,688	279,802	796,546	918,023	413,435	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 5/20/2024 2:35 pm
-------------------------------------	--	-----------------------	---	--

Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		PARAMED PRGM	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM. COSTS		
			16.00	17.00		
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
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
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	266,901				16.00
17.00 01700	SOCIAL SERVICE	0	101,392			17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	118,006		21.00
22.00 02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	63,612	22.00
23.00 02300	PARAMED PRGM-(SPECFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	89,254	27,222			30.00
31.00 03100	INTENSIVE CARE UNIT	8,582	14,992			31.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	9,440	1,156			34.00
43.00 04300	NURSERY	27,462	1,626			43.00
44.00 04400	SKILLED NURSING FACILITY	0	2,101			44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	25,746	8,291			50.00
51.00 05100	RECOVERY ROOM	0	1,183			51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	13,731	3,810			52.00
52.01 03190	OP INFUSION	0	2,035			52.01
53.00 05300	ANESTHESIOLOGY	0	243			53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	5,281			54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	3,531			55.00
56.00 05600	RADIOISOTOPE	0	122			56.00
57.00 05700	CT SCAN	0	183			57.00
58.00 05800	MRI	0	722			58.00
59.00 05900	CARDIAC CATHETERIZATION	0	5,138			59.00
60.00 06000	LABORATORY	0	3,239			60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0			63.00
65.00 06500	RESPIRATORY THERAPY	0	458			65.00
66.00 06600	PHYSICAL THERAPY	0	1,304			66.00
67.00 06700	OCCUPATIONAL THERAPY	0	65			67.00
68.00 06800	SPEECH PATHOLOGY	0	204			68.00
69.00 06900	ELECTROCARDIOLOGY	0	1,082			69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	2,259			70.00
70.01 07001	SLEEP LAB	0	0			70.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0			73.00
76.97 07697	CARDIAC REHABILITATION	0	595			76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	633			76.98
77.00 07700	ALLOGENEIC STEM CELL ACQUISITION	0	0			77.00
78.00 07800	CAR T-CELL IMMUNOTHERAPY	0	0			78.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	21,455	0			90.00
91.00 09100	EMERGENCY	71,231	13,917			91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
92.01 09201	OBSERVATION BEDS-DISTINCT	0	0			92.01
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0			95.00
102.00 10200	OPIOID TREATMENT PROGRAM	0	0			102.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	266,901	101,392	0	0	118.00
NONREIMBURSABLE COST CENTERS						
194.00 07950	MISCELLANEOUS	0	0			194.00
194.01 07951	PUBLIC RELATIONS	0	0			194.01
194.03 07952	LIGHTHOUSE	0	0			194.03
194.04 07953	KIDS & FAMILY	0	0			194.04
194.05 07954	OTHER NON REIMBURABLE	0	0			194.05
194.06 07955	GRANTS/TRIALS	0	0			194.06

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-0041

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

Worksheet B
Part II
Date/Time Prepared:
5/20/2024 2:35 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		PARAMED PRGM		
				SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM. COSTS			
				16.00	17.00			21.00
194.07	07956	RETAIL PHARMACY	0	0				194.07
200.00		Cross Foot Adjustments			118,006	63,612	4,812	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	266,901	101,392	118,006	63,612	4,812	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 5/20/2024 2:35 pm
-------------------------------------	--	-----------------------	---	--

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
6.00	00600				6.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
21.00	02100				21.00
22.00	02200				22.00
23.00	02300				23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	4,654,580	0	4,654,580	30.00
31.00	03100	2,771,988	0	2,771,988	31.00
34.00	03400	260,460	0	260,460	34.00
43.00	04300	295,977	0	295,977	43.00
44.00	04400	360,646	0	360,646	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	2,714,742	0	2,714,742	50.00
51.00	05100	188,282	0	188,282	51.00
52.00	05200	600,456	0	600,456	52.00
52.01	03190	283,662	0	283,662	52.01
53.00	05300	35,408	0	35,408	53.00
54.00	05400	1,371,227	0	1,371,227	54.00
55.00	05500	1,102,223	0	1,102,223	55.00
56.00	05600	77,062	0	77,062	56.00
57.00	05700	75,350	0	75,350	57.00
58.00	05800	261,034	0	261,034	58.00
59.00	05900	981,691	0	981,691	59.00
60.00	06000	960,982	0	960,982	60.00
63.00	06300	0	0	0	63.00
65.00	06500	390,326	0	390,326	65.00
66.00	06600	220,270	0	220,270	66.00
67.00	06700	31,087	0	31,087	67.00
68.00	06800	30,149	0	30,149	68.00
69.00	06900	297,304	0	297,304	69.00
70.00	07000	424,891	0	424,891	70.00
70.01	07001	0	0	0	70.01
71.00	07100	770,353	0	770,353	71.00
72.00	07200	705,103	0	705,103	72.00
73.00	07300	1,075,951	0	1,075,951	73.00
76.97	07697	87,075	0	87,075	76.97
76.98	07698	77,153	0	77,153	76.98
77.00	07700	0	0	0	77.00
78.00	07800	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	39,601	0	39,601	90.00
91.00	09100	2,336,244	0	2,336,244	91.00
92.00	09200	0	0	0	92.00
92.01	09201	118,574	0	118,574	92.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	16,852	0	16,852	95.00
102.00	10200	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
118.00		23,616,703	0	23,616,703	118.00
NONREIMBURSABLE COST CENTERS					
194.00	07950	0	0	0	194.00
194.01	07951	6	0	6	194.01
194.03	07952	865	0	865	194.03
194.04	07953	68	0	68	194.04
194.05	07954	53,083	0	53,083	194.05
194.06	07955	32	0	32	194.06

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-0041

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

Worksheet B
Part II
Date/Time Prepared:
5/20/2024 2:35 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
194.07	07956	RETAIL PHARMACY	0	0	0	194.07
200.00		Cross Foot Adjustments	186,430	0	186,430	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	23,857,187	0	23,857,187	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 31-0041

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

Worksheet B-1

Date/Time Prepared:
5/20/2024 2: 35 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				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	523,355				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		9,350,751			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	5,403	0	183,397,816		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	26,911	4,170,737	11,203,279	-110,774,825	374,269,783
6.00 00600	MAINTENANCE & REPAIRS	1,663	3,185	184,550	0	762,105
7.00 00700	OPERATION OF PLANT	8,317	612,350	4,119,192	0	14,645,270
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	1,219,806
9.00 00900	HOUSEKEEPING	6,103	8,269	3,614,617	0	6,266,290
10.00 01000	DIETARY	10,836	51,661	2,125,229	0	4,961,541
11.00 01100	CAFETERIA	9,018	3,317	1,424,832	0	1,960,526
13.00 01300	NURSING ADMINISTRATION	4,411	493,212	4,380,185	0	6,322,554
14.00 01400	CENTRAL SERVICES & SUPPLY	20,730	231,644	2,060,682	0	5,100,282
15.00 01500	PHARMACY	5,412	116,666	6,151,615	0	7,789,419
16.00 01600	MEDICAL RECORDS & LIBRARY	8,026	0	1,247,290	0	2,165,078
17.00 01700	SOCIAL SERVICE	0	0	3,014,364	0	5,135,185
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	5,721,009	0	6,839,420
22.00 02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	589,345	0	4,224,814
23.00 02300	PARAMED PRGM-(SPECIFY)	0	0	206,716	0	282,808
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	111,837	66,289	34,666,332	0	47,892,839
31.00 03100	INTENSIVE CARE UNIT	61,586	68,162	26,358,653	0	34,634,520
34.00 03400	SURGICAL INTENSIVE CARE UNIT	4,749	6,247	3,321,322	0	4,622,507
43.00 04300	NURSERY	6,679	5,703	3,008,646	0	3,996,609
44.00 04400	SKILLED NURSING FACILITY	8,632	855	3,422,097	0	4,954,269
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	34,058	1,188,913	10,554,427	0	17,981,706
51.00 05100	RECOVERY ROOM	4,860	4,984	1,689,446	0	2,173,650
52.00 05200	DELIVERY ROOM & LABOR ROOM	15,650	40,049	3,474,396	0	4,741,076
52.01 03190	OP INFUSION	8,360	0	1,712,766	0	2,353,442
53.00 05300	ANESTHESIOLOGY	1,000	4,235	104,849	0	170,211
54.00 05400	RADIOLOGY-DIAGNOSTIC	21,696	501,998	6,461,472	0	10,778,088
55.00 05500	RADIOLOGY-THERAPEUTIC	14,504	486,519	4,275,676	0	8,279,780
56.00 05600	RADIOISOTOPE	500	31,629	614,959	0	1,700,919
57.00 05700	CT SCAN	750	0	2,112,658	0	3,395,134
58.00 05800	MRI	2,966	133,585	866,659	0	1,476,995
59.00 05900	CARDIAC CATHETERIZATION	21,106	242,119	3,532,733	0	5,612,892
60.00 06000	LABORATORY	13,306	267,597	0	0	19,063,009
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	1,882	215,831	3,574,292	0	5,338,621
66.00 06600	PHYSICAL THERAPY	5,355	14,190	2,531,455	0	3,232,971
67.00 06700	OCCUPATIONAL THERAPY	268	0	1,186,702	0	1,425,429
68.00 06800	SPEECH PATHOLOGY	838	0	339,797	0	427,484
69.00 06900	ELECTROCARDIOLOGY	4,445	79,481	2,663,328	0	4,496,420
70.00 07000	ELECTROENCEPHALOGRAPHY	9,280	108,978	1,274,472	0	1,954,861
70.01 07001	SLEEP LAB	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	20,617,037
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	18,870,417
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	44,837,283
76.97 07697	CARDIAC REHABILITATION	2,446	1,608	621,472	0	824,382
76.98 07698	HYPERBARIC OXYGEN THERAPY	2,600	0	0	0	362,739
77.00 07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0
78.00 07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	177,999	0	845,139
91.00 09100	EMERGENCY	57,172	151,616	14,341,022	0	22,797,720
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
92.01 09201	OBSERVATION BEDS-DISTINCT	0	0	3,871,572	0	5,135,010
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	1,140,517
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	523,355	9,311,629	182,802,107	-110,774,825	373,808,774
NONREIMBURSABLE COST CENTERS						
194.00 07950	MISCELLANEOUS	0	0	0	0	0
194.01 07951	PUBLIC RELATIONS	0	0	0	0	384
194.03 07952	LIGHTHOUSE	0	0	46,922	0	56,255
194.04 07953	KIDS & FAMILY	0	0	0	0	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 31-0041

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

Worksheet B-1

Date/Time Prepared:
5/20/2024 2:35 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				
194.05 07954 OTHER NON REIMBURABLE	0	39,122	547,941	0	402,847	194.05
194.06 07955 GRANTS/TRIALS	0	0	846	0	1,523	194.06
194.07 07956 RETAIL PHARMACY	0	0	0	0	0	194.07
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)	12,972,827	10,884,360	35,852,861		110,774,825	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	24.787815	1.164009	0.195492		0.295976	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			133,929		5,530,024	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.000730		0.014776	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: 31-0041

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

Worksheet B-1

Date/Time Prepared:
5/20/2024 2:35 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						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	489,378					6.00
7.00	00700	8,317	481,061				7.00
8.00	00800	0	0	1,952,740			8.00
9.00	00900	6,103	6,103	0	3,065		9.00
10.00	01000	10,836	10,836	19,524	0	451,640	10.00
11.00	01100	9,018	9,018	0	0	0	11.00
13.00	01300	4,411	4,411	0	0	0	13.00
14.00	01400	20,730	20,730	22,890	0	0	14.00
15.00	01500	5,412	5,412	0	0	0	15.00
16.00	01600	8,026	8,026	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	111,837	111,837	523,534	1,168	242,491	30.00
31.00	03100	61,586	61,586	388,534	616	174,356	31.00
34.00	03400	4,749	4,749	35,035	0	12,929	34.00
43.00	04300	6,679	6,679	0	56	0	43.00
44.00	04400	8,632	8,632	35,104	56	21,864	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	34,058	34,058	120,175	80	0	50.00
51.00	05100	4,860	4,860	23,857	0	0	51.00
52.00	05200	15,650	15,650	62,247	56	0	52.00
52.01	03190	8,360	8,360	21,003	40	0	52.01
53.00	05300	1,000	1,000	0	0	0	53.00
54.00	05400	21,696	21,696	76,003	56	0	54.00
55.00	05500	14,504	14,504	0	0	0	55.00
56.00	05600	500	500	16,904	0	0	56.00
57.00	05700	750	750	0	0	0	57.00
58.00	05800	2,966	2,966	15,776	0	0	58.00
59.00	05900	21,106	21,106	17,732	80	0	59.00
60.00	06000	13,306	13,306	3,245	19	0	60.00
63.00	06300	0	0	0	0	0	63.00
65.00	06500	1,882	1,882	0	0	0	65.00
66.00	06600	5,355	5,355	17,575	19	0	66.00
67.00	06700	268	268	0	0	0	67.00
68.00	06800	838	838	0	0	0	68.00
69.00	06900	4,445	4,445	0	19	0	69.00
70.00	07000	9,280	9,280	30,024	80	0	70.00
70.01	07001	0	0	0	0	0	70.01
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
76.97	07697	2,446	2,446	0	0	0	76.97
76.98	07698	2,600	2,600	27,602	0	0	76.98
77.00	07700	0	0	0	0	0	77.00
78.00	07800	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	48	0	90.00
91.00	09100	57,172	57,172	495,976	616	0	91.00
92.00	09200	0	0	0	0	0	92.00
92.01	09201	0	0	0	56	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
102.00	10200	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
118.00		489,378	481,061	1,952,740	3,065	451,640	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.03	07952	0	0	0	0	0	194.03
194.04	07953	0	0	0	0	0	194.04
194.05	07954	0	0	0	0	0	194.05
194.06	07955	0	0	0	0	0	194.06
194.07	07956	0	0	0	0	0	194.07

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 31-0041

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

Worksheet B-1

Date/Time Prepared:
5/20/2024 2:35 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	
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)	987,670	18,996,703	1,580,839	8,374,280	6,895,618	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	2.018215	39.489177	0.809549	2,732.228385	15.267952	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	56,325	1,139,304	18,024	271,291	430,688	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.115095	2.368315	0.009230	88.512561	0.953609	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: 31-0041

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

Worksheet B-1
Date/Time Prepared:
5/20/2024 2:35 pm

Cost Center Description		CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	167,759					11.00
13.00	01300	3,315	158,934,679				13.00
14.00	01400	3,584	0	40,642,108			14.00
15.00	01500	6,076	0	14,260	44,840,109		15.00
16.00	01600	1,945	1,564,900	178,565	0	311	16.00
17.00	01700	3,011	3,649,938	0	0	0	17.00
21.00	02100	7,657	0	0	0	0	21.00
22.00	02200	453	0	0	0	0	22.00
23.00	02300	289	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	38,372	53,946,149	193,941	0	104	30.00
31.00	03100	26,479	37,122,815	174,664	0	10	31.00
34.00	03400	2,861	4,854,918	26,408	0	11	34.00
43.00	04300	2,338	1,595,995	0	0	32	43.00
44.00	04400	3,426	2,860,851	11,480	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	10,685	12,871,024	180,300	0	30	50.00
51.00	05100	1,255	2,609,694	700	0	0	51.00
52.00	05200	3,116	5,052,339	38,186	0	16	52.00
52.01	03190	1,832	2,124,758	7,782	0	0	52.01
53.00	05300	221	0	126	0	0	53.00
54.00	05400	6,929	1,547,397	43,997	0	0	54.00
55.00	05500	3,552	1,082,343	1,205	0	0	55.00
56.00	05600	447	0	180	0	0	56.00
57.00	05700	1,802	0	0	0	0	57.00
58.00	05800	797	0	0	0	0	58.00
59.00	05900	2,776	4,178,901	35,506	0	0	59.00
60.00	06000	0	0	0	0	0	60.00
63.00	06300	0	0	0	0	0	63.00
65.00	06500	3,427	0	4,697	0	0	65.00
66.00	06600	2,960	0	562	0	0	66.00
67.00	06700	1,070	0	0	0	0	67.00
68.00	06800	316	0	0	0	0	68.00
69.00	06900	3,197	1,398,047	3,537	0	0	69.00
70.00	07000	1,342	436,854	48,852	0	0	70.00
70.01	07001	0	0	0	0	0	70.01
71.00	07100	0	0	20,617,900	0	0	71.00
72.00	07200	0	0	18,871,711	0	0	72.00
73.00	07300	0	0	0	44,840,109	0	73.00
76.97	07697	516	877,501	365	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
77.00	07700	0	0	0	0	0	77.00
78.00	07800	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	209	168,971	3,683	0	25	90.00
91.00	09100	16,740	15,441,531	164,721	0	83	91.00
92.00	09200	0	0	0	0	0	92.00
92.01	09201	4,007	5,548,553	18,780	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
102.00	10200	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		167,002	158,933,479	40,642,108	44,840,109	311	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.03	07952	0	0	0	0	0	194.03
194.04	07953	41	0	0	0	0	194.04
194.05	07954	715	0	0	0	0	194.05
194.06	07955	1	1,200	0	0	0	194.06

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 31-0041

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

Worksheet B-1

Date/Time Prepared:
5/20/2024 2:35 pm

Cost Center Description		CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
194.07	07956 RETAIL PHARMACY	0	0	0	0	0	194.07
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)	2,915,108	8,434,571	7,551,101	10,427,768	3,289,049	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	17.376761	0.053069	0.185795	0.232554	10,575.720257	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	279,802	796,546	918,023	413,435	266,901	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1.667881	0.005012	0.022588	0.009220	858.202572	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: 31-0041

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

Worksheet B-1

Date/Time Prepared:
5/20/2024 2:35 pm

Cost Center Description	SOCIAL SERVICE (SQUARE FEET)	INTERNS & RESIDENTS		PARAMED PRGM (ASSIGNED TIME)		
		SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)			
		17.00	21.00			
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
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	416,525				17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	216,360			21.00
22.00 02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0		216,360		22.00
23.00 02300	PARAMED PRGM-(SPECIFY)	0			100	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	111,837	104,048	104,048	0	30.00
31.00 03100	INTENSIVE CARE UNIT	61,586	17,896	17,896	0	31.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	4,749	0	0	0	34.00
43.00 04300	NURSERY	6,679	0	0	0	43.00
44.00 04400	SKILLED NURSING FACILITY	8,632	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	34,058	12,992	12,992	0	50.00
51.00 05100	RECOVERY ROOM	4,860	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	15,650	0	0	0	52.00
52.01 03190	OP INFUSION	8,360	1,472	1,472	0	52.01
53.00 05300	ANESTHESIOLOGY	1,000	3,944	3,944	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	21,696	1,624	1,624	0	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	14,504	0	0	0	55.00
56.00 05600	RADIOISOTOPE	500	0	0	0	56.00
57.00 05700	CT SCAN	750	0	0	0	57.00
58.00 05800	MRI	2,966	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	21,106	0	0	0	59.00
60.00 06000	LABORATORY	13,306	832	832	0	60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00 06500	RESPIRATORY THERAPY	1,882	3,368	3,368	0	65.00
66.00 06600	PHYSICAL THERAPY	5,355	0	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	268	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	838	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	4,445	2,184	2,184	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	9,280	0	0	0	70.00
70.01 07001	SLEEP LAB	0	0	0	0	70.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	100	73.00
76.97 07697	CARDIAC REHABILITATION	2,446	0	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	2,600	0	0	0	76.98
77.00 07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	77.00
78.00 07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	18,448	18,448	0	90.00
91.00 09100	EMERGENCY	57,172	49,552	49,552	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
92.01 09201	OBSERVATION BEDS-DISTINCT	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	416,525	216,360	216,360	100	118.00
NONREIMBURSABLE COST CENTERS						
194.00 07950	MISCELLANEOUS	0	0	0	0	194.00
194.01 07951	PUBLIC RELATIONS	0	0	0	0	194.01
194.03 07952	LIGHTHOUSE	0	0	0	0	194.03
194.04 07953	KIDS & FAMILY	0	0	0	0	194.04
194.05 07954	OTHER NON REIMBURABLE	0	0	0	0	194.05

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 31-0041

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

Worksheet B-1

Date/Time Prepared:
5/20/2024 2:35 pm

Cost Center Description	SOCIAL SERVICE (SQUARE FEET)	INTERNS & RESIDENTS		PARAMED PRGM (ASSIGNED TIME)		
		SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)			
		17.00	21.00			
194.06 07955 GRANTS/TRIALS	0	0	0	0		194.06
194.07 07956 RETAIL PHARMACY	0	0	0	0		194.07
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)	6,901,097	8,996,778	5,483,130	371,534		202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	16.568266	41.582446	25.342623	3,715.340000		203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	101,392	118,006	63,612	4,812		204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.243424	0.545415	0.294010	48.120000		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: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/20/2024 2:35 pm	
			Title XVIII	Hospital	PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		80,545,965	0	80,545,965	30.00
31.00	03100 INTENSIVE CARE UNIT		55,690,202	0	55,690,202	31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT		6,920,822	0	6,920,822	34.00
43.00	04300 NURSERY		6,184,149	0	6,184,149	43.00
44.00	04400 SKILLED NURSING FACILITY		7,650,654	0	7,650,654	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		26,817,159	0	26,817,159	50.00
51.00	05100 RECOVERY ROOM		3,278,991	0	3,278,991	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		7,755,178	0	7,755,178	52.00
52.01	03190 OP INFUSION		3,807,848	0	3,807,848	52.01
53.00	05300 ANESTHESIOLOGY		282,527	0	282,527	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		15,653,382	0	15,653,382	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC		11,692,110	0	11,692,110	55.00
56.00	05600 RADIOISOTOPE		2,254,873	0	2,254,873	56.00
57.00	05700 CT SCAN		4,474,882	0	4,474,882	57.00
58.00	05800 MRI		2,113,022	0	2,113,022	58.00
59.00	05900 CARDIAC CATHETERIZATION		9,009,456	0	9,009,456	59.00
60.00	06000 LABORATORY		25,532,495	0	25,532,495	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	7,088,446	0	7,088,446	65.00
66.00	06600 PHYSICAL THERAPY	0	4,618,528	0	4,618,528	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,881,479	0	1,881,479	67.00
68.00	06800 SPEECH PATHOLOGY	0	608,167	0	608,167	68.00
69.00	06900 ELECTROCARDIOLOGY		6,267,714	14,262	6,281,976	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		3,370,859	0	3,370,859	70.00
70.01	07001 SLEEP LAB		0	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		30,549,891	0	30,549,891	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		27,961,878	0	27,961,878	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		68,907,345	0	68,907,345	73.00
76.97	07697 CARDIAC REHABILITATION		1,266,035	0	1,266,035	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY		643,442	0	643,442	76.98
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION		0	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY		0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		1,504,103	0	1,504,103	90.00
91.00	09100 EMERGENCY		36,968,912	0	36,968,912	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		451,637	0	451,637	92.00
92.01	09201 OBSERVATION BEDS-DISTINCT		7,175,429	0	7,175,429	92.01
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES		1,478,083	0	1,478,083	95.00
102.00	10200 OPIOID TREATMENT PROGRAM		0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)		470,405,663	0	470,419,925	200.00
201.00	Less Observation Beds		451,637		451,637	201.00
202.00	Total (see instructions)		469,954,026	0	469,968,288	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 31-0041		Period: From 01/01/2023 To 12/31/2023		Worksheet C Part I Date/Time Prepared: 5/20/2024 2:35 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	502,760,634		502,760,634				30.00
31.00	03100	INTENSIVE CARE UNIT	466,788,849		466,788,849				31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	43,127,435		43,127,435				34.00
43.00	04300	NURSERY	20,126,493		20,126,493				43.00
44.00	04400	SKILLED NURSING FACILITY	17,934,175		17,934,175				44.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	47,724,306	55,005,187	102,729,493	0.261046	0.000000		50.00
51.00	05100	RECOVERY ROOM	8,513,004	11,005,512	19,518,516	0.167994	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,333,380	6,888,755	25,222,135	0.307475	0.000000		52.00
52.01	03190	OP INFUSION	46,039	18,525,170	18,571,209	0.205040	0.000000		52.01
53.00	05300	ANESTHESIOLOGY	8,922,420	9,270,205	18,192,625	0.015530	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	33,710,587	45,738,447	79,449,034	0.197024	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,922,192	77,251,280	80,173,472	0.145835	0.000000		55.00
56.00	05600	RADIOISOTOPE	2,210,133	4,002,307	6,212,440	0.362961	0.000000		56.00
57.00	05700	CT SCAN	71,459,084	68,038,537	139,497,621	0.032079	0.000000		57.00
58.00	05800	MRI	18,293,751	15,372,831	33,666,582	0.062763	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	34,342,700	28,876,082	63,218,782	0.142512	0.000000		59.00
60.00	06000	LABORATORY	138,322,575	78,461,435	216,784,010	0.117778	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	44,949,926	1,917,418	46,867,344	0.151245	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	13,972,897	2,694,518	16,667,415	0.277099	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	10,178,281	965,302	11,143,583	0.168840	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	2,559,732	629,520	3,189,252	0.190693	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	32,464,435	53,764,865	86,229,300	0.072687	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,889,189	8,488,263	11,377,452	0.296275	0.000000		70.00
70.01	07001	SLEEP LAB	0	0	0	0.000000	0.000000		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,122,097	10,154,512	23,276,609	1.312472	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,137,676	17,811,195	35,948,871	0.777824	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,122,367	70,115,528	96,237,895	0.716011	0.000000		73.00
76.97	07697	CARDIAC REHABILITATION	1,099	4,149,110	4,150,209	0.305053	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	8,969	3,291,628	3,300,597	0.194947	0.000000		76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0.000000	0.000000		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000		78.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	95,927	13,095,004	13,190,931	0.114026	0.000000		90.00
91.00	09100	EMERGENCY	135,452,723	217,729,876	353,182,599	0.104674	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,848,500	1,302,800	3,151,300	0.143318	0.000000		92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	22,820,998	52,202,830	75,023,828	0.095642	0.000000		92.01
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0	80,070	80,070	18.459885	0.000000		95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0				102.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	1,760,162,573	876,828,187	2,636,990,760				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	1,760,162,573	876,828,187	2,636,990,760				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/20/2024 2:35 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT			34.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.261046		50.00
51.00	05100 RECOVERY ROOM	0.167994		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.307475		52.00
52.01	03190 OP INFUSION	0.205040		52.01
53.00	05300 ANESTHESIOLOGY	0.015530		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.197024		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.145835		55.00
56.00	05600 RADIOISOTOPE	0.362961		56.00
57.00	05700 CT SCAN	0.032079		57.00
58.00	05800 MRI	0.062763		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.142512		59.00
60.00	06000 LABORATORY	0.117778		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500 RESPIRATORY THERAPY	0.151245		65.00
66.00	06600 PHYSICAL THERAPY	0.277099		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.168840		67.00
68.00	06800 SPEECH PATHOLOGY	0.190693		68.00
69.00	06900 ELECTROCARDIOLOGY	0.072852		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.296275		70.00
70.01	07001 SLEEP LAB	0.000000		70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.312472		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.777824		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.716011		73.00
76.97	07697 CARDIAC REHABILITATION	0.305053		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.194947		76.98
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0.000000		77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0.000000		78.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.114026		90.00
91.00	09100 EMERGENCY	0.104674		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.143318		92.00
92.01	09201 OBSERVATION BEDS-DISTINCT	0.095642		92.01
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	18.459885		95.00
102.00	10200 OPIOID TREATMENT PROGRAM			102.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 31-0041

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

Worksheet C
Part I
Date/Time Prepared:
5/20/2024 2:35 pm

		Title XIX		Hospital		TEFRA		
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total 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	80,545,965		80,545,965	0	80,545,965	30.00
31.00	03100	INTENSIVE CARE UNIT	55,690,202		55,690,202	0	55,690,202	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	6,920,822		6,920,822	0	6,920,822	34.00
43.00	04300	NURSERY	6,184,149		6,184,149	0	6,184,149	43.00
44.00	04400	SKILLED NURSING FACILITY	7,650,654		7,650,654	0	7,650,654	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	26,817,159		26,817,159	0	26,817,159	50.00
51.00	05100	RECOVERY ROOM	3,278,991		3,278,991	0	3,278,991	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,755,178		7,755,178	0	7,755,178	52.00
52.01	03190	OP INFUSION	3,807,848		3,807,848	0	3,807,848	52.01
53.00	05300	ANESTHESIOLOGY	282,527		282,527	0	282,527	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,653,382		15,653,382	0	15,653,382	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	11,692,110		11,692,110	0	11,692,110	55.00
56.00	05600	RADIOISOTOPE	2,254,873		2,254,873	0	2,254,873	56.00
57.00	05700	CT SCAN	4,474,882		4,474,882	0	4,474,882	57.00
58.00	05800	MRI	2,113,022		2,113,022	0	2,113,022	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,009,456		9,009,456	0	9,009,456	59.00
60.00	06000	LABORATORY	25,532,495		25,532,495	0	25,532,495	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	7,088,446	0	7,088,446	0	7,088,446	65.00
66.00	06600	PHYSICAL THERAPY	4,618,528	0	4,618,528	0	4,618,528	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,881,479	0	1,881,479	0	1,881,479	67.00
68.00	06800	SPEECH PATHOLOGY	608,167	0	608,167	0	608,167	68.00
69.00	06900	ELECTROCARDIOLOGY	6,267,714		6,267,714	14,262	6,281,976	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,370,859		3,370,859	0	3,370,859	70.00
70.01	07001	SLEEP LAB	0		0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	30,549,891		30,549,891	0	30,549,891	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,961,878		27,961,878	0	27,961,878	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	68,907,345		68,907,345	0	68,907,345	73.00
76.97	07697	CARDIAC REHABILITATION	1,266,035		1,266,035	0	1,266,035	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	643,442		643,442	0	643,442	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,504,103		1,504,103	0	1,504,103	90.00
91.00	09100	EMERGENCY	36,968,912		36,968,912	0	36,968,912	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	451,637		451,637	0	451,637	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	7,175,429		7,175,429	0	7,175,429	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,478,083		1,478,083	0	1,478,083	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	470,405,663	0	470,405,663	14,262	470,419,925	200.00
201.00		Less Observation Beds	451,637		451,637		451,637	201.00
202.00		Total (see instructions)	469,954,026	0	469,954,026	14,262	469,968,288	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 31-0041

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

Worksheet C
Part I
Date/Time Prepared:
5/20/2024 2:35 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	502,760,634		502,760,634			30.00
31.00	03100 INTENSIVE CARE UNIT	466,788,849		466,788,849			31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	43,127,435		43,127,435			34.00
43.00	04300 NURSERY	20,126,493		20,126,493			43.00
44.00	04400 SKILLED NURSING FACILITY	17,934,175		17,934,175			44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	47,724,306	55,005,187	102,729,493	0.261046	0.261046	50.00
51.00	05100 RECOVERY ROOM	8,513,004	11,005,512	19,518,516	0.167994	0.167994	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	18,333,380	6,888,755	25,222,135	0.307475	0.307475	52.00
52.01	03190 OP INFUSION	46,039	18,525,170	18,571,209	0.205040	0.205040	52.01
53.00	05300 ANESTHESIOLOGY	8,922,420	9,270,205	18,192,625	0.015530	0.015530	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	33,710,587	45,738,447	79,449,034	0.197024	0.197024	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	2,922,192	77,251,280	80,173,472	0.145835	0.145835	55.00
56.00	05600 RADIOISOTOPE	2,210,133	4,002,307	6,212,440	0.362961	0.362961	56.00
57.00	05700 CT SCAN	71,459,084	68,038,537	139,497,621	0.032079	0.032079	57.00
58.00	05800 MRI	18,293,751	15,372,831	33,666,582	0.062763	0.062763	58.00
59.00	05900 CARDIAC CATHETERIZATION	34,342,700	28,876,082	63,218,782	0.142512	0.142512	59.00
60.00	06000 LABORATORY	138,322,575	78,461,435	216,784,010	0.117778	0.117778	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000	63.00
65.00	06500 RESPIRATORY THERAPY	44,949,926	1,917,418	46,867,344	0.151245	0.151245	65.00
66.00	06600 PHYSICAL THERAPY	13,972,897	2,694,518	16,667,415	0.277099	0.277099	66.00
67.00	06700 OCCUPATIONAL THERAPY	10,178,281	965,302	11,143,583	0.168840	0.168840	67.00
68.00	06800 SPEECH PATHOLOGY	2,559,732	629,520	3,189,252	0.190693	0.190693	68.00
69.00	06900 ELECTROCARDIOLOGY	32,464,435	53,764,865	86,229,300	0.072687	0.072687	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	2,889,189	8,488,263	11,377,452	0.296275	0.296275	70.00
70.01	07001 SLEEP LAB	0	0	0	0.000000	0.000000	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	13,122,097	10,154,512	23,276,609	1.312472	1.312472	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	18,137,676	17,811,195	35,948,871	0.777824	0.777824	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	26,122,367	70,115,528	96,237,895	0.716011	0.716011	73.00
76.97	07697 CARDIAC REHABILITATION	1,099	4,149,110	4,150,209	0.305053	0.305053	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	8,969	3,291,628	3,300,597	0.194947	0.194947	76.98
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0.000000	0.000000	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	95,927	13,095,004	13,190,931	0.114026	0.114026	90.00
91.00	09100 EMERGENCY	135,452,723	217,729,876	353,182,599	0.104674	0.104674	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,848,500	1,302,800	3,151,300	0.143318	0.143318	92.00
92.01	09201 OBSERVATION BEDS-DISTINCT	22,820,998	52,202,830	75,023,828	0.095642	0.095642	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	80,070	80,070	18.459885	18.459885	95.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0			102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	1,760,162,573	876,828,187	2,636,990,760			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	1,760,162,573	876,828,187	2,636,990,760			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/20/2024 2:35 pm
			Title XIX	Hospital	TEFRA
Cost Center Description			PPS Inpatient Ratio		
			11.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT			34.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
52.01	03190	OP INFUSION	0.000000		52.01
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	MRI	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
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
70.01	07001	SLEEP LAB	0.000000		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000		78.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0.000000		92.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
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: 31-0041

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

Worksheet C Part II Date/Time Prepared: 5/20/2024 2:35 pm

Cost Center Description		Title XIX			Hospital	TEFRA		
		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	26,817,159	2,714,742	24,102,417	271,474	1,397,940	50.00
51.00	05100	RECOVERY ROOM	3,278,991	188,282	3,090,709	18,828	179,261	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,755,178	600,456	7,154,722	60,046	414,974	52.00
52.01	03190	OP INFUSION	3,807,848	283,662	3,524,186	28,366	204,403	52.01
53.00	05300	ANESTHESIOLOGY	282,527	35,408	247,119	3,541	14,333	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,653,382	1,371,227	14,282,155	137,123	828,365	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	11,692,110	1,102,223	10,589,887	110,222	614,213	55.00
56.00	05600	RADIOISOTOPE	2,254,873	77,062	2,177,811	7,706	126,313	56.00
57.00	05700	CT SCAN	4,474,882	75,350	4,399,532	7,535	255,173	57.00
58.00	05800	MRI	2,113,022	261,034	1,851,988	26,103	107,415	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,009,456	981,691	8,027,765	98,169	465,610	59.00
60.00	06000	LABORATORY	25,532,495	960,982	24,571,513	96,098	1,425,148	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	7,088,446	390,326	6,698,120	39,033	388,491	65.00
66.00	06600	PHYSICAL THERAPY	4,618,528	220,270	4,398,258	22,027	255,099	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,881,479	31,087	1,850,392	3,109	107,323	67.00
68.00	06800	SPEECH PATHOLOGY	608,167	30,149	578,018	3,015	33,525	68.00
69.00	06900	ELECTROCARDIOLOGY	6,267,714	297,304	5,970,410	29,730	346,284	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,370,859	424,891	2,945,968	42,489	170,866	70.00
70.01	07001	SLEEP LAB	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	30,549,891	770,353	29,779,538	77,035	1,727,213	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,961,878	705,103	27,256,775	70,510	1,580,893	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	68,907,345	1,075,951	67,831,394	107,595	3,934,221	73.00
76.97	07697	CARDIAC REHABILITATION	1,266,035	87,075	1,178,960	8,708	68,380	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	643,442	77,153	566,289	7,715	32,845	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,504,103	39,601	1,464,502	3,960	84,941	90.00
91.00	09100	EMERGENCY	36,968,912	2,336,244	34,632,668	233,624	2,008,695	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	451,637	26,099	425,538	2,610	24,681	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	7,175,429	118,574	7,056,855	11,857	409,298	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,478,083	16,852	1,461,231	1,685	84,751	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	313,413,871	15,299,151	298,114,720	1,529,913	17,290,654	200.00
201.00		Less Observation Beds	451,637	26,099	425,538	2,610	24,681	201.00
202.00		Total (line 200 minus line 201)	312,962,234	15,273,052	297,689,182	1,527,303	17,265,973	202.00

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

Provider CCN: 31-0041

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

Worksheet C Part II Date/Time Prepared: 5/20/2024 2:35 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	25,147,745	102,729,493	0.244796		50.00
51.00	05100 RECOVERY ROOM	3,080,902	19,518,516	0.157845		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	7,280,158	25,222,135	0.288642		52.00
52.01	03190 OP INFUSION	3,575,079	18,571,209	0.192507		52.01
53.00	05300 ANESTHESIOLOGY	264,653	18,192,625	0.014547		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	14,687,894	79,449,034	0.184872		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	10,967,675	80,173,472	0.136799		55.00
56.00	05600 RADIOISOTOPE	2,120,854	6,212,440	0.341388		56.00
57.00	05700 CT SCAN	4,212,174	139,497,621	0.030195		57.00
58.00	05800 MRI	1,979,504	33,666,582	0.058797		58.00
59.00	05900 CARDIAC CATHETERIZATION	8,445,677	63,218,782	0.133594		59.00
60.00	06000 LABORATORY	24,011,249	216,784,010	0.110761		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000		63.00
65.00	06500 RESPIRATORY THERAPY	6,660,922	46,867,344	0.142123		65.00
66.00	06600 PHYSICAL THERAPY	4,341,402	16,667,415	0.260472		66.00
67.00	06700 OCCUPATIONAL THERAPY	1,771,047	11,143,583	0.158930		67.00
68.00	06800 SPEECH PATHOLOGY	571,627	3,189,252	0.179235		68.00
69.00	06900 ELECTROCARDIOLOGY	5,891,700	86,229,300	0.068326		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	3,157,504	11,377,452	0.277523		70.00
70.01	07001 SLEEP LAB	0	0	0.000000		70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	28,745,643	23,276,609	1.234958		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	26,310,475	35,948,871	0.731886		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	64,865,529	96,237,895	0.674012		73.00
76.97	07697 CARDIAC REHABILITATION	1,188,947	4,150,209	0.286479		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	602,882	3,300,597	0.182658		76.98
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000		77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.000000		78.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	1,415,202	13,190,931	0.107286		90.00
91.00	09100 EMERGENCY	34,726,593	353,182,599	0.098325		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	424,346	3,151,300	0.134657		92.00
92.01	09201 OBSERVATION BEDS-DISTINCT	6,754,274	75,023,828	0.090028		92.01
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	1,391,647	80,070	17.380380		95.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0.000000		102.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (sum of lines 50 thru 199)	294,593,304	1,586,253,174			200.00
201.00	Less Observation Beds	424,346	0			201.00
202.00	Total (line 200 minus line 201)	294,168,958	1,586,253,174			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part I Date/Time Prepared: 5/20/2024 2:35 pm
--	--	-----------------------	---	---

Cost Center Description		Title XVIII			Hospital	PPS		
		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	4,654,580	0	4,654,580	66,165	70.35	30.00	
31.00	INTENSIVE CARE UNIT	2,771,988		2,771,988	48,180	57.53	31.00	
34.00	SURGICAL INTENSIVE CARE UNIT	260,460		260,460	3,566	73.04	34.00	
43.00	NURSERY	295,977		295,977	3,946	75.01	43.00	
44.00	SKILLED NURSING FACILITY	360,646		360,646	5,975	60.36	44.00	
200.00	Total (lines 30 through 199)	8,343,651		8,343,651	127,832		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	46,606	3,278,732					30.00
31.00	INTENSIVE CARE UNIT	2,974	171,094					31.00
34.00	SURGICAL INTENSIVE CARE UNIT	1,541	112,555					34.00
43.00	NURSERY	0	0					43.00
44.00	SKILLED NURSING FACILITY	3,680	222,125					44.00
200.00	Total (lines 30 through 199)	54,801	3,784,506					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Prepared: 5/20/2024 2:35 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	2,714,742	102,729,493	0.026426	17,961,704	474,656	50.00
51.00	05100 RECOVERY ROOM	188,282	19,518,516	0.009646	3,111,924	30,018	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	600,456	25,222,135	0.023807	0	0	52.00
52.01	03190 OP INFUSION	283,662	18,571,209	0.015274	31,017	474	52.01
53.00	05300 ANESTHESIOLOGY	35,408	18,192,625	0.001946	2,781,756	5,413	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,371,227	79,449,034	0.017259	14,642,944	252,723	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	1,102,223	80,173,472	0.013748	1,217,090	16,733	55.00
56.00	05600 RADIOISOTOPE	77,062	6,212,440	0.012404	962,117	11,934	56.00
57.00	05700 CT SCAN	75,350	139,497,621	0.000540	31,167,905	16,831	57.00
58.00	05800 MRI	261,034	33,666,582	0.007754	7,618,862	59,077	58.00
59.00	05900 CARDIAC CATHETERIZATION	981,691	63,218,782	0.015528	13,589,722	211,021	59.00
60.00	06000 LABORATORY	960,982	216,784,010	0.004433	60,069,033	266,286	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	390,326	46,867,344	0.008328	18,130,696	150,992	65.00
66.00	06600 PHYSICAL THERAPY	220,270	16,667,415	0.013216	6,723,102	88,853	66.00
67.00	06700 OCCUPATIONAL THERAPY	31,087	11,143,583	0.002790	4,589,771	12,805	67.00
68.00	06800 SPEECH PATHOLOGY	30,149	3,189,252	0.009453	1,283,413	12,132	68.00
69.00	06900 ELECTROCARDIOLOGY	297,304	86,229,300	0.003448	14,418,390	49,715	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	424,891	11,377,452	0.037345	1,032,907	38,574	70.00
70.01	07001 SLEEP LAB	0	0	0.000000	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	770,353	23,276,609	0.033096	4,664,336	154,371	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	705,103	35,948,871	0.019614	7,352,906	144,220	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,075,951	96,237,895	0.011180	12,327,697	137,824	73.00
76.97	07697 CARDIAC REHABILITATION	87,075	4,150,209	0.020981	998	21	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	77,153	3,300,597	0.023375	8,934	209	76.98
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	39,601	13,190,931	0.003002	84,679	254	90.00
91.00	09100 EMERGENCY	2,336,244	353,182,599	0.006615	37,751,318	249,725	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	26,099	3,151,300	0.008282	571,671	4,735	92.00
92.01	09201 OBSERVATION BEDS-DISTINCT	118,574	75,023,828	0.001580	4,664,895	7,371	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	15,282,299	1,586,173,104		266,759,787	2,396,967	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part III Date/Time Prepared: 5/20/2024 2:35 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	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
200.00		Total (lines 30 through 199)	0	0	0	0	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	66,165	0.00	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	48,180	0.00	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	3,566	0.00	34.00
43.00	04300	NURSERY	0	0	3,946	0.00	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	5,975	0.00	44.00
200.00		Total (lines 30 through 199)	0	0	127,832	0.00	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
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0				34.00
43.00	04300	NURSERY	0				43.00
44.00	04400	SKILLED NURSING FACILITY	0				44.00
200.00		Total (lines 30 through 199)	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 31-0041

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

Worksheet D
Part IV
Date/Time Prepared:
5/20/2024 2:35 pm

Cost Center Description			Title XVIII				Hospital	PPS	
			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
52.01	03190	OP INFUSION	0	0	0	0	0	0	52.01
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	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
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	0	63.00
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
70.01	07001	SLEEP LAB	0	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	371,534	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	0	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	0	76.98
77.00	07700	ALLOGENEIC STEM CELL 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									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
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
92.01	09201	OBSERVATION BEDS-DISTINCT	0	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	371,534	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/20/2024 2:35 pm
--	-----------------------	---	--

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	102,729,493	0.000000	50.00
51.00 05100 RECOVERY ROOM	0	0	0	19,518,516	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	25,222,135	0.000000	52.00
52.01 03190 OP INFUSION	0	0	0	18,571,209	0.000000	52.01
53.00 05300 ANESTHESIOLOGY	0	0	0	18,192,625	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	79,449,034	0.000000	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	80,173,472	0.000000	55.00
56.00 05600 RADIOISOTOPE	0	0	0	6,212,440	0.000000	56.00
57.00 05700 CT SCAN	0	0	0	139,497,621	0.000000	57.00
58.00 05800 MRI	0	0	0	33,666,582	0.000000	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	63,218,782	0.000000	59.00
60.00 06000 LABORATORY	0	0	0	216,784,010	0.000000	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	46,867,344	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	16,667,415	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	11,143,583	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	3,189,252	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	86,229,300	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	11,377,452	0.000000	70.00
70.01 07001 SLEEP LAB	0	0	0	0	0.000000	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	23,276,609	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	35,948,871	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	371,534	371,534	96,237,895	0.003861	73.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	4,150,209	0.000000	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	3,300,597	0.000000	76.98
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0.000000	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	13,190,931	0.000000	90.00
91.00 09100 EMERGENCY	0	0	0	353,182,599	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,151,300	0.000000	92.00
92.01 09201 OBSERVATION BEDS-DISTINCT	0	0	0	75,023,828	0.000000	92.01
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	371,534	371,534	1,586,173,104		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/20/2024 2:35 pm
--	-----------------------	---	--

Cost Center Description		Title XVIII				Hospital		PPS
		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	17,961,704	0	14,976,599	0	50.00	
51.00	05100 RECOVERY ROOM	0.000000	3,111,924	0	2,849,002	0	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00	
52.01	03190 OP INFUSION	0.000000	31,017	0	7,200,464	0	52.01	
53.00	05300 ANESTHESIOLOGY	0.000000	2,781,756	0	2,568,061	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	14,642,944	0	9,773,732	0	54.00	
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	1,217,090	0	27,923,298	0	55.00	
56.00	05600 RADIOISOTOPE	0.000000	962,117	0	1,057,224	0	56.00	
57.00	05700 CT SCAN	0.000000	31,167,905	0	20,297,752	0	57.00	
58.00	05800 MRI	0.000000	7,618,862	0	4,211,762	0	58.00	
59.00	05900 CARDIAC CATHETERIZATION	0.000000	13,589,722	0	11,804,418	0	59.00	
60.00	06000 LABORATORY	0.000000	60,069,033	0	13,904,786	0	60.00	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00	
65.00	06500 RESPIRATORY THERAPY	0.000000	18,130,696	0	438,652	0	65.00	
66.00	06600 PHYSICAL THERAPY	0.000000	6,723,102	0	147,198	0	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0.000000	4,589,771	0	37,637	0	67.00	
68.00	06800 SPEECH PATHOLOGY	0.000000	1,283,413	0	6,224	0	68.00	
69.00	06900 ELECTROCARDIOLOGY	0.000000	14,418,390	0	19,108,561	0	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	1,032,907	0	2,189,940	0	70.00	
70.01	07001 SLEEP LAB	0.000000	0	0	0	0	70.01	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	4,664,336	0	3,023,380	0	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	7,352,906	0	6,552,075	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0.003861	12,327,697	47,597	33,594,591	129,709	73.00	
76.97	07697 CARDIAC REHABILITATION	0.000000	998	0	2,057,786	0	76.97	
76.98	07698 HYPERBARI C OXYGEN THERAPY	0.000000	8,934	0	1,102,684	0	76.98	
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00	
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000 CLINIC	0.000000	84,679	0	6,288,651	0	90.00	
91.00	09100 EMERGENCY	0.000000	37,751,318	0	45,094,194	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	571,671	0	747,257	0	92.00	
92.01	09201 OBSERVATION BEDS-DISTINCT	0.000000	4,664,895	0	13,073,939	0	92.01	
OTHER REIMBURSABLE COST CENTERS								
95.00	09500 AMBULANCE SERVICES						95.00	
200.00	Total (lines 50 through 199)		266,759,787	47,597	250,029,867	129,709	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 5/20/2024 2:35 pm
--	--	-----------------------	---	---

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
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.261046	14,976,599	0	0	3,909,581	50.00
51.00	05100	RECOVERY ROOM	0.167994	2,849,002	0	0	478,615	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.307475	0	0	0	0	52.00
52.01	03190	OP INFUSION	0.205040	7,200,464	0	0	1,476,383	52.01
53.00	05300	ANESTHESIOLOGY	0.015530	2,568,061	0	0	39,882	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.197024	9,773,732	0	0	1,925,660	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.145835	27,923,298	0	0	4,072,194	55.00
56.00	05600	RADIOISOTOPE	0.362961	1,057,224	0	0	383,731	56.00
57.00	05700	CT SCAN	0.032079	20,297,752	0	0	651,132	57.00
58.00	05800	MRI	0.062763	4,211,762	0	0	264,343	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.142512	11,804,418	0	0	1,682,271	59.00
60.00	06000	LABORATORY	0.117778	13,904,786	0	0	1,637,678	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.151245	438,652	0	0	66,344	65.00
66.00	06600	PHYSICAL THERAPY	0.277099	147,198	0	0	40,788	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.168840	37,637	0	0	6,355	67.00
68.00	06800	SPEECH PATHOLOGY	0.190693	6,224	0	0	1,187	68.00
69.00	06900	ELECTROCARDIOLOGY	0.072687	19,108,561	0	0	1,388,944	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.296275	2,189,940	0	0	648,824	70.00
70.01	07001	SLEEP LAB	0.000000	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.312472	3,023,380	0	0	3,968,102	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.777824	6,552,075	0	0	5,096,361	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.716011	33,594,591	0	31,168	24,054,097	73.00
76.97	07697	CARDIAC REHABILITATION	0.305053	2,057,786	0	0	627,734	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.194947	1,102,684	0	0	214,965	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.114026	6,288,651	0	0	717,070	90.00
91.00	09100	EMERGENCY	0.104674	45,094,194	0	0	4,720,190	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.143318	747,257	0	0	107,095	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0.095642	13,073,939	0	0	1,250,418	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	18.459885		0			95.00
200.00		Subtotal (see instructions)		250,029,867	0	31,168	59,429,944	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		250,029,867	0	31,168	59,429,944	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 5/20/2024 2:35 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
52.01 03190 OP INFUSION	0	0		52.01
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 MRI	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
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
70.01 07001 SLEEP LAB	0	0		70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	22,317		73.00
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0		76.98
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		78.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
92.01 09201 OBSERVATION BEDS-DISTINCT	0	0		92.01
OTHER REIMBURSABLE COST CENTERS				
95.00 09500 AMBULANCE SERVICES	0	0		95.00
200.00 Subtotal (see instructions)	0	22,317		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	0	22,317		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 31-0041 Component CCN: 31-5490	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/20/2024 2:35 pm
--	---	---	--

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
52.01	03190 OP INFUSION	0	0	0	0	0	52.01
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 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
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
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
70.01	07001 SLEEP LAB	0	0	0	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	371,534	73.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
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
92.01	09201 OBSERVATION BEDS-DISTINCT	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00	Total (lines 50 through 199)	0	0	0	0	371,534	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 31-0041 Component CCN: 31-5490	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/20/2024 2:35 pm
--	---	---	--

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	102,729,493	0.000000	50.00
51.00	05100 RECOVERY ROOM	0	0	0	19,518,516	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	25,222,135	0.000000	52.00
52.01	03190 OP INFUSION	0	0	0	18,571,209	0.000000	52.01
53.00	05300 ANESTHESIOLOGY	0	0	0	18,192,625	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	79,449,034	0.000000	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	80,173,472	0.000000	55.00
56.00	05600 RADIOISOTOPE	0	0	0	6,212,440	0.000000	56.00
57.00	05700 CT SCAN	0	0	0	139,497,621	0.000000	57.00
58.00	05800 MRI	0	0	0	33,666,582	0.000000	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	63,218,782	0.000000	59.00
60.00	06000 LABORATORY	0	0	0	216,784,010	0.000000	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	46,867,344	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	16,667,415	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	11,143,583	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	3,189,252	0.000000	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	86,229,300	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	11,377,452	0.000000	70.00
70.01	07001 SLEEP LAB	0	0	0	0	0.000000	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	23,276,609	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	35,948,871	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	371,534	371,534	96,237,895	0.003861	73.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	4,150,209	0.000000	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	3,300,597	0.000000	76.98
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	13,190,931	0.000000	90.00
91.00	09100 EMERGENCY	0	0	0	353,182,599	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,151,300	0.000000	92.00
92.01	09201 OBSERVATION BEDS-DISTINCT	0	0	0	75,023,828	0.000000	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0.000000	95.00
200.00	Total (lines 50 through 199)	0	371,534	371,534	1,586,173,104		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 31-0041 Component CCN: 31-5490	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/20/2024 2:35 pm
--	---	---	--

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	1,750	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
52.01	03190 OP INFUSION	0.000000	0	0	0	0	52.01
53.00	05300 ANESTHESIOLOGY	0.000000	390	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	33,816	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	14,363	0	0	0	57.00
58.00	05800 MRI	0.000000	3,227	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	735,975	0	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.000000	42,758	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	2,042,067	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	1,346,778	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	11,923	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	6,752	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001 SLEEP LAB	0.000000	0	0	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	956	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	0.003861	270,601	1,045	0	0	73.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
92.01	09201 OBSERVATION BEDS-DISTINCT	0.000000	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		4,511,356	1,045	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 31-0041 Component CCN: 31-5490	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 5/20/2024 2:35 pm
Title XVIII			Skilled Nursing Facility	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			PPS Services (see inst.)	Costs (see inst.)
		Cost Reimbursed Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Subject To Ded. & Coins. (see inst.)	Cost Reimbursed 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	0.261046	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0.167994	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.307475	0	0	0	0	52.00
52.01 03190 OP INFUSION	0.205040	0	0	0	0	52.01
53.00 05300 ANESTHESIOLOGY	0.015530	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.197024	0	0	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0.145835	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0.362961	0	0	0	0	56.00
57.00 05700 CT SCAN	0.032079	0	0	0	0	57.00
58.00 05800 MRI	0.062763	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.142512	0	0	0	0	59.00
60.00 06000 LABORATORY	0.117778	0	0	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0.151245	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.277099	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.168840	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.190693	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.072687	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.296275	0	0	0	0	70.00
70.01 07001 SLEEP LAB	0.000000	0	0	0	0	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.312472	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.777824	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.716011	0	0	3,116	0	73.00
76.97 07697 CARDIAC REHABILITATION	0.305053	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0.194947	0	0	0	0	76.98
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.114026	0	0	0	0	90.00
91.00 09100 EMERGENCY	0.104674	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.143318	0	0	0	0	92.00
92.01 09201 OBSERVATION BEDS-DISTINCT	0.095642	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	18.459885	0	0	0	0	95.00
200.00 Subtotal (see instructions)		0	0	3,116	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	3,116	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 31-0041 Component CCN: 31-5490	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 5/20/2024 2:35 pm
		Title XVIII	Skilled Nursing Facility	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
52.01 03190 OP INFUSION	0	0		52.01
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 MRI	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
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
70.01 07001 SLEEP LAB	0	0		70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	2,231		73.00
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0		76.98
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		78.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
92.01 09201 OBSERVATION BEDS-DISTINCT	0	0		92.01
OTHER REIMBURSABLE COST CENTERS				
95.00 09500 AMBULANCE SERVICES	0	0		95.00
200.00 Subtotal (see instructions)	0	2,231		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	0	2,231		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part I Date/Time Prepared: 5/20/2024 2:35 pm
--	--	-----------------------	---	---

Cost Center Description		Title XIX			Hospital	TEFRA		
		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	4,654,580	0	4,654,580	66,165	70.35	30.00	
31.00	INTENSIVE CARE UNIT	2,771,988		2,771,988	48,180	57.53	31.00	
34.00	SURGICAL INTENSIVE CARE UNIT	260,460		260,460	3,566	73.04	34.00	
43.00	NURSERY	295,977		295,977	3,946	75.01	43.00	
44.00	SKILLED NURSING FACILITY	360,646		360,646	5,975	60.36	44.00	
200.00	Total (lines 30 through 199)	8,343,651		8,343,651	127,832		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	565	39,748					30.00
31.00	INTENSIVE CARE UNIT	574	33,022					31.00
34.00	SURGICAL INTENSIVE CARE UNIT	0	0					34.00
43.00	NURSERY	1,829	137,193					43.00
44.00	SKILLED NURSING FACILITY	0	0					44.00
200.00	Total (lines 30 through 199)	2,968	209,963					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Prepared: 5/20/2024 2:35 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	2,714,742	102,729,493	0.026426	311,214	8,224	50.00
51.00	05100 RECOVERY ROOM	188,282	19,518,516	0.009646	77,593	748	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	600,456	25,222,135	0.023807	200,452	4,772	52.00
52.01	03190 OP INFUSION	283,662	18,571,209	0.015274	0	0	52.01
53.00	05300 ANESTHESIOLOGY	35,408	18,192,625	0.001946	90,130	175	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,371,227	79,449,034	0.017259	251,074	4,333	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	1,102,223	80,173,472	0.013748	0	0	55.00
56.00	05600 RADIOISOTOPE	77,062	6,212,440	0.012404	31,895	396	56.00
57.00	05700 CT SCAN	75,350	139,497,621	0.000540	934,208	504	57.00
58.00	05800 MRI	261,034	33,666,582	0.007754	250,962	1,946	58.00
59.00	05900 CARDIAC CATHETERIZATION	981,691	63,218,782	0.015528	328,606	5,103	59.00
60.00	06000 LABORATORY	960,982	216,784,010	0.004433	1,417,592	6,284	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	390,326	46,867,344	0.008328	157,949	1,315	65.00
66.00	06600 PHYSICAL THERAPY	220,270	16,667,415	0.013216	65,322	863	66.00
67.00	06700 OCCUPATIONAL THERAPY	31,087	11,143,583	0.002790	40,613	113	67.00
68.00	06800 SPEECH PATHOLOGY	30,149	3,189,252	0.009453	16,237	153	68.00
69.00	06900 ELECTROCARDIOLOGY	297,304	86,229,300	0.003448	290,557	1,002	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	424,891	11,377,452	0.037345	21,864	817	70.00
70.01	07001 SLEEP LAB	0	0	0.000000	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	770,353	23,276,609	0.033096	76,091	2,518	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	705,103	35,948,871	0.019614	82,587	1,620	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,075,951	96,237,895	0.011180	159,129	1,779	73.00
76.97	07697 CARDIAC REHABILITATION	87,075	4,150,209	0.020981	0	0	76.97
76.98	07698 HYPERBARI C OXYGEN THERAPY	77,153	3,300,597	0.023375	0	0	76.98
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	39,601	13,190,931	0.003002	7,739	23	90.00
91.00	09100 EMERGENCY	2,336,244	353,182,599	0.006615	1,118,127	7,396	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	26,099	3,151,300	0.008282	21,234	176	92.00
92.01	09201 OBSERVATION BEDS-DISTINCT	118,574	75,023,828	0.001580	143,401	227	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	15,282,299	1,586,173,104		6,094,576	50,487	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part III Date/Time Prepared: 5/20/2024 2:35 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	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
200.00		Total (lines 30 through 199)	0	0	0	0	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	66,165	0.00	565 30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	48,180	0.00	574 31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	3,566	0.00	0 34.00
43.00	04300	NURSERY	0	0	3,946	0.00	1,829 43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	5,975	0.00	0 44.00
200.00		Total (lines 30 through 199)	0	0	127,832		2,968 200.00
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
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0				34.00
43.00	04300	NURSERY	0				43.00
44.00	04400	SKILLED NURSING FACILITY	0				44.00
200.00		Total (lines 30 through 199)	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 31-0041

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

Worksheet D
Part IV
Date/Time Prepared:
5/20/2024 2:35 pm

Cost Center Description		Title XIX			Hospital		TEFRA	
		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
52.01	03190	OP INFUSION	0	0	0	0	0	52.01
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	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
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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
70.01	07001	SLEEP LAB	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	371,534	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
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
92.01	09201	OBSERVATION BEDS-DISTINCT	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	0	0	0	0	371,534	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/20/2024 2:35 pm
--	-----------------------	---	--

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)	Title XIX		
						Hospital	TEFRA	
	4.00	5.00	6.00	7.00	8.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	102,729,493	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	19,518,516	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	25,222,135	0.000000	52.00
52.01	03190	OP INFUSION	0	0	0	18,571,209	0.000000	52.01
53.00	05300	ANESTHESIOLOGY	0	0	0	18,192,625	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	79,449,034	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	80,173,472	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	6,212,440	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	139,497,621	0.000000	57.00
58.00	05800	MRI	0	0	0	33,666,582	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	63,218,782	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	216,784,010	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	46,867,344	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	16,667,415	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	11,143,583	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,189,252	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	86,229,300	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	11,377,452	0.000000	70.00
70.01	07001	SLEEP LAB	0	0	0	0	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	23,276,609	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	35,948,871	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	371,534	371,534	96,237,895	0.003861	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	4,150,209	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	3,300,597	0.000000	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	13,190,931	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	353,182,599	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,151,300	0.000000	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0	0	0	75,023,828	0.000000	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0.000000	95.00
200.00		Total (lines 50 through 199)	0	371,534	371,534	1,586,173,104		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/20/2024 2:35 pm
--	-----------------------	---	--

Cost Center Description		Title XIX			Hospital		TEFRA	
		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			
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	0.000000	311,214	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	77,593	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	200,452	0	0	0	0	52.00
52.01	03190 OP INFUSION	0.000000	0	0	0	0	0	52.01
53.00	05300 ANESTHESIOLOGY	0.000000	90,130	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	251,074	0	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	31,895	0	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	934,208	0	0	0	0	57.00
58.00	05800 MRI	0.000000	250,962	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	328,606	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	1,417,592	0	0	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.000000	157,949	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	65,322	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	40,613	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	16,237	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	290,557	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	21,864	0	0	0	0	70.00
70.01	07001 SLEEP LAB	0.000000	0	0	0	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	76,091	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	82,587	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.003861	159,129	614	0	0	0	73.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97
76.98	07698 HYPERBARI C OXYGEN THERAPY	0.000000	0	0	0	0	0	76.98
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000 CLINIC	0.000000	7,739	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	1,118,127	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	21,234	0	0	0	0	92.00
92.01	09201 OBSERVATION BEDS-DISTINCT	0.000000	143,401	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500 AMBULANCE SERVICES							95.00
200.00	Total (lines 50 through 199)		6,094,576	614	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 5/20/2024 2:35 pm
--	--	-----------------------	---	---

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	0.244796	0	119,131	0	0
51.00	05100 RECOVERY ROOM	0.157845	0	27,418	0	0
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.288642	0	475,893	0	0
52.01	03190 OP INFUSION	0.192507	0	29,844	0	0
53.00	05300 ANESTHESIOLOGY	0.014547	0	23,038	0	0
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.184872	0	281,515	0	0
55.00	05500 RADIOLOGY-THERAPEUTIC	0.136799	0	97,884	0	0
56.00	05600 RADIO SOTOPE	0.341388	0	17,622	0	0
57.00	05700 CT SCAN	0.030195	0	418,672	0	0
58.00	05800 MRI	0.058797	0	77,176	0	0
59.00	05900 CARDIAC CATHETERIZATION	0.133594	0	13,226	0	0
60.00	06000 LABORATORY	0.110761	0	13,060	0	0
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0
65.00	06500 RESPIRATORY THERAPY	0.142123	0	7,725	0	0
66.00	06600 PHYSICAL THERAPY	0.260472	0	8,389	0	0
67.00	06700 OCCUPATIONAL THERAPY	0.158930	0	4,162	0	0
68.00	06800 SPEECH PATHOLOGY	0.179235	0	0	0	0
69.00	06900 ELECTROCARDIOLOGY	0.068326	0	93,662	0	0
70.00	07000 ELECTROENCEPHALOGRAPHY	0.277523	0	6,283	0	0
70.01	07001 SLEEP LAB	0.000000	0	0	0	0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.234958	0	16,052	0	0
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.731886	0	23,247	0	0
73.00	07300 DRUGS CHARGED TO PATIENTS	0.674012	0	33,729	0	0
76.97	07697 CARDIAC REHABILITATION	0.286479	0	0	0	0
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.182658	0	0	0	0
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0.107286	0	10,723	0	0
91.00	09100 EMERGENCY	0.098325	0	3,014,389	0	0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.134657	0	26,285	0	0
92.01	09201 OBSERVATION BEDS-DISTINCT	0.090028	0	568,130	0	0
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	17.380380	0	0	0	95.00
200.00	Subtotal (see instructions)		0	5,407,255	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	5,407,255	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 5/20/2024 2:35 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	29,163	0	50.00
51.00	05100 RECOVERY ROOM	4,328	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	137,363	0	52.00
52.01	03190 OP INFUSION	5,745	0	52.01
53.00	05300 ANESTHESIOLOGY	335	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	52,044	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	13,390	0	55.00
56.00	05600 RADIOISOTOPE	6,016	0	56.00
57.00	05700 CT SCAN	12,642	0	57.00
58.00	05800 MRI	4,538	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	1,767	0	59.00
60.00	06000 LABORATORY	1,447	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	1,098	0	65.00
66.00	06600 PHYSICAL THERAPY	2,185	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	661	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	6,400	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1,744	0	70.00
70.01	07001 SLEEP LAB	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	19,824	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	17,014	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	22,734	0	73.00
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	78.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	1,150	0	90.00
91.00	09100 EMERGENCY	296,390	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3,539	0	92.00
92.01	09201 OBSERVATION BEDS-DISTINCT	51,148	0	92.01
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0	0	95.00
200.00	Subtotal (see instructions)	692,665	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)	692,665	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/20/2024 2:35 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		66,165	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		66,165	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)		65,794	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)		46,606	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)		80,545,965	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)		80,545,965	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)		80,545,965	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)		1,217.35	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		56,735,814	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)		56,735,814	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/20/2024 2:35 pm		
Cost Center Description			Title XVIII		Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	55,690,202	48,180	1,155.88	2,974	3,437,587	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT	6,920,822	3,566	1,940.78	1,541	2,990,742	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)					51,302,889	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)					114,467,032	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)					3,562,381	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,444,564	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					6,006,945	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					108,460,087	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
55.01	Permanent adjustment amount per discharge					0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)					0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					371	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,217.35	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					451,637	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 31-0041		Period: From 01/01/2023 To 12/31/2023		Worksheet D-1 Date/Time Prepared: 5/20/2024 2:35 pm	
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	4,654,580	80,545,965	0.057788	451,637	26,099	90.00
91.00	Nursing Program cost	0	80,545,965	0.000000	451,637	0	91.00
92.00	Allied health cost	0	80,545,965	0.000000	451,637	0	92.00
93.00	All other Medical Education	0	80,545,965	0.000000	451,637	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 31-0041 Component CCN: 31-5490	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/20/2024 2:35 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)		5,975	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,975	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)		5,975	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		3,680	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)		7,650,654	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)		7,650,654	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)		7,650,654	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: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1
				Component CCN: 31-5490		Date/Time Prepared: 5/20/2024 2:35 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)					7,650,654 70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					1,280.44 71.00
72.00	Program routine service cost (line 9 x line 71)					4,712,019 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)					4,712,019 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)					4,712,019 83.00
84.00	Program inpatient ancillary services (see instructions)					1,091,795 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)					5,803,814 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: 31-0041 Component CCN: 31-5490	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/20/2024 2:35 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: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/20/2024 2:35 pm
Cost Center Description				TEFRA
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		66,165	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		66,165	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)		65,794	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)		565	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)		3,946	15.00
16.00	Nursery days (title V or XIX only)		1,829	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)		80,545,965	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)		80,545,965	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)		80,545,965	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)		1,217.35	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		687,803	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)		687,803	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/20/2024 2:35 pm		
Cost Center Description			Title XIX		Hospital	TEFRA	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00	NURSERY (title V & XIX only)	6,184,149	3,946	1,567.19	1,829	2,866,391	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	55,690,202	48,180	1,155.88	574	663,475	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT	6,920,822	3,566	1,940.78	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)					970,128	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					5,187,797	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)					209,963	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					51,101	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					261,064	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					4,926,733	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					276	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)					-4,926,733	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)					261,064	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)					371	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,217.35	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					451,637	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 31-0041		Period: From 01/01/2023 To 12/31/2023		Worksheet D-1 Date/Time Prepared: 5/20/2024 2:35 pm	
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	4,654,580	80,545,965	0.057788	451,637	26,099	90.00
91.00	Nursing Program cost	0	80,545,965	0.000000	451,637	0	91.00
92.00	Allied health cost	0	80,545,965	0.000000	451,637	0	92.00
93.00	All other Medical Education	0	80,545,965	0.000000	451,637	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 5/20/2024 2:35 pm	
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		415,143,889	30.00
31.00	03100	INTENSIVE CARE UNIT		54,623,186	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		70,798	34.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.261046	17,961,704	50.00
51.00	05100	RECOVERY ROOM	0.167994	3,111,924	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.307475	0	52.00
52.01	03190	OP INFUSION	0.205040	31,017	52.01
53.00	05300	ANESTHESIOLOGY	0.015530	2,781,756	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.197024	14,642,944	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.145835	1,217,090	55.00
56.00	05600	RADIOISOTOPE	0.362961	962,117	56.00
57.00	05700	CT SCAN	0.032079	31,167,905	57.00
58.00	05800	MRI	0.062763	7,618,862	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.142512	13,589,722	59.00
60.00	06000	LABORATORY	0.117778	60,069,033	60.00
63.00	06300	BLOOD STORAGE, PROCESSING & TRANS.	0.000000	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.151245	18,130,696	65.00
66.00	06600	PHYSICAL THERAPY	0.277099	6,723,102	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.168840	4,589,771	67.00
68.00	06800	SPEECH PATHOLOGY	0.190693	1,283,413	68.00
69.00	06900	ELECTROCARDIOLOGY	0.072852	14,418,390	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.296275	1,032,907	70.00
70.01	07001	SLEEP LAB	0.000000	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.312472	4,664,336	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.777824	7,352,906	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.716011	12,327,697	73.00
76.97	07697	CARDIAC REHABILITATION	0.305053	998	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.194947	8,934	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	78.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.114026	84,679	90.00
91.00	09100	EMERGENCY	0.104674	37,751,318	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.143318	571,671	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0.095642	4,664,895	92.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		266,759,787	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)		266,759,787	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 31-0041 Component CCN: 31-5490	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 5/20/2024 2:35 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
34.00	03400	SURGICAL INTENSIVE CARE UNIT			34.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.261046	0	50.00
51.00	05100	RECOVERY ROOM	0.167994	1,750	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.307475	0	52.00
52.01	03190	OP INFUSION	0.205040	0	52.01
53.00	05300	ANESTHESIOLOGY	0.015530	390	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.197024	33,816	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.145835	0	55.00
56.00	05600	RADIOISOTOPE	0.362961	0	56.00
57.00	05700	CT SCAN	0.032079	14,363	57.00
58.00	05800	MRI	0.062763	3,227	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.142512	0	59.00
60.00	06000	LABORATORY	0.117778	735,975	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.151245	42,758	65.00
66.00	06600	PHYSICAL THERAPY	0.277099	2,042,067	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.168840	1,346,778	67.00
68.00	06800	SPEECH PATHOLOGY	0.190693	11,923	68.00
69.00	06900	ELECTROCARDIOLOGY	0.072852	6,752	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.296275	0	70.00
70.01	07001	SLEEP LAB	0.000000	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.312472	956	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.777824	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.716011	270,601	73.00
76.97	07697	CARDIAC REHABILITATION	0.305053	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.194947	0	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	78.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.114026	0	90.00
91.00	09100	EMERGENCY	0.104674	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.143318	0	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0.095642	0	92.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,511,356	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		4,511,356	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 5/20/2024 2:35 pm	
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		4,154,807	30.00
31.00	03100	INTENSIVE CARE UNIT		5,730,347	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	34.00
43.00	04300	NURSERY		783,977	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.261046	311,214	50.00
51.00	05100	RECOVERY ROOM	0.167994	77,593	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.307475	200,452	52.00
52.01	03190	OP INFUSION	0.205040	0	52.01
53.00	05300	ANESTHESIOLOGY	0.015530	90,130	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.197024	251,074	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.145835	0	55.00
56.00	05600	RADIOISOTOPE	0.362961	31,895	56.00
57.00	05700	CT SCAN	0.032079	934,208	57.00
58.00	05800	MRI	0.062763	250,962	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.142512	328,606	59.00
60.00	06000	LABORATORY	0.117778	1,417,592	60.00
63.00	06300	BLOOD STORAGE, PROCESSING & TRANS.	0.000000	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.151245	157,949	65.00
66.00	06600	PHYSICAL THERAPY	0.277099	65,322	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.168840	40,613	67.00
68.00	06800	SPEECH PATHOLOGY	0.190693	16,237	68.00
69.00	06900	ELECTROCARDIOLOGY	0.072687	290,557	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.296275	21,864	70.00
70.01	07001	SLEEP LAB	0.000000	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.312472	76,091	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.777824	82,587	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.716011	159,129	73.00
76.97	07697	CARDIAC REHABILITATION	0.305053	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.194947	0	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	78.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.114026	7,739	90.00
91.00	09100	EMERGENCY	0.104674	1,118,127	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.143318	21,234	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0.095642	143,401	92.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		6,094,576	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		6,094,576	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/20/2024 2:35 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)		66,827,832	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		23,573,276	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)		897,133	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		76,131	2.04
3.00	Managed Care Simulated Payments		60,547,903	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		408.98	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
5.01	FTE cap adjustment for 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)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		7.11	11.00
12.00	Current year allowable FTE (see instructions)		7.11	12.00
13.00	Total allowable FTE count for the prior year.		4.43	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.		1.51	14.00
15.00	Sum of lines 12 through 14 divided by 3.		4.35	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)		61.62	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		65.97	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.161304	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.160698	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.160698	21.00
22.00	IME payment adjustment (see instructions)		7,592,427	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		5,085,176	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		7,592,427	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		5,085,176	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.49	30.00
31.00	Percentage of Medicaid patient days (see instructions)		10.47	31.00
32.00	Sum of lines 30 and 31		12.96	32.00
33.00	Allowable disproportionate share percentage (see instructions)		0.00	33.00
34.00	Disproportionate share adjustment (see instructions)		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/20/2024 2:35 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)		0	0 35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)		0	0 35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)		0	0 36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges (see instructions)		0	0 40.00
41.00	Total ESRD Medicare discharges (see instructions)		0	0 41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)		0	0 41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	0 42.00
43.00	Total Medicare ESRD inpatient days (see instructions)		0	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	0 44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0 45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	0 46.00
47.00	Subtotal (see instructions)		98,966,799	0 47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	0 48.00
				Amount
				1.00
49.00	Total payment for inpatient operating costs (see instructions)		104,051,975	0 49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		7,461,995	0 50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	0 51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		4,158,030	0 52.00
53.00	Nursing and Allied Health Managed Care payment		80,314	0 53.00
54.00	Special add-on payments for new technologies		438,297	0 54.00
54.01	Islet isolation add-on payment		0	0 54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	0 55.00
55.01	Cellular therapy acquisition cost (see instructions)		0	0 55.01
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0 56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	0 57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		47,597	0 58.00
59.00	Total (sum of amounts on lines 49 through 58)		116,238,208	0 59.00
60.00	Primary payer payments		0	0 60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		116,238,208	0 61.00
62.00	Deductibles billed to program beneficiaries		9,162,852	0 62.00
63.00	Coinurance billed to program beneficiaries		835,916	0 63.00
64.00	Allowable bad debts (see instructions)		1,537,725	0 64.00
65.00	Adjusted reimbursable bad debts (see instructions)		999,521	0 65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		372,159	0 66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		107,238,961	0 67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	0 68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	0 69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0 70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	0 70.50
70.75	N95 respirator payment adjustment amount (see instructions)		0	0 70.75
70.87	Demonstration payment adjustment amount before sequestration		0	0 70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	0 70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	0 70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	0 70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	0 70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	0 70.92
70.93	HVBP payment adjustment amount (see instructions)		-152,660	0 70.93
70.94	HRR adjustment amount (see instructions)		-1,205,990	0 70.94
70.95	Recovery of accelerated depreciation		0	0 70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/20/2024 2:35 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3	0	0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		105,880,311	71.00
71.01	Sequestration adjustment (see instructions)		2,117,606	71.01
71.02	Demonstration payment adjustment amount after sequestration		39,982	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		107,108,322	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)		-3,385,599	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		2,791,837	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)			90.00
91.00	Capital outlier from Wkst. L, Pt. 1, line 2			91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			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)			95.00
96.00	Time value of money for capital related expenses (see instructions)			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. 11, 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

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 31-0041

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/20/2024 2:35 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	66,827,832	0	66,827,832		66,827,832	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	23,573,276	0		23,573,276	23,573,276	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	897,133	0	897,133		897,133	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	76,131	0		76,131	76,131	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	60,547,903	0	43,829,210	16,718,693	60,547,903	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.160698	0.160698	0.160698	0.160698		5.00
6.00	IME payment adjustment (see instructions)	22.00	7,592,427	0	5,612,602	1,979,825	7,592,427	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	5,085,176	0	3,681,040	1,404,136	5,085,176	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	7,592,427	0	5,612,602	1,979,825	7,592,427	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	5,085,176	0	3,681,040	1,404,136	5,085,176	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	0	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	98,966,799	0	73,337,567	25,629,232	98,966,799	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	104,051,975	0	77,018,607	27,033,368	104,051,975	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	7,461,995	0	5,480,275	1,981,720	7,461,995	16.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 31-0041

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/20/2024 2:35 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	438,297	0	438,297	0	438,297	17.00
17.01	Net organ acquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	82,937,179	29,015,088	111,952,267	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	6,852,311	0	5,027,704	1,824,607	6,852,311	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	28,608	0	26,222	2,386	28,608	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0583	0.0583	0.0583	0.0583		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	399,490	0	293,115	106,375	399,490	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0265	0.0265	0.0265	0.0265		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	181,586	0	133,234	48,352	181,586	25.00
26.00	Total prospective capital payments (see instructions)	12.00	7,461,995	0	5,480,275	1,981,720	7,461,995	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 31-0041

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

Worksheet E
Part A Exhibit 5
Date/Time Prepared:
5/20/2024 2:35 pm

		Title XVIII			Hospital	PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (col s. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00				1.00	
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	66,827,832	66,827,832		66,827,832 1.01	
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	23,573,276		23,573,276	23,573,276 1.02	
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0 1.03	
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0 1.04	
2.00	Outlier payments for discharges (see instructions)	2.00				2.00	
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0 2.01	
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	897,133	897,133		897,133 2.02	
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	76,131		76,131	76,131 2.03	
3.00	Operating outlier reconciliation	2.01	0	0	0	0 3.00	
4.00	Managed care simulated payments	3.00	60,547,903	43,829,210	16,718,693	60,547,903 4.00	
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.160698	0.160698	0.160698	0.160698 5.00	
6.00	IME payment adjustment (see instructions)	22.00	7,592,427	5,612,602	1,979,825	7,592,427 6.00	
6.01	IME payment adjustment for managed care (see instructions)	22.01	5,085,176	3,681,040	1,404,136	5,085,176 6.01	
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000 7.00	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0 8.00	
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0 8.01	
9.00	Total IME payment (sum of lines 6 and 8)	29.00	7,592,427	5,612,602	1,979,825	7,592,427 9.00	
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	5,085,176	3,681,040	1,404,136	5,085,176 9.01	
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000	0.0000 10.00	
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0 11.00	
11.01	Uncompensated care payments	36.00	0	0	0	0 11.01	
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0 12.00	
13.00	Subtotal (see instructions)	47.00	98,966,799	73,337,567	25,629,232	98,966,799 13.00	
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0 14.00	
15.00	Total payment for inpatient operating costs (see instructions)	49.00	104,051,975	77,018,607	27,033,368	104,051,975 15.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	7,461,995	5,480,275	1,981,720	7,461,995 16.00	
17.00	Special add-on payments for new technologies	54.00	438,297	438,297	0	438,297 17.00	
17.01	Net organ acquisition cost					17.01	
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0 17.02	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0 18.00	
19.00	SUBTOTAL			82,937,179	29,015,088	111,952,267 19.00	

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 31-0041

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

Worksheet E
Part A Exhibit 5
Date/Time Prepared:
5/20/2024 2:35 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	6,852,311	5,027,704	1,824,607	6,852,311	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	28,608	26,222	2,386	28,608	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0583	0.0583	0.0583		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	399,490	293,115	106,375	399,490	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0265	0.0265	0.0265		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	181,586	133,234	48,352	181,586	25.00
26.00	Total prospective capital payments (see instructions)	12.00	7,461,995	5,480,275	1,981,720	7,461,995	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-152,660	0	-152,660	-152,660	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-1,205,990	-753,381	-452,609	-1,205,990	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0		32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/20/2024 2:35 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		22,317	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		59,300,235	2.00
3.00	OPPS or REH payments		47,566,346	3.00
4.00	Outlier payment (see instructions)		68,038	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		129,709	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		22,317	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		31,168	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)		31,168	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		31,168	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		8,851	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)		22,317	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)		47,764,093	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)		8,369,386	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)		39,417,024	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		2,028,788	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)		41,445,812	30.00
31.00	Primary payer payments		24,630	31.00
32.00	Subtotal (line 30 minus line 31)		41,421,182	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)		350,936	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		228,108	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		246,261	36.00
37.00	Subtotal (see instructions)		41,649,290	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-232	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)		41,649,522	40.00
40.01	Sequestration adjustment (see instructions)		832,990	40.01
40.02	Demonstration payment adjustment amount after sequestration		3,812	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00	Interim payments		38,455,000	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)		2,357,720	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: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/20/2024 2:35 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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 31-0041 Component CCN: 31-5490	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/20/2024 2:35 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		2,231	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS or REH payments			3.00
4.00	Outlier payment (see instructions)			4.00
4.01	Outlier reconciliation amount (see instructions)			4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		2,231	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		3,116	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)		3,116	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)		3,116	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		885	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		2,231	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		2,231	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
28.50	REH facility payment amount (see instructions)			28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)		2,231	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		2,231	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)		2,231	37.00
38.00	MSP-LCC reconciliation amount from PS&R			38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.75	N95 respirator payment adjustment amount (see instructions)		0	39.75
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		2,231	40.00
40.01	Sequestration adjustment (see instructions)		45	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00	Interim payments		3,054	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)		-868	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)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 31-0041 Component CCN: 31-5490	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/20/2024 2:35 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00
				1.00
MEDICARE PART B ANCILLARY COSTS				
200.00	Part B Combined Billed Days			200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 31-0041

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

Worksheet E-1
Part I
Date/Time Prepared:
5/20/2024 2:35 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		103,164,228		38,455,000	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	07/20/2023	3,767,110		0	3.01
3.02		09/20/2023	176,984		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)		3,944,094		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)		107,108,322		38,455,000	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		2,357,720	6.01
6.02	SETTLEMENT TO PROGRAM		3,385,599		0	6.02
7.00	Total Medicare program liability (see instructions)		103,722,723		40,812,720	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: 31-0041
Component CCN: 31-5490

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

Worksheet E-1
Part I
Date/Time Prepared:
5/20/2024 2:35 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		2,537,676		3,054	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,537,676		3,054	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		1,045		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		868	6.02
7.00	Total Medicare program liability (see instructions)		2,538,721		2,186	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		Provider CCN: 31-0041 Component CCN: 31-5490	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VI Date/Time Prepared: 5/20/2024 2:35 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)		2,622,465	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		1,045	3.00
4.00	Subtotal (sum of lines 1 through 3)		2,623,510	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		33,000	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)		2,590,510	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)		2,590,510	15.00
15.01	Sequestration adjustment (see instructions)		51,789	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		2,537,676	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)		1,045	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: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/20/2024 2:35 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	261,064		1.00
2.00	Medical and other services		692,665	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	261,064	692,665	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)	261,064	692,665	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	9,885,154		8.00
9.00	Ancillary service charges	6,094,576	5,407,255	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)	15,979,730	5,407,255	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)	15,979,730	5,407,255	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	15,718,666	4,714,590	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)	261,064	692,665	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)	261,064	692,665	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)	261,064	692,665	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)	261,064	692,665	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	261,064	692,665	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)	261,064	692,665	40.00
41.00	Interim payments	2,428,074	732,960	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-2,167,010	-40,295	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: 31-0041 Component CCN: 31-5490	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/20/2024 2:35 pm
		Title XIX	Skilled Nursing Facility	Cost
		Inpatient	Outpatient	
		1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	0		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)	0	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)	0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	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)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	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)	0	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	0	24.00
25.00	Capital exception payments (see instructions)	0	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)	0	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)	0	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	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	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: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet E-4 Date/Time Prepared: 5/20/2024 2:35 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.			0.00	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			0.00	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)			0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.00	6.00
7.00	Enter the lesser of line 5 or line 6			0.00	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.	0.00	0.00	0.00	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.	0.00	0.00	0.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		7.11		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		7.11		10.01
11.00	Total weighted FTE count	0.00	7.11		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	4.43		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	1.51		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	4.35		14.00
15.00	Adjustment for residents in initial years of new programs	28.73	32.90		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	28.73	32.90		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	28.73	37.25		17.00
18.00	Per resident amount	0.00	0.00		18.00
18.01	Per resident amount under §131 of the CAA 2021	130,058.09	130,058.09		18.01
19.00	Approved amount for resident costs	3,736,569	4,844,664	8,581,233	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)			0.00	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)			8,581,233	25.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet E-4 Date/Time Prepared: 5/20/2024 2:35 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)	51,121	35,524		26.00
27.00	Total Inpatient Days (see instructions)	118,567	118,567		27.00
28.00	Ratio of inpatient days to total inpatient days	0.431157	0.299611		28.00
29.00	Program direct GME amount	3,699,859	2,571,032	6,270,891	29.00
29.01	Percent reduction for MA DGME		3.27		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		84,073	84,073	30.00
31.00	Net Program direct GME amount			6,186,818	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)			0	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)			121,802,561	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)			121,802,561	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			59,454,492	42.00
43.00	Primary payer payments (see instructions)			24,630	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			59,429,862	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			181,232,423	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.672079	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.327921	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			6,186,818	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			4,158,030	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			2,028,788	50.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT		Provider CCN: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet E-5 Date/Time Prepared: 5/20/2024 2:35 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: 31-0041

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

Worksheet G

Date/Time Prepared:
5/20/2024 2:35 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	10,025	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	61,053,558	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-11,780,343	0	0	0	6.00
7.00	Inventory	9,616,197	0	0	0	7.00
8.00	Prepaid expenses	4,256,749	0	0	0	8.00
9.00	Other current assets	16,529,004	0	0	0	9.00
10.00	Due from other funds	258,353,813	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	338,039,003	0	0	0	11.00
FIXED ASSETS						
12.00	Land	198,713	0	0	0	12.00
13.00	Land improvements	3,070,534	0	0	0	13.00
14.00	Accumulated depreciation	-2,355,661	0	0	0	14.00
15.00	Buildings	318,099,740	0	0	0	15.00
16.00	Accumulated depreciation	-146,974,676	0	0	0	16.00
17.00	Leasehold improvements	17,860,652	0	0	0	17.00
18.00	Accumulated depreciation	-5,606,180	0	0	0	18.00
19.00	Fixed equipment	78,755,860	0	0	0	19.00
20.00	Accumulated depreciation	-73,561,110	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	208,109,528	0	0	0	23.00
24.00	Accumulated depreciation	-122,593,221	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)	275,004,179	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	500	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	36,094,761	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	36,095,261	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	649,138,443	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	19,963,553	0	0	0	37.00
38.00	Salaries, wages, and fees payable	18,554,000	0	0	0	38.00
39.00	Payroll taxes payable	976,826	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	5,307,636	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	26,179,753	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	70,981,768	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	170,187,773	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	170,187,773	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	241,169,541	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	407,968,902	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	407,968,902	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	649,138,443	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 31-0041

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

Worksheet G-1

Date/Time Prepared:
5/20/2024 2:35 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		365,156,459		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-2,686,124			2.00
3.00	Total (sum of line 1 and line 2)		362,470,335		0	3.00
4.00	OTHER CHANGES IN NET ASSETS	48,835,862		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		48,835,862		0	10.00
11.00	Subtotal (line 3 plus line 10)		411,306,197		0	11.00
12.00	NON-OPERATING REVENUE	3,337,295		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		3,337,295		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		407,968,902		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	OTHER CHANGES IN NET ASSETS		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	NON-OPERATING REVENUE		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: 31-0041

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/20/2024 2:35 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	532,184,060		532,184,060	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	18,119,997		18,119,997	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	550,304,057		550,304,057	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	471,365,736		471,365,736	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT	43,935,961		43,935,961	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	515,301,697		515,301,697	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,065,605,754		1,065,605,754	17.00
18.00	Ancillary services	549,733,673	610,183,555	1,159,917,228	18.00
19.00	Outpatient services	162,650,022	289,995,498	452,645,520	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	1,777,989,449	900,179,053	2,678,168,502	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		524,006,180		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)		524,006,180		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 31-0041

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

Worksheet G-3

Date/Time Prepared:
5/20/2024 2:35 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	2,678,168,502	1.00
2.00	Less contractual allowances and discounts on patients' accounts	2,165,365,615	2.00
3.00	Net patient revenues (line 1 minus line 2)	512,802,887	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	524,006,180	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-11,203,293	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 OPERATING REVENUE	7,166,640	24.00
24.01	FEMA C-19	-222,824	24.01
24.02	ER RETENTION TAX CREDIT	1,573,353	24.02
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	8,517,169	25.00
26.00	Total (line 5 plus line 25)	-2,686,124	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)	-2,686,124	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 31-0041	Period: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III Date/Time Prepared: 5/20/2024 2:35 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		6,852,311	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		28,608	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)		328.19	3.00
4.00	Number of interns & residents (see instructions)		65.97	4.00
5.00	Indirect medical education percentage (see instructions)		5.83	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)		399,490	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		2.49	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		10.47	8.00
9.00	Sum of lines 7 and 8		12.96	9.00
10.00	Allowable disproportionate share percentage (see instructions)		2.65	10.00
11.00	Disproportionate share adjustment (see instructions)		181,586	11.00
12.00	Total prospective capital payments (see instructions)		7,461,995	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