This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 31-3300 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/8/2024 9: 17 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/8/2024 9:17 am use only] Manually prepared cost report Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. NPR Date:
[12] 13. NPR Date:
[13] 14. NPR Date:
[14] 15. NPR Date:
[15] 15. NPR Date:
[16] 16. NPR Date:
[17] 17. NPR Date:
[18] 17. NPR Date:
[18] 18. NPR Date:
[18] 18. NPR Date:
[18] 19. NPR Da Contractor use only (3) Settled with Audit number of times reopened = 0-9.

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

(4) Reopened (5) Amended

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 CHILDRENS SPECIALIZED HOPSITAL (31-3300) 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	ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1	Richa	rd 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	Ri chard Henwood			2
3	Signatory Title	VP CORPORATE REIMBURSEMENT			3
4	Date	(Dated when report is electronica			4

			Title	XVIII			
		Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	0	4, 963	0	-2, 103, 232	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	0	0		0	7. 00
8.00	NURSING FACILITY	0				0	8. 00
200.00	TOTAL	0	0	4, 963	0	-2, 103, 232	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: 31-3300 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/8/2024 9:17 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 150 PROVIDENCE ROAD 1.00 PO Box: 1.00 Zip Code: 07094 2.00 City: MOUNTAINSIDE State: NJ County: UNION 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)
V XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 CHILDRENS SPECIALIZED 313300 35084 01/01/1970 Ν 3.00 HOPSI TAI Subprovider - IPF (combined) 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6 00 Swing Beds - SNF 7 00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF CHILDRENS SPECIALIZED 315239 35084 10/06/1986 Ρ Ν 9.00 HOSPI TAI 10.00 Hospi tal -Based NF CHILDRENS SPECIALIIZED 315239 35084 10/06/1986 N 10.00 N HOSPI TAI 11.00 Hospi tal -Based OLTC 11.00 Hospi tal -Based HHA 12.00 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 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) 21.00 1. 00 2.00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Ν Ν 22.00 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. Did this hospital receive interim UCPs, including supplemental UCPs, for Ν Ν 22.01 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) 22.02 Is this a newly merged hospital that requires a final UCP to be Ν Ν 22.02 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. 22.03 Did this hospital receive a geographic reclassification from urban to Ν N Ν 22 03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for ves or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 3 Ν 23.00 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.

45.00 boes this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412. 3207 (see instructions) 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. 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 N N N N N N N N N N N N N N N N	Prospective Payment System (PPS)-Capital				
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Pt. III. 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 N A 47.00 48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. N N N N N N N N N N N N N N N N N N N		l IN	IN IN	I IN	46.00
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48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. N N N N A 48.00 Teaching Hospitals 56.00 Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2. 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 "N", 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. 58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as N 658.00 defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.		l N	N	l N	47 00
Teaching Hospitals 156.00 Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2. 157.00 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. 158.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as N 58.00 defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.		1			
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		N			58. 00
MCRI F32 - 22. 1. 178. 1	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				
MCRI F32 - 22. 1. 178. 1					
MCRI F32 - 22. 1. 178. 1					
MCRIF32 - 22. I. 178. I	NODI 500 - 00 4 470 4				
	MURIT32 - 22. I. I/8. I				

	ler agram aleast a sylvian and a silvian are a silvian and a silvian are							
	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.							
					1. 00			
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	2.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.							
	your hospital received HRSA PCRE funding (see instruc	ctions)						
62.01	Enter the number of FTE residents that rotated from a	a Teaching Health Cent	er (THC) into	your hospital	0.00	62. 01		
	during in this cost reporting period of HRSA THC prog	gram. (see instruction	s)					
	Teaching Hospitals that Claim Residents in Nonprovide	er Settings						
63.00	Has your facility trained residents in nonprovider se	ettings during this co	st reporting p	eriod? Enter	N	63.00		
	"Y" for yes or "N" for no in column 1. If yes, comple	ete lines 64 through 6	7. (see instru	ctions)				
		-						

Health Financial Systems	CHI LDRENS	SPECIALIZED HOPSITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP				eriod: rom 01/01/2023	Worksheet S-2 Part I Date/Time Pre 5/8/2024 9:17	pared:
			Unwei ghted FTEs Nonprovi der	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			Si te			
Section 5504 of the ACA Base Yea	ar FTF Dasidants in N	onnrovider Settings	1.00	2.00	3.00	
period that begins on or after of the control of th	July 1, 2009 and before yes, or your facilianter of unweighted nor obtations occurring in the number of unweighted our hospital. Enter in	re June 30, 2010. ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0. 00			64. 00
of (column 1 divided by (column	1 + column 2)). (see Program Name	Program Code	Unweighted	Unwei ghted	Ratio (col. 3/	
	Trogram Name	Trogram code	FTEs Nonprovi der Si te	FTEs in Hospital	(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 Ratio (col. 1/	65. 00
			FTEs Nonprovi der Si te	FTES in Hospital	(col. 1 + col. 2))	
Cootion FEOA of the ACA Cumpont	Voor ETE Dooidonto i	n Nannnavidar Catting	1.00	2.00	3.00	
Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider Settings	sETTECTIVE TO	or cost reporti	ng periods	
66.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 divided b	unweighted non-priman occurring in all nonpo unweighted non-priman cal. Enter in column 3	rovider settings. ry care resident 3 the ratio of	0. 00	3. 73	0. 000000	66. 00
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
(7.00 ls)	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)	PEDI ATRI CS	2000	0.00	2. 03	0. 000000	67. 00
67. 01 (See Thistructions)	FAMILY MEDICINE	1350	0. 00	0. 19	0. 000000	67. 01

0.00

Ν

0 00

0.00

Ν

0.00

95.00

96.00

97.00

95.00

96.00

applicable column.

applicable column.

If line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the

97.00 If line 96 is "Y", enter the reduction percentage in the applicable column.

Miscellaneous Cost Reporting Information 115.00 s this an all-inclusive rate provider? Enter "Y" for yes or "N" for no N 0115.00 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. 116.00 Is this facility classified as a referral center? Enter "Y" for yes or 116. 00 Ν "N" for no. 117.00 is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no. 117. 00 118.00|s the mal practice insurance a claims-made or occurrence policy? Enter 1 118. 00 if the policy is claim-made. Enter 2 if the policy is occurrence.

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der C	CN: 31-3300	Peri od: From 01/01/2023 To 12/31/2023		repared
		Premi ums	Losses	Insurance	
		1.00	2.00	3.00	
18.01 List amounts of malpractice premiums and paid losses:		518, 5		0	0 118. 0
			1. 00	2.00	
18.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting scheduland amounts contained therein. 19.00 DO NOT USE THIS LINE			N		118. (
20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	column 1, "Y alifies for t	" for yes or he Outpatient		Y	120. 0
21.00 Did this facility incur and report costs for high cost implan	ntable device	s charged to	N		121. (
patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defi Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.					122. 0
23.00 Did the facility and/or its subproviders (if applicable) pure services, e.g., legal, accounting, tax preparation, bookkeepi management/consulting services, from an unrelated organization for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., professional services expenses, for services purchased from a located in a CBSA outside of the main hospital CBSA? In column "N" for no.	ing, payroll, on? In column greater than unrelated org	and/or 1, enter "Y" 50% of total ani zati ons		N	123. (
Certified Transplant Center Information 25.00 Does this facility operate a Medicare-certified transplant co	ontor2 Entor	"V" for yes	N		125.
and "N" for no. If yes, enter certification date(s) (mm/dd/y	yyy) below.	,			
26.00 f this is a Medicare-certified kidney transplant program, en in column 1 and termination date, if applicable, in column 2. 27.00 f this is a Medicare-certified heart transplant program, en					126. 127.
in column 1 and termination date, if applicable, in column 2. 28.00 If this is a Medicare-certified liver transplant program, en	ter the certi	fication date			128.
in column 1 and termination date, if applicable, in column 2. 29.00 If this is a Medicare-certified lung transplant program, ento in column 1 and termination date, if applicable, in column 2.	er the certif	ication date			129.
30.00 f this is a Medicare-certified pancreas transplant program, date in column 1 and termination date, if applicable, in colu 31.00 f this is a Medicare-certified intestinal transplant program	umn 2.				130.
date in column 1 and termination date, if applicable, in colu 2.00 f this is a Medicare-certified islet transplant program, en	umn 2. ter the certi				132.
In column 1 and termination date, if applicable, in column 2. 33.00 Removed and reserved 34.00 If this is a hospital-based organ procurement organization ((In column 1 and termination date, if applicable, in column 2.	OPO), enter t	he OPO number			133. 134.
All Providers	ofined in CMC	Dub 1E 1	Y	LIESE (O	140
40.00 Are there any related organization or home office costs as de chapter 10? Enter "Y" for yes or "N" for no in column 1. If y are claimed, enter in column 2 the home office chain number. 1.00 2.00	yes, and home (see instruc	office costs		H53560	140.
If this facility is part of a chain organization, enter on I home office and enter the home office contractor name and contrac	ines 141 thro ntractor numb	er.	name and address		
I1.00 Name: RWJBARNABAS HEALTH Contractor's Name: NOV I2.00 Street: 95 OLD SHORT HILLS PO Box: I3.00 City: WEST ORANGE State: NJ	TIAS SULUTION	Zi p Code	or's Number: 120 : 070		141. 142. 143.
				1.00	
	?			1. 00 Y	144.
			1.00	2.00	
15.00 f costs for renal services are claimed on Wkst. A, line 74, inpatient services only? Enter "Y" for yes or "N" for no in o no, does the dialysis facility include Medicare utilization of	column 1. If	column 1 is	1.00	2.00	145.
period? Enter "Y" for yes or "N" for no in column 2. 46.00 Has the cost allocation methodology changed from the previous Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 19	sly filed cos	t report?	N		146.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der C	CN: 31-3300		1/01/2023 2/31/2023		epared:
						1.00	
147.00 Was there a change in the statisti	cal basis? Enter "Y" f	or 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" f	or no.			N	148. 00
149.00 Was there a change to the simplifi	ed cost finding method	? Enter "Y" for y	es or "N" f	or no.		N	149. 00
		Part A	Part B	T	itle V	Title XIX	
		1.00	2.00		3. 00	4. 00	
Does this facility contain a provi or charges? Enter "Y" for yes or '							
155. 00 Hospi tal	N TOT TO TOT EACT COIL	N	N	366 42	N 9413	N N	155.00
156. 00 Subprovider - IPF		N N	N N		N	N	156. 00
157. 00 Subprovi der – IRF		N N	N N		N	N	157. 00
158. 00 SUBPROVI DER							158. 00
159. 00 SNF		N	l N		N	N	159. 00
160.00 HOME HEALTH AGENCY		N	l N		N	N	160.00
161. 00 CMHC			l N	1	N	N	161. 00
Multicampus						1.00	
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	SAs?	N	165. 00				
, , , , , , , , , , , , , , , , , , , ,	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2. 00	3.00	4. 00	5. 00	
166.00 f 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)						0.0	00 166. 00
						1. 00	_
Health Information Technology (HI) incentive in the Ame	rican Recovery a	nd Reinvestm	ent Act			
167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 10 reasonable cost incurred for the h	05 is "Y") and ís a mea	ningful user (lir		"), enter	the	N	167. 00 168. 00
168.01 If this provider is a CAH and is rexception under §413.70(a)(6)(ii)?	ot a meaningful user,	does this provide			Ishi p		168. 01
169.00 If this provider is a meaningful transition factor. (see instruction	ıser (line 167 is "Y")				enter the	0.0	00169.00
				Ве	gi nni ng	Endi ng	
170.00 Enter in columns 1 and 2 the EHR k	eginning date and endi	ng date for the r	eporting		1. 00	2.00	170. 00
period respectively (mm/dd/yyyy)	<u> </u>	<u> </u>					
					1. 00	2.00	
171.00 If line 167 is "Y", does this proves section 1876 Medicare cost plans r "Y" for yes and "N" for no in column 2. (s	eported on Wkst. S-3, umn 1. If column 1 is y	Pt. I, line 2, co	ol. 6? Enter		N		0 171. 00

Heal th	Financial Systems CHILDRENS SPECIA	LIZED HOPSITAL		In Lie	u of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der Co		Period: From 01/01/2023	Worksheet S-2 Part II	
				To 12/31/2023	Date/Time Pre	
				Y/N	5/8/2024 9: 13 Date	/ am
				1. 00	2. 00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS			er all dates in t	the	
1. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the			N		1. 00
	reporting period? If yes, enter the date of the change in c	olumn 2. (see	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
2.00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	n 3, "V" for	N 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)					3.00
			Y/N	Туре	Date	
	Financial Data and Reports		1.00	2. 00	3. 00	
4. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	or Compiled, ilable in	Y	A	04/07/2024	4. 00
5. 00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N			5. 00
	those on the fired financial statements: If yes, submit rec	oner i rati on.		Y/N	Legal Oper.	
				1. 00	2. 00	
6. 00	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column	2. If you is	the provide	r N		6.00
7. 00	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in		the provide	N N		7.00
8. 00 9. 00	Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved			8. 00 9. 00		
10. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated o	S.		N		10.00
11. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	roved	Y		11. 00
	reaching frogram on worksheet A: IT yes, see that detrons.				Y/N	
	I				1. 00	
	Bad Debts Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p			ost reporting	N N	12. 00 13. 00
	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsura				N	14. 00
15 00	<pre>instructions. Bed Complement Did total beds available change from the prior cost reporti</pre>	ng noriod2 lf		trusti ene	N	15 00
15.00	pro total beds avairable change from the prior cost reporti		yes, see ms t A		t B	15. 00
		Y/N	Date	Y/N	Date	
	PS&R Data	1.00	2. 00	3. 00	4. 00	
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	Y	03/28/2024	Y	03/28/2024	16.00
17. 00	instructions) 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	N		N		17. 00
18. 00	in columns 2 and 4. (see instructions) 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	N		N		18. 00
19. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		N		19. 00

Heal th	Financial Systems CHILDRENS SPECIA	LIZED HOPSITAL		In Lie	u of Form CM	S-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der Co	CN: 31-3300	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S Part II Date/Time P 5/8/2024 9:	repared:
			pti on	Y/N	Y/N	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R)	1. 00 N	3. 00 N	20. 00
20.00	Report data for Other? Describe the other adjustments:			IN	IN	20.00
	<u> </u>	Y/N	Date	Y/N	Date	
	I	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 (EXCE	PT CHILDRENS H	OSPI TALS)		1.00	
	Capital Related Cost		•			
22. 00	Have assets been relifed for Medicare purposes? If yes, see				N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	als made dur	ing the cost	N	23. 00
24. 00	Were new leases and/or amendments to existing leases entere	ed into during	this cost re	porting period?	N	24. 00
	If yes, see instructions	· ·				
25. 00	Have there been new capitalized leases entered into during	the cost repor	ting period?	If yes, see	N	25. 00
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during th	ne cost reporti	na period? L	f ves. see	N	26. 00
	instructions.	•	0 .			
27. 00	Has the provider's capitalization policy changed during the	e cost reportin	g period? If	yes, submit	N	27. 00
	copy. Interest Expense					
28. 00	Were new loans, mortgage agreements or letters of credit er	ntered into dur	ing the cost	reporting	N	28. 00
20.00	period? If yes, see instructions.	band funda (Da	h+ Comilas D	accenta Fund)	N	20.00
29. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see instr		edt Service R	eserve Funa)	N	29. 00
30. 00	Has existing debt been replaced prior to its scheduled matu		debt? If yes	, see	N	30. 00
	instructions.					04.00
31. 00	Has debt been recalled before scheduled maturity without is instructions.	ssuance of new	debt? If yes	, see	N	31. 00
	Purchased Servi ces					
32. 00	Have changes or new agreements occurred in patient care ser		d through co	ntractual	N	32. 00
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app		a ta aamnati	tivo biddingO LE		33. 00
33.00	no, see instructions.	orred pertainin	ig to competi	tive broating? II		33.00
	Provi der-Based Physi ci ans					
34. 00	Were services furnished at the provider facility under an a	arrangement wit	h provider-b	ased physicians?	N	34. 00
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exi	sting agreemen	ts with the	nrovi der-hased		35. 00
33.00	physicians during the cost reporting period? If yes, see in		its with the	pi ovi dei -based		33.00
				Y/N	Date	
	U 066: 0t-			1. 00	2. 00	
36. 00	Home Office Costs Were home office costs claimed on the cost report?			Υ		36.00
37. 00	If line 36 is yes, has a home office cost statement been pr	repared by the	home office?			37. 00
	If yes, see instructions.					
38. 00	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end			N		38. 00
39. 00				, Y		39. 00
	see instructions.	,				
40. 00	If line 36 is yes, did the provider render services to the	home office?	If yes, see	N		40. 00
	instructions.					
		1.	00	2.	00	
	Cost Report Preparer Contact Information	la ausaa		HENWOOD		
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	RI CHARD		41. 00		
	respectively.					
42. 00	Enter the employer/company name of the cost report	RWJBARNABAS HE			42. 00	
43. 00	preparer. Enter the telephone number and email address of the cost	732 923-8074		RI CH. HENWOOD@RI	NIBH OPC	43.00
43.00	report preparer in columns 1 and 2, respectively.	132 723-0014		INT CIT. HENWOOD@R	טאט וומכייו	#3.00
		•		•		"

Heal th	Financial Systems	CHILDRENS SPECIA	ALIZED HOPSITA	AL	In Lie	In Lieu of Form CMS-2552-10		
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi der		Peri od:	Worksheet S-2		
					From 01/01/2023 To 12/31/2023	Date/Time Pre	nared·	
						5/8/2024 9: 17	am	
			3	3. 00				
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the		VP CORPORATE	REIMBURSEMENT			41. 00	
	held by the cost report preparer in colur	mns 1, 2, and 3,						
	respecti vel y.							
42.00	Enter the employer/company name of the co	ost report					42. 00	
	preparer.							
43.00	Enter the telephone number and email add	ress of the cost					43.00	
	report preparer in columns 1 and 2, respe	ecti vel y.						

| Period: | Worksheet S-3 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared:
 Heal th Financial
 Systems
 CHILDRENS

 HOSPITAL
 AND
 HOSPITAL
 HEALTH CARE COMPLEX
 STATISTICAL
 DATA
 Provider CCN: 31-3300

					-	To 12/31/2023	Date/Time Prep 5/8/2024 9:17	
							I/P Days / 0/P	CIII
							Visits / Trips	
	Component	Worksheet A	No	o. of Beds	Bed Days	CAH/REH Hours	Title V	
		Li ne No.		2.00	Avai I abl e	4.00	F 00	
	PART I - STATISTICAL DATA	1. 00		2. 00	3. 00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		68	24, 820	0.00	0	1. 00
1.00	8 exclude Swing Bed, Observation Bed and	30.00		00	24, 020	0.00		1.00
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO I RF Subprovi der						_	4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF				0.4.00	0.00	0	
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)			68	24, 820	0.00	0	7. 00
8. 00	INTENSIVE CARE UNIT							8. 00
9. 00	CORONARY CARE UNIT							9. 00
10. 00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY							13.00
14. 00	Total (see instructions)			68	24, 820	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	SUBPROVI DER - I RF							17. 00
18.00	SUBPROVI DER	44.00		40	17 50/			18.00
19. 00 20. 00	SKILLED NURSING FACILITY NURSING FACILITY	44. 00 45. 00		48 26			0	19. 00 20. 00
21. 00	OTHER LONG TERM CARE	45.00		20	9, 490		U	21. 00
22. 00	HOME HEALTH AGENCY							22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24. 00	HOSPI CE							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	
27. 00	Total (sum of lines 14-26)			142				27. 00
28. 00	Observation Bed Days						0	
29. 00	Ambul ance Tri ps							29. 00
30.00	Employee discount days (see instruction)							30.00
31. 00 32. 00	Employee discount days - IRF Labor & delivery days (see instructions)			0				31. 00 32. 00
32. 00	Total ancillary labor & delivery room			U	1			32.00
JZ. UI	outpatient days (see instructions)							JZ. U1
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	34. 00

 Heal th Financial
 Systems
 CHILDRENS

 HOSPITAL
 AND
 HOSPITAL
 HEALTH CARE COMPLEX
 STATISTICAL
 DATA
 In Lieu of Form CMS-2552-10 CHILDRENS SPECIALIZED HOPSITAL Provider CCN: 31-3300

Component Title XVIII					'	0 12/31/2023	5/8/2024 9: 17	
Part - Statistical Data - Company			I/P Days	s / O/P Visits	/ Trips	Full Time		diii
PART I - STATISTICAL DATA		Component	Title XVIII	Title XIX				
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 Reckude Swing Bed. Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 7,894 2.00			6. 00	7. 00	8.00	9. 00		
8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 1,000 1,		PART I - STATISTICAL DATA			•		•	
Hospice days) (see instructions for col. 2 7	1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	0	1, 942	19, 803			1.00
For the portion of LDP room available beds) 3.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00		8 exclude Swing Bed, Observation Bed and						
2.00 HMO and other (see instructions)								
1.00 HMO I PF Subprovi der		for the portion of LDP room available beds)						
MO IRF Subprovi der		` ,	0	7, 894				
5.00 Hospi tal Adult s & Peds. Swing Bed SNF 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 ·	0	0				•
6.00 Hospi tal Adult s & Peds. Swing Bed NF Total Adult s and Peds. (exclude observation beds) (see instructions) Total Adult s and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT 9,000			0	_				1
7.00 Total Adult sand Peds. (exclude observation beds) (see instructions) 8.00 1,942 19,803 8.00 10 1,942 19,803 8.00 10 1,942 19,803 8.00 10 1,942 19,803 10 1,942 19,803 10 1,942 19,803 10 1,942 19,803 10 1,942 19,803 10 1,942 19,803 10 1,942 19,803 10 1,942 19,803 10 1,942 19,803 10 1,942 19,803 1,942 1,94			0	_	1			
beds) (see instructions) 8.00 1.77KSI VE CARE UNIT 9.00 1.00				_				•
8. 00 INTENSIVE CARE UNIT	7.00	· ·	0	1, 942	19, 803			7. 00
9.00 CORONARY CARE UNIT 9.00 BURN INTENSIVE CARE UNIT 10.00		1						
10.00 BURN INTENSIVE CARE UNIT 10.00 SURGICAL INTENSIVE CARE UNIT 11.00 11								
11.00 SURGI CAL INTENSIVE CARE UNIT 12.00 12.00 0THER SPECIAL CARE (SPECIFY) 13.00 12.00 13.00 14.00 15.00 15.00 16.40 15.00 16.40 15.00 15.10 16.00 16.40 16.00								
12.00 OTHER SPECIAL CARE (SPECIFY)								1
13.00 NURSERY								
14. 00 Total (see instructions) 15. 00 CAH visits 0 0 0 0 0 0 0 0 15. 00 CAH visits 15. 10 REH hours and visits 0 0 0 0 0 0 0 0 0 15. 10 REH hours and visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 O NURSING FACILITY 0		· · ·						•
15. 00 CAH visits 0 CAA visits			_					•
15. 10 REH hours and visits 0 0 0 0 0 0 16.00 16.00 17.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 19.00 SKILLED NURSING FACILITY 0 16.624 17,199 0.00 104.18 19.00 20.00 NURSING FACILITY 6,6624 7,300 0.00 0.00 20.00 20.00 NURSING FACILITY 6,6624 7,300 0.00 20.00 20.00 20.00 NURSING FACILITY 20 0 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 22.00 HOME HEALTH AGENCY 22.00 HOME CONTROL CENTER (D.P.) 22.00 24.00 HOSPICE 20.00 CMHC - CMHC 24.10 HOSPICE 10.00 CMHC - CMHC 25.00 CMHC - CMHC 25.00 CMHC - CMHC 25.00 Total (sum of lines 14-26) 25.00 Total (sum of lines 14-26) 5.95 1,279.10 27.00 28.00 Observation Bed Days 0 0 Diservation Diservation Days - IRF 0 0 Diservation Days - IRF 0 0 Diservation Days - IRF 0 D		1 '	0		· ·		1, 174. 92	•
16. 00 SUBPROVI DER - I PF 17. 00 SUBPROVI DER - I RF 18. 00 SUBPROVI DER - I RF 18. 00 SUBPROVI DER 19. 00 SKI LLED NURSI NG FACI LI TY 20. 00 NURSI NG FACI LI TY 20. 00 THER LONG TERM CARE 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGI CAL CENTER (D. P.) 24. 10 HOSPI CE (non-di stinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINI C 26. 00 RURAL HEALTH CLINI C 26. 00 RURAL HEALTH CLINI C 27. 00 Total (sum of lines 14-26) 28. 00 Observati on Bed Days 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH site neutral days and discharges 16. 00 17. 00 17. 00 18. 00 17. 199 0. 00 10. 01 18. 00 17. 199 0. 00 10. 00 10. 00 10. 01 10. 4. 18 19. 00 19. 00 10. 00			0	_				•
17. 00 SUBPROVI DER - IRF 17. 00 18. 00 SUBPROVI DER 18. 00 SKILLED NURSI NG FACILITY 0 16, 462 17, 199 0. 00 104. 18 19. 00 20. 00 NURSI NG FACILITY 6, 624 7, 300 0. 00 0. 00 20. 00 21. 00 0. 00 0. 00 22. 00 0. 00 0. 00 0. 00 23. 00 24. 00 0. 00 0. 00 24. 00 0. 00			0	0	0			•
18. 00 SUBPROVI DER 18. 00 10. 00 10. 11. 11. 11. 11. 11. 11. 11. 11. 11.								1
19. 00 SKILLED NURSING FACILITY 0 16, 462 17, 199 0. 00 104. 18 19. 00 20. 00 NURSING FACILITY 6 6, 624 7, 300 0. 00 0. 00 20. 00 20. 00 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 00 HOSPI CE 24. 10 HOSPI CE (non-distinct part) 25. 00 CMHC - CMHC 25. 00 CMHC - CMHC 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 Observation Bed Days 0 Observation Bed Days 0 Observation Bed Days 0 Ambul ance Trips 0 Cmpl oyee discount days (see instruction) 31. 00 Empl oyee discount days - IRF 0 Cmpl oyee discount days (see instructions) 1 Count of the days (see instructions) 1 Count of the days (see instructions) 1 CTCH non-covered days 1. CTCH non-covered days 1. CTCH non-covered days and discharges 0 Cmpl oyee discount days 0 Cmpl oyee d								
20.00 NURSING FACILITY 6,624 7,300 0.00 0.00 20.00 21.00 21.00 22.00 22.00 22.00 23.00 24.00 24.00 24.00 24.00 24.10 25.00 26.25 26.00 26.25 27.00 26.25 27.00 28.00 29.00 28.00 29.00 28.00 29.00				4 / 4 / 0	47.400		104.40	•
21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 21.00 22.00 22.00 22.00 22.00 23.00 24.10 24.10 25.00 26.00 0 0 0 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 26.25 27.00 0 0 0 0 0.00 28.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			U					
22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPI CE 24.10 HOSPI CE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.00 LTCH site neutral days and discharges 22.00 23.00				6, 624	7, 300	0.00	0.00	1
23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE								
24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.00 LTCH site neutral days and discharges								1
24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 29. 00 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 31. 00 LTCH site neutral days and discharges								1
25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 29. 00 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 01 Total ancillary labor & delivery comount outpatient days (see instructions) 33. 00 LTCH non-covered days 31. 00 LTCH site neutral days and discharges 25. 00 26. 00 26. 00 27. 00 0					,			
26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambul ance Trips 29.00 Employee discount days (see instruction) 29.00 Employee discount days - IRF 20.00 Labor & delivery days (see instructions) 20.00 Total ancillary labor & delivery room outpatient days (see instructions) 20.01 Total ancillary labor & see instructions) 20.01 TCH non-covered days 20.02 TCH site neutral days and discharges 20.03 O O O O O O O O O O O O O O O O O O O					·			ł
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0.00 0.00 26. 25 27. 00 Total (sum of lines 14-26) 5. 95 1, 279. 10 27. 00 28. 00 Observation Bed Days 0 0 0 0 0 0 28. 00 29. 00 Ambul ance Trips 0 0 29. 00 Employee discount days (see instruction) Employee discount days - IRF 0 0 31. 00 29								
27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 0 Employee discount days (see instruction) 27.00 Employee discount days - IRF 28.00 Labor & delivery days (see instructions) 32.00 Labor & delivery days (see instructions) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 0 5.95 1,279.10 27.00 28.00 29.00 29.00 30.00 30.00 Employee discount days (see instructions) 31.00 31.00 32.01 32.00 33.01 Signature (sum of lines 14-26) 27.00 28.00 29.00 28.00 29.00 29.00 30.00 30.00 30.00 Employee discount days (see instructions) 31.00			0	0		0.00	0.00	ł
28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 31.00 Total ancillary labor & delivery room outpatient days (see instructions) 32.01 TCH non-covered days 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 0 0 0 28.00 29.00 30.00 30.00 31.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			O	0				
29.00 Ambulance Trips 0 29.00 30.00 Employee discount days (see instruction) 0 30.00 31.00 Employee discount days - IRF 0 0 31.00 32.00 Labor & delivery days (see instructions) 0 0 0 0 32.00 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 0 0 0 32.01 LTCH non-covered days 0 0 33.00 33.01 LTCH site neutral days and discharges 0 0 33.01		,		0			1, 279. 10	1
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 30.00 30.00 30.00 30.00 0 0 0 0 0 0 0 0		,	0	0				1
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 31.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		· ·	O		_			•
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 . 3						•
32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 0 32.01		1 1 3	0	0				1
outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 0 33.01				0				•
33.00 LTCH non-covered days 0 33.00 33.01 LTCH si te neutral days and discharges 0 33.01	JZ. U1							32.01
33.01 LTCH site neutral days and discharges 0 33.01	33 00		n					33 00
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		, and a second s	o	0	C)		ł

 Heal th Financial
 Systems
 CHILDRENS

 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA

Provider CCN: 31-3300

Peri od: Worksheet S-3 From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared: 5/8/2024 9: 17 am

						5/8/2024 9: 17	am
		Full Time		Di sch	arges		
	Component	Equi val ents Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	Component	Workers	TILLE V	II tie Aviii	II LI E XIX	Patients	
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	0	31	533	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)			_			
2.00	HMO and other (see instructions)			0	223		2.00
3.00	HMO I PF Subprovi der				0		3.00
4.00	HMO I RF Subprovi der				0		4.00
5. 00 6. 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF						5. 00 6. 00
7.00	Total Adults and Peds. (exclude observation						7. 00
7.00	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	0	31	533	14.00
15. 00	CAH visits						15. 00
15. 10	REH hours and visits						15. 10
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY	0.00					19. 00
20.00	NURSING FACILITY	0. 00					20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00 23. 00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.)						22. 00 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	Ambul ance Tri ps						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						32. 01
	outpatient days (see instructions)						
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	I I		I I			34.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 31-3300

Peri od: Worksheet S-3 From 01/01/2023 Part II To 12/31/2023 Date/Time Prepared:

5/8/2024 9:17 am Wkst. A Line Amount Recl assi fi cati Adj usted Paid Hours Average Hourly on of Salaries Number Reported Sal ari es Related to Wage (col. 4 (col.2 ± col (from Wkst. Salaries in col. 5) A-6)3) col. 4 2.00 5.00 6. 00 1.00 3.00 4.00 PART II - WAGE DATA SALARI ES 110, 095, 738 0.00 1.00 200. 00 110, 095, 738 0.00 1.00 Total salaries (see instructions) 2.00 Non-physician anesthetist Part 0 0 0.00 0.00 2.00 3.00 Non-physician anesthetist Part 0 0.00 0.00 3.00 4.00 Physician-Part A -0 0.00 0.00 4.00 Administrative 4.01 Physicians - Part A - Teaching 0 0.00 0.00 4.01 Physician and Non 0 0.00 5.00 0.00 5.00 Physician-Part B Non-physician-Part B for 6.00 O 0.00 0.00 6.00 hospital-based RHC and FQHC servi ces 7.00 Interns & residents (in an 21.00 0 0.00 0.00 7.00 approved program) 7.01 Contracted interns and 0.00 0.00 7.01 residents (in an approved programs) 8.00 Home office and/or related 0 0.00 0.00 8.00 organization personnel 9.00 44.00 7, 559, 931 675, 140 8, 235, 071 0.00 0.00 9.00 3, 475, 360 3, 520, 706 10.00 Excluded area salaries (see 45, 346 0.00 0.00 10.00 instructions) OTHER WAGES & RELATED COSTS 11.00 Contract labor: Direct Patient 0 0 0.00 0.00 11.00 0 0.00 12.00 Contract labor: Top level 0.00 12.00 management and other management and administrative servi ces Contract Labor: Physician-Part 13.00 0 0.00 0.00 13.00 A - Administrative Home office and/or related 14.00 0.00 0.00 14.00 organization salaries and wage-related costs 14.01 Home office salaries 5, 063, 674 5, 063, 674 144, 346. 59 35. 08 14.01 14.02 Related organization salaries 0.00 0.00 14.02 15.00 Home office: Physician Part A 0 0 0.00 0.00 15.00 - Administrative Home office and Contract 0 0 0.00 0.00 16.00 16.00 Physicians Part A - Teaching 16.01 Home office Physicians Part A 0 0.00 0.00 16.01 Teachi ng 16. 02 Home office contract 0 0.00 0.00 16.02 Physicians <u>Part A - Teaching</u> WAGE-RELATED COSTS 0 n 17.00 Wage-related costs (core) (see 17.00 instructions) 18.00 Wage-related costs (other) 18.00 (see instructions) 19.00 Excluded areas 1, 109, 390 1, 109, 390 19.00 Non-physician anesthetist Part 20.00 20.00 21.00 Non-physician anesthetist Part 0 21.00 22.00 Physician Part A -22.00 0 0 Admi ni strati ve 22.01 Physician Part A - Teaching 0 22 01 23.00 Physician Part B 0 0 23.00 24.00 Wage-related costs (RHC/FQHC) 0 0 24.00 Interns & residents (in an 25.00 0 0 0 25.00 approved program) 25.50 Home office wage-related 920, 930 0 920, 930 25.50 (core) 25.51 Related organization 0 25.51 wage-related (core) Home office: Physician Part A 0 0 25, 52 25. 52 - Administrative wage-related (core)

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 31-3300

					To	o 12/31/2023	Date/Time Prep 5/8/2024 9:17	
		Wkst. A Line		Recl assi fi cati		Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1.00	2.00	3. 00	4. 00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0	0			25. 53
	- Teaching - wage-related (core)							
	OVERHEAD COSTS - DIRECT SALARII	ES						
26.00	Employee Benefits Department	4. 00	-4, 628, 155	0	-4, 628, 155	0.00	0.00	26. 00
27.00	Administrative & General	5. 00	21, 224, 157	-3, 188, 886	18, 035, 271	0.00	0. 00	27. 00
28.00	Administrative & General under		0	0	0	0.00	0.00	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0. 00		29. 00
30.00	Operation of Plant	7. 00	955, 885	2, 217	958, 102	0. 00	0. 00	30.00
31. 00	Laundry & Linen Service	8. 00	0	0	0	0. 00		
32.00	Housekeepi ng	9. 00	1, 587, 540	1, 665	1, 589, 205	0.00	0.00	32.00
33.00	Housekeeping under contract		0	0	0	0.00	0.00	33.00
	(see instructions)							
34.00	Di etary	10. 00	1, 431, 369	1, 024	1, 432, 393			34. 00
35.00	Dietary under contract (see		0	0	0	0.00	0.00	35. 00
	instructions)							
36.00	Cafeteri a	11. 00	0	0	0	0. 00		36. 00
37. 00	Maintenance of Personnel	12. 00	0	0	0	0. 00		
38. 00	Nursing Administration	13. 00	1, 375, 615	-1, 136, 853	238, 762	0. 00	0. 00	38. 00
39. 00	Central Services and Supply	14. 00	0	0	0	0.00	0.00	39. 00
40.00	Pharmacy	15. 00	1, 893, 560	-99, 552	1, 794, 008	0.00	0.00	40.00
41.00	Medical Records & Medical	16. 00	969, 075	691	969, 766	0.00	0. 00	41. 00
	Records Library							
42.00	Social Service	17. 00	793, 224	-605, 867	187, 357			42.00
43.00	Other General Service	18. 00	433, 475	-491, 088	-57, 613	0.00	0.00	43.00

0.00

7.00

HOSPITAL WAGE INDEX INFORMATION Worksheet S-3 Part III Date/Time Prepared: Provider CCN: 31-3300 Peri od: From 01/01/2023 To 12/31/2023 5/8/2024 9:17 am Average Hourly Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 (col . 2 ± col . col. 5) (from Salaries in Works<u>heet A-6)</u> 3) col. 4 1.00 2.00 5.00 6.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 110, 095, 738 110, 095, 738 0.00 0. 00 1.00 instructions) 2.00 Excluded area salaries (see 11, 035, 291 720, 486 11, 755, 777 0.00 0.00 2.00 instructions) 3.00 Subtotal salaries (line 1 99, 060, 447 -720, 486 98, 339, 961 0.00 0.00 3.00 minus line 2) 4.00 Subtotal other wages & related 5, 063, 674 5, 063, 674 144, 346. 59 35. 08 4.00 costs (see inst.) Subtotal wage-related costs 5.00 920, 930 Ω 920, 930 0.00 0.94 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 105, 045, 051 -720, 486 104, 324, 565 144, 346. 59 722 74

-5, 516, 649

20, 519, 096

0.00

26, 035, 745

7.00

Total overhead cost (see

instructions)

	10 12/31/2023	5/8/2024 9: 17	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		1
	RETI REMENT COST		
1.00	401K Empl oyer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	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	0	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	0	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15.00	'Workers' Compensation Insurance	0	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Noncumul ati ve porti on)		
	TAXES		
17. 00	FICA-Employers Portion Only	0	17. 00
18. 00	Medicare Taxes - Employers Portion Only	0	
19. 00	Unempl oyment Insurance	0	
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	0	21. 00
	instructions))		
22. 00	Day Care Cost and Allowances	0	
23. 00	Tuition Reimbursement	0	
24. 00	Total Wage Related cost (Sum of lines 1 -23)	0	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	ļ	25. 00

Health Financial Systems CF	HILDRENS SPECIAL	IZED HOPSITAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CO		Peri od:	Worksheet A	
				rom 01/01/2023	Doto/Time Dro	aanad.
			'	o 12/31/2023	Date/Time Pre 5/8/2024 9:17	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Reclassi fi ed	Cili
cost contor bood (ptron	00.0	0 21101	+ col . 2)	ons (See A-6)	Trial Balance	
			' ' ' ' ' ' ' '	(222 2)	(col. 3 +-	
					col . 4)	
	1.00	2.00	3.00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS			•			
1.00 O0100 CAP REL COSTS-BLDG & FLXT		10, 292, 455	10, 292, 455	-4, 972, 828	5, 319, 627	1. 00
2.00 00200 CAP REL COSTS-MVBLE EQUIP		0	(1, 616, 181	1, 616, 181	2.00
3.00 00300 OTHER CAP REL COSTS		0	C	0	0	3.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-4, 628, 155	25, 275, 345	20, 647, 190	-1, 737, 038	18, 910, 152	4.00
5.00 00500 ADMINISTRATIVE & GENERAL	21, 224, 157	28, 112, 096	49, 336, 253	-2, 035, 378	47, 300, 875	5.00
7.00 O0700 OPERATION OF PLANT	955, 885	2, 590, 768	3, 546, 653	15, 792	3, 562, 445	7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	0	0	C	0	0	8. 00
9. 00 00900 HOUSEKEEPI NG	1, 587, 540	795, 701	2, 383, 241	6, 190	2, 389, 431	9. 00
10. 00 01000 DI ETARY	1, 431, 369	1, 083, 371	2, 514, 740	27, 762	2, 542, 502	10.00
13.00 O1300 NURSING ADMINISTRATION	1, 375, 615	49, 686	1, 425, 301	-1, 105, 122	320, 179	13.00
15. 00 01500 PHARMACY	1, 893, 560	179, 389	2, 072, 949	-78, 152	1, 994, 797	15. 00
16.00 O1600 MEDICAL RECORDS & LIBRARY	969, 075	200, 088		5, 216	1, 174, 379	16. 00
17.00 01700 SOCIAL SERVICE	793, 224	8, 740			203, 874	17. 00
18. 00 01080 I NSERVI CE EDUCATI ON	433, 475	72, 508	505, 983	-475, 840	30, 143	18. 00
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	(0	0	21. 00
22.00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	1, 002, 306	1, 002, 306	0	1, 002, 306	22. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	17, 926, 788	868, 220			21, 004, 479	30. 00
44.00 04400 SKILLED NURSING FACILITY	7, 559, 931	465, 956			8, 781, 012	44. 00
45.00 04500 NURSING FACILITY	2, 365, 970	594, 857	2, 960, 827	386, 255	3, 347, 082	45. 00
ANCILLARY SERVICE COST CENTERS						
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	C	-	0	54. 00
60. 00 06000 LABORATORY	0	1, 720	1, 720	0	1, 720	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	(0	0	62. 30
65. 00 06500 RESPI RATORY THERAPY	3, 266, 737	420, 718			3, 729, 582	65. 00
66. 00 06600 PHYSI CAL THERAPY	5, 250, 851	163, 467			6, 917, 937	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	5, 762, 063	77, 013			7, 499, 139	67. 00
68. 00 06800 SPEECH PATHOLOGY	5, 717, 860	98, 735			7, 106, 169	68. 00
68. 01 06801 PEDS FEEDI NG DI SORDER RU CARES	768, 967	10, 863			911, 851	68. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2, 574, 937			2, 574, 937	71. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	657, 375			657, 375	73. 00
76. 00 03550 MEDI CAL SERVI CES	10, 254, 894	398, 996			5, 865, 377	76. 00
76. 01 03950 PSYCHI ATRI C	4, 345, 494	284, 108			6, 342, 097	76. 01
76. 02 03020 SEVERE BEHAVI OR	1, 292, 243	421, 369	1, 713, 612	200, 239	1, 913, 851	76. 02
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0			0	76. 98
76. 99 07699 LI THOTRI PSY	0	0			0	76. 99
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	(FO4 202	122 010	/ 717 010	E 057 043	11 774 054	00 00
	6, 594, 302	122, 910 0				
90. 01 09001 PEDS PRIMARY CARE CLINIC 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	۷	U		7	Ü	90. 01 92. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 93.00 04950 SCHOOL BASED PROGRAMS	11 044 502	E1E 000	12, 359, 592	401 114	12 040 700	
93. 00 04930 SCHOOL BASED PROGRAMS 93. 01 04951 OTHER OUTPATIENT SERVICE COST CENTER	11, 844, 503	515, 089	12, 339, 392	601, 116	12, 960, 708 0	93. 00 93. 01
93. 01 04931 OTHER OUTPATTENT SERVICE COST CENTER 93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0	0			0	93. 01
OTHER REIMBURSABLE COST CENTERS	U U	0		<u> </u>	U	93. 99
102.00 10200 OPLOID TREATMENT PROGRAM	0	0		ol	0	102. 00
	U U			<u> </u>	U	102.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE		1, 451, 902	1, 451, 902	1 451 002	0	113. 00
	108, 986, 348	1, 451, 902 78, 790, 688				
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	100, 980, 348	10, 190, 088	187, 777, 036	η -22, 5/5 <u> </u>	107, 754, 461	110.00
191.00 19100 RESEARCH	1, 109, 390	663, 456	1, 772, 846	22, 575	1, 795, 421	101 00
194.00 07950 CHILD CARE CENTER (MEDICAL DAY CARE	1, 109, 390	003, 450				191.00
200.00 TOTAL (SUM OF LINES 118 through 199)	110, 095, 738	79, 454, 144		′I "I	189, 549, 882	
200.00 TOTAL (SUM OF LINES TTO LITTOUGH 199)	110,070,730	17,404,144	107, 347, 002	- ₁	107, 347, 002	200.00

Provider CCN: 31-3300

| Peri od: | Worksheet A | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/8/2024 9: 17 am |

68. 01 06801 PEDS FEEDING DISORDER RU CARES 0 2911, 851 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 2, 574, 937 73. 073. 00 07300 DRUGS CHARGED TO PATIENTS 0 657, 375 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 657, 375 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 657, 375 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 657, 375 73. 00 07500 DRUGS CHARGED TO PATIENTS 0 657, 375 73. 00 07500 DRUGS CHARGED TO PATIENTS 0 657, 375 73. 00 07500 DRUGS CHARGED TO PATIENTS 0 657, 375 73. 00 07500 DRUGS CHARGED TO PATIENTS 0 0 657, 375 75. 00 03950 PSYCHI ATRI C 75. 00 03950 PSYCHI ATRI C 75. 00 03950 PSYCHI ATRI C 75. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					5/8/2024 9	: 17 am
GENERAL SERVICE COST CENTERS		Cost Center Description				
CEMBRAL SERVICE COST CENTERS						
1.00 001001 CAP REL COSTS-BLOG & FIXT 0 5,319,627 1.01 0.01		DENERAL DERIVISE DOOT DENTERO	6. 00	7. 00		
2.00 00200 CAP REL COSTS-IMBLE EQUIP 0 1,616,181 2.0 3.00 00300 TIPRE CAP REL COSTS 0 3.0 4.00 00400 EUPLOYEE BENEFITS 0 67,00 3.0 4.00 00400 EUPLOYEE BENEFITS 0 67,00 3.0 4.00 00400 EUPLOYEE BENEFITS 0 67,00 3.0 6.00 00800 LAMIN STRATU PE 4,00 4.0 6.00 00800 LAMINEST AD LINE STRUCE 0 4.0 6.00 00800 LAMINEST AD LINE STRUCE 0 4.0 6.00 00800 LETARY 0 7,00 7,00 7,00 7,00 7,00 7,00 7,00 7	4 00			F 040 (07		
3.00 0.0300 OTHER CAP REL COSTS						
4.00 00400 EMPLOYER BENEFITS DEPARTMENT						
5.00 0.000 DOSOO ADMIN ISTRATI VE & GENERAL 916, 714 49, 217, 589 5.0 8.00 0.0000 COPERATION OF PLANT -424, 433 3, 138, 012 7.0 8.00 0.0000 COPERATION OF PLANT -424, 433 3, 138, 012 7.0 8.00 0.0000 DOSOO COPERATION OF PLANT -424, 433 3, 138, 012 7.0 8.00 0.0000 DOSOO COPERATION OF PLANT -424, 433 3, 138, 012 7.0 8.00 0.0000 DOSOO COPERATION OF PLANT -424, 433 3, 138, 012 7.0 8.00 0.0000 DOSOO COPERATION OF PLANT -424, 433 7.0 9.00 DOSOO COPERATION OF PLANT -424, 433 3, 138, 012 7.0 9.00 DOSOO COPERATION OF PLANT -424, 433 3, 138, 012 7.0 9.00 DOSOO COPERATION OF PLANT -424, 433 -424, 433 -424, 433 -424, 433 -424, 433 -424, 434 -424, 433 -424, 434 -			_			
7. 00 00700 OPERATION OF PLANT		1 1				
8.00 0.0000 AUNDRY & LINEN SERVICE 0 0 0 8.00 0.00000 0.000000 0.000000 0.000000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.00000000						
9,00 0,0900 MUSEKEEPI NG 0 0,0000 DIETARY 13,00 0 10300 MURSI NG ADMINI STRATION 13,00 0 10300 MURSI NG ADMINI STRATION 13,00 0 10300 MURSI NG ADMINI STRATION 15,00 101500 MURSI NG ADMINI STRATION 16,00 0 10400 MEDI CAL RECORDS & LIBRARY 16,00 0 10400 MEDI CAL RECORDS & LIBRARY 17,00 1700 07		1 1				
10.00 01000 DETARY -185, 728 2, 356, 774 10.00 320, 779 13.00		1 1				
13.00 01300 NURSI NG ADMINISTRATION 0 320, 179 15.00 15.00 01500 DEPARMACY 0 1,994, 797 15.00 15.00 01500 DEPARMACY 0 1,994, 797 15.00 17.00 01700 0		1 1	_			•
15.00 01500 PHARBACY 0 1.994, 797 15.0						
16.00 01600 MEDICAL RECORDS & LIBRARY -52, 672 1, 121, 707 16.00 170, 00 170, 00 170, 00 170, 00 170, 00 170, 00 170, 00 170, 00 170, 00 170, 00 170, 00 170, 00 170, 00 18.00 100, 00 18.5 ERVI CES -SALARY & FRI NGES APPRV 0 0 0 0 0 0 0 0 0		1 1	0			
17.00 01700 SOCIAL SERVICE 0 203,874 17.0 18.8 01080 018ERVICE EDUCATION 0 0 21.0 0 22.0 02.00 02.0 018R SERVICES-SALARY & FRINGES APPRV 0 0 0 21.0 02.0		1 1	E2 472			
18.00 101080 INSERVI CE EDUCATION 0 30, 143 18.0 221.0 00 210.0 18.8 SERVI CES-SALARY & FRI NIGES APPRV 0 1,002,306 22.0 22.0 22.0 18.7 SERVI CES-OTHER PROM COSTS APPRV 0 1,002,306 22.0			_			
21.00 02100 RR SERVICES-SALARY & FRINCES APPRW 0 1,002,306 22.00 222.00 RR SERVICES-OTHER PREMI COSTS APPRW 0 1,002,306 22.00 30.00 30.00 AUNITS & PEDIATRIC S -924,359 20,080,120 34.00 44.00 AUNITS & PEDIATRIC S -924,359 20,080,120 44.00 44.00 AUNITS & PEDIATRIC S -924,359 45.00 4						
22.00 0.2200 LAR SERVICES-OTHER PREM COSTS APPRY 0 1,002,306 22.00			-			
IMPATI ENT ROUTI NE SERVICE COST CENTERS 30.00 030		1 1		-		•
03000 ADULTS & PEDI ATRICS -924, 359 20, 080, 120 44, 00 40400 SKILLED NURSING FACILITY 0 3, 7347, 082 45, 00 45, 00 04500 NURSING FACILITY 0 3, 7347, 082 45, 00 46, 00 04500 NURSING FACILITY 0 3, 7347, 082 45, 00 46, 00 05400 RADIOLOGY-DIAGNOSTIC 0 1, 720 66, 00 66, 00 6600 LABORATORY 0 1, 720 66, 00 66, 00 6600 PHYSICAL THERAPY 0 6, 917, 937 66, 50 66, 00 6600 PHYSICAL THERAPY 0 6, 917, 937 66, 50 66, 00 6600 PHYSICAL THERAPY 0 6, 917, 937 66, 50 66, 00 6600 SPEECH PATHOLOGY 0 7, 499, 139 67, 00 68, 01 6800 SPEECH PATHOLOGY 0 7, 106, 169 68, 00 6800 SPEECH PATHOLOGY 0 7, 106, 169 68, 00 6800 SPEECH PATHOLOGY 0 7, 106, 169 68, 00 6800 SPEECH PATHOLOGY 0 7, 106, 169 68, 00 67, 00 68, 01 6800 SPEECH PATHOLOGY 0 7, 106, 169 68, 00 6800 SPEECH PATHOLOGY 0 7, 106, 169 68, 00 6800 SPEECH PATHOLOGY 0 7, 106, 169 68, 00 6800 SPEECH PATHOLOGY 0 7, 106, 169 68, 00 6800 SPEECH PATHOLOGY 0 7, 106, 169 68, 00 73, 00 7	22.00		U	1,002,300		22.00
44.00 04400 SKILLED NURSING FACILITY 0 8,781,012 45.00	30 00		-924 359	20 080 120		30.00
15.00 04500 NURSI NG FACILITY 0 3,347,082 45.00						
ANCILLARY SERVICE COST CENTERS						•
54.00	45.00		0	3, 347, 002		- 45.00
60.00 06000 LABORATORY 0 1,720 60.00 62.30 6250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 62.30 6250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 62.30 6250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 62.30	54 00		0	0		54 00
62. 30 66250 BLOOD CLOTTING FOR HEMOPHILIACS 0 65. 00 6650 665. 00 66500 66500 66500 66500 66500 66500 66500 66500 66500 66500 66500 66500 66500 66500 66600 66500 66500 66500 66700 66700 66700 66700 66700 66700 66700 66700 66700 668. 00 6680. 00 6				- 1		
65.00 06500 RESPIRATORY THERAPY 0 3,729,582 66.00 06600 PHYSI CAL THERAPY 0 6,97,937 66.00 06600 PHYSI CAL THERAPY 0 7,499,139 67.00 68.00 06800 SPEECH PATHOLOGY 0 7,106,169 68.00 06801 PEDS FEEDING DISORDER RU CARES 0 91,851 68.00 06801 PEDS FEEDING DISORDER RU CARES 0 91,851 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 2,574,937 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 657,375 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 657,375 73.00 73.00 03550 MEDICAL SERVICES -4,043,218 1,822,159 76.00 03550 MEDICAL SERVICES -4,043,218 1,822,159 76.00 03550 SEVERE BEHAVIOR -1,447,668 4,894,429 76.00 76.90 76			0			
66. 00 06600 PHYSI CAL THERAPY 0 6, 917, 937 66. 00			0	-1		
67. 00 06700 06700 06700 06700 06700 06700 06700 06800 9680 06800 9680 9680 0 06800 9680			0			
68. 00 06800 SPEECH PATHOLOGY 68. 00 7, 106, 169 68. 01 68. 01 68. 01 FEDS FEEDING DI SORDER RU CARES 0 911, 851 68. 01 68. 01 70. 100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 2, 574, 937 71. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 657, 375 73. 00 73. 00 03550 MEDI CAL SERVI CES -4, 043, 218 1, 822, 159 76. 00 76. 02 03020 SEVERE BEHAVI OR -1, 447, 668 4, 894, 429 76. 00 76. 02 03020 SEVERE BEHAVI OR 0 1, 913, 851 76. 00 76. 90 76.			0	1		•
68. 01 06801 PEDS FEEDING DISORDER RU CARES 0 2911, 851 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 2, 574, 937 73. 073. 00 07300 DRUGS CHARGED TO PATIENTS 0 657, 375 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 657, 375 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 657, 375 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 657, 375 73. 00 07500 DRUGS CHARGED TO PATIENTS 0 657, 375 73. 00 07500 DRUGS CHARGED TO PATIENTS 0 657, 375 73. 00 07500 DRUGS CHARGED TO PATIENTS 0 657, 375 73. 00 07500 DRUGS CHARGED TO PATIENTS 0 0 657, 375 75. 00 03950 PSYCHI ATRI C 75. 00 03950 PSYCHI ATRI C 75. 00 03950 PSYCHI ATRI C 75. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0			68. 00
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73. 00 07300 DRUGS CHARGED TO PATIENTS 0 657, 375 76. 00 03550 MEDI CAL SERVICES -4,043,218 1,822,159 76. 00 03550 MEDI CAL SERVICES -4,043,218 1,822,159 76. 00 76. 00 03550 MEDI CAL SERVICES -4,043,218 1,822,159 76. 00 76. 00 76. 00 03500 PSYCHIATRI C -1,447,668 4,894,429 76. 00 770. 00 7700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 77. 00 7700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						71. 00
76. 00 03550 MEDI CAL SERVI CES			0			73. 00
76. 01 03950 PSYCHIATRIC	76. 00		-4. 043. 218			76. 00
76. 02 03020 SEVERE BEHAVI OR 0 1, 913, 851 76. 07. 76. 97 07697 CARDI AC REHABI LITATION 0 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 76. 99 07699 LITHOTRI PSY 0 0 0 0 76. 99 07699 LITHOTRI PSY 0 0 0 0 0 76. 99 07699 LITHOTRI PSY 0 0 0 0 0 77. 00 07700 ALLOGENEI C STEM CELL ACQUISITION 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						76. 01
76. 97						76. 02
76. 98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 76. 99 07699 LI THOTRI PSY 0 0 0 0 77. 09 07700 07700 07700 07700 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 0 0			0			76. 97
76. 99			0	o		76. 98
177. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 778. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 0 0			0	o		76. 99
78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 00TPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC -3,736,826 8,037,428 90. 00 90. 01 09001 PEDS PRI MARY CARE CLINIC 0 0 90. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 92. 00 93. 00 04950 SCHOOL BASED PROGRAMS -15,380,260 -2,419,552 93. 00 93. 01 04951 OTHER OUTPATIENT SERVICE COST CENTER 0 0 93. 00 93. 99 09399 PARTI AL HOSPI TALI ZATI ON PROGRAM 0 0 0 93. 99 OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI 0I D TREATMENT PROGRAM 0 0 0 SPECIAL PURPOSE COST CENTERS 113. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) -26,086,342 161,668,119 NONREI MBURSABLE COST CENTERS 191. 00 19100 RESEARCH 0 1,795,421 194. 00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 194. 00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 194. 00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 178. 00 194. 00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 189. 00 0 0 190. 00 0 0 190. 00 0 0 190. 00 0 0 190. 00 0 0 190. 00 0 0 190. 00 0 0 190. 00 0 0 190. 00 0 0 190. 00 0 0 190. 00 0		1 1	0	o		77. 00
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC -3,736,826 8,037,428 90. 00		1 1				78. 00
90. 01 09001 PEDS PRIMARY CARE CLINIC 0 0 0 99. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 92. 00 93. 00 04950 SCHOOL BASED PROGRAMS -15, 380, 260 -2, 419, 552 93. 01 93. 91 04951 OTHER OUTPATI ENT SERVICE COST CENTER 0 0 0 93. 99 OTHER REI MBURSABLE COST CENTERS 0 0 102. 00 OTHER REI MBURSABLE COST CENTERS 0 0 113. 00 SPECIAL PURPOSE COST CENTERS 0 0 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) -26, 086, 342 161, 668, 119 1191. 00 19100 RESEARCH 0 1, 795, 421 194. 00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 194. 00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 194. 00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 194. 00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 195. 00 0 0 197. 00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 197. 00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 0 197. 00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 0 197. 00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 0 197. 00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 0 197. 00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 0 197. 00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 0 0 197. 00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 0 0 0 197. 00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 0 0 0 0 0 0 0				'		
90. 01 09001 PEDS PRIMARY CARE CLINIC 0 0 0 99. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 92. 00 93. 00 04950 SCHOOL BASED PROGRAMS -15, 380, 260 -2, 419, 552 93. 01 93. 91 04951 OTHER OUTPATI ENT SERVICE COST CENTER 0 0 0 93. 99 OTHER REI MBURSABLE COST CENTERS 0 0 102. 00 OTHER REI MBURSABLE COST CENTERS 0 0 113. 00 SPECIAL PURPOSE COST CENTERS 0 0 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) -26, 086, 342 161, 668, 119 1191. 00 19100 RESEARCH 0 1, 795, 421 194. 00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 194. 00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 194. 00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 194. 00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 195. 00 0 0 197. 00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 197. 00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 0 197. 00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 0 197. 00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 0 197. 00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 0 197. 00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 0 197. 00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 0 0 197. 00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 0 0 0 197. 00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 0 0 0 0 0 0 0	90.00		-3, 736, 826	8, 037, 428		90.00
92. 00	90. 01		0	1		90. 01
93. 00	92.00	1 1				92. 00
93. 01	93.00		-15, 380, 260	-2, 419, 552		93. 00
OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI 0I D TREATMENT PROGRAM 0 0 0 102. 00 SPECI AL PURPOSE COST CENTERS 113. 00 11300 I INTEREST EXPENSE 0 0 0 113. 00 SUBTOTALS (SUM OF LI NES 1 through 117) -26, 086, 342 161, 668, 119 118. 00 NONREI MBURSABLE COST CENTERS 191. 00 19100 RESEARCH 0 1, 795, 421 191. 00 194. 00 07950 CHI LD CARE CENTER (MEDI CAL DAY CARE 0 0 194. 00 194. 00 1950 CHI LD CARE CENTER (MEDI CAL DAY CARE 0 0 194. 00 1950 CHI LD CARE CENTER (MEDI CAL DAY CARE 0 0 194. 00 1950 CHI LD CARE CENTER (MEDI CAL DAY CARE 0 0 194. 00 1950 CHI LD CARE CENTER (MEDI CAL DAY CARE 0 0 194. 00 1950 CHI LD CARE CENTER (MEDI CAL DAY CARE 0 1950 CHI LD CARE CENTER (MED	93. 01					93. 01
OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI 0I D TREATMENT PROGRAM 0 0 0 102. 00 SPECI AL PURPOSE COST CENTERS 113. 00 11300 I INTEREST EXPENSE 0 0 0 113. 00 SUBTOTALS (SUM OF LI NES 1 through 117) -26, 086, 342 161, 668, 119 118. 00 NONREI MBURSABLE COST CENTERS 191. 00 19100 RESEARCH 0 1, 795, 421 191. 00 194. 00 07950 CHI LD CARE CENTER (MEDI CAL DAY CARE 0 0 194. 00 194. 00 1950 CHI LD CARE CENTER (MEDI CAL DAY CARE 0 0 194. 00 1950 CHI LD CARE CENTER (MEDI CAL DAY CARE 0 0 194. 00 1950 CHI LD CARE CENTER (MEDI CAL DAY CARE 0 0 194. 00 1950 CHI LD CARE CENTER (MEDI CAL DAY CARE 0 0 194. 00 1950 CHI LD CARE CENTER (MEDI CAL DAY CARE 0 1950 CHI LD CARE CENTER (MED	93. 99	†				93. 99
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				<u>'</u>		
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	102.00		0	0		102. 00
113. 00						
SUBTOTALS (SUM OF LINES 1 through 117) -26, 086, 342 161, 668, 119 118. 00 NONREI MBURSABLE COST CENTERS 191. 00 19100 RESEARCH 0 1, 795, 421 194. 00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 194. 00	113.00		0	0		113. 00
NONREL MBURSABLE COST CENTERS 191.00 19100 RESEARCH 194.00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 194.00			-26, 086, 342	161, 668, 119		118. 00
191. 00 19100 RESEARCH						
194.00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 194.00	191.00		0	1, 795, 421		191. 00
		1				194. 00
1 1 2 2 2 7 1 2 2 2 2 1 2 2 2 2 2 2 2 2			_	-		200. 00
						, , .

Provider CCN: 31-3300

Peri od: Worksheet A-6 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/8/2024 9:17 am

					5/8/2024	4 9: 17 am
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
	A - NURSING ADMINISTRATION					
1.00	ADMINISTRATIVE & GENERAL	5. 00	24, 469	0		1. 00
2.00	ADULTS & PEDIATRICS	30.00	529, 313	0		2. 00
3.00	SKILLED NURSING FACILITY	44. 00	391, 131	0		3. 00
5. 00	SEVERE BEHAVI OR	76. 02	3, 782	O		5. 00
6. 00	CLINIC	90.00	122, 324	O		6. 00
7. 00	CLINIC	90.00	6 <u>6, 1</u> 24	0		7. 00
	0		1, 137, 143	0		
	B - INTEREST		٦.	4 454 000		
1.00	CAP REL COSTS-BLDG & FIXT		0	<u>1, 451, 902</u>		1. 00
	O THE TANK DELINGUESIT		0	1, 451, 902		
	C - TUITION REIMBURSMENT		ء -	70 107		
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	79, 497		1.00
2.00	NURSI NG ADMI NI STRATI ON	13. 00	0	0		2.00
3.00	PHARMACY	15.00	0	5, 250		3.00
4.00	ADULTS & PEDIATRICS SKILLED NURSING FACILITY	30. 00 44. 00	0	59, 810		4. 00 5. 00
5. 00 6. 00	PHYSICAL THERAPY	66. 00	0	25, 755 5, 250		6. 00
7. 00	OCCUPATI ONAL THERAPY	67. 00	0	5, 250 5, 250		7.00
8. 00	SPEECH PATHOLOGY	68. 00	0	2, 364		8.00
9. 00	MEDICAL SERVICES	76. 00	o	7, 655		9. 00
10. 00	PSYCHI ATRI C	76. 00 76. 01	o	8, 070		10.00
11. 00	CLINIC	90.00	0	39, 681		11.00
12. 00	SCHOOL BASED PROGRAMS	93.00	0	10, 500		12.00
13. 00	SEVERE BEHAVIOR	76. 02	0	15, 750		13. 00
14. 00	CLINIC	90. 00	0	8, 058		14. 00
14.00	0	<u> </u>	— — —)	<u>8, 038</u> 272, 890		14.00
	D - MME		U _I	272, 890		
1. 00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	1, 616, 181		1.00
1.00	n KEE COSTS-WVDEE EQUIT		— — — ў	1, 616, 181		1.00
	E - MALPRACTICE		<u> </u>	1,010,101		
1. 00	ADMI NI STRATI VE & GENERAL	5. 00	0	3, 494		1.00
2. 00	DI ETARY	10. 00	0	107		2. 00
3. 00	NURSING ADMINISTRATION	13. 00	o	3, 858		3. 00
4. 00	PHARMACY	15. 00	0	11, 625		4. 00
5. 00	SOCI AL SERVI CE	17. 00	0	3, 252		5. 00
6. 00	ADULTS & PEDIATRICS	30.00	o	101, 384		6. 00
7. 00	SKILLED NURSING FACILITY	44.00	0	42, 137		7. 00
8. 00	NURSING FACILITY	45. 00	o	15, 230		8. 00
9. 00	RESPIRATORY THERAPY	65. 00	0	20, 714		9. 00
10. 00	PHYSI CAL THERAPY	66.00	o	32, 677		10.00
11. 00	OCCUPATI ONAL THERAPY	67. 00	0	38, 493		11. 00
12. 00	SPEECH PATHOLOGY	68.00	o	37, 185		12. 00
13. 00	PEDS FEEDING DISORDER RU	68. 01	o	5, 071		13. 00
10.00	CARES	00.01	J	3, 37 1		10.00
14. 00	MEDICAL SERVICES	76.00	0	76, 618		14. 00
15. 00	PSYCHI ATRI C	76. 01	Ö	27, 769		15. 00
	SEVERE BEHAVI OR	76. 02	0	7, 899		16.00
17. 00	CLINIC	90.00	o	13, 399		17. 00
18. 00	CLINIC	90.00	o	7, 835		18. 00
19. 00	SCHOOL BASED PROGRAMS	93.00	o	65, 404		19. 00
20. 00	RESEARCH	191. 00	o	4, 412		20.00
	0	— — · ¶	— — <u> </u>	518, 563		====
	F - OUTPATIENT SITE DIRECTORS	5		-,		
1.00	ADMINISTRATIVE & GENERAL	5. 00	312, 060	0		1. 00
2.00	PHYSI CAL THERAPY	66.00	154, 033	Ö		2. 00
3.00	OCCUPATI ONAL THERAPY	67. 00	209, 228	Ö		3. 00
4.00	SPEECH PATHOLOGY	68. 00	183, 491	0		4. 00
5.00	PEDS FEEDING DISORDER RU	68. 01	26, 469	0		5. 00
	CARES					
6.00	PSYCHI ATRI C	76. 01	115, 517	0		6. 00
7.00	SEVERE BEHAVIOR	76. 02	55, 600	0		7. 00
8.00	CLINIC	90.00	147, 102	О		8. 00
9. 00	CLINIC	90.00	<u>49, 8</u> 51	0		9. 00
	0		1, 253, 351			
	G - THERAPY LEADS RECLASS					
1.00	SKILLED NURSING FACILITY	44. 00	0	0		1. 00
2.00	NURSING FACILITY	45. 00	0	0		2. 00
3.00	PHYSI CAL THERAPY	66. 00	0	0		3. 00
4.00	OCCUPATI ONAL THERAPY	67. 00	143, 827	0		4. 00
5.00	SPEECH PATHOLOGY	68. 00	135, 377	0		5. 00
6.00	PSYCHI ATRI C	<u>76.</u> 01	15 <u>4, 2</u> 70	0		6. 00
	0 — — — — —	_ T	433, 474	o		

Health Financial Systems RECLASSIFICATIONS Provider CCN: 31-3300

					To 12/31/2023 Date/Time Prepa 5/8/2024 9:17 a	
		Increases			37 67 2021 7. 17	
	Cost Center	Li ne #	Sal ary	Other 5.00		
	H - MEDI CAL DI RECTOR	3. 00	4. 00	5. 00		
1.00	MEDI CAL SERVI CES	76. 00	186, 088	0		1. 00
2.00	CLINIC	90.00	169, 562	0		2.00
3.00	CLINIC	90.00	7 <u>0, 2</u> 78	0		3.00
	O L DUADMACY STAFE DECLASS		425, 928	0		
1. 00	I - PHARMACY STAFF RECLASS SKILLED NURSING FACILITY	44.00	100, 380	0		1. 00
1.00	0		100, 380	— — <u>ŏ</u>		1.00
	J - INCENTIVES RECLASS	•				
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	218, 666		1. 00
2.00	OPERATION OF PLANT	7.00	0	13, 575		2.00
3. 00 4. 00	HOUSEKEEPI NG DI ETARY	9. 00 10. 00	0	4, 525 26, 631	-	3. 00 4. 00
5. 00	NURSING ADMINISTRATION	13. 00	o	27, 873		5. 00
6.00	PHARMACY	15.00	O	4, 525		6. 00
7.00	MEDICAL RECORDS & LIBRARY	16. 00	0	4, 525		7. 00
8. 00	SOCI AL SERVI CE	17. 00	0	4, 525		8. 00
9. 00 10. 00	INSERVICE EDUCATION ADULTS & PEDIATRICS	18. 00 30. 00	0	15, 248 221, 804	1	9. 00 10. 00
11. 00	SKILLED NURSING FACILITY	44.00	o	12, 093		11. 00
12. 00	NURSING FACILITY	45. 00	O	42, 548		12. 00
13.00	RESPI RATORY THERAPY	65. 00	0	20, 945		13. 00
14. 00	PHYSI CAL THERAPY	66. 00	0	103, 987		14.00
15. 00	OCCUPATIONAL THERAPY	67.00	0	84, 088		15.00
16. 00 17. 00	SPEECH PATHOLOGY PEDS FEEDING DISORDER RU	68. 00 68. 01	0	92, 272 0		16. 00 17. 00
17.00	CARES	00.01		J	'	17.00
18.00	MEDICAL SERVICES	76. 00	0	21, 914		18. 00
19. 00	PSYCHI ATRI C	76. 01	0	98, 408		19. 00
20.00	SEVERE BEHAVI OR	76. 02	0	0		20.00
21. 00 22. 00	CLINIC SCHOOL BASED PROGRAMS	90. 00 93. 00	0	6, 788 421, 045		21. 00 22. 00
23. 00	RESEARCH	191.00	o	18, 163		23. 00
	0			1, 464, 148		
	L - LEASES		-			
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	1, 370, 414		1.00
2. 00 3. 00	NURSING FACILITY PHYSICAL THERAPY	45. 00 66. 00	0	283, 131 893, 531		2. 00
4. 00	OCCUPATI ONAL THERAPY	67. 00	Ö	752, 365		4. 00
5.00	SPEECH PATHOLOGY	68.00	0	432, 499		5. 00
6.00	PEDS FEEDING DISORDER RU	68. 01	0	74, 520		6. 00
7. 00	CARES MEDI CAL SERVI CES	76. 00	o	14, 685		7. 00
8. 00	PSYCHI ATRI C	76. 00 76. 01	0	315, 221		8. 00
9. 00	SEVERE BEHAVIOR	76. 02	Ö	74, 520		9. 00
10.00	CLINIC	90.00	0	500, 308	1	10.00
12.00	SCHOOL BASED PROGRAMS	93.00	•	97, 355	1	12.00
	O DUVSI CLAN DECLASS		0	4, 808, 549		
1. 00	M - PHYSICIAN RECLASS ADULTS & PEDIATRICS	30.00	763, 448	0		1. 00
2. 00	SKILLED NURSING FACILITY	44.00	141, 057	Ö		2. 00
3.00	PSYCHI ATRI C	76. 01	750, 562	0		3.00
4.00	CLINIC	90.00	2, 809, 167	0		4. 00
5. 00	CLINIC	<u>90.</u> 00	633, 901	0		5. 00
	O N - THERAPY SCHEDULING		5, 098, 135	0		
1. 00	PHYSI CAL THERAPY	66.00	311, 646	0		1. 00
2.00	OCCUPATI ONAL THERAPY	67. 00	424, 195	Ö		2. 00
3. 00	SPEECH PATHOLOGY	68. 00	403, 951	0		3. 00
4.00	PSYCHI ATRI C	76. 01	240, 885	0		4. 00
5. 00 6. 00	SEVERE BEHAVIOR PEDS FEEDING DISORDER RU	76. 02 68. 01	41, 602 25, 444	0		5. 00 6. 00
0.00	CARES	00.01	25, 444	J		0.00
7.00	CLINIC	90.00	348, 419	0		7. 00
8. 00	CLINIC	<u> </u>	61, 103	0		8. 00
	O INSERVICE EDUCATION		1, 857, 245	0		
1. 00	O - INSERVICE EDUCATION ADMINISTRATIVE & GENERAL	5. 00	11, 109	0		1. 00
2. 00	OPERATION OF PLANT	7. 00	2, 217	0		2. 00
3. 00	HOUSEKEEPI NG	9. 00	1, 665	Ö		3. 00
4.00	DI ETARY	10. 00	1, 024	0		4. 00
5.00	NURSI NG ADMI NI STRATI ON	13.00	290	0		5.00
6. 00 7. 00	PHARMACY MEDICAL RECORDS & LIBRARY	15. 00 16. 00	828 691	0		6. 00 7. 00
7.00	PRIEDI OAL RECORDS & LI DRART	10.00	071	O _I	I	7.00

Health Financial Systems RECLASSIFICATIONS

CHILDRENS SPECIALIZED HOPSITAL

In Lieu of Form CMS-2552-10

Provider CCN: 31-3300

						5/8/2024 9: 1	<u>/ am</u>
		Increases					
	Cost Center	Li ne #	Sal ary	0ther			
	2. 00	3.00	4.00	5. 00			
8.00	SOCI AL SERVI CE	17. 00	351	0			8. 00
9.00	ADULTS & PEDIATRICS	30.00	8, 109	0			9. 00
10.00	SKILLED NURSING FACILITY	44.00	7, 303	0			10.00
12.00	RESPI RATORY THERAPY	65.00	468	0			12. 00
13.00	PHYSI CAL THERAPY	66.00	2, 495	0			13. 00
14.00	OCCUPATI ONAL THERAPY	67.00	2, 617	0			14. 00
15.00	SPEECH PATHOLOGY	68.00	2, 435	0			15. 00
16.00	PEDS FEEDING DISORDER RU	68. 01	517	0			16. 00
	CARES						
17.00	MEDICAL SERVICES	76. 00	2, 662	0			17. 00
18. 00	PSYCHI ATRI C	76. 01	1, 793	0			18. 00
19.00	SEVERE BEHAVIOR	76. 02	1, 086	0			19. 00
20.00	CLINIC	90.00	2, 221	0			20. 00
21.00	CLINIC	90.00	921	0			21. 00
22.00	SCHOOL BASED PROGRAMS	93.00	6, 812	0			22. 00
	0		57, 614	0			
	P - SOCIAL SERVICE						
1.00	ADULTS & PEDIATRICS	30.00	525, 603	0			1.00
2.00	SKILLED NURSING FACILITY	44.00	35, 269	0			2. 00
3.00	NURSING FACILITY	45.00	45, 346	0			3. 00
	0 = = = = =		606, 218				
500.00	Grand Total: Increases		10, 969, 488	10, 132, 233			500.00
	•				•		•

Health Financial Systems RECLASSIFICATIONS Provider CCN: 31-3300

						Date/lime Prepared: 5/8/2024 9:17 am
		Decreases				
	Cost Center	Li ne #	Sal ary	Other Other	Wkst. A-7 Ref.	
	6. 00 A - NURSI NG ADMI NI STRATI ON	7. 00	8. 00	9. 00	10. 00	
1.00	NURSING ADMINISTRATION	13. 00	1, 137, 143	0	0	1.00
2. 00	NORST NO ADMINISTRATION	0.00	1, 137, 143	0		2. 00
3.00		0.00	O	0		3. 00
5.00		0.00	O	0	0	5. 00
6.00		0.00	0	0		6. 00
7. 00		0.00	0_	0		7. 00
	0		1, 137, 143	0		
1. 00	B - INTEREST INTEREST EXPENSE	113. 00	0	1, 451, 902	9	1. 00
1.00	0	113.00		1, 451, 902		1.00
	C - TUITION REIMBURSMENT		<u> </u>	17 10 17 702	1	
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	272, 890	0	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 6. 00		0. 00 0. 00	0	0		5. 00 6. 00
7. 00		0.00	0	0		7. 00
8. 00		0.00	Ö	0		8. 00
9. 00		0.00	Ö	0		9. 00
10.00		0.00	О	0	0	10.00
11.00		0.00	0	0	0	11. 00
12.00		0.00	0	0		12. 00
13.00		0.00	0	0	-	13. 00
14. 00			0	00 272, 890	0	14. 00
	D - MME		U _I	272, 890		
1.00	CAP REL COSTS-BLDG & FLXT	1.00	0	1, 616, 181	9	1. 00
	0			1, 616, 181		
	E - MALPRACTICE					
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	518, 563		1. 00
2.00		0. 00	0	0		2. 00
3.00		0.00	0	0		3.00
4. 00 5. 00		0. 00 0. 00	0	0		4. 00 5. 00
6.00		0.00	0	0		6. 00
7. 00		0.00	ő	0		7. 00
8. 00		0.00	Ö	0		8. 00
9.00		0.00	O	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 14. 00		0. 00 0. 00	0	0		13. 00 14. 00
15. 00		0.00	o	0		15. 00
16. 00		0.00	ő	0		16. 00
17. 00		0.00	O	0	0	17. 00
18.00		0.00	O	0	0	18. 00
19. 00		0.00	0	0	-	19. 00
20.00		0.00	0	0	0	20. 00
	U CUITDATI ENT. CLITE DI DECTORO		0	518, 563		
1. 00	F - OUTPATIENT SITE DIRECTORS ADMINISTRATIVE & GENERAL	5. 00	1, 253, 351	0	0	1. 00
2.00	ADMINISTRATIVE & GENERAL	0.00	1, 200, 001	0		2.00
3.00		0.00	ol	0		3. 00
4. 00		0.00	o	0	0	4. 00
5.00		0.00	O	0	0	5. 00
6.00		0.00	0	0	0	6. 00
7. 00		0. 00	0	0		7. 00
8.00		0.00	0	0		8.00
9. 00		0.00	00 1, 253, 351	$ \frac{0}{0}$	<u>├</u>	9. 00
	G - THERAPY LEADS RECLASS		1, 203, 301	0		
1.00	I NSERVI CE EDUCATI ON	18.00	433, 474	0	0	1.00
2. 00		0.00	0	Ö		2. 00
3.00		0.00	o	0		3. 00
4.00		0. 00	o	0	-	4. 00
5.00		0.00	0	0		5. 00
6.00			0	0	<u> </u>	6. 00
	0	I	433, 474	0	1	

Health Financial Systems RECLASSIFICATIONS Provider CCN: 31-3300

						o 12/31/2023 Date/lime 5/8/2024 9	
	Cost Conton	Decreases	Calami	Othor	Wko+ A 7 Dof		
	Cost Center 6.00	Li ne # 7.00	Sal ary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00		
	H - MEDICAL DIRECTOR	7.00	0.00	71.00	10.00		
1.00	ADMINISTRATIVE & GENERAL	5. 00	425, 928	0			1. 00
2.00		0.00	0	0			2.00
3. 00			00 425, 928	0	0		3. 00
	I - PHARMACY STAFF RECLASS		420, 720				
1.00	PHARMACY	1500	100, 380	0	0		1. 00
	O LANGENTLIVES DEGLASS		100, 380	0			
1. 00	J - INCENTIVES RECLASS EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 464, 148	0		1. 00
2. 00	EWI LOTEL BENEFITS BEFARTWENT	0.00	o	0 1, 404, 140			2. 00
3.00		0. 00	О	0	0		3. 00
4.00		0. 00	0	0			4. 00
5. 00 6. 00		0. 00 0. 00	0	0			5. 00 6. 00
7. 00		0.00	o	0			7. 00
8.00		0.00	О	0	0		8. 00
9.00		0. 00	0	0			9. 00
10. 00 11. 00		0. 00 0. 00	0	0			10. 00 11. 00
12. 00		0.00	o	0			12. 00
13.00		0.00	0	0			13. 00
14. 00		0.00	0	0			14. 00
15. 00 16. 00		0. 00 0. 00	0	0			15. 00 16. 00
17. 00		0.00	o	0			17. 00
18. 00		0.00	Ö	Ö			18. 00
19. 00		0.00	0	0			19. 00
20. 00 21. 00		0. 00 0. 00	0	0	-		20. 00 21. 00
22. 00		0.00	0	0			22.00
23. 00		0.00	0	0	0		23. 00
	0		0	1, 464, 148			
1. 00	L - LEASES CAP REL COSTS-BLDG & FIXT	1.00	0	4, 808, 549	9		1.00
2.00		0.00	O	0	0		2. 00
3.00		0.00	0	0			3. 00
4. 00 5. 00		0. 00 0. 00	0	0			4. 00 5. 00
6. 00		0.00	o	0			6. 00
7.00		0. 00	О	0			7. 00
8.00		0.00	0	0			8. 00
9. 00 10. 00		0. 00 0. 00	0	0			9. 00 10. 00
12. 00		0.00	Ö	Ö	Ö		12. 00
	0		0	4, 808, 549			
1. 00	M - PHYSICIAN RECLASS MEDICAL SERVICES	76. 00	5, 098, 135	0	0		1.00
2. 00	WEDI ONE SERVICES	0.00	0	0	o		2. 00
3.00		0.00	0	0	-		3. 00
4. 00 5. 00		0. 00 0. 00	0	0			4. 00 5. 00
5.00			5, 098, 135	0			5.00
	N - THERAPY SCHEDULING						
1.00	ADMINISTRATIVE & GENERAL	5. 00	1, 857, 245	0			1.00
2. 00 3. 00		0. 00 0. 00	0	0			2. 00 3. 00
4. 00		0.00	o	Ö			4. 00
5.00		0.00	0	0			5. 00
6. 00 7. 00		0. 00 0. 00	0	0			6. 00 7. 00
8. 00		0.00	o				8. 00
	0		1, 857, 245	0			
1 00	O - INSERVICE EDUCATION	10.00	E7 (44	^			1 00
1. 00 2. 00	INSERVICE EDUCATION	18. 00 0. 00	57, 614 0	0			1. 00 2. 00
3. 00		0.00	o o	Ö			3. 00
4.00		0.00	O	0	-		4. 00
5.00		0. 00 0. 00	0	0			5. 00
6. 00 7. 00		0.00	0	0	-		6. 00 7. 00
8. 00		0. 00	Ö	Ö			8. 00
9.00		0.00	0	0			9. 00
10. 00		0. 00	0	0	0		10. 00

Health Financial Systems RECLASSI FI CATI ONS

500.00 Grand Total: Decreases

3.00

CHILDRENS SPECIALIZED HOPSITAL

Provider CCN: 31-3300

0

10, 132, 233

In Lieu of Form CMS-2552-10 Worksheet A-6

3.00

500.00

Peri od:

0

o

From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/8/2024 9:17 am Decreases Wkst. A-7 Ref. 10.00 Cost Center Li ne # Sal ary 0ther 8.00 6. 00 9. 00 7.00 12. 00 0.00 12.00 0 0 13.00 0.00 0 0 0 0 0 0 0 0 0 0 0 0 13.00 14.00 0.00 14.00 0 0 15.00 0.00 15.00 0.00 16.00 16.00 0 17.00 0.00 17.00 18.00 0.00 18.00 0.00 0 19.00 19.00 0.00 0 0 20.00 20.00 21.00 0.00 0 0 21.00 22.00 0.00 0 0 22. 00 57, 614 - SOCIAL SERVICE 1.00 SOCIAL SERVICE 17.00 606, 218 0 0 1.00 2.00 0.00 2. 00

606, 218

10, 969, 488

0.00

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 31-3300 Peri od: Worksheet A-7 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/8/2024 9:17 am Acqui si ti ons Begi nni ng Total Di sposal s and Purchases Donati on Bal ances Retirements 2.00 3.00 4. 00 5. 00 1 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 1, 075, 800 0 0 1.00 0 2.00 Land Improvements 3, 485, 763 0 0 0 0 0 0 0 2.00 3. 00 3.00 Buildings and Fixtures 144, 309, 475 0 0 Building Improvements 16, 277, 251 0 0 4.00 0 4.00 5.00 Fixed Equipment 38, 025, 960 0 0 5.00 65, 899, 073 0 0 6.00 Movable Equipment 0 6.00 0 7.00 HIT designated Assets 0 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 269, 073, 322 0 8.00 9.00 Reconciling Items 0 0 0 9.00 Total (line 8 minus line 9) 269, 073, 322 10.00 10.00 0 0 0 Endi ng Bal ance Fully Depreciated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 1,075,800 0 1.00 2.00 Land Improvements 3, 485, 763 0 2.00 144, 309, 475 3.00 Buildings and Fixtures 0 3.00 0) 4.00 Building Improvements 16, 277, 251 4.00 5.00 Fi xed Equipment 38, 025, 960 0 5.00 Movable Equipment 65, 899, 073 0 6.00 6.00 7.00 HIT designated Assets 0 7.00

269, 073, 322

269, 073, 322

0

0

Health Financial Systems C	HILDRENS SPECIA	LIZED HOPSITAL	_	In Lieu of Form CMS-2552-10			
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 31-3300	Peri od:	Worksheet A-7		
				From 01/01/2023 To 12/31/2023		narodi	
				10 12/31/2023	5/8/2024 9: 17		
		SI	UMMARY OF CAP	PI TAL			
Cost Center Description	Depreciation	Lease	Interest	Insurance (see			
				instructions)			
	9.00	10.00	11.00	12. 00	13. 00		
PART II - RECONCILIATION OF AMOUNTS FROM WOR			and 2				
1. 00 CAP REL COSTS-BLDG & FLXT	10, 292, 455)	0	0	1.00	
2.00 CAP REL COSTS-MVBLE EQUIP	10 202 455			0	0	2.00	
3.00 Total (sum of lines 1-2)	10, 292, 455)	0 0	0	3. 00	
	SUMMARY 0	F CAPITAL					
Cost Center Description	Other	Total (1) (sum					
cost center bescription	Capi tal -Rel ate		'				
	d Costs (see	through 14)					
	instructions)	····					
	14.00	15. 00					
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	IN 2, LINES 1 a	and 2				
1.00 CAP REL COSTS-BLDG & FLXT	0	10, 292, 455	5			1.00	
2.00 CAP REL COSTS-MVBLE EQUIP	0	C				2. 00	
3.00 Total (sum of lines 1-2)	0	10, 292, 455	5			3. 00	

Heal th	n Financial Systems C	HILDRENS SPECIA	LIZED HOPSITAL		In Lieu of Form CMS-2552-10			
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider Co		Period: From 01/01/2023 To 12/31/2023		pared:	
		COMI	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	aiii	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance		
			Leases	for Ratio (col. 1 - col	instructions)			
				2)	•			
		1. 00	2. 00	3. 00	4. 00	5. 00		
	PART III - RECONCILIATION OF CAPITAL COSTS C							
1.00	CAP REL COSTS-BLDG & FLXT	10, 292, 455	0	10, 292, 45			1. 00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0. 000000		2. 00	
3.00	Total (sum of lines 1-2)	10, 292, 455		10, 292, 45			3. 00	
		ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL						
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease		
			Capi tal -Relate					
			d Costs	through 7)				
		6. 00	7. 00	8. 00	9. 00	10. 00		
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS		1				
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0 5, 319, 627	0	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 1, 616, 181		2.00	
3.00	Total (sum of lines 1-2)	0	0	JMMARY OF CAPI	0 6, 935, 808	0	3. 00	
				JIMIMARY OF CAPI	TAL			
	Cost Center Description	Interest	Insurance (see			Total (2) (sum		
			instructions)	instructions)	Capi tal -Relate			
					d Costs (see	through 14)		
					instructions)			
	DART III DECONOLILIATION OF CARLTAL COCTO	11. 00	12. 00	13. 00	14. 00	15. 00		
1 00	PART III - RECONCILIATION OF CAPITAL COSTS C					F 210 (27	1 00	
1. 00 2. 00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	0	0		0 0	5, 319, 627	1. 00 2. 00	
2. 00 3. 00	Total (sum of lines 1-2)	0			0 0	1, 616, 181 6, 935, 808		
3.00	Total (Suil Of Titles 1-2)	1	ı	1	u _l u	J 0, 730, 808	J 3.00	

Health Financial Systems
ADJUSTMENTS TO EXPENSES CHILDRENS SPECIALIZED HOPSITAL In Lieu of Form CMS-2552-10 Provider CCN: 31-3300 Peri od: From 01/01/2023 To 12/31/2023 Worksheet A-8 Date/Time Prepared: 5/8/2024 9:17 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted

	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	oost conten bescriptron	1.00	2.00	3. 00	4. 00	5. 00	
1. 00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	1. 00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3. 00	Investment income - other (chapter 2)		0		0.00	0	3. 00
4. 00	Trade, quantity, and time discounts (chapter 8)	В	-11, 497	ADMINISTRATIVE & GENERAL	5.00	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)	В	-424, 433	OPERATION OF PLANT	7. 00	0	6. 00
7. 00	Telephone services (pay stations excluded) (chapter		0		0.00	0	7. 00
8. 00	21) Television and radio service (chapter 21)		0		0. 00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -5, 306, 261		0.00	0	
11. 00	adjustment Sale of scrap, waste, etc.	H-0-2	-3, 300, 201		0. 00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	1, 327, 575			0	
13. 00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13. 00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		-185, 728 0	DIETARY OPERATION OF PLANT	10. 00 7. 00	0	14. 00 15. 00
16. 00	and others Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
17. 00	patients Sale of drugs to other than		0		0.00	0	17. 00
18. 00	patients Sale of medical records and	В	-52, 672	MEDICAL RECORDS & LIBRARY	16.00	0	18. 00
19. 00	abstracts Nursing and allied health	В	0		0.00	0	19. 00
	education (tuition, fees, books, etc.)						
20. 00 21. 00	Vending machines Income from imposition of interest, finance or penalty	В	-154, 945	ADMINISTRATIVE & GENERAL	0. 00 5. 00	0	20. 00 21. 00
22. 00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24. 00
25. 00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
26. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant		0		0.00		29. 00
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67.00		30. 00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0. 00	0	32. 00
	Depreciation and Interest		_				
33. 00	MARKETING COST	A	-2, 119	ADMINISTRATIVE & GENERAL	5. 00	0	33. 00

12/31/2023 Date/Time Prepared: 5/8/2024 9:17 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 1.00 2.00 3.00 4.00 5.00 34.00 AUTI SM GRANT -530, 473 PSYCHI ATRI C 34. 00 В 76.01 MISC OTHER OPERATING REVENUE -242, 300 ADMI NI STRATI VE & GENERAL 0 35.00 В 5.00 35.00 36.00 CEC GRANT В -680, 439 MEDICAL SERVICES 76.00 36.00 37.00 CHGME REV В -58, 669 ADULTS & PEDIATRICS 30.00 37.00 NURSE PRACTITIONER SALARIES -3, 362, 779 MEDI CAL SERVI CES o 38.00 38 00 76.00 Α -807, 892 EMPLOYEE BENEFITS DEPARTMENT NURSE PRAC BENEFITS 39.00 Α 4.00 39.00 40.00 PHYSICIAN PART C Α -60, 423 ADULTS & PEDIATRICS 30.00 40.00 41.00 PHYSICIAN PART C -108, 004 CLI NI C 90.00 ol 41.00 Α -1, 798 PSYCHI ATRI C PHYSICIAN PART C 43.00 Α 76.01 43.00 44.00 PEDIATRIC PRACTICE В -2, 530 CLI NI C 90.00 44.00 CEPHALON DRUG TRIAL -40, 695 PSYCHI ATRI C 45.00 В 76.01 45.00 -15, 380, 260 SCHOOL BASED PROGRAMS SCHOOL BASED PROGRAM GRANTS 46.00 46.00 В 93.00 50.00 TOTAL (sum of lines 1 thru 49) -26, 086, 342 50.00 (Transfer to Worksheet A, column 6, line 200.)

- (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.

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

			Related Organization(s) and/or Home Office		
Symbol (1)	Name		Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2. 00	3.00	4. 00	5. 00	
INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME OFFICE:	_		
	1.00	1.00 2.00	Symbol (1) Name Percentage of Ownership	Symbol (1) Name Percentage of Ownership 1.00 2.00 3.00 4.00	Symbol (1) Name Percentage of Ownershi p Name Percentage of Ownershi p 1.00 2.00 3.00 4.00 5.00

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	7. 00
8.00		0.00	8. 00
9.00		0.00	9. 00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

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

Transfer column 6, line 5 to Worksheet A-8, column 2,

line 12.

- 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.

Health Financial Systems			CI	HILDRENS SPECIALIZ	ZED HOPSITAL		In Lieu of Form CMS-255		
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED ORGANIZ	ATIONS AND HOME	Provi der CC	N: 31-3300	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS						From 01/01/2023		
							To 12/31/2023		
					<u> </u>			5/8/2024 9: 17	/ am
	Net	Wkst. A-7 Ref.							
	Adjustments								
	(col. 4 minus								
	col. 5)*								
	6. 00	7. 00							
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRED A	AS A RESULT OF TRA	NSACTIONS WI	TH RELATED (ORGANIZATIONS OR (CLAI MED	
	HOME OFFICE CO:	STS:							
1.00	1, 327, 575	0							1.00
2.00	0	0							2.00
3.00	0	0							3.00
4.00	0	0							4.00
5.00	1, 327, 575								5.00
* The	amounts on line	es 1-4 (and sub	scripts as appr	opriate) are tran	sferred in de	etail to Wor	ksheet A. column	6. Lines as	-
				itive amounts decr					whi ch
				or 2, the amount a					
	Related Orga								
		me Office							

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
7. 00 8. 00 9. 00 10. 00 100. 00		10	100.00

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

Type of Business

- 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.

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Peri od: Worksheet A-8-2 From 01/01/2023 To 12/31/2023 Date/Time Prepared: Provider CCN: 31-3300

					-	Γο 12/31/2023	Date/Time Pre 5/8/2024 9:17	epared:
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	diii
		I denti fi er	Remuneration	Component	Component		ider Component	
				·	•		Hours	
	1. 00	2. 00	3.00	4. 00	5. 00	6. 00	7. 00	
1.00		AGGREGATE-ADULTS &	958, 096	763, 448	194, 648	211, 500	1, 503	1. 00
0.00		PEDI ATRI CS	4 047 074	040 540	205 200	044 500	4 400	0.00
2.00		AGGREGATE - PSYCHI ATRI C	1, 017, 871		· ·			2. 00 3. 00
3.00		AGGREGATE CLINIC	3, 466, 855					
4. 00 5. 00	0.00	AGGREGATE-CLI NI C	917, 685 0			ľ	2, 444 0	4. 00 5. 00
6.00	0.00				_	0	0	6. 00
7. 00	0.00			0	J	0	0	7. 00
8. 00	0.00				0	0	0	8. 00
9. 00	0.00			0	0	0	0	9. 00
10. 00	0.00			0	0	0	0	10. 00
200.00	0.00		6, 360, 507	5, 019, 078	1, 341, 429	Ĭ	10, 368	
200.00	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	200.00
		I denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14. 00	
1. 00		AGGREGATE-ADULTS & PEDIATRICS	152, 829	7, 641	0	0	0	1. 00
2.00		AGGREGATE-PSYCHI ATRI C	143, 169	7, 158	0	0	0	2. 00
3. 00		AGGREGATE-CLINIC	509, 735			0	0	3. 00
4.00	90. 00	AGGREGATE-CLINIC	248, 513			0	0	4. 00
5.00	0.00		0		0	0	0	5. 00
6.00	0.00		0	0	0	0	0	6.00
7.00	0. 00		0	0	0	0	0	7. 00
8.00	0. 00		0	0	0	0	0	8. 00
9.00	0.00		0	0	0	0	0	9. 00
10.00	0. 00		0	0	0	0	-	10.00
200.00			1, 054, 246			0	0	200. 00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	14 15. 00	16. 00	17. 00	18. 00		
1. 00		AGGREGATE-ADULTS &	0					1. 00
		PEDI ATRI CS		·		·		
2.00		AGGREGATE-PSYCHI ATRI C	0		· ·			2. 00
3. 00	90. 00 AGGREGATE-CLI NI C		0					3. 00
4.00	90. 00 AGGREGATE-CLI NI C		0	2.0,0.0	·	669, 172		4. 00
5. 00	0. 00		0	l ~	-	0		5. 00
6.00	0.00		0	0	0	0		6. 00
7.00	0.00		0	0	0	0		7. 00
8.00	0.00		0	0	0	0		8.00
9.00	0.00							9. 00
10.00	0. 00		0 0		207 102	E 204 241		10.00
200.00	1		1	1, 054, 246	287, 183	5, 306, 261		200. 00

		II LUNLING SELCTA		21 24 222		u 01 101111 0113-2	2552-10
COST A	NLLOCATION - GENERAL SERVICE COSTS		Provi der CC		Period: From 01/01/2023 To 12/31/2023	Date/Time Pre	
			CAPI TAL REI	ATED COSTS		5/8/2024 9: 17	am
			OALLIAE KEE	LATED COSTS			
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	'	for Cost			BENEFI TS		
		Allocation			DEPARTMENT		
		(from Wkst A					
		col . 7)					
	CENEDAL CEDALCE COCT CENTEDO	0	1. 00	2.00	4. 00	4A	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	5, 319, 627	5, 319, 627				1.00
2. 00	00200 CAP REL COSTS-BLDG & FIXT	1, 616, 181	5, 519, 627	1, 616, 18	1		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	18, 102, 260	65, 384			I	4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	48, 217, 589	2, 019, 069				5.00
7. 00	00700 OPERATION OF PLANT	3, 138, 012	263, 580				1
8.00	00800 LAUNDRY & LINEN SERVICE	0	26, 362			34, 371	1
9.00	00900 HOUSEKEEPI NG	2, 389, 431	37, 629				9. 00
10.00	01000 DI ETARY	2, 356, 774	158, 305	48, 09	5 232, 350	2, 795, 524	10.00
13.00	01300 NURSING ADMINISTRATION	320, 179	0		0 42, 445	362, 624	13. 00
15. 00	01500 PHARMACY	1, 994, 797	55, 944	16, 99	7 286, 486	2, 354, 224	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 121, 707	69, 038				1
17. 00	01700 SOCIAL SERVICE	203, 874	21, 969				1
18. 00	01080 I NSERVI CE EDUCATI ON	30, 143	7, 526	1	. 1		1
21. 00	02100 &R SERVICES-SALARY & FRINGES APPRV	0	0		0 0	0	21.00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	1, 002, 306	0		0 0	1, 002, 306	22. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	20, 080, 120	0		0 3, 182, 005	23, 262, 125	30.00
44. 00	04400 SKI LLED NURSING FACILITY	8, 781, 012	693, 121				
45. 00	04500 NURSING FACILITY	3, 347, 082	073, 121		0 409, 152		
43.00	ANCILLARY SERVICE COST CENTERS	3, 347, 002			0 407, 132	3, 730, 234	45.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	O	2, 088	63	4 0	2, 722	54.00
60.00	06000 LABORATORY	1, 720	0	ı	o o	1, 720	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	o	0		0 0	0	62. 30
65. 00	06500 RESPI RATORY THERAPY	3, 729, 582	4, 350	1, 32	2 523, 932	4, 259, 186	65. 00
66. 00	06600 PHYSI CAL THERAPY	6, 917, 937	680, 418			8, 732, 645	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	7, 499, 139	430, 890				
68. 00	06800 SPEECH PATHOLOGY	7, 106, 169	144, 732	43, 97			1
68. 01	06801 PEDS FEEDING DISORDER RU CARES	911, 851	0		0 8, 273		1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 574, 937	0		0	2, 574, 937	•
73. 00 76. 00	07300 DRUGS CHARGED TO PATIENTS 03550 MEDICAL SERVICES	657, 375	9, 222	2, 80	0 2 847, 247	657, 375	
76. 00 76. 01	03950 PSYCHI ATRI C	1, 822, 159 4, 894, 429	344, 712			2, 681, 430 6, 224, 543	1
76. 01	03020 SEVERE BEHAVI OR	1, 913, 851	344, /12 N	104, 72	0 16, 093		
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0 10, 0,0	1, ,2,, ,11	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	l ol	0		ol ol	0	76. 98
76. 99	07699 LI THOTRI PSY	o	0		o o	0	76. 99
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	o	0		o o	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	8, 037, 428	212, 987	64, 70	9 1, 757, 615	10, 072, 739	
90. 01	09001 PEDS PRIMARY CARE CLINIC	0	0		0 0	0	
92.00		0 440 550	70.004	04.04	4 0/0 /0/	0	
93. 00 93. 01	04950 SCHOOL BASED PROGRAMS 04951 OTHER OUTPATIENT SERVICE COST CENTER	-2, 419, 552	72, 301	21, 96	6 1, 962, 606	-362, 679 0	1
	09399 PARTI AL HOSPI TALI ZATI ON PROGRAM	0	0		0 0	-	ł
73. 77	OTHER REIMBURSABLE COST CENTERS	ı o			0 0	0	73.77
102 00	10200 OPI OI D TREATMENT PROGRAM	O	0		0 0	0	102. 00
.02.00	SPECIAL PURPOSE COST CENTERS	٥,			<u> </u>		102.00
113.00	11300 NTEREST EXPENSE						113. 00
118.00		161, 668, 119	5, 319, 627	1, 616, 18	1 18, 007, 820	161, 488, 430	118. 00
	NONREI MBURSABLE COST CENTERS						
	19100 RESEARCH	1, 795, 421	0		0 179, 689	1, 975, 110	
	07950 CHILD CARE CENTER (MEDICAL DAY CARE	0	0		0 0		194. 00
200.00							200. 00
201.00		1/0 //0 5/0	0	4 /4/ 40	U 10 10 7 500		201. 00
202.00	TOTAL (sum lines 118 through 201)	163, 463, 540	5, 319, 627	1, 616, 18	1 18, 187, 509	163, 463, 540	J2U2. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 31-3300

Peri od: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Ti me Prepared:

5/8/2024 9:17 am

Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9.00 10.00 5.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 53 757 295 5 00 5 00 7.00 00700 OPERATION OF PLANT 1, 775, 893 5, 412, 059 7.00 00800 LAUNDRY & LINEN SERVICE 16, 787 99, 171 8.00 48,013 8.00 9.00 00900 HOUSEKEEPI NG 1, 314, 866 68, 533 4, 076, 873 9.00 1.267 4, 676, 461 01000 DI FTARY 10.00 1, 365, 326 288, 315 5.330 221, 966 10.00 01300 NURSING ADMINISTRATION 177, 104 13.00 13.00 0 15 00 01500 PHARMACY 1, 149, 796 101,889 1,884 78, 441 0 15.00 01600 MEDICAL RECORDS & LIBRARY 667, 578 125, 737 16.00 2, 325 96.801 16 00 0 17.00 01700 SOCIAL SERVICE 128, 468 40, 011 740 30, 803 0 17.00 18.00 01080 INSERVICE EDUCATION 20, 701 13, 707 253 10, 552 0 18.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 21.00 21.00 0 0 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 489, 523 22.00 0 0 0 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 30 00 11, 361, 112 2,090,379 1, 815, 504 04400 SKILLED NURSING FACILITY 44.00 5. 380. 149 23, 339 971, 854 44.00 1, 262, 354 04500 NURSING FACILITY 45.00 1,834,533 0 770, 578 45.00 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 329 3, 803 70 2, 928 n 54.00 06000 LABORATORY 60.00 840 C 0 0 0 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0 62.30 65.00 06500 RESPIRATORY THERAPY 2,080,174 7, 923 146 6, 100 0 65.00 06600 PHYSI CAL THERAPY 4, 264, 998 1, 239, 222 22, 911 954, 044 66.00 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 4, 452, 451 784, 764 14,509 604, 169 Λ 67.00 68.00 06800 SPEECH PATHOLOGY 4,071,266 263, 595 4,873 202, 935 0 68.00 06801 PEDS FEEDING DISORDER RU CARES 449, 386 68.01 0 68.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 1, 257, 592 0 ol 71.00 71.00 Ω 0 07300 DRUGS CHARGED TO PATIENTS 321,060 73.00 \cap 0 0 73.00 76.00 03550 MEDICAL SERVICES 1, 309, 602 16, 797 311 12, 931 0 76.00 03950 PSYCHI ATRI C 3, 040, 048 76. 01 627, 811 11,607 483, 335 0 76.01 76 02 03020 SEVERE BEHAVIOR 942 579 0 76 02 C 0 07697 CARDIAC REHABILITATION 76.97 0 C 0 0 0 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 76. 98 76. 99 07699 LI THOTRI PSY 0 0 0 0 0 76.99 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 77.00 C 0 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 4 919 496 7, 172 n 90.00 logodol ce enec 387 906 298 638 09001 PEDS PRIMARY CARE CLINIC 90.01 0 90.01 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 93.00 04950 SCHOOL BASED PROGRAMS 131, 679 2, 434 101, 376 93.00 0 0 04951 OTHER OUTPATIENT SERVICE COST CENTER 0 93 01 93 01 C 0 93.99 09399 PARTIAL HOSPITALIZATION PROGRAM 0 0 93.99 OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 102. 00 0 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 52, 792, 657 5, 412, 059 99, 171 4, 076, 873 4, 676, 461 118. 00 118.00 NONREI MBURSABLE COST CENTERS 0 191, 00 191 00 19100 RESEARCH 964, 638 0 194.00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 0 194.00 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118 through 201) 53.757.295 5, 412, 059 99. 171 4, 076, 873 4, 676, 461 202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 31-3300

				1	0 12/31/2023	5/8/2024 9:17	
						OTHER GENERAL	- Calli
						SERVI CE	
	Cost Center Description	NURSI NG	PHARMACY	MEDI CAL	SOCIAL SERVICE		
	, , , , , , , , , , , , , , , , , , ,	ADMI NI STRATI ON		RECORDS &		EDUCATI ON	
				LI BRARY			
		13.00	15. 00	16. 00	17. 00	18. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10. 00
13.00	01300 NURSING ADMINISTRATION	539, 728					13. 00
15. 00	01500 PHARMACY	0	3, 686, 234				15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	2, 259, 316			16. 00
17. 00	01700 SOCIAL SERVICE	0	0	0	463, 062		17. 00
18. 00	01080 I NSERVI CE EDUCATI ON	0	0	0	1, 339	88, 937	18. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	259, 069	0				30. 00
44. 00	04400 SKILLED NURSING FACILITY	188, 905	0				1
45. 00	04500 NURSING FACILITY	0	0	0	0	0	45. 00
	ANCILLARY SERVICE COST CENTERS	1					
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0			72	1
60.00	06000 LABORATORY	0	0	·		·	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		0	62. 30
65. 00	06500 RESPI RATORY THERAPY	0	0	0		149	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	158, 152		l	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	135, 559			67.00
68. 00	06800 SPEECH PATHOLOGY	0	0	45, 186		4, 961	68.00
68. 01	06801 PEDS FEEDING DISORDER RU CARES	0	0	0	0	0	68. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2 (0(224	0	0	0	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS		3, 686, 234		_	0	73.00
76. 00	03550 MEDI CAL SERVI CES		0	1		316	76.00
76. 01 76. 02	03950 PSYCHI ATRI C 03020 SEVERE BEHAVI OR		0	45, 186 0		11, 815 0	76. 01 76. 02
76. 02 76. 97	07697 CARDI AC REHABI LI TATI ON		0	0	0	0	76. 02
76. 97 76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 97
76. 96 76. 99	07699 LI THOTRI PSY		0	0	0	0	76. 99
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION		0		0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY		0			0	78.00
70.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	O		0	<u> </u>	70.00
90. 00	09000 CLI NI C	91, 754	0	90, 373	37, 899	7, 300	90.00
90. 00	09001 PEDS PRIMARY CARE CLINIC	71, 734	0		· ·	l	90.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		J	l	0	ı	92. 00
	04950 SCHOOL BASED PROGRAMS	0	0	0	12, 865	2, 478	1
	04951 OTHER OUTPATIENT SERVICE COST CENTER	0	0			1	1
	09399 PARTI AL HOSPI TALI ZATI ON PROGRAM	0	0		_		93. 99
70. 77	OTHER REIMBURSABLE COST CENTERS	<u> </u>	<u> </u>				70.77
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
.02.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	<u>_</u>			<u> </u>	1.02.00
113.00	11300 NTEREST EXPENSE						113. 00
118.00		539, 728	3, 686, 234	2, 259, 316	463, 062	88, 937	118. 00
	NONREI MBURSABLE COST CENTERS	<u> </u>			<u> </u>	· ·	
191.00	19100 RESEARCH	0	0	0	0	0	191. 00
	07950 CHILD CARE CENTER (MEDICAL DAY CARE	0	0	0	0	0	194. 00
200.00	Cross Foot Adjustments						200. 00
201.00		0	0	0	_		201. 00
202.00	TOTAL (sum lines 118 through 201)	539, 728	3, 686, 234	2, 259, 316	463, 062	88, 937	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 31-3300 Peri od: Worksheet B From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/8/2024 9:17 am INTERNS & RESIDENTS Cost Center Description SERVI CES-SALAR SERVI CES-OTHER Subtotal Intern & Total Y & FRINGES PRGM COSTS Residents Cost APPRV **APPRV** & Post Stepdown Adjustments 21. 00 22.00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI FTARY 10 00 10 00 13.00 01300 NURSING ADMINISTRATION 13.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16, 00 16, 00 01700 SOCIAL SERVICE 17.00 17.00 18.00 01080 INSERVICE EDUCATION 18.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV INPATIENT ROUTINE SERVICE COST CENTERS 1, 491, 829 22.00 22.00 30.00 03000 ADULTS & PEDIATRICS 0 39, 059, 518 38, 283, 089 30.00 776, 429 -776, 429 44.00 04400 SKILLED NURSING FACILITY 0 21, 279, 583 21, 279, 583 44.00 04500 NURSING FACILITY 45.00 0 6, 361, 345 6, 361, 345 45.00 0 0 ANCILLARY SERVICE COST CENTERS 05400 RADI OLOGY-DI AGNOSTI C 11, 296 11, 296 54.00 54.00 60.00 06000 LABORATORY 0 0 0 60.00 2.560 2.560 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 0 0 62.30 65.00 06500 RESPIRATORY THERAPY r 6, 354, 452 0 6, 354, 452 65.00 06600 PHYSI CAL THERAPY 15, 982, 225 66.00 0 0 465, 858 -465, 858 15, 516, 367 66.00 06700 OCCUPATIONAL THERAPY 67.00 C 15, 199, 352 0 15, 199, 352 67.00 68.00 06800 SPEECH PATHOLOGY C 12, 954, 547 0 12, 954, 547 68.00 06801 PEDS FEEDING DISORDER RU CARES 00000000 1, 369, 510 0 1, 369, 510 68.01 68.01 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 3, 832, 529 3, 832, 529 71.00 07300 DRUGS CHARGED TO PATIENTS 4.664.669 0 4, 664, 669 73 00 73 00 0 76.00 03550 MEDICAL SERVICES 4, 023, 028 4, 023, 028 76.00 03950 PSYCHI ATRI C 10, 505, 683 10, 505, 683 76.01 0 76.01 03020 SEVERE BEHAVI OR 2, 872, 523 2, 872, 523 76.02 76.02 07697 CARDIAC REHABILITATION 76. 97 76.97 C Ω 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 76.98 76. 99 07699 LI THOTRI PSY 0 0 0 76.99 0 0 ol 07700 ALLOGENEIC STEM CELL ACQUISITION 0 77.00 77 00 C 0 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 249, 542 16, 162, 819 -249, 542 15, 913, 277 90.00 09001 PEDS PRIMARY CARE CLINIC 0 90 01 90 01 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 92.00 04950 SCHOOL BASED PROGRAMS 0 -111, 847 0 -111, 847 93.00 93.00 0 93. 01 04951 OTHER OUTPATIENT SERVICE COST CENTER 0 0 0 93.01 09399 PARTIAL HOSPITALIZATION PROGRAM 93.99 0 Ω O 0 0 93.99 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 102. 00 0 0 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 1, 491, 829 160, 523, 792 -1, 491, 829 159, 031, 963 118. 00 NONREI MBURSABLE COST CENTERS 2, 939, 748 191. 00 191 00 19100 RESEARCH 0 Ω 2, 939, 748 0 0 194.00 07950 CHILD CARE CENTER (MEDICAL DAY CARE C 0 0 194.00 200.00 Cross Foot Adjustments 0 0 200. 00 C 0 0 201.00 Negative Cost Centers 0 0 201, 00 TOTAL (sum lines 118 through 201) -1, 491, 829 1, 491, 829 163, 463, 540 161, 971, 711 202. 00 202.00

Health Financial Systems CHILDRENS SPECIALIZED HOPSITAL In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 31-3300 Peri od: Worksheet B From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/8/2024 9:17 am CAPITAL RELATED COSTS Cost Center Description Directly BLDG & FIXT MVBLE EQUIP Subtotal **EMPLOYEE** Assigned New **BENEFITS** DEPARTMENT Capi tal Related Costs 1.00 2.00 2A 4.00 0 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 65, 384 19, 865 85, 249 85, 249 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 0 0 0 2,019,069 613, 424 2, 632, 493 13, 627 5.00 00700 OPERATION OF PLANT 263, 580 80. 079 7 00 343 659 7 00 724 00800 LAUNDRY & LINEN SERVICE 8.00 26, 362 8,009 34, 371 Λ 8.00 9.00 00900 HOUSEKEEPI NG 37, 629 11, 432 49, 061 1, 189 9.00 158, 305 01000 DI ETARY 00000 48.095 206, 400 1.089 10.00 10 00 01300 NURSING ADMINISTRATION 13.00 199 13.00 15.00 01500 PHARMACY 55, 944 16, 997 72, 941 1, 343 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 69,038 20, 975 90, 013 727 16.00 01700 SOCIAL SERVICE 17 00 21, 969 6.674 28 643 17 00 143 18.00 01080 INSERVICE EDUCATION 7, 526 2, 286 9, 812 11 18.00 02100 | &R SERVICES-SALARY & FRINGES APPRV 0 0 21.00 21.00 C 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 0 0 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 14, 913 30.00 04400 SKILLED NURSING FACILITY 0 693, 121 210, 580 903, 701 6, 240 44.00 44.00 04500 NURSING FACILITY 1, 918 45.00 45.00 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 2, 088 634 2, 722 54.00 0 06000 LABORATORY 0 60.00 0 0 60.00 0 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 62.30 0 0 0 06500 RESPIRATORY THERAPY 65.00 4, 350 1.322 5.672 2 456 65 00 06600 PHYSI CAL THERAPY 00000000 680, 418 206, 721 887, 139 4, 348 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 430, 890 130, 911 561, 801 4, 948 67.00 06800 SPEECH PATHOLOGY 43, 972 188, 704 4,880 68.00 144, 732 68.00 06801 PEDS FEEDING DISORDER RU CARES 68.01 C 0 39 68.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 Ω 73.00 03550 MEDICAL SERVICES 9. 222 12,024 3, 971 76.00 2.802 76.00 76. 01 03950 PSYCHI ATRI C 344, 712 104, 728 449, 440 4, 128 76.01 03020 SEVERE BEHAVI OR 76.02 0 0 0 0 75 76.02 07697 CARDIAC REHABILITATION 76.97 76.97 C 0 0 0 07698 HYPERBARI C OXYGEN THERAPY 0 76. 98 C 0 0 76.98 0 76.99 07699 LI THOTRI PSY 0 0 0 0 76.99 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 o 77.00 0 07800 CAR T-CELL IMMUNOTHERAPY 0 O 78.00 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 212, 987 64, 709 277, 696 8, 239 90.00 09001 PEDS PRIMARY CARE CLINIC 0 90.01 90.01 C 0

09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 92.00 93.00 04950 SCHOOL BASED PROGRAMS 0 72, 301 21, 966 94, 267 9, 200 93.00 04951 OTHER OUTPATIENT SERVICE COST CENTER 0 93.01 C 0 93.01 93 99 09399 PARTIAL HOSPITALIZATION PROGRAM 93 99 0 0 Ω 0 0 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 0 5, 319, 627 1, 616, 181 6, 935, 808 84, 407 118. 00 NONREI MBURSABLE COST CENTERS 191. 00 19100 RESEARCH C 842 191. 00 0 194.00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 0 0 194. 00 C 200.00 Cross Foot Adjustments 0 200.00 Negative Cost Centers 201.00 0 201.00 5, 319, 627 6, 935, 808 85, 249 202. 00 202.00 TOTAL (sum lines 118 through 201) 0 1, 616, 181

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-3300

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared: 5/8/2024 9:17 am

				'	0 12/31/2023	5/8/2024 9: 17	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	•	& GENERAL	PLANT	LINEN SERVICE			
		5. 00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						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	2, 646, 120					5. 00
7. 00	00700 OPERATION OF PLANT	87, 417	431, 800				7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	826	3, 831	39, 028			8.00
9. 00	00900 HOUSEKEEPI NG	64, 723	5, 468				9. 00
10. 00	01000 DI ETARY	67, 207	23, 003			306, 382	10.00
13. 00	01300 NURSING ADMINISTRATION	8, 718	23,003	2,090	0, 363	0	13.00
15. 00	01500 PHARMACY	56, 598	8, 129	741	2, 327	0	15.00
							1
16.00	01600 MEDICAL RECORDS & LIBRARY	32, 861	10, 032	915		0	16.00
17. 00	01700 SOCIAL SERVICE	6, 324	3, 192	291	914	0	17. 00
18. 00	01080 I NSERVI CE EDUCATI ON	1, 019	1, 094	100	313	0	18. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	24, 096	0	0	0	0	22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	559, 198	0	0	-	136, 953	30. 00
44. 00	04400 SKILLED NURSING FACILITY	264, 834	100, 717	9, 184	28, 828	118, 944	44. 00
45. 00	04500 NURSING FACILITY	90, 304	0	0	0	50, 485	45. 00
	ANCILLARY SERVICE COST CENTERS						
54.00	05400 RADI OLOGY-DI AGNOSTI C	65	303	28	87	0	54.00
60.00	06000 LABORATORY	41	0	0	0	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	102, 395	632	58	181	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	209, 942	98, 871	9, 016	28, 302	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	219, 169	62, 612	5, 710	17, 923	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	200, 405	21, 031	1, 918		0	68. 00
68. 01	06801 PEDS FEEDING DISORDER RU CARES	22, 121	0	0	0	0	68. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	61, 904	0	0	0	Ö	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	15, 804	0	0	0	0	73. 00
76. 00	03550 MEDI CAL SERVI CES	64, 464	1, 340	122	384	0	76.00
76. 00	03950 PSYCHI ATRI C	149, 644	50, 090			0	76. 00
76. 01	03020 SEVERE BEHAVI OR	46, 398	30, 070	4, 300	14, 550	0	76. 02
76. 02		40, 390	0		0	0	76. 02
	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	_	1
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0	0	0	76. 99
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 CLI NI C	242, 159	30, 949	2, 822	8, 859	0	90. 00
90. 01	09001 PEDS PRIMARY CARE CLINIC	0	0	0	0	0	90. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
93. 00	04950 SCHOOL BASED PROGRAMS	0	10, 506	958	3, 007	0	93. 00
93. 01	04951 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93. 01
93. 99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93. 99
	OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
	SPECIAL PURPOSE COST CENTERS						1
113.00	11300 INTEREST EXPENSE						113. 00
118.00		2, 598, 636	431, 800	39, 028	120, 940	306, 382	118. 00
	NONREI MBURSABLE COST CENTERS						
191. 00	19100 RESEARCH	47, 484	0	0	0	n	191. 00
	07950 CHILD CARE CENTER (MEDICAL DAY CARE	0	0				194. 00
200.00		1	Ü	l			200.00
201.00			Λ	_	Λ	n	201.00
202.00		2, 646, 120	431, 800	39, 028	120, 940		
202.00	TOTAL (Sum Times 110 till ough 201)	2,040,120	431,000	J 37, U20	120, 740	300, 362	1202.00

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 31-3300

				Т	o 12/31/2023		pared:
						5/8/2024 9: 17 OTHER GENERAL	am
						SERVI CE	
	Cost Center Description	NURSI NG	PHARMACY	MEDI CAL	SOCIAL SERVICE	I NSERVI CE	
	'	ADMI NI STRATI ON		RECORDS &		EDUCATI ON	
				LI BRARY			
		13. 00	15. 00	16. 00	17. 00	18. 00	
	GENERAL SERVICE COST CENTERS	1			I		
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00	OO200 CAP REL COSTS-MVBLE EQUIP OO400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	1					5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10. 00	01000 DI ETARY						10.00
13.00	01300 NURSING ADMINISTRATION	8, 917					13.00
15.00	01500 PHARMACY	0	142, 079				15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	137, 420			16. 00
17. 00	01700 SOCIAL SERVICE	0	0	0	39, 507		17. 00
18. 00	01080 I NSERVI CE EDUCATI ON	0	0	0	114	12, 463	18. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0		0	21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	4 200	0	70.705		0	20.00
30.00	03000 ADULTS & PEDIATRICS	4, 280	0			2 220	30.00
44. 00 45. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	3, 121	0			3, 329 0	44. 00 45. 00
43.00	ANCILLARY SERVICE COST CENTERS	J U	U		U	U	43.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	32	10	54. 00
60. 00	06000 LABORATORY		0	Ö		0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65.00	06500 RESPIRATORY THERAPY	0	0	0	66	21	65.00
66. 00	06600 PHYSI CAL THERAPY	0	0	9, 619	10, 330	3, 268	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	8, 245		2, 070	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	2, 748		695	68. 00
68. 01	06801 PEDS FEEDING DISORDER RU CARES	0	0	0		0	68. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	140.070	0		0	71. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	142, 079			0	73. 00
76. 00 76. 01	03550 MEDI CAL SERVI CES 03950 PSYCHI ATRI C		0	0 2, 748		44	76. 00 76. 01
76. 01	03020 SEVERE BEHAVI OR		0	2, 740		1, 656 0	76. 01
76. 97	07697 CARDI AC REHABILI TATI ON		0			0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY		0	0	0	0	76. 98
76. 99	07699 LI THOTRI PSY		0	Ö	0	0	76. 99
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 CLI NI C	1, 516	0		3, 233	1, 023	90. 00
90. 01	09001 PEDS PRIMARY CARE CLINIC	0	0	0	0	0	90. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				4 000	0.17	92.00
93.00	04950 SCHOOL BASED PROGRAMS	0	0	0		347	93. 00
	04951 OTHER OUTPATIENT SERVICE COST CENTER		0			0	
93. 99	09399 PARTIAL HOSPITALIZATION PROGRAM OTHER REIMBURSABLE COST CENTERS	<u> </u>	U		U	U	93. 99
102 00	10200 OPI OI D TREATMENT PROGRAM	O	0	0	0	0	102. 00
.02.00	SPECIAL PURPOSE COST CENTERS	91	<u> </u>		<u> </u>	<u> </u>	.02.00
113.00	11300 NTEREST EXPENSE						113. 00
118.00		8, 917	142, 079	137, 420	39, 507	12, 463	118. 00
40.	NONREI MBURSABLE COST CENTERS	1			1		
	19100 RESEARCH	0	0				191. 00 194. 00
194. 00 200. 00	07950 CHILD CARE CENTER (MEDICAL DAY CARE Cross Foot Adjustments	0	0	0	0		194. 00 200. 00
200.00	1 1		0	0	0	0	200. 00
201.00		8, 917	142, 079		_		
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ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 31-3300 Peri od: Worksheet B From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/8/2024 9:17 am INTERNS & RESIDENTS Cost Center Description SERVI CES-SALAR SERVI CES-OTHER Subtotal Intern & Total Y & FRINGES PRGM COSTS Residents Cost APPRV **APPRV** & Post Stepdown Adjustments 21. 00 22.00 24.00 25. 00 26.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 13.00 01300 NURSING ADMINISTRATION 13.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16, 00 01700 SOCIAL SERVICE 17.00 17.00 18.00 01080 INSERVICE EDUCATION 18.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV INPATIENT ROUTINE SERVICE COST CENTERS 24, 096 22.00 22.00 30.00 03000 ADULTS & PEDIATRICS 795, 049 795, 049 30.00 44.00 04400 SKILLED NURSING FACILITY 1, 478, 279 0 1, 478, 279 44.00 04500 NURSING FACILITY 45.00 142, 707 0 142, 707 45.00 ANCILLARY SERVICE COST CENTERS 05400 RADI OLOGY-DI AGNOSTI C 3, 247 54.00 3, 247 54.00 0 60.00 06000 LABORATORY 60.00 41 41 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 C 0 62.30 06500 RESPIRATORY THERAPY 0 65.00 111, 481 111, 481 65.00 06600 PHYSI CAL THERAPY 66.00 1, 260, 835 0 0 1, 260, 835 66.00 06700 OCCUPATIONAL THERAPY 67.00 889, 019 889, 019 67.00 06800 SPEECH PATHOLOGY 68.00 428, 598 428, 598 68.00 06801 PEDS FEEDING DISORDER RU CARES 22, 160 0 0 0 68.01 22, 160 68.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 61, 904 61, 904 71.00 07300 DRUGS CHARGED TO PATIENTS 157.883 157, 883 73 00 73 00 03550 MEDICAL SERVICES 76.00 82, 489 82, 489 76.00 03950 PSYCHI ATRI C 681, 845 76.01 0 681, 845 76.01 03020 SEVERE BEHAVI OR 46, 473 76.02 76.02 46, 473 07697 CARDIAC REHABILITATION 76.97 0 Λ 76.97 0 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 76.98 0 76. 99 07699 LI THOTRI PSY 0 0 76.99 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 77.00 0 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 581, 993 90.00 09000 CLI NI C 0 581, 993 90.00 09001 PEDS PRIMARY CARE CLINIC 0 90 01 90 01 C 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 92.00 04950 SCHOOL BASED PROGRAMS 119, 383 0 119, 383 93.00 93.00 93. 01 04951 OTHER OUTPATIENT SERVICE COST CENTER 0 93.01 0 09399 PARTIAL HOSPITALIZATION PROGRAM 93.99 93.99 O 0 0 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 102. 00 0 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 6, 863, 386 6, 863, 386 118. 00 0 NONREI MBURSABLE COST CENTERS 191. 00 19100 RESEARCH 48, 326 191. 00 48, 326 0 194.00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 194.00 200.00 Cross Foot Adjustments 24, 096 0 24, 096 200. 00 0 24,096 0 0 201. 00 201.00 Negative Cost Centers 0 TOTAL (sum lines 118 through 201) 24, 096 6, 935, 808 202. 00 6, 935, 808 202.00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 31-3300 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/8/2024 9: 17 am CAPITAL RELATED COSTS Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE (SQUARE FEET) (SQUARE FEET) BENEFITS & GENERAL DEPARTMENT (ACCUM COST) (GROSS SALARI ES) 1.00 2.00 5A 5. 00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 122 284 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 122, 284 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 1,503 1,503 114, 126, 826 4.00 00500 ADMINISTRATIVE & GENERAL 46, 413 18, 242, 827 5 00 -53, 757, 295 110 068 924 5 00 46 413 7.00 00700 OPERATION OF PLANT 6,059 6,059 969, 460 3, 636, 166 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 606 606 34, 371 8.00 00900 HOUSEKEEPI NG 865 865 1, 592, 065 0 2, 692, 207 9.00 9.00 01000 DI FTARY 2, 795, 524 1, 458, 000 10 00 10 00 3,639 3, 639 13.00 01300 NURSING ADMINISTRATION 266, 344 362, 624 13.00 01500 PHARMACY 1, 286 1, 797, 705 2, 354, 224 15.00 1, 286 0 15.00 01600 MEDICAL RECORDS & LIBRARY 973, 600 1, 366, 875 16, 00 1.587 1.587 16, 00 01700 SOCIAL SERVICE 17.00 505 505 191, 531 263, 040 17.00 18.00 01080 INSERVICE EDUCATION 173 173 15, 248 0 42, 385 18.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 0 0 21.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV INPATIENT ROUTINE SERVICE COST CENTERS 0 1, 002, 306 0 0 22.00 22.00 30.00 03000 ADULTS & PEDIATRICS 19, 966, 954 0 23, 262, 125 30.00 44.00 04400 SKILLED NURSING FACILITY 15, 933 15, 933 8, 353, 436 0 11, 015, 933 44.00 04500 NURSING FACILITY 3, 756, 234 45.00 2, 567, 439 0 45.00 0 ANCILLARY SERVICE COST CENTERS 05400 RADI OLOGY-DI AGNOSTI C 54.00 48 48 2,722 54.00 0 60.00 06000 LABORATORY 1,720 0 0 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 C 0 0 62.30 65.00 06500 RESPIRATORY THERAPY 100 100 3, 287, 682 0 4, 259, 186 65.00 06600 PHYSI CAL THERAPY 66.00 15, 641 15, 641 5, 820, 517 0 0 8, 732, 645 66, 00 67.00 06700 OCCUPATIONAL THERAPY 9,905 9, 905 6, 623, 401 9, 116, 458 67.00 68.00 06800 SPEECH PATHOLOGY 3, 327 3, 327 6, 532, 951 8, 335, 977 68.00 06801 PEDS FEEDING DISORDER RU CARES 51, 913 0 0 0 920, 124 68.01 68.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 C 0 2, 574, 937 71.00 07300 DRUGS CHARGED TO PATIENTS 657, 375 73 00 0 73 00 2, 681, 430 76.00 03550 MEDICAL SERVICES 212 212 5, 316, 495 76.00 03950 PSYCHI ATRI C 76.01 7.924 7,924 5, 526, 251 0 6, 224, 543 76.01 03020 SEVERE BEHAVI OR 100, 985 1, 929, 944 76.02 76.02 0 07697 CARDIAC REHABILITATION 0 76.97 0 0 Ω 76.97 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 76.98 76. 99 07699 LI THOTRI PSY 0 0 0 76.99 0 ol 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 77.00 77 00 C 0 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 4,896 4, 896 11, 029, 071 0 10, 072, 739 90.00 09001 PEDS PRIMARY CARE CLINIC 90 01 90 01 0 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 04950 SCHOOL BASED PROGRAMS 12, 315, 398 362, 679 93.00 93.00 1,662 1,662 0 93.01 04951 OTHER OUTPATIENT SERVICE COST CENTER 93.01 0 09399 PARTIAL HOSPITALIZATION PROGRAM 93.99 0 Ω O 0 0 93.99 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 102. 00 0 0 0 0 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 122, 284 122, 284 112, 999, 273 -53, 394, 616 108, 093, 814 118. 00 NONREI MBURSABLE COST CENTERS 1, 975, 110 191. 00 191 00 19100 RESEARCH 0 1, 127, 553 194.00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 194.00 Cross Foot Adjustments 200.00 200.00 201.00 Negative Cost Centers 201.00 53, 757, 295 202. 00 202.00 Cost to be allocated (per Wkst. B, 5, 319, 627 1, 616, 181 18, 187, 509 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 43.502233 13. 216619 0.159362 0. 488397 203. 00 204.00 Cost to be allocated (per Wkst. B, 85, 249 2, 646, 120 204. 00 Part II) 205.00 0.000747 0. 024041 205. 00 Unit cost multiplier (Wkst. B, Part 11) 206.00 NAHE adjustment amount to be allocated 206. 00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 31-3300

Peri od: Worksheet B-1 From 01/01/2023

12/31/2023 Date/Time Prepared: 5/8/2024 9:17 am Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY NURSI NG (SQUARE FEET) (PATIENT DAYS) ADMINISTRATION PLANT LINEN SERVICE (SQUARE FEET) (SQUARE FEET) (DIRECT NRSING HRS) 7.00 9.00 8.00 10.00 13.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 68.309 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 606 67, 703 8.00 9.00 00900 HOUSEKEEPI NG 865 865 66,838 9.00 10.00 01000 DI ETARY 3,639 3, 639 3, 639 44, 302 10.00 01300 NURSING ADMINISTRATION 13 00 C 100 13 00 01500 PHARMACY 15.00 1, 286 1, 286 1, 286 0 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 1,587 1, 587 1, 587 0 0 16.00 01700 SOCIAL SERVICE 17.00 505 505 505 0 0 17.00 01080 INSERVICE EDUCATION 0 18 00 18 00 173 173 173 0 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 0 C 0 0 0 21.00 02200 | &R SERVICES-OTHER PRGM COSTS APPRV 22.00 0 0 0 0 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 19,803 48 30.00 04400 SKILLED NURSING FACILITY 15, 933 15, 933 15, 933 17, 199 35 44.00 44.00 04500 NURSING FACILITY 45.00 7, 300 0 45.00 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 48 48 48 0 54.00 06000 LABORATORY 0 0 60.00 0 0 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 C 0 0 0 62.30 06500 RESPIRATORY THERAPY 100 100 65.00 100 0 65.00 66.00 06600 PHYSI CAL THERAPY 15, 641 15, 641 15, 641 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 9.905 9, 905 9.905 0 0 0 0 0 0 0 0 0 0 0 67.00 06800 SPEECH PATHOLOGY 68.00 3, 327 3, 327 3, 327 0 68.00 06801 PEDS FEEDING DISORDER RU CARES 68.01 0 C 0 0 68.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 71.00 71.00 C 07300 DRUGS CHARGED TO PATIENTS 73 00 0 C 0 73.00 03550 MEDICAL SERVICES 76, 00 76.00 212 212 0 212 03950 PSYCHI ATRI C 76.01 7 924 7.924 7.924 0 76.01 03020 SEVERE BEHAVI OR 76.02 76.02 0 76. 97 07697 CARDIAC REHABILITATION 0 0 0 0 76. 97 07698 HYPERBARI C OXYGEN THERAPY 76.98 0 76.98 C 0 0 0 0 76.99 07699 LI THOTRI PSY C 0 76.99 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 78.00 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 4, 896 4, 896 4, 896 0 17 90.00 90. 01 09001 PEDS PRIMARY CARE CLINIC o 0 90.01 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 93.00 04950 SCHOOL BASED PROGRAMS 1,662 1, 662 1,662 0 0 93.00 93. 01 04951 OTHER OUTPATIENT SERVICE COST CENTER 0 93.01 09399 PARTIAL HOSPITALIZATION PROGRAM 93.99 93.99 0 0 0 0 OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 68, 309 67, 703 66, 838 44, 302 100 118. 00 NONREI MBURSABLE COST CENTERS 0 191. 00 191. 00 19100 RESEARCH 0 194. 00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 0 0 0 194 00 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201. 00 Cost to be allocated (per Wkst. B, 202.00 5, 412, 059 99, 171 4, 076, 873 539, 728 202. 00 4, 676, 461 Part I) 60. 996334 5, 397. 280000 203. 00 203 00 Unit cost multiplier (Wkst. B, Part I) 79 229077 105, 558688 1.464795 204.00 Cost to be allocated (per Wkst. B, 120, 940 8, 917 204. 00 431,800 39, 028 306, 382 Part II) 89. 170000 205. 00 205.00 Unit cost multiplier (Wkst. B, Part 6. 321275 0.576459 1.809450 6. 915760 II)206.00 NAHE adjustment amount to be allocated 206. 00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207. 00 Parts III and IV)

Heal th Financial Systems

CHILDRENS SPECIALIZED HOPSITAL

In Lieu of Form CMS-2552-10

Provider CCN: 31-3300

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

Pate/Time Prepared:
5/8/2024 9: 17 am

OTHER GENERAL
SERVICE
RECORDS &
REQUIS.)

PHARMACY
(COSTED
RECORDS &
LIBRARY
(TIME SPENT)

IN Lieu of Form CMS-2552-10

Worksheet B-1
Date/Time Prepared:
5/8/2024 9: 17 am

OTHER GENERAL
SERVICE
RESIDENTS

SOCIAL SERVICE
FOUCATION
Y & FRINGES
APPRV
(ASSIGNED)

Cost Conter Description							OTHER GENERAL	INTERNS &	
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Parts III and IV)	207.00		NAHE unit cost multiplier (Wkst. D,						207. 00
			Parts III and IV)			l			

Health Financial Systems CHILDRENS SPECIALIZED HOPSITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 31-3300 Period: Worksheet B-1

From 01/01/2023 12/31/2023 Date/Time Prepared: 5/8/2024 9:17 am INTERNS & **RESI DENTS** Cost Center Description SERVI CES-OTHER PRGM COSTS **APPRV** (ASSI GNED TIME) 22.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10 00 13.00 01300 NURSING ADMINISTRATION 13.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16, 00 01700 SOCIAL SERVICE 17.00 17.00 18.00 01080 INSERVICE EDUCATION 18.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 21.00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV INPATIENT ROUTINE SERVI CE COST CENTERS 22.00 22.00 2, 200 30.00 03000 ADULTS & PEDIATRICS 30.00 1, 145 44.00 04400 SKILLED NURSING FACILITY 44.00 0 04500 NURSING FACILITY 45.00 45.00 0 ANCILLARY SERVICE COST CENTERS 05400 RADI OLOGY-DI AGNOSTI C 54.00 54.00 0 0 60.00 06000 LABORATORY 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0 62.30 65.00 06500 RESPIRATORY THERAPY 0 65.00 06600 PHYSI CAL THERAPY 66.00 687 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 67.00 0 68.00 06800 SPEECH PATHOLOGY 68.00 06801 PEDS FEEDING DISORDER RU CARES 68.01 0000000 68.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 07300 DRUGS CHARGED TO PATIENTS 73 00 73 00 76.00 03550 MEDICAL SERVICES 76.00 03950 PSYCHI ATRI C 76.01 76.01 03020 SEVERE BEHAVI OR 76.02 76.02 07697 CARDIAC REHABILITATION 76.97 76.97 76.98 07698 HYPERBARI C OXYGEN THERAPY 76.98 0 76. 99 07699 LI THOTRI PSY 76.99 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 77 00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 368 09001 PEDS PRIMARY CARE CLINIC 90 01 0 90 01 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 04950 SCHOOL BASED PROGRAMS 0 93.00 93.00 93. 01 04951 OTHER OUTPATIENT SERVICE COST CENTER 0 93.01 09399 PARTIAL HOSPITALIZATION PROGRAM 93.99 0 93.99 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS 113.00 113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 2, 200 118. 00 NONREI MBURSABLE COST CENTERS 191. 00 19100 RESEARCH 191.00 0 194.00 07950 CHILD CARE CENTER (MEDICAL DAY CARE 0 194.00 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 1, 491, 829 202.00 Cost to be allocated (per Wkst. B, 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 678. 104091 203.00 204.00 Cost to be allocated (per Wkst. B, 24,096 204.00 Part II) 205.00 10 952727 205 00 Unit cost multiplier (Wkst. B, Part 11) 206.00 NAHE adjustment amount to be allocated 206. 00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

Health Financial Systems	CHILDRENS SPECIALIZED HOPSITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 31-3300	Peri od: Worksheet C

			T.	rom 01/01/2023 o 12/31/2023	Part Date/Time Pre 5/8/2024 9:17	
		Title	XVIII	Hospi tal	TEFRA	alli
			7,111	Costs	12.101	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	38, 283, 089		38, 283, 089		38, 283, 089	30. 00
44.00 04400 SKILLED NURSING FACILITY	21, 279, 583		21, 279, 583	l	21, 279, 583	
45. 00 04500 NURSING FACILITY	6, 361, 345		6, 361, 345	0	6, 361, 345	45. 00
ANCI LLARY SERVI CE COST CENTERS			•			
54. 00 05400 RADI OLOGY-DI AGNOSTI C	11, 296		11, 296	0	11, 296	
60. 00 06000 LABORATORY	2, 560		2, 560	0	2, 560	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62. 30
65. 00 06500 RESPI RATORY THERAPY	6, 354, 452	0		0	6, 354, 452	
66. 00 06600 PHYSI CAL THERAPY	15, 516, 367	0	15, 516, 367	0	15, 516, 367	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	15, 199, 352	0	15, 199, 352	0	15, 199, 352	67. 00
68. 00 06800 SPEECH PATHOLOGY	12, 954, 547	0	12, 954, 547	0	12, 954, 547	
68. 01 06801 PEDS FEEDING DISORDER RU CARES	1, 369, 510	0	1, 369, 510	0	1, 369, 510	68. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 832, 529		3, 832, 529	0	3, 832, 529	71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 664, 669		4, 664, 669	0	4, 664, 669	73. 00
76. 00 03550 MEDI CAL SERVI CES	4, 023, 028		4, 023, 028	0	4, 023, 028	76. 00
76. 01 03950 PSYCHI ATRI C	10, 505, 683		10, 505, 683	0	10, 505, 683	76. 01
76. 02 03020 SEVERE BEHAVI OR	2, 872, 523		2, 872, 523	0	2, 872, 523	76. 02
76. 97 07697 CARDIAC REHABILITATION	0		0	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0		0	0	0	76. 98
76. 99 07699 LI THOTRI PSY	o		0	o	0	76. 99
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	o		0	o	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	o		0	o	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	15, 913, 277		15, 913, 277	0	15, 913, 277	90. 00
90.01 09001 PEDS PRIMARY CARE CLINIC	0		0	0	0	90. 01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
93.00 04950 SCHOOL BASED PROGRAMS	0		0	0	0	93. 00
93. 01 04951 OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93. 01
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0	93. 99
OTHER REIMBURSABLE COST CENTERS						
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)	159, 143, 810	0	159, 143, 810	0	159, 143, 810	
201.00 Less Observation Beds	0		0			201. 00
202.00 Total (see instructions)	159, 143, 810	0	159, 143, 810	0	159, 143, 810	202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 31-3300 Peri od: Worksheet C From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/8/2024 9:17 am Title XVIII Hospi tal TEFRA Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 83, 690, 905 83, 690, 905 30.00 30.00 44.00 04400 SKILLED NURSING FACILITY 27, 532, 750 27, 532, 750 44.00 11, 666, 140 04500 NURSING FACILITY 45.00 45.00 11, 666, 140 ANCILLARY SERVICE COST CENTERS 0. 139275 54.00 51, 956 29, 150 0.139275 54 00 05400 RADI OLOGY-DI AGNOSTI C 81, 106 60.00 06000 LABORATORY 1, 019, 744 96, 218 1, 115, 962 0.002294 0.002294 60.00 0.000000 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 62.30 06500 RESPIRATORY THERAPY 0. 248427 25, 558, 408 20.331 25, 578, 739 0.248427 65.00 65.00 06600 PHYSI CAL THERAPY 0. 786944 0.786944 66.00 4, 222, 603 15, 494, 645 19, 717, 248 66.00 67.00 06700 OCCUPATIONAL THERAPY 4, 135, 296 20, 581, 725 24, 717, 021 0.614935 0.614935 67.00 68.00 06800 SPEECH PATHOLOGY 6, 099, 807 22, 360, 041 28, 459, 848 0. 455187 0.455187 68.00 2, 808, 575 0. 487617 06801 PEDS FEEDLING DISORDER RU CARES 2, 808, 575 0.487617 68.01 68.01 2, 177, 588 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 495, 921 2, 673, 509 1.433520 1.433520 71.00 07300 DRUGS CHARGED TO PATIENTS 2, 648, 942 330, 040 2, 978, 982 1.565860 1.565860 73.00 73.00 76.00 03550 MEDICAL SERVICES 891 891 4, 515. 182941 4, 515. 182941 76.00 03950 PSYCHLATRIC 350, 872 15, 320, 228 15, 671, 100 0.670386 76.01 0.670386 76.01 76.02 03020 SEVERE BEHAVI OR 0 4, 703, 600 4, 703, 600 0.610707 0.610707 76.02 07697 CARDIAC REHABILITATION 0 0.000000 76. 97 0 0.000000 76.97 0 07698 HYPERBARI C OXYGEN THERAPY 0.000000 0.000000 76. 98 76.98 0 0 07699 LI THOTRI PSY 0 76. 99 0 0.000000 0.000000 76. 99 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0.000000 0.000000 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 0 0 0.000000 0.000000 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 29, 550, 842 29, 550, 842 0.538505 0.538505 90.00 09001 PEDS PRIMARY CARE CLINIC 0 0.000000 0.000000 90.01 90.01 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0.000000 0.000000 92.00 04950 SCHOOL BASED PROGRAMS 0 0.000000 0.000000 93.00 0 93.00 93.01 04951 OTHER OUTPATIENT SERVICE COST CENTER 0 0 0 0.000000 0.000000 93.01 09399 PARTIAL HOSPITALIZATION PROGRAM 93.99 0 0 0 0.000000 0.000000 93.99 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS

169 155 902

169, 155, 902

111, 791, 316

111, 791, 316

280, 947, 218

280, 947, 218

113.00

200. 00

201.00

202. 00

113.00 11300 INTEREST EXPENSE

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

200 00

201.00

202.00

				10 12/31/2023	5/8/2024 9: 17	
			Title XVIII	Hospi tal	TEFRA	
Cost Center Descripti	on	PPS Inpatient	·			
		Ratio				
		11. 00				
INPATIENT ROUTINE SERVICE C	OST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS						30. 00
44.00 04400 SKILLED NURSING FACIL	I TY					44.00
45.00 04500 NURSING FACILITY						45. 00
ANCILLARY SERVICE COST CENT	ERS					
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 139275				54.00
60. 00 06000 LABORATORY		0. 002294				60.00
62. 30 06250 BLOOD CLOTTING FOR HE	MOPHI LI ACS	0. 000000				62. 30
65. 00 06500 RESPI RATORY THERAPY		0. 248427				65.00
66. 00 06600 PHYSI CAL THERAPY		0. 786944				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 614935				67.00
68.00 06800 SPEECH PATHOLOGY		0. 455187				68. 00
68. 01 06801 PEDS FEEDING DISORDER		0. 487617				68. 01
71.00 07100 MEDICAL SUPPLIES CHAR		1. 433520				71. 00
73.00 07300 DRUGS CHARGED TO PATI	ENTS	1. 565860				73.00
76. 00 03550 MEDI CAL SERVI CES		4, 515. 182941				76. 00
76. 01 03950 PSYCHI ATRI C		0. 670386				76. 01
76. 02 03020 SEVERE BEHAVI OR		0. 610707				76. 02
76. 97 07697 CARDI AC REHABI LI TATI 0		0. 000000				76. 97
76. 98 07698 HYPERBARI C OXYGEN THE	RAPY	0. 000000				76. 98
76. 99 07699 LI THOTRI PSY		0. 000000				76. 99
77.00 07700 ALLOGENEIC STEM CELL		0. 000000				77. 00
78.00 07800 CAR T-CELL IMMUNOTHER		0. 000000				78. 00
OUTPATIENT SERVICE COST CEN	TERS					
90. 00 09000 CLI NI C		0. 538505				90. 00
90. 01 09001 PEDS PRIMARY CARE CLI		0. 000000				90. 01
92. 00 09200 OBSERVATI ON BEDS (NON		0. 000000				92.00
93. 00 04950 SCHOOL BASED PROGRAMS		0. 000000				93. 00
93. 01 04951 OTHER OUTPATIENT SERV		0. 000000				93. 01
93. 99 09399 PARTI AL HOSPI TALI ZATI		0. 000000				93. 99
OTHER REIMBURSABLE COST CEN						
102. 00 10200 OPI OI D TREATMENT PROG						102. 00
SPECIAL PURPOSE COST CENTER	S					
113. 00 11300 INTEREST EXPENSE						113. 00
200.00 Subtotal (see instruc	tions)					200. 00
201.00 Less Observation Beds						201. 00
202.00 Total (see instruction	ns)					202. 00

Health Financial Systems	CHILDRENS SPECIALIZED HOPSITAL	In Lie	eu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 31-3300	Peri od:	Worksheet C

From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared: 5/8/2024 9:17 am Title XIX Hospi tal TEFRA Costs Therapy Limit Cost Center Description Total Cost Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 2.00 4. 00 5.00 1.00 3.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 38, 283, 089 38, 283, 089 41, 819 38, 324, 908 44.00 04400 SKILLED NURSING FACILITY 21, 279, 583 21, 279, 583 21, 279, 583 44.00 04500 NURSING FACILITY 45.00 6, 361, 345 6, 361, 345 0 6, 361, 345 45.00 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 11, 296 11, 296 11, 296 54.00 60.00 06000 LABORATORY 2,560 2,560 0 2,560 60.00 0 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 06500 RESPIRATORY THERAPY 6, 354, 452 65.00 6. 354. 452 6. 354. 452 65.00 66.00 06600 PHYSI CAL THERAPY 15, 516, 367 15, 516, 367 0 15, 516, 367 66.00 67.00 06700 OCCUPATIONAL THERAPY 15, 199, 352 15, 199, 352 15, 199, 352 67.00 0 06800 SPEECH PATHOLOGY 12, 954, 547 12, 954, 547 12, 954, 547 68.00 68.00 06801 PEDS FEEDING DISORDER RU CARES 1.369.510 1, 369, 510 1, 369, 510 68.01 68.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 3, 832, 529 3, 832, 529 0 3, 832, 529 71.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 4,664,669 4, 664, 669 4, 664, 669 73.00 03550 MEDICAL SERVICES 4. 023. 028 ol 4, 023, 028 76 00 4 023 028 76 00 76.01 03950 PSYCHI ATRI C 10, 505, 683 10, 505, 683 62, 140 10, 567, 823 76.01 76.02 03020 SEVERE BEHAVI OR 2, 872, 523 2, 872, 523 0 2, 872, 523 76.02 07697 CARDIAC REHABILITATION 76. 97 0 76.97 0 C 0 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 76. 98 76 98 0 76.99 07699 LI THOTRI PSY 0 0 0 0 76.99 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 77.00 0 0 77.00 78 00 07800 CAR T-CELL IMMUNOTHERAPY 0 78 00 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 15, 913, 277 15, 913, 277 183, 224 16, 096, 501 90.00 09001 PEDS PRIMARY CARE CLINIC 90.01 90.01 0 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92 00 0 0 92.00 0 0 93.00 04950 SCHOOL BASED PROGRAMS 0 0 0 93.00 04951 OTHER OUTPATIENT SERVICE COST CENTER 0 0 0 0 93.01 93.01 09399 PARTIAL HOSPITALIZATION PROGRAM 93.99 0 0 0 93.99 OTHER REIMBURSABLE COST CENTERS 0 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 102. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 287, 183 159, 143, 810 0 159, 143, 810 159, 430, 993 200. 00 200.00 Subtotal (see instructions) 201.00 Less Observation Beds 0 201. 00 202.00 Total (see instructions) 159, 143, 810 159, 143, 810 287, 183 159, 430, 993 202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2023 | Part | | Date/Time Prepared: | 5/8/2024 9:17 am | Provider CCN: 31-3300

						5/8/2024 9:1/	am
			Ti tl	e XIX	Hospi tal	TEFRA	
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	'		•	+ col. 7)	Ratio	Inpati ent	
				'		Ratio	
		6. 00	7. 00	8.00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1 2.22					_
30.00	03000 ADULTS & PEDIATRICS	83, 690, 905		83, 690, 90	5		30.00
44. 00	04400 SKILLED NURSING FACILITY	27, 532, 750		27, 532, 75			44. 00
45. 00	04500 NURSING FACILITY	11, 666, 140		11, 666, 14			45. 00
45.00	ANCI LLARY SERVI CE COST CENTERS	11,000,140		11,000,14	J		1 43.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	51, 956	29, 150	81, 10	6 0. 139275	0. 139275	54.00
60.00	06000 LABORATORY	1, 019, 744	96, 218			0. 002294	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	1,017,744	70, 210		0.002274	0.000000	
65. 00	06500 RESPIRATORY THERAPY	25, 558, 408	20, 331	1		0. 248427	65. 00
66. 00	06600 PHYSI CAL THERAPY	4, 222, 603	15, 494, 645			0. 786944	
67. 00	06700 OCCUPATIONAL THERAPY		20, 581, 725			0. 614935	
		4, 135, 296					
68.00	06800 SPEECH PATHOLOGY	6, 099, 807	22, 360, 041			0. 455187	
68. 01	06801 PEDS FEEDING DISORDER RU CARES	0	2, 808, 575			0. 487617	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 177, 588	495, 921			1. 433520	
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 648, 942	330, 040			1. 565860	
76. 00	03550 MEDI CAL SERVI CES	891	0			4, 515. 182941	
76. 01	03950 PSYCHI ATRI C	350, 872	15, 320, 228			0. 670386	
76. 02	03020 SEVERE BEHAVI OR	0	4, 703, 600	4, 703, 60		0. 610707	
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0.000000	0. 000000	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0.000000	0. 000000	
76. 99	07699 LI THOTRI PSY	0	0		0.000000	0. 000000	
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0.000000	0.000000	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0.000000	0.000000	78. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	29, 550, 842	29, 550, 84	0. 538505	0. 538505	90.00
90. 01	09001 PEDS PRIMARY CARE CLINIC	0	0		0.000000	0.000000	90. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0.000000	0.000000	92.00
93.00	04950 SCHOOL BASED PROGRAMS	0	0		0. 000000	0.000000	93. 00
93. 01	04951 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0. 000000	0. 000000	93. 01
93. 99	09399 PARTIAL HOSPITALIZATION PROGRAM	O	0		0. 000000	0. 000000	
	OTHER REIMBURSABLE COST CENTERS	-1	-				1
102 00	10200 OPI OI D TREATMENT PROGRAM	0	0		O		102. 00
.02.00	SPECIAL PURPOSE COST CENTERS	ا م					1.02.00
113 00	11300 I NTEREST EXPENSE						113. 00
200.00		169, 155, 902	111, 791, 316	280, 947, 21	B		200. 00
201.00	1 /	107, 100, 702	, , , , , , , , , , , , , , , , ,	200, 717, 21			201. 00
202.00	1 1	169, 155, 902	111, 791, 316	280, 947, 21	R		202. 00
202.00	Total (See Histiactions)	107, 133, 702	111, 771, 310	200, 747, 21	ا		1202.00

			10 12/31/2023	5/8/2024 9: 17	
		Title XIX	Hospi tal	TEFRA	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30. 00
44.00 04400 SKILLED NURSING FACILITY					44. 00
45. 00 04500 NURSING FACILITY					45. 00
ANCILLARY SERVICE COST CENTERS					
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60. 00 06000 LABORATORY	0. 000000				60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000				62. 30
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000				67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000				68. 00
68. 01 06801 PEDS FEEDING DISORDER RU CARES	0. 000000				68. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73. 00
76. 00 03550 MEDI CAL SERVI CES	0. 000000				76. 00
76. 01 03950 PSYCHI ATRI C	0. 000000				76. 01
76. 02 03020 SEVERE BEHAVI OR	0. 000000				76. 02
76. 97 O7697 CARDI AC REHABI LI TATI ON	0. 000000				76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000				76. 98
76. 99 07699 LI THOTRI PSY	0. 000000				76. 99
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000				77. 00
78. 00 O7800 CAR T-CELL IMMUNOTHERAPY	0. 000000				78. 00
OUTPATIENT SERVICE COST CENTERS	0.000000				00.00
90. 00 09000 CLI NI C	0. 000000				90.00
90. 01 09001 PEDS PRIMARY CARE CLINIC	0. 000000				90. 01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 93.00 04950 SCHOOL BASED PROGRAMS	0.000000				92.00
	0.000000				93.00
93. 01 04951 OTHER OUTPATIENT SERVICE COST CENTER	0.000000				93. 01
93.99 O9399 PARTIAL HOSPITALIZATION PROGRAM OTHER REIMBURSABLE COST CENTERS	0. 000000				93. 99
102. 00 10200 OPI OI D TREATMENT PROGRAM					102.00
SPECIAL PURPOSE COST CENTERS					102. 00
113. 00 11300 NTEREST EXPENSE					113. 00
200.00 Subtotal (see instructions)					200.00
201. 00 Less Observation Beds					200.00
202.00 Total (see instructions)					201.00
202.00 TOTAL (SEE THSTINCTIONS)	I I				1202.00

Health Financial Systems	CHI LDRENS SPECI ALI Z	ED HOPSITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE (COST TO CHARGE RATIOS NET OF	Provi der CCN: 31-3300	Peri od:	Worksheet C
REDUCTIONS FOR MEDICALD ONLY			From 01/01/2023	Part II

12/31/2023 Date/Time Prepared: To 5/8/2024 9:17 am Title XIX Hospi tal TEFRA Operating Cost Capital Cost Operating Cost Cost Center Description Total Cost Capi tal (Wkst. B, Part (Wkst. B, Part Net of Capital Reducti on Reducti on I, col. 26) II col. 26) Cost (col. 1 Amount col. 2) 5. 00 1.00 2.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 05400 RADI OLOGY-DI AGNOSTI C 11, 296 3, 247 8, 049 54.00 54.00 0 0 0 0 0 0 0 0 0 0 0 0 0 06000 LABORATORY 60.00 60.00 2,560 41 2, 519 0 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 06500 RESPIRATORY THERAPY 6, 354, 452 6, 242, 971 65.00 111, 481 0 65.00 06600 PHYSI CAL THERAPY 66.00 15, 516, 367 1, 260, 835 14, 255, 532 0 66.00 06700 OCCUPATI ONAL THERAPY 67.00 15, 199, 352 889, 019 14, 310, 333 0 67.00 68.00 06800 SPEECH PATHOLOGY 12, 954, 547 428, 598 12, 525, 949 68.00 06801 PEDS FEEDING DISORDER RU CARES 1, 369, 510 22, 160 1, 347, 350 68.01 68.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 61, 904 3, 770, 625 71 00 3, 832, 529 71.00 Λ 73.00 07300 DRUGS CHARGED TO PATIENTS 4,664,669 157, 883 4, 506, 786 0 73.00 76.00 03550 MEDICAL SERVICES 4, 023, 028 82, 489 3, 940, 539 76.00 76. 01 03950 PSYCHI ATRI C 10, 505, 683 681, 845 9, 823, 838 76.01 0 03020 SEVERE BEHAVI OR 76.02 76.02 2, 872, 523 46, 473 2, 826, 050 0 76.97 07697 CARDIAC REHABILITATION 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 0 0 76. 98 76. 98 0 0 0 0 07699 LI THOTRI PSY 0 76.99 76 99 Ω 0 0 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION C 0 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLINIC 15, 913, 277 581, 993 15, 331, 284 0 0 0 90.01 09001 PEDS PRIMARY CARE CLINIC 0 90.01 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 0 92.00 93 00 04950 SCHOOL BASED PROGRAMS 0 119, 383 -119, 383 93.00 0 04951 OTHER OUTPATIENT SERVICE COST CENTER 0 0 93.01 C 0 93.01 09399 PARTIAL HOSPITALIZATION PROGRAM 0 93.99 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 102. 00 0 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 Subtotal (sum of lines 50 thru 199) 0 200.00 93, 219, 793 4, 447, 351 88, 772, 442 0 200. 00 201.00 0 201. 00 Less Observation Beds

93, 219, 793

4, 447, 351

88, 772, 442

0

0 202. 00

202.00

Total (line 200 minus line 201)

Title XIX Hospital TEFRA
Capital and Operating Cost Ratio (col. 6 Reduction 8) / col. 7) ANCILLARY SERVICE COST CENTERS 54. 00 05400 RADIOLOGY-DIAGNOSTIC 111, 296 81, 106 0. 139275 54. 00 06000 LABORATORY 2, 560 1, 115, 962 0. 002294 60. 00 06000 LABORATORY 6. 30 06550 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0. 0000000 62. 30 06500 RESPIRATORY THERAPY 6. 354, 452 25, 578, 739 0. 248427 65. 00 06600 PHYSICAL THERAPY 15, 516, 367 19, 717, 248 0. 786944 66. 00 0670 0CCUPATIONAL THERAPY 15, 199, 352 24, 717, 021 0. 614935 67. 00 06800 SPEECH PATHOLOGY 12, 954, 547 28, 459, 848 0. 455187 68. 00 06801 PEDS FEEDING DISORDER RU CARES 1, 369, 510 2, 808, 575 0. 487617 68. 01 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 3, 832, 529 2, 673, 509 1. 433520 71. 00 7300 DRUGS CHARGED TO PATIENT 3, 832, 529 2, 673, 509 1. 433520 71. 00 76. 00 03550 MEDICAL SERVICES 4, 023, 028 891 4, 515. 182941 76. 00 76. 01 03950 PSYCHIATRIC
ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY - DI AGNOSTI C 11, 296 81, 106 0. 139275 54.00 06000 LABORATORY 2, 560 1, 115, 962 0. 002294 60. 00 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 0 0. 0. 000000 62. 30 06250 RESPI RATORY THERAPY 6, 354, 452 25, 578, 739 0. 248427 65. 00 06000 PHYSI CAL THERAPY 15, 516, 367 19, 717, 248 0. 786944 66. 00 67. 00 0. 000000 0. 000000 62. 30 65. 00 06500 RESPI RATORY THERAPY 15, 516, 367 19, 717, 248 0. 786944 66. 00 67. 00 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 00000000
Reduction 8)
6. 00 7. 00 8. 00 ANCI LLARY SERVI CE COST CENTERS 54. 00 05400 RADI OLOGY-DI AGNOSTI C 11, 296 81, 106 0. 139275 54. 00 60. 00 06000 LABORATORY 2, 560 1, 115, 962 0. 002294 60. 00 65. 00 06500 RESPI RATORY THERAPY 6, 354, 452 25, 578, 739 0. 248427 65. 00 66. 00 06600 PHYSI CAL THERAPY 15, 516, 367 19, 717, 248 0. 786944 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 15, 199, 352 24, 717, 021 0. 614935 67. 00 68. 00 06800 SPEECH PATHOLOGY 12, 954, 547 28, 459, 848 0. 455187 68. 00 68. 01 06801 PEDS FEEDI NG DI SORDER RU CARES 1, 369, 510 2, 808, 575 0. 487617 68. 01 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 3, 832, 529 2, 673, 509 1. 433520 71. 00 73. 00 07300 DRUGS CHARGED TO PATI ENT 3, 832, 529 2, 78, 982 1. 565860 73. 00 76. 00 03550 MEDI CAL SERVI CES 4, 023, 028 891 4, 515. 182941 76. 00 76. 01 03950 PSYCHI ATRI C 10, 505, 683 15, 671, 100 0. 670386
ANCI LLARY SERVI CE COST CENTERS
54. 00 05400 RADI OLOGY-DI AGNOSTI C 11, 296 RS1, 106 O. 139275 54. 00 60. 00 06000 LABORATORY 2, 560 I, 115, 962 O. 002294 60. 00 62. 30 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS O. 0 O. 0. 000000 0. 0. 000000 65. 00 06500 RESPI RATORY THERAPY 6, 354, 452 D. 578, 739 O. 248427 65. 00 66. 00 06600 PHYSI CAL THERAPY 15, 516, 367 D. 717, 248 O. 786944 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 15, 199, 352 D. 24, 717, 021 O. 614935 67. 00 68. 00 06800 SPEECH PATHOLOGY 12, 954, 547 D. 28, 459, 848 O. 455187 68. 00 68. 01 06801 PEDS FEEDI NG DI SORDER RU CARES 1, 369, 510 D. 488, 575 O. 487617 68. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 3, 832, 529 D. 433, 509 D. 433520 1, 433520 71. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 4, 664, 669 D. 497, 297, 982 D. 45515, 182941 1, 565860 73. 00 76. 01 03950 PSYCHI ATRI C 10, 505, 683 D. 56, 681 D. 56, 671, 100 D. 670386 76. 01
60. 00 60.
62. 30
65. 00 06500 RESPI RATORY THERAPY 6, 354, 452 25, 578, 739 0. 248427 66. 00 06600 PHYSI CAL THERAPY 15, 516, 367 19, 717, 248 0. 786944 66. 00 06700 0CCUPATI ONAL THERAPY 15, 199, 352 24, 717, 021 0. 614935 67. 00 06800 SPEECH PATHOLOGY 12, 954, 547 28, 459, 848 0. 455187 68. 00 06801 PEDS FEEDI NG DI SORDER RU CARES 1, 369, 510 2, 808, 575 0. 487617 68. 01 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 3, 832, 529 2, 673, 509 1. 433520 71. 00 07300 DRUGS CHARGED TO PATI ENTS 4, 664, 669 2, 978, 982 1. 565860 73. 00 76. 01 03950 PSYCHI ATRI C 10, 505, 683 15, 671, 100 0. 670386 76. 01
66. 00 06600 PHYSI CAL THERAPY 15, 516, 367 19, 717, 248 0.786944 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 15, 199, 352 24, 717, 021 0.614935 67. 00 68. 00 06800 SPEECH PATHOLOGY 12, 954, 547 28, 459, 848 0.455187 68. 00 68. 01 06801 PEDS FEEDI NG DI SORDER RU CARES 1, 369, 510 2, 808, 575 0.487617 68. 01 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 3, 832, 529 2, 673, 509 1.433520 71. 00 7300 DRUGS CHARGED TO PATI ENTS 4, 664, 669 2, 978, 982 1.565860 73. 00 76. 01 03950 PSYCHI ATRI C 10, 505, 683 15, 671, 100 0.670386 76. 01
67. 00 06700 0CCUPATI ONAL THERAPY 15, 199, 352 24, 717, 021 0. 614935 67. 00 68. 00 06800 SPEECH PATHOLOGY 12, 954, 547 28, 459, 848 0. 455187 68. 00 68. 01 06801 PEDS FEEDI NG DI SORDER RU CARES 1, 369, 510 2, 808, 575 0. 487617 68. 01 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 3, 832, 529 2, 673, 509 1. 433520 71. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 4, 664, 669 2, 978, 982 1. 565860 73. 00 76. 01 03950 MEDI CAL SERVI CES 4, 023, 028 891 4, 515. 182941 76. 00 76. 01 03950 PSYCHI ATRI C
68. 00 06800 SPEECH PATHOLOGY 12, 954, 547 28, 459, 848 0. 455187 68. 00 68. 01 68. 01 68. 01 71. 00 71. 00 73. 00 73. 00 73. 00 73. 00 76. 01 03950 PSYCHI ATRI C 68. 01 12, 954, 547 28, 459, 848 0. 455187 68. 01 2, 808, 575 0. 487617 68. 01 71. 00 73. 00 73. 00 73. 00 73. 00 73. 00 74. 01 74.
68. 01
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 3, 832, 529 2, 673, 509 1. 433520 71. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 4, 664, 669 2, 978, 982 1. 565860 73. 00 76. 00 03550 MEDI CAL SERVI CES 4, 023, 028 891 4, 515. 182941 76. 00 76. 01 03950 PSYCHI ATRI C 10, 505, 683 15, 671, 100 0. 670386 76. 01
73. 00 07300 DRUGS CHARGED TO PATIENTS 4, 664, 669 2, 978, 982 1. 565860 73. 00 76. 00 03550 MEDI CAL SERVI CES 4, 023, 028 891 4, 515. 182941 76. 00 76. 01 76. 0
76. 00 03550 MEDI CAL SERVI CES 4, 023, 028 891 4, 515. 182941 76. 00 76. 01 03950 PSYCHI ATRI C 10, 505, 683 15, 671, 100 0. 670386 76. 01
76. 01 03950 PSYCHI ATRI C 10, 505, 683 15, 671, 100 0. 670386 76. 01
76. 02 03020 SEVERE BEHAVI OR 2, 872, 523 4, 703, 600 0. 610707 76. 02
76. 97 07697 CARDI AC REHABI LI TATI ON 0 0. 000000 76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0.000000 76. 98
76. 99 07699 LI THOTRI PSY 0 0 0. 000000 76. 99
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0.000000 77.00
78. 00 07800 CAR T-CELL I MMUNOTHERAPY 0 0.000000 78. 00
OUTPATIENT SERVICE COST CENTERS
90. 00 09000 CLI NI C 15, 913, 277 29, 550, 842 0. 538505 90. 00
90. 01 09001 PEDS PRIMARY CARE CLINIC 0 0.000000 90. 01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0.000000 92.00
93. 00 04950 SCHOOL BASED PROGRAMS 0 0 0.000000 93. 00
93. 01 04951 OTHER OUTPATIENT SERVICE COST CENTER 0 0.000000 93. 01
93. 99 09399 PARTI AL HOSPI TALI ZATI ON PROGRAM 0 0 0. 000000 93. 99
OTHER REIMBURSABLE COST CENTERS
102. 00 10200 OPI 0I D TREATMENT PROGRAM 0 0 0.000000 102. 00
SPECIAL PURPOSE COST CENTERS
113. 00 11300 I NTEREST EXPENSE 113. 00
200.00 Subtotal (sum of lines 50 thru 199) 93, 219, 793 158, 057, 423 200.00
201.00 Less Observation Beds 0 0 201.00
202.00 Total (line 200 minus line 201) 93,219,793 158,057,423 202.00

Health Financial Systems	HILDRENS SPECIA	ZED HOPSITAL In Li			eu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS		Provider CCN: 31-3300		Peri od:	Worksheet D	
					From 01/01/2023 To 12/31/2023		narod:
					10 12/31/2023	5/8/2024 9: 17	
			Titl∈	XVIII	Hospi tal	TEFRA	
Cost Center Description	Capi tal	S	wing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Ac	djustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,			Related Cost			
	Part II, col.			(col. 1 - col	,		
	26)			2)			
	1. 00		2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 ADULTS & PEDIATRICS	795, 049		0	795, 04	9 19, 803	40. 15	30.00
44.00 SKILLED NURSING FACILITY	1, 478, 279			1, 478, 27	9 17, 199	85. 95	44. 00
45.00 NURSING FACILITY	142, 707	'		142, 70	7, 300	19. 55	45. 00
200.00 Total (lines 30 through 199)	2, 416, 035	5		2, 416, 03	5 44, 302		200. 00
Cost Center Description	I npati ent	- 1	npati ent				
	Program days		Program				
		Cap	oital Cost				
		(col	. 5 x col.				
			6)				
	6. 00		7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 ADULTS & PEDIATRICS	0		0				30.00
44.00 SKILLED NURSING FACILITY	0		0				44. 00
45.00 NURSING FACILITY	0)	0				45. 00
200.00 Total (lines 30 through 199)	0)	0				200. 00

Health Financial Systems	CHILDRENS SPECIA	LIZED HOPSITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2023 To 12/31/2023	Part II Date/Time Pre	nared·
					5/8/2024 9: 17	am
			XVIII	Hospi tal	TEFRA	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	·		. Charges	column 4)	
	Part II, col.	8)	2)			
	26)	2.00	2.00	4.00	F 00	
ANCLLIADY CEDVICE COCT CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS 54. 00 O5400 RADI OLOGY-DI AGNOSTI C	3, 247	81, 106	0. 04003	4	0	54.00
60. 00 06000 LABORATORY	3, 247	1	•		0	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	41		1		0	62. 30
65. 00 06500 RESPIRATORY THERAPY	111, 481	ļ			0	65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 260, 835				0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	889, 019				0	67. 00
68. 00 06800 SPEECH PATHOLOGY	428, 598				0	68. 00
68. 01 06801 PEDS FEEDING DI SORDER RU CARES	22, 160				0	68. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	61, 904				0	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	157, 883				0	73. 00
76. 00 03550 MEDI CAL SERVI CES	82, 489				0	76. 00
76. 01 03950 PSYCHI ATRI C	681, 845				0	76. 01
76. 02 03020 SEVERE BEHAVI OR	46, 473				0	76. 02
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0.00000		0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0.00000		0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0. 00000	0 0	0	76. 99
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0.00000	0 0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0. 00000	0 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	581, 993	29, 550, 842			0	90. 00
90.01 09001 PEDS PRIMARY CARE CLINIC	0	0	0.00000		0	90. 01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.00000		0	92. 00
93. 00 04950 SCHOOL BASED PROGRAMS	0	0	0.00000		0	93. 00
93. 01 04951 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0. 00000		0	, 0. 0.
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	0. 00000		0	1 , 0 . , ,
200.00 Total (lines 50 through 199)	4, 327, 968	158, 057, 423	l	0	0	200. 00

		LIZED HOPSITAL			eu of Form CMS-	2002 10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ISS THROUGH COST	S Provider CO		Period: From 01/01/2023	Worksheet D Part III	
				To 12/31/2023		pared:
					5/8/2024 9: 17	'am
		Title	XVIII	Hospi tal	TEFRA	
Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other	
	Program	Program	Post-Stepdowr	Cost	Medi cal	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0	0	30.00
44.00 04400 SKILLED NURSING FACILITY	0	0		0		44.00
45. 00 04500 NURSING FACILITY	0	0		0		45. 00
200.00 Total (lines 30 through 199)	0	0		0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	I npati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
		minus col. 4)				
	4. 00	5. 00	6. 00	7. 00	8. 00	
I NPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	1 , , 00			
44.00 04400 SKILLED NURSING FACILITY		0	17, 19			
45.00 04500 NURSING FACILITY		0	7, 30			
200.00 Total (lines 30 through 199)		0	44, 30	2	0	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS	_1					
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
44. 00 04400 SKILLED NURSING FACILITY	0					44. 00
45.00 O4500 NURSING FACILITY	0					45. 00 200. 00
200.00 Total (lines 30 through 199)						

THROUGH COSTS

					10 12/31/2023	5/8/2024 9:17	
			Title	· XVIII	Hospi tal	TEFRA	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
		1.00	Adjustments	0.00	0.4	0.00	
	ANCI LLARY SERVI CE COST CENTERS	1.00	2A	2. 00	3A	3. 00	
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0		0	0	54. 00
60.00	06000 LABORATORY		0		0	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS		0		0	0	62. 30
65. 00	06500 RESPIRATORY THERAPY		0		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY		0		0 0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY		0		0 0	0	67. 00
	06800 SPEECH PATHOLOGY		0		0 0	0	68. 00
68. 01	06801 PEDS FEEDING DISORDER RU CARES	0	0		0 0	0	68. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	0		0 0	0	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73. 00
76.00	03550 MEDI CAL SERVI CES	o	0		0 0	0	76. 00
76. 01	03950 PSYCHI ATRI C	0	0		0 0	0	76. 01
76. 02	03020 SEVERE BEHAVI OR	0	0		0 0	0	76. 02
	07697 CARDI AC REHABI LI TATI ON	0	0		0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0	0	76. 98
	07699 LI THOTRI PSY	0	0		0	0	76. 99
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0	78. 00
00.00	OUTPATIENT SERVICE COST CENTERS			1			00.00
	09000 CLINIC	0	0		0	_	90.00
90. 01	09001 PEDS PRIMARY CARE CLINIC	0	0		0	0	90. 01
92. 00 93. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0	0	92. 00 93. 00
	04950 SCHOOL BASED PROGRAMS 04951 OTHER OUTPATIENT SERVICE COST CENTER		0		0	0	93. 00
	09399 PARTI AL HOSPI TALI ZATI ON PROGRAM		0		0	0	93. 01
200.00	1		0		0 0	-	200. 00
200.00	Total (Tries so through 199)	١	U	1	0	١	200.00

Health Financial Systems	CHILDRENS SPECIALIZ	ZED HOPSITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 31-3300	Peri od:	Worksheet D

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		S Provider C	Provi der CCN: 31-3300 F		Worksheet D Part IV Date/Time Pre 5/8/2024 9:17	pared: am
			XVIII	Hospi tal	TEFRA	
Cost Center Description	All Other	Total Cost	Total	Total Charges		
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
				7.00	instructions)	
ANGLE ARY OFRICE COOT OFFITERS	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS		1		0.1.101		
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0)	0 81, 106		
60. 00 06000 LABORATORY	0)	0 1, 115, 962	0.000000	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		2	0	0.000000	
65. 00 06500 RESPI RATORY THERAPY	0)	0 25, 578, 739	l .	1
66. 00 06600 PHYSI CAL THERAPY	0)	0 19, 717, 248		1
67. 00 06700 OCCUPATI ONAL THERAPY	0)	0 24, 717, 021	0. 000000	•
68. 00 06800 SPEECH PATHOLOGY	0	0)	0 28, 459, 848	l	
68. 01 06801 PEDS FEEDI NG DI SORDER RU CARES	0	0)	0 2, 808, 575		1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0)	0 2, 673, 509		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0)	0 2, 978, 982	l e	1
76. 00 03550 MEDI CAL SERVI CES	0	0)	0 891	0. 000000	1
76. 01 03950 PSYCHI ATRI C	0	0)	0 15, 671, 100	l e	
76. 02 03020 SEVERE BEHAVI OR	0	0)	0 4, 703, 600		1
76. 97 07697 CARDI AC REHABI LITATI ON	0	0)	0	0. 000000	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0)	0	0. 000000	
76. 99 07699 LI THOTRI PSY	0	0)	0	0. 000000	
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0)	0	0. 000000	
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0)	0 0	0. 000000	78. 00
OUTPATIENT SERVICE COST CENTERS		T			T	
90. 00 09000 CLI NI C	0	0)	0 29, 550, 842	0. 000000	1
90.01 09001 PEDS PRIMARY CARE CLINIC	0	0)	0	0. 000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0)	0	0. 000000	
93.00 04950 SCHOOL BASED PROGRAMS	0	0)	0	0. 000000	
93. 01 04951 OTHER OUTPATIENT SERVICE COST CENTER	0	0)	0	0. 000000	
93. 99 09399 PARTI AL HOSPI TALI ZATI ON PROGRAM	0	0)	0	0. 000000	1
200.00 Total (lines 50 through 199)	0	0	P	0 158, 057, 423		200. 00

Health Financial Systems		CHILDRENS SPECIALIZ	'ED HOPSITAL	In Lieu of Form CMS-2552-10		
	APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 31-3300	Peri od:	Worksheet D	

Health Financial Systems C	HILDRENS SPECIALI	IZED HOPSITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS	Provi der Co		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2023		
				To 12/31/2023		
		-	20111		5/8/2024 9: 17	am
			XVIII	Hospi tal	TEFRA	
Cost Center Description	Outpati ent	Inpati ent	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)	40.00	x col . 10)	40.00	x col . 12)	
ANOULL ARV. CERVILOE, COCT, CENTERC	9. 00	10. 00	11. 00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS	0.000000		1			F 4 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	0	1	0	0	54.00
60. 00 06000 LABORATORY	0. 000000	0	1	0	0	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0	1	0	0	62. 30
65. 00 06500 RESPI RATORY THERAPY	0. 000000	0	1	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	0	1	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	0	1	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	0	1	0	0	68. 00
68. 01 06801 PEDS FEEDING DISORDER RU CARES	0. 000000	0	1	0	0	68. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0	1	0	0	71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	0)	0 126		73. 00
76. 00 03550 MEDI CAL SERVI CES	0. 000000	0)	0	0	76. 00
76. 01 03950 PSYCHI ATRI C	0. 000000	0)	0	0	76. 01
76. 02 03020 SEVERE BEHAVI OR	0. 000000	0)	0	0	76. 02
76. 97 O7697 CARDI AC REHABI LI TATI ON	0. 000000	0	1	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0	1	0	0	76. 98
76. 99 07699 LI THOTRI PSY	0. 000000	0	1	0	0	76. 99
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0	1	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 CLI NI C	0. 000000	0	1	0 18, 215	0	90.00
90.01 09001 PEDS PRIMARY CARE CLINIC	0. 000000	0		0	0	90. 01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0)	0	0	92. 00
93.00 04950 SCHOOL BASED PROGRAMS	0. 000000	0)	0	0	93. 00
93. 01 04951 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000	0)	0	0	93. 01
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0. 000000	0)	0	0	93. 99
200.00 Total (lines 50 through 199)		0		0 18, 341	0	200. 00

Cost Center Description	Health Financial Systems	CHILDRENS SPECIA	LIZED HOPSITAL		In Lie	eu of Form CMS-2	2552-10
Title Title Title Title	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	ID VACCINE COST	Provi der CO	CN: 31-3300		Worksheet D	
Cost Center Description						Part V	
Cost Center Description					To 12/31/2023	Date/Time Pre	pared:
Cost Center Description				\0.41.1.			am
Cost Center Description			litle		Hospi tai		
Ratio From Worksheet C, Part I, col. 9							
Note Part	Cost Center Description						
Part I, col. 9						(see inst.)	
NC NC NC NC NC NC NC NC							
ANCILLARY SERVICE COST CENTERS		Part I, col. 9		,			
NOTE							
ANCILLARY SERVICE COST CENTERS							
54.00		1.00	2.00	3.00	4. 00	5.00	
60. 00 06000 LABORATORY 0. 002294 0 0 0 0 0 0 60. 00 62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0. 0000000 0 0 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 0. 248427 0 0 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0. 786944 0 0 0 0 0 0 67. 00 06700 0CCUPATI ONAL THERAPY 0. 614935 0 0 0 0 0 0 68. 01 06801 PEDS FEED ING DISORDER RU CARES 0. 455187 0 0 0 0 0 0 68. 01 06801 PEDS FEED ING DISORDER RU CARES 0. 487617 0 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIE SC CHARGED TO PATIENT 1. 433520 0 0 0 0 0 0 76. 00 03550 MEDI CAL SUPPLIE SC CHARGED TO PATIENT 1. 565860 126 0 0 0 197 73. 00 76. 00 03550 MEDI CAL SERVI CES 4. 515. 1829411 0 0 0 0 76. 01 76. 01 03950 PSVCHI ATRI C 0. 670386 0 0 0 0 76. 01 76. 02 03020 SEVERE BEHAVI OR 0. 617077 0 0 0 0 0 76. 02 76. 97 07697 07801 CARDIA C REHABI LI TATI ON 0. 000000 0 0 0 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0. 000000 0 0 0 0 76. 98 76. 99 07699 LI THOTRI PSY 0. 0000000 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL I IMMUNOTHERAPY 0. 000000 0 0 0 0 0 78. 00 78. 00 07800 CAR T-CELL I IMMUNOTHERAPY 0. 000000 0 0 0 0 0 0 79. 00 09000 CLIN I C 0. 538505 18, 215 0 138 9, 809 90. 01 79. 01 09001 PEDS PRI MARY CARE CLIN IC 0. 000000 0 0 0 0 0 0 79. 00 09000 CLIN I C 0. 000000 0 0 0 0 0 0 79. 00 09000 CLIN I C 0. 000000 0 0 0 0 0 79. 00 09000 Subtotal (see instructions) 0. 000000 0 0 0 0 0 79. 00 0901 PEDS PRI MARY CARE CLIN IC 0. 000000 0 0 0 0 79. 00 09000 Subtotal (see instructions) 0. 000000 0 0 0 0 79. 00 00000 00000 000000 000000 000000							4
62.30 66.250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0 0 0 0 62.30 65.00 06500 RESPIRATORY THERAPY 0.248427 0 0 0 0 0 65.00 66.00 06600 PHYSICAL THERAPY 0.786944 0 0 0 0 0 0 67.00 06700 0CCUPATIONAL THERAPY 0.614935 0 0 0 0 0 0 68.00 06800 SPEECH PATHOLOGY 0.455187 0 0 0 0 0 68.01 06801 PEDS FEEDING DI SORDER RU CARES 0.487617 0 0 0 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 1.433520 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENT 1.433520 0 0 0 0 171.00 76.01 03950 PSYCHIATRIC 0.570386 0 0 0 0 76.00 76.02 03020 SEVERE BEHAVIOR 0.610707 0 0 0 0 76.00 76.92 07697 CARDIAC REHABILITATION 0.000000 0 0 0 76.97 76.99 07699 LTHOTRIP PSY 0.000000 0 0 0 0 76.99 77.00 07700 ALLOGENEI C 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 0 79.01 07900 CAR T-CELL IMMUNOTHERAPY 0.000000 0 0 0 0 0 0 79.01 07901 PEDS PRIMARY CARE CLINIC 0.000000 0 0 0 0 0 79.01 07901 PEDS PRIMARY CARE CLINIC 0.000000 0 0 0 0 0 79.01 07901 THEROTRY SERVICE COST CENTERS 0.000000 0 0 0 0 0 79.01 07901 THEROTRY SERVICE COST CENTERS 0.000000 0 0 0 0 79.01 07901 DTHOR OUTPATIENT SERVICE COST CENTER 0.000000 0 0 0 0 79.01 07907 CARDIAC REPORTALIS SERVICE COST CENTER 0.000000 0 0 0 0 79.01 07907 CARDIAC REPORTALIS SERVICE COST CENTER 0.000000 0 0 0 0 79.01 07907 CARDIAC REPORTALIS SERVICE COST CENTER 0.000000 0 0 0 0 79.01 07907 CARDIAC REPORTALIS SERVICE COST CENTER 0.000000 0 0 0 0 79.01 07907 CARDIAC REPORTALIS SERVICE COST CENTER 0.000000 0 0 0 0 79.01 07907 CARDIAC REPORTALIS SERVICE SERVICES SERVICES SERVICES SERVICES SERVICES SERVICES SERVICES					ا ا	· ·	
65. 00					0	0	
66. 00 06600 PHYSI CAL THERAPY 0.786944 0 0 0 0 0 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0.614935 0 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.455187 0 0 0 0 0 68. 00 68. 01 06801 PEDS FEEDING DI SORDER RU CARES 0.487617 0 0 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 1.433520 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 1.565860 126 0 0 0 197 73. 00 76. 00 03550 MEDI CAL SERVI CES 4,515. 182941 0 0 0 0 0 0 76. 00 76. 01 03950 PSYCHI ATRI C 0.670386 0 0 0 0 0 76. 01 76. 02 03200 SEVERE BEHAVI OR 0.610707 0 0 0 0 0 76. 02 76. 97 07697 CARDI AC REHABI LI TATI ON 0.000000 0 0 0 0 0 76. 92 76. 98 07699 LI THOTRI PSY 0.000000 0 0 0 0 76. 98 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0.000000 0 0 0 0 0 77. 00 78. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0.000000 0 0 0 0 0 90. 01 09000 CLI NI C 0.538505 18, 215 0 138 9, 809 90. 00 90. 01 09000 CLI NI C 0.000000 0 0 0 0 0 90. 01 09000 CLI NI C 0.000000 0 0 0 0 0 93. 00 04950 SCHOOL BASED PROGRAMS 0.000000 0 0 0 0 0 93. 00 04950 SCHOOL BASED PROGRAMS 0.000000 0 0 0 0 0 90. 01 OND ON			l		0	0	
67. 00 06700 OCCUPATIONAL THERAPY			l ~		0	0	1
68. 00 06800 SPEECH PATHOLOGY			l		0	0	66. 00
68. 01 06801 PEDS FEEDING DISORDER RU CARES 0. 487617 0 0 0 0 0 0 0 71. 00 71. 00 71.00 MCDI CAL SUPPLIES CHARGED TO PATI ENT 1. 433520 0 0 0 0 0 0 771. 00 73. 00 7300 DRUGS CHARGED TO PATI ENTS 1. 565860 126 0 0 0 197 73. 00 76. 00 03550 MEDI CAL SERVI CES 4, 515. 182941 0 0 0 0 0 76. 00 76. 00 76. 01 03950 PSYCHI ATRI C 0. 670386 0 0 0 0 0 76. 01 76. 02 03020 SEVERE BEHAVI OR 0. 6107077 0 0 0 0 0 76. 01 76. 02 76. 97 07697 CARDI AC REHABI LI TATI ON 0. 000000 0 0 0 0 0 76. 97 77. 00 0 0 0 0 76. 98 76. 99 07699 LI THOTRI PSY 0. 000000 0 0 0 0 0 0 76. 98 76. 99 07699 LI THOTRI PSY 0. 000000 0 0 0 0 0 0 76. 99 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0. 000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0	67. 00 06700 OCCUPATI ONAL THERAPY	0. 614935	0		0	0	67. 00
71. 00	68.00 06800 SPEECH PATHOLOGY	0. 455187	0		0 0	0	68. 00
73. 00	68. 01 06801 PEDS FEEDING DISORDER RU CARES	0. 487617	0		0	0	68. 01
76. 00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1. 433520	0		0 0	0	71. 00
76. 01 03950 PSYCHIATRIC 0.670386 0 0 0 0 0 76. 01 76. 02 03020 SEVERE BEHAVI OR 0.610707 0 0 0 0 0 76. 02 76. 97 07697 CARDI AC 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 76. 99 07699 LITHOTRI PSY 0.000000 0 0 0 0 0 76. 99 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0.000000 0 0 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0 0 0 0 0 77. 00 00000 CLINIC 0.000000 0 0 0 0 0 0 0 77. 00 00000 CLINIC 0.000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	73.00 07300 DRUGS CHARGED TO PATIENTS	1. 565860	126		0 0	197	73. 00
76. 02 03020 SEVERE BEHAVI OR 0. 610707 0 0 0 0 0 76. 02 76. 97 07697 CARDI AC REHABI LITATI ON 0. 000000 0 0 0 0 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0. 000000 0 0 0 0 0 76. 97 76. 99 07699 LITHOTRI PSY 0. 000000 0 0 0 0 0 0 76. 99 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0. 000000 0 0 0 0 0 0 0 77. 00 07800 CAR T-CELL IMMUNOTHERAPY 0. 000000 0 0 0 0 0 0 77. 00 07800 CAR T-CELL IMMUNOTHERAPY 0. 000000 0 0 0 0 0 0 78. 00 00000 0 0 0 0 0 0 0 0 0 0 0 0 0 0	76. 00 03550 MEDI CAL SERVI CES	4, 515. 182941	0		0	0	76. 00
76. 97	76. 01 03950 PSYCHI ATRI C	0. 670386	0		o o	0	76. 01
76. 98	76. 02 03020 SEVERE BEHAVI OR	0. 610707	0		o o	0	76. 02
76. 99 07699 LITHOTRIPSY 0.000000 0 0 0 0 76. 99 77. 00 07700 ALLOGENEI C STEM CELL ACQUISITION 0.000000 0 0 0 0 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0 0 0 0 0 OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0.538505 18, 215 0 138 9, 809 90. 00 90. 01 09001 PEDS PRIMARY CARE CLINIC 0.000000 0 0 0 0 0 0 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0.000000 0 0 0 0 0 92. 00 93. 00 04950 SCHOOL BASED PROGRAMS 0.000000 0 0 0 0 93. 00 93. 01 04951 OTHER OUTPATIENT SERVICE COST CENTER 0.000000 0 0 0 0 93. 01 93. 99 09399 09399 PARTIAL HOSPITALIZATION PROGRAM 0.000000 0 0 0 0 0 93. 99 200. 00 Subtotal (see instructions) 18, 341 0 138 10, 006 200. 00 201. 00 Charges	76. 97 07697 CARDIAC REHABILITATION	0. 000000	0		o o	0	76. 97
77. 00 07700 ALLOGENEI C STEM CELL ACQUI SITION 0.000000 0 0 0 0 0 77. 00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0 0 0 0 0 78. 00 0 0 0 0 0 0 0 0 0	76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		o o	0	76. 98
78. 00	76. 99 07699 LI THOTRI PSY	0. 000000	0		o o	0	76. 99
OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTER OUTPATIENT SERVICE CUINIC OUTPATIENT SERVICE CUINIC OUTPATIENT SERVICE CUINIC OUTPATIENT SERVICE COST CENTER OUTPATIENT	77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTER OUTPATIENT SERVICE CUINIC OUTPATIENT SERVICE CUINIC OUTPATIENT SERVICE CUINIC OUTPATIENT SERVICE COST CENTER OUTPATIENT	78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		o o	0	78. 00
90. 01 09001				'	•		1
90. 01 09001 PEDS PRIMARY CARE CLINIC 0. 000000 0 0 0 90. 01 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0. 000000 0 0 0 92. 00 93. 00 04950 SCHOOL BASED PROGRAMS 0. 000000 0 0 0 93. 00 93. 01 04951 OTHER OUTPATIENT SERVICE COST CENTER 0. 000000 0 0 0 93. 01 93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM 0. 000000 0 0 0 0 93. 91 90. 01 04951 05000000 0 0 0 0 0 93. 01 04951 05000000 0 0 0 0 93. 01 05000000 0 0 0 0 93. 01 05000000 0 0 0 0 93. 01 05000000 0 0 0 94. 02 050000000 0 0 0 95. 05000000 0 0 0 96. 07 07 07 07 07 97 07 07 07 07 97 07 07 07 07 97 07 07 07 07 97 07 07 07 07 97	90. 00 09000 CLINIC	0. 538505	18, 215		0 138	9, 809	90.00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0.000000 0 0 0 92. 00 93. 00 94950 SCHOOL BASED PROGRAMS 0.000000 0 0 0 93. 00 93. 01 04951 OTHER OUTPATIENT SERVICE COST CENTER 0.000000 0 0 0 0 93. 01 93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM 0.000000 0 0 0 0 0 93. 99 09399 Subtotal (see instructions) 18,341 0 138 10,006 200. 00 201. 00 001 y Charges	90.01 09001 PEDS PRIMARY CARE CLINIC	0. 000000			o o	0	90. 01
93. 00 04950 SCHOOL BASED PROGRAMS 0.000000 0 0 0 93. 00 93. 01 04951 OTHER OUTPATIENT SERVICE COST CENTER 93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM 0.000000 0 0 0 93. 99 200. 00 Subtotal (see instructions) Less PBP Clinic Lab. Services-Program 0 0 0 0 0 00 0 0 0					o o	0	92.00
93. 01 04951 07HER OUTPATIENT SERVICE COST CENTER 0.000000 0 0 0 93. 01 093.99 093.99 PARTIAL HOSPITALIZATION PROGRAM 0.000000 0 0 0 0 93. 99 093.99			l e		0	0	93.00
93. 99 O9399 PARTIAL HOSPITALIZATION PROGRAM O. 000000 O O O O O O O O					0	0	
200.00 Subtotal (see instructions) 18,341 0 138 10,006 200.00 201.00 0 0 0 0 0 0 0 0 0					0	0	
201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00 Only Charges					0 138	10 006	
Only Charges			.5,511		0 0		
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			18, 341		0 138	10, 006	202. 00

Cost Cost Cost Cost Cost Rel mbursed Services Subject To Ded. & Coins. (See inst.) Subject To Ded. & Coins. Subject To Ded. & Coins. (See inst.) Subject To Ded. & Coins. (See inst.) Subject To Ded. & Coins. (See inst.) Subject To Ded. & Coins. Subject To Ded.	ALTONITONIMENT OF MEDICAE, OTHER HEALTH SERVICES AND	VACCINE COST	Trovider co	ON. 31-3300	From 01/01/2023 To 12/31/2023	Part V Date/Time Pre 5/8/2024 9: 17	
Cost Center Description			Title	XVIII	Hospi tal	TEFRA	
Reimbursed Servi Ces Subject To Ded. & Colns. (See inst.) Servi Ces Subject To Ded. & Colns. (See inst.) See inst.)		Costs					
Servi ces Subject To Ded. & Col ns. (see inst.) Ded. & Col ns. Ded. & D	Cost Center Description	Cost	Cost				
Subject To Ded. & Coins. (See Inst.) Ded. & Coins. (See Inst.)							
Ded. & Coins. (See inst.) See inst.) Csee inst. See inst. Csee inst. See inst. Csee inst. See inst							
See inst. See							
ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 0 0 0							
ANCILLARY SERVICE COST CENTERS							
54. 00		6.00	7. 00				
60. 00 66000 LABORATORY 0 0 0 0 62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0 0 0 0 0 0 0				1			
62. 30		-	0				
65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 0 0 0 0 0		0	0				
66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 660.0 67. 00 06700 OCCUPATIONAL THERAPY 0 0 0 0 68. 00 68. 00 6800 SPEECH PATHOLOGY 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 68. 00 0 68. 01 06801 PEDS FEEDING DISORDER RU CARES 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0				
67. 00 06700 OCCUPATIONAL THERAPY 0 0 0 0 68. 00 68.00 SPEECH PATHOLOGY 0 0 0 68. 00 6800 SPEECH PATHOLOGY 0 0 0 0 68. 00 680. 01 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 71. 00 73. 00 7300 DRUGS CHARGED TO PATI ENTS 0 0 0 75. 00 75. 00 075. 00		0	0				
68. 00		0	0	1			
68. 01 06801 PEDS FEEDING DISORDER RU CARES 0 0 0 0 71. 00 MCDIC AL SUPPLIES CHARGED TO PATIENT 0 0 0 0 773.00 77300 DRUGS CHARGED TO PATIENTS 0 0 0 0 773.00 77300 DRUGS CHARGED TO PATIENTS 0 0 0 0 773.00 773.00 77300 DRUGS CHARGED TO PATIENTS 0 0 0 0 774.00 775.00 77		0	0	1			
71. 00		0	0	1			
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 76. 00 76. 00 76. 00 03550 MEDI CAL SERVI CES 0 0 0 76. 00 76. 00 76. 00 76. 01 03950 PSYCHI ATRI C 0 0 0 76. 01 76. 01 03950 PSYCHI ATRI C 0 0 0 0 76. 01 76. 01 03950 PSYCHI ATRI C 0 0 0 0 76. 01 03950 PSYCHI ATRI C 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0	1			
76. 00		0	0				
76. 01 03950 PSYCHIATRIC 0 0 0 0 76. 01 76. 02 03020 SEVERE BEHAVIOR 0 0 0 76. 02 76. 97 07697 CARDIAC REHABILITATION 0 0 0 76. 97 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 0 0 76. 98 76. 99 07699 LITHOTRIPSY 0 0 0 76. 98 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 78. 00 0017PATIENT SERVICE COST CENTERS 90. 01 09001 PEDS PRIMARY CARE CLINIC 0 74 90. 01 09001 PEDS PRIMARY CARE CLINIC 0 0 990. 01 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 993. 01 93. 01 04950 SCHOOL BASED PROGRAMS 0 0 0 93. 01 93. 01 04951 OTHER OUTPATIENT SERVICE COST CENTER 0 0 0 93. 01 93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM 0 0 0 93. 01 93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM 0 0 0 93. 01 001 Cless PBP Clinic Lab. Services-Program 0 0 01 y Charges		0	0	1			
76. 02 76. 97 76. 97 76. 97 76. 98 76. 98 76. 99 76. 99 76. 99 76. 99 76. 99 76. 99 77. 00 770 78. 00 770 78. 00 770 78. 00 79. 00 79.		0	0	1			
76. 97 76. 97 76. 98 76. 98 76. 99 76. 99 76. 99 76. 99 76. 99 76. 99 76. 99 76. 99 76. 99 76. 99 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 00 00 00 00 00 00 00 00 00 00 00 0		0	0	1			
76. 98 76. 99 76. 99 76. 99 77. 00 77. 00 77. 00 77. 00 77. 00 78. 00 00 00 00 00 00 00 00 00 00		0	0	1			
76. 99 77. 00 770 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 0 0 0 0		0	0	1			
77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 0 0 0 0 0		0	0				
78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 0 0		0	0				
OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 90.00 90.01 09001 PEDS PRIMARY CARE CLINIC 0 0 0 0 90.01 92.00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 0 93.00 04950 SCHOOL BASED PROGRAMS 0 0 0 93.00 93.01 04951 OTHER OUTPATIENT SERVICE COST CENTER 0 0 93.01 93.99 09399 PARTIAL HOSPITALIZATION PROGRAM 0 0 93.91 93.99 09399 PARTIAL (Gee instructions) 0 74 200.00 201.00 Cless PBP Clinic Lab. Services-Program 0 0 0 0 0 0 0 0 0	· · · · · · · · · · · · · · · · · · ·	1	0				
90. 00 09000 CLINIC 09001 PEDS PRIMARY CARE CLINIC 0 0 0 0 09200 08SERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 09200 08SERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 09200 08SERVATION BEDS (NON-DISTINCT PART 0 0 0 0 093. 00 093. 01 094950 SCHOOL BASED PROGRAMS 0 0 0 093. 00 093. 01 093. 09 09399 PARTIAL HOSPITALIZATION PROGRAM 0 0 0 093. 09 09399 PARTIAL HOSPITALIZATION PROGRAM 0 0 0 093. 09 09399 09399 09399 09399 09399 09399 09399 Clinic Lab. Services-Program 0 0 0 00 00 00 00 00 00		J U	U	1			/8.00
90. 01 09001			7.1				00 00
92. 00 09200 09200 095ERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 0 0			74				
93. 00 04950 04950 04951			0				
93. 01 04951 04951 07HER OUTPATIENT SERVICE COST CENTER 0 0 0 0 0 0 0 0 0			0				
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM 0 0 0 0 0 0 0 0 0			0				
200.00 Subtotal (see instructions) 0 74 201.00 Less PBP Clinic Lab. Services-Program 0 0nly Charges			0				
201.00 Less PBP Clinic Lab. Services-Program 0 001y Charges			7.4				
Only Charges			74				
							231.00
202.00 Net charges (The 200 - The 201) 0 74	202.00 Net Charges (line 200 - line 201)	o	74				202. 00

APPORT	Financial Systems C ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS	HILDRENS SPECIA RVICE OTHER PAS:	S Provider CO Component (CN: 31-3300 CCN: 31-5239	То	d: 01/01/2023 12/31/2023	Date/Time Pre 5/8/2024 9:17	pared:
			Title	xVIII	Fa	ed Nursing acility		
	Cost Center Description	Non Physician Anesthetist Cost	Nursi ng Program Post-Stepdown Adj ustments		Pos	t-Stepdown justments	Allied Health	
	ANCI LLARY SERVI CE COST CENTERS	1. 00	2A	2.00		3A	3. 00	
	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	1	1 0 00
	06000 LABORATORY 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	0		60.00
	06500 RESPIRATORY THERAPY	0	0		0	0	0	
	06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
	06700 OCCUPATI ONAL THERAPY	0	Ō		0	0	Ō	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0		0	0	0	68. 00
68. 01	06801 PEDS FEEDING DISORDER RU CARES	0	0		0	0	0	68. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	
	03550 MEDI CAL SERVI CES	0	0		0	0	0	76. 00
	03950 PSYCHI ATRI C	0	0		0	0	0	,
	03020 SEVERE BEHAVIOR 07697 CARDIAC REHABILITATION	0	0		0	0	0	76. 02 76. 97
	07698 HYPERBARI C OXYGEN THERAPY		0		0	0	0	
	07699 LI THOTRI PSY	0	0		0	0	0	
	07700 ALLOGENEIC STEM CELL ACQUISITION	Ö	Ö		0	0	· -	1
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS							
	09000 CLI NI C	0	0		0	0	0	
	09001 PEDS PRIMARY CARE CLINIC	0	0		0	0		
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0		0	
	04950 SCHOOL BASED PROGRAMS	0	0		U	0	0	70.00
	04951 OTHER OUTPATIENT SERVICE COST CENTER 09399 PARTIAL HOSPITALIZATION PROGRAM				0	0	0	
73. 77	U7377 PAKITAL HUSPITALIZATIUN PKUGRAM	1	1 0	1	U	U	0	73. 79

APPOR	Heal th Financial Systems CHILDRENS SPECIALIZED HOPSITAL In Lieu of Form CMS-2552-10 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 31-3300 Period: Worksheet D THROUGH COSTS From 01/01/2023 Part IV								
THROUG	GH COSTS		Component	CCN: 31-5239	To 12/31/2023	Date/Time Prep 5/8/2024 9:17	pared: am		
			Title	× XVIII	Skilled Nursing Facility	PPS			
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost			
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,				
		Education Cost		Cost (sum of		(col. 5 ÷ col.			
			4)	col s. 2, 3,	8)	7)			
			,	and 4)		(see			
						instructions)			
		4. 00	5. 00	6. 00	7. 00	8. 00			
	ANCILLARY SERVICE COST CENTERS								
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 81, 106	0.000000	54. 00		
60.00	06000 LABORATORY	0	0	1	0 1, 115, 962	0.000000	60.00		
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0)	0 0	0.000000	62. 30		
65.00	06500 RESPIRATORY THERAPY	0	0)	0 25, 578, 739	0.000000	65. 00		
66.00	06600 PHYSI CAL THERAPY	o	0)	0 19, 717, 248		66.00		
67.00	06700 OCCUPATI ONAL THERAPY	o	0)	0 24, 717, 021		67.00		
68. 00	06800 SPEECH PATHOLOGY	o	0)	0 28, 459, 848	0.000000	68. 00		
68. 01	06801 PEDS FEEDING DISORDER RU CARES	o	0)	0 2, 808, 575		68. 01		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	0)	0 2, 673, 509		71. 00		
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	1	0 2, 978, 982	0.000000	73. 00		
76.00	03550 MEDI CAL SERVI CES	O	0)	0 891		76. 00		
76. 01	03950 PSYCHI ATRI C	O	0)	0 15, 671, 100	0.000000	76. 01		
76. 02	03020 SEVERE BEHAVI OR	0	0)	0 4, 703, 600	0.000000	76. 02		
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0)	0 0	0.000000	76. 97		
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0)	0 0	0.000000	76. 98		
76. 99	07699 LI THOTRI PSY	0	0	1	0 0	0.000000	76. 99		
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	<u>'</u>		•					
90.00	09000 CLI NI C	0	0		0 29, 550, 842	0.000000	90.00		
90. 01	09001 PEDS PRIMARY CARE CLINIC	0	0)	0 0	0.000000	90. 01		
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	ol	0)	0	0. 000000			
93. 00	04950 SCHOOL BASED PROGRAMS	ol	0	,	0 0	0. 000000			
93. 01	04951 OTHER OUTPATIENT SERVICE COST CENTER	ol	0	,	0 0	0. 000000			
	09399 PARTI AL HOSPI TALI ZATI ON PROGRAM	ol	0	,	0 0	0. 000000			
200.00		0	0	,	0 158, 057, 423		200. 00		
				'					

Wastab Firensial Custom	ULL DDENC CDECLALL	ZED HODGLEAL		1 1 :-	£ F OMC	2552 10
Health Financial Systems CI APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	HILDRENS SPECIALI	Provider CO	N. 21 2200	Period:	eu of Form CMS-2 Worksheet D	2552-10
THROUGH COSTS	VICE UINER PASS	Provider Co	JN. 31-3300	From 01/01/2023		
111K00011 00313		Component (CCN: 31-5239	To 12/31/2023	Date/Time Pre	
					5/8/2024 9: 17	am
		Title	XVIII	Skilled Nursing	PPS	
Cook Cooks Doors at the	0	1+:+	1	Facility	0	
Cost Center Description	Outpatient Ratio of Cost	Inpatient Program	Inpatient Program	Outpatient Program	Outpatient Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.	criai ges	Costs (col.		Costs (col. 9	
	7)		x col . 10)	0	x col . 12)	
	9, 00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	7. 00	10.00	11.00	12.00	13.00	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	0		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	0		0	1	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0 0	Ö	62. 30
65. 00 06500 RESPIRATORY THERAPY	0. 000000	0		0	Ö	1
66. 00 06600 PHYSI CAL THERAPY	0. 000000	0		0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	0		0 0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68. 00
68. 01 06801 PEDS FEEDING DISORDER RU CARES	0. 000000	0		0 0	Ö	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0		0 0	Ö	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	0		0 0	0	73. 00
76. 00 03550 MEDI CAL SERVI CES	0. 000000	0		0 0	0	76.00
76. 01 03950 PSYCHI ATRI C	0. 000000	0		0 0	0	76. 01
76. 02 03020 SEVERE BEHAVI OR	0. 000000	0		0 0	0	76. 02
76. 97 O7697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	1
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	76. 98
76. 99 07699 LI THOTRI PSY	0. 000000	0		0 0	0	76. 99
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						1
90. 00 09000 CLI NI C	0. 000000	0		0 0	0	90. 00
90.01 09001 PEDS PRIMARY CARE CLINIC	0. 000000	0		0 0	0	90. 01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92.00
93. 00 04950 SCHOOL BASED PROGRAMS	0. 000000	0		0 0	0	93. 00
93. 01 04951 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000	0		0 0	0	
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0. 000000	0		0 0	0	
200.00 Total (lines 50 through 199)		0		0 0	0	200. 00

Health Financial Systems C	HILDRENS SPECIA	ALIZED HOPSITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS			Peri od:	Worksheet D	
				From 01/01/2023 To 12/31/2023		narodi
				10 12/31/2023	5/8/2024 9: 17	
		Ti tI	e XIX	Hospi tal	TEFRA	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,	-	Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	795, 049	0	795, 04	9 19, 803	40. 15	30.00
44.00 SKILLED NURSING FACILITY	1, 478, 279		1, 478, 27	9 17, 199	85. 95	44.00
45.00 NURSING FACILITY	142, 707	1	142, 70	7, 300	19. 55	45.00
200.00 Total (lines 30 through 199)	2, 416, 035		2, 416, 03	5 44, 302		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 942	77, 971				30.00
44.00 SKILLED NURSING FACILITY	16, 462	1, 414, 909				44. 00
45.00 NURSING FACILITY	6, 624	129, 499				45. 00
200.00 Total (lines 30 through 199)	25, 028	1, 622, 379	1			200. 00

Health Financial Systems	CHI LDRENS SPECI A	LIZED HOPSITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAP	ITAL COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2023 To 12/31/2023	Part II Date/Time Pre	nanad.
				10 12/31/2023	5/8/2024 9: 17	pareu: am
		Ti tl	e XIX	Hospi tal	TEFRA	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 247				484	
60. 00 06000 LABORATORY	41				2	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0.0000		0	62. 30
65. 00 06500 RESPI RATORY THERAPY	111, 481				4, 726	
66. 00 06600 PHYSI CAL THERAPY	1, 260, 835				15, 965	
67. 00 06700 OCCUPATI ONAL THERAPY	889, 019				8, 611	67. 00
68. 00 06800 SPEECH PATHOLOGY	428, 598				10, 417	
68. 01 06801 PEDS FEEDING DI SORDER RU CARES	22, 160				0	68. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	61, 904				2, 412	
73.00 07300 DRUGS CHARGED TO PATIENTS	157, 883				14, 726	
76. 00 03550 MEDI CAL SERVI CES	82, 489				0	
76. 01 03950 PSYCHI ATRI C	681, 845				244	76. 01
76. 02 03020 SEVERE BEHAVI OR	46, 473	4, 703, 600	0. 00988	0	0	76. 02
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0.00000	0 0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0.00000	0 0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0.00000	0 0	0	76. 99
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0.00000	0 0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.00000	00	0	78. 00
OUTPAȚI ENT SERVI CE COST CENTERS						
90. 00 09000 CLI NI C	581, 993	29, 550, 842			0	,
90.01 09001 PEDS PRIMARY CARE CLINIC	0	0	0.00000		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.00000		0	
93.00 04950 SCHOOL BASED PROGRAMS	0	0	0.00000		0	93. 00
93. 01 04951 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0. 00000		0	93. 01
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	0. 00000		0	93. 99
200.00 Total (lines 50 through 199)	4, 327, 968	158, 057, 423		2, 731, 905	57, 587	200. 00

Health Financial Systems	CHI LDRENS SPECI AL			In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE	CE OTHER PASS THROUGH COSTS	Provider CO	F	Period: From 01/01/2023 Fo 12/31/2023	Date/Time Pre 5/8/2024 9:17	pared:
		Ti tl	e XIX	Hospi tal	TEFRA	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown	_	Adjustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2.00	3. 00	
INPATIENT ROUTINE SERVICE COST CEN	TERS		•			
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	(0	0	30.00
44.00 04400 SKILLED NURSING FACILITY	o	0		0		44.00
45. 00 04500 NURSING FACILITY	l ol	0		0		45.00
200.00 Total (lines 30 through 199)	o	0		0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpatient	
F		sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	through 3,		_		
	instructions) n	ninus col. 4)				
	4.00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CEN	TERS					
30. 00 03000 ADULTS & PEDIATRICS	0	0	19, 803	0.00	1, 942	30.00
44.00 04400 SKILLED NURSING FACILITY	1	0	17, 199	0.00	16, 462	44.00
45. 00 04500 NURSING FACILITY		0	7, 300	0.00	6, 624	45. 00
200.00 Total (lines 30 through 199)		0	44, 302			200. 00
Cost Center Description	I npati ent					
·	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9. 00					
I NPATIENT ROUTINE SERVICE COST CEN	TERS					
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
44.00 04400 SKILLED NURSING FACILITY	o					44.00
45. 00 04500 NURSING FACILITY	o					45. 00
200.00 Total (lines 30 through 199)	o					200.00
,	1					

| Period: | Worksheet D | From 01/01/2023 | Part IV | To | 12/31/2023 | Date/Time | Prepared: THROUGH COSTS

					To 12/31/2023	Date/Time Pre 5/8/2024 9:17	
-			Ti tl	e XIX	Hospi tal	TEFRA	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
	T	1.00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	_1		1		1	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54. 00
60.00	06000 LABORATORY	0	0		0	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	0	62. 30
65. 00	06500 RESPI RATORY THERAPY	0	0		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
68. 01	06801 PEDS FEEDING DISORDER RU CARES	0	0		0	0	68. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	71. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
76. 00	03550 MEDI CAL SERVI CES	0	0		0	0	76. 00
76. 01	03950 PSYCHI ATRI C	0	0		0	0	76. 01
	03020 SEVERE BEHAVI OR	0	0		0	0	76. 02
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0		0	0	76. 99
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0	78. 00
00.00	OUTPATIENT SERVICE COST CENTERS			ı			00.00
	09000 CLI NI C	0	0		0	0	90.00
90. 01	09001 PEDS PRIMARY CARE CLINIC	0	0		0	0	90. 01
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	_		0	0	92. 00
93. 00	04950 SCHOOL BASED PROGRAMS	0	0		0	0	93. 00
93. 01	04951 OTHER OUTPATIENT SERVICE COST CENTER	0	0		U	0	93. 01
93. 99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	0			0	93. 99
200.00	Total (lines 50 through 199)	0	0	1	0 0	0	200. 00

Health Financial Systems	ealth Financial Systems CHILDRENS SPECIALI			u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 31-3300	Peri od:	Worksheet D

From 01/01/2023 Part IV To 12/31/2023 Date/Time Prepared: THROUGH COSTS 5/8/2024 9:17 am Title XIX Hospi tal TEFRA All Other Ratio of Cost Cost Center Description Total Cost Total Total Charges to Charges Medi cal (from Wkst. C, (sum of cols. Outpati ent Education Cost 1, 2, 3, and Cost (sum of Part I, col. (col. 5 ÷ col 4) col s. 2, 3, 8) 7) and 4) (see instructions) 4.00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 0.000000 54.00 05400 RADI OLOGY-DI AGNOSTI C 81, 106 54.00 60.00 06000 LABORATORY 0 0 1, 115, 962 0.000000 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0.000000 62.30 06500 RESPIRATORY THERAPY 0 0 25, 578, 739 0.000000 65 00 65 00 06600 PHYSI CAL THERAPY 0 0 66.00 19, 717, 248 0.000000 66.00 67.00 06700 OCCUPATIONAL THERAPY 24, 717, 021 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 28, 459, 848 0.000000 68.00 06801 PEDS FEEDING DISORDER RU CARES 0 0 0.000000 68.01 2, 808, 575 68.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 2, 673, 509 0.000000 71.00 07300 DRUGS CHARGED TO PATIENTS 0 0.000000 73.00 2, 978, 982 73.00 03550 MEDICAL SERVICES 0 891 0.000000 76 00 76 00 76.01 03950 PSYCHI ATRI C 15, 671, 100 0.000000 76.01 76. 02 03020 SEVERE BEHAVI OR 4, 703, 600 0.000000 76.02 07697 CARDIAC REHABILITATION 76. 97 0.000000 76.97 07698 HYPERBARI C OXYGEN THERAPY 76. 98 0 76. 98 0 0 0.000000 76. 99 07699 LI THOTRI PSY 0 0 0 0.000000 76.99 07700 ALLOGENEIC STEM CELL ACQUISITION 0.000000 77.00 77.00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0.000000 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 29, 550, 842 0.000000 90.00 0 0 0 0 0 09001 PEDS PRIMARY CARE CLINIC 0 0 0.000000 90. 01 90.01 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 0 0.000000 92.00 93.00 04950 SCHOOL BASED PROGRAMS 0 0 0.000000 93.00 0 93.01 04951 OTHER OUTPATIENT SERVICE COST CENTER 0 0 0.000000 93.01 93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM 0 93. 99 0 0.000000 0 200.00 Total (lines 50 through 199) 0 158, 057, 423 200.00

Health Financial Systems	CHILDRENS SPECIALIZED HOPSITAL			In Lieu of Form CMS-2552-10
ADDODTI ONMENT OF LNDATLENT (OUTDATLENT	ANCILLARY CERVICE OTHER DACC	Drovi don CCN, 21 2200	Dori od:	Workshoot D

Health Financial Systems C	HILDRENS SPECIAL	IZED HOPSITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PASS	Provider CO		Period: From 01/01/2023 To 12/31/2023	Date/Time Prep 5/8/2024 9:17	
			e XIX	Hospi tal	TEFRA	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
	7)	10.00	x col. 10)	10.00	x col . 12)	
ANOLLI ADV. CEDVI OF COCT. CENTEDO	9. 00	10.00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS	0.000000	40.400	Γ			
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	12, 102		0	0	54.00
60. 00 06000 LABORATORY	0. 000000	66, 908		0	0	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	1 004 470		0	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	0. 000000	1, 084, 478		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	249, 663		0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	239, 398		0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0.000000	691, 718		0	0	68. 00
68. 01 06801 PEDS FEEDING DISORDER RU CARES	0. 000000	0		0	0	68. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	104, 179		0	0	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	277, 852		0	0	73. 00
76. 00 03550 MEDI CAL SERVI CES	0. 000000	0		0	0	76.00
76. 01 03950 PSYCHI ATRI C	0. 000000	5, 607		0	0	76. 01
76. 02 03020 SEVERE BEHAVI OR	0. 000000	0		0	0	76. 02
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0	0	76. 98
76. 99 07699 LI THOTRI PSY	0. 000000	0		0	0	76. 99
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0	0	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS	0.000000					00.00
90. 00 09000 CLINIC 90. 01 09001 PEDS PRIMARY CARE CLINIC	0. 000000 0. 000000	0		0	0	90.00
90. 01 09001 PEDS PRIMARY CARE CLINIC 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0	0	90. 01 92. 00
	1	0		0	0	92.00
93. 00 04950 SCHOOL BASED PROGRAMS 93. 01 04951 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000 0. 000000	0		0	0	93.00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0. 000000	0		0	0	93.01
200.00 Total (lines 50 through 199)	0.000000	2, 731, 905			"	200.00
200.00 Total (Tries 30 through 199)	1 1	2, 731, 703	I	ο ₁	, 01	1200.00

Heal th	Financial Systems C	HILDRENS SPECIA	ALIZED HOPSITAL		In Lie	u of Form CMS-:	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider Co	F	reriod: rom 01/01/2023 o 12/31/2023	Worksheet D Part V Date/Time Pre 5/8/2024 9:17	
			Ti tl	e XIX	Hospi tal	TEFRA	
				Charges		Costs	
	Cost Center Description		PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Servi ces Not		
		Part I, col. 9	1	Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
		1.00		(see inst.)	(see inst.)		
	ANOLULARY OFRICAS COOT OFFITERS	1. 00	2.00	3. 00	4. 00	5. 00	
	ANCI LLARY SERVI CE COST CENTERS	0.400075		1			
	05400 RADI OLOGY-DI AGNOSTI C	0. 139275			0	0	0 00
	06000 LABORATORY	0. 002294			0	0	
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			0	0	62. 30
65. 00	06500 RESPIRATORY THERAPY	0. 248427		45 540	0	0	65. 00
	06600 PHYSI CAL THERAPY	0. 786944	1	15, 513		0	66. 00
	06700 OCCUPATI ONAL THERAPY	0. 614935		19, 466		0	67. 00
	06800 SPEECH PATHOLOGY	0. 455187		16, 868		0	68. 00
	06801 PEDS FEEDING DISORDER RU CARES	0. 487617			0	0	68. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1. 433520			0	0	71.00
	07300 DRUGS CHARGED TO PATIENTS	1. 565860	1		0	0	73. 00
	03550 MEDI CAL SERVI CES	4, 515. 182941	1	, 700 (0	0	0	76. 00
	03950 PSYCHI ATRI C	0. 670386	1	6, 783, 691	0	0	76. 01
	03020 SEVERE BEHAVI OR	0. 610707			0	0	76. 02
	07697 CARDI AC REHABI LI TATI ON	0. 000000			0	0	76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0. 000000	1		0	0	76. 98
	07699 LI THOTRI PSY	0.000000			0	0	76. 99
	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000			0	0	77. 00
	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0	C	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS			1		_	
	09000 CLI NI C	0. 538505		1, 424, 295		0	70.00
	09001 PEDS PRIMARY CARE CLINIC	0. 000000			0	0	90. 01
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			0	0	
	04950 SCHOOL BASED PROGRAMS	0. 000000			0	0	70.00
	04951 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000			0	0	, , , , , ,
	09399 PARTI AL HOSPI TALI ZATI ON PROGRAM	0. 000000	0		0	0	
200.00			0	8, 259, 833	0	0	200.00
201.00					0		201. 00
202. 00	Only Charges Net Charges (line 200 - line 201)		0	8, 259, 833		_	202 00
202.00		1	1	η δ, 259, 833	0	0	202. 00

					To 12/31/2023	Date/Time Pre 5/8/2024 9:17	epared: 7 am
			Ti tl	e XIX	Hospi tal	TEFRA	
	·	Cos	sts		· · · · · · · · · · · · · · · · · · ·		
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subj ect To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
	MALLIARY OFFICE OF CONT. OFFITTED	6. 00	7. 00				
	ICI LLARY SERVI CE COST CENTERS						
	6400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
	0000 LABORATORY	0	0				60.00
	5250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62. 30
	5500 RESPIRATORY THERAPY	10.000	0				65. 00
	6600 PHYSI CAL THERAPY	12, 208	0				66.00
	0700 OCCUPATI ONAL THERAPY	11, 970	0	1			67. 00
	9800 SPEECH PATHOLOGY	7, 678	0				68. 00
	9801 PEDS FEEDING DISORDER RU CARES	0	0				68. 01
	1100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
	7300 DRUGS CHARGED TO PATIENTS	0	0				73.00
	8550 MEDI CAL SERVI CES	0	0				76.00
	8950 PSYCHI ATRI C	4, 547, 691	0				76. 01
	3020 SEVERE BEHAVI OR	0	0	1			76. 02
	7697 CARDI AC REHABI LI TATI ON	0	0				76. 97
	698 HYPERBARI C OXYGEN THERAPY	0	0				76. 98
	1699 LI THOTRI PSY	0	0				76. 99
	7700 ALLOGENEIC STEM CELL ACQUISITION	0	0	1			77. 00
	7800 CAR T-CELL IMMUNOTHERAPY	0	0	1			78. 00
	ODDOO CLINIC	766, 990	0				90. 00
	2001 PEDS PRIMARY CARE CLINIC	700, 990	0	1			90.00
		0	0				90.01
	2200 OBSERVATION BEDS (NON-DISTINCT PART 1950 SCHOOL BASED PROGRAMS	0	0				93.00
	1951 OTHER OUTPATIENT SERVICE COST CENTER	0	0				93.00
	2399 PARTIAL HOSPITALIZATION PROGRAM	0	0				93. 01
200.00	Subtotal (see instructions)	5, 346, 537	0				200. 00
200.00	Less PBP Clinic Lab. Services-Program	0, 340, 337					200.00
201.00	Only Charges						201.00
202. 00	Net Charges (line 200 - line 201)	5, 346, 537	0	,			202. 00
202.00	proceedings (Trice 200 Trice 201)	3, 340, 337		Т			1202.00

Health Financial Systems	CHILDRENS SPECIALIZED HOPSITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 31-3300	Peri od: From 01/01/2023		
		10 12/31/2023	Date/Time Prep 5/8/2024 9:17	
	Title XVIII	Hospi tal	TEFRA	
0 1 0 1 D : 1:				

Title XVIII Hospital	TEFRA	
Cost Center Description		
	00	
PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS		
1.00 Inpatient days (including private room days and swing-bed days, excluding newborn)	19, 803	1.00
2.00 Inpatient days (including private room days, excluding swing-bed and newborn days)	19, 803	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)	19, 803	4. 00
5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
reporting period 6.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	o	6. 00
reporting period (if calendar year, enter 0 on this line)	۷	0.00
7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
reporting period		0.00
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	0	9. 00
newborn days) (see instructions)		40.00
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	0	11. 00
December 31 of the cost reporting period (if calendar year, enter 0 on this line)	_	
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)	0	13. 00
after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00 15. 00
15.00 Total nursery days (title V or XIX only) 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	0. 00	17. 00
reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
reporting period	0.00	10.00
19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19. 00
reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
reporting period	0.00	20.00
	283, 089	
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)	0	23. 00
x line 18)		
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	0	25. 00
x line 20)	-	
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) 38, PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	283, 089	27.00
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) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	000000 (30. 00 31. 00
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3)	0.00	
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)	0.00	
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35)	0.00	35. 00 36. 00
	283, 089	37. 00
27 minus line 36)		
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)	, 933. 20	38. 00
39.00 Program general inpatient routine service cost (line 9 x line 38)	, 733. 20	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)	0	41. 00

COMPUTA	ATION OF INPATIENT OPERATING COST		Provi der C		eriod: rom 01/01/2023	Worksheet D-1	
					o 12/31/2023	Date/Time Pre 5/8/2024 9:17	
		1		e XVIII	Hospi tal	TEFRA	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per sDiem (col. 1 ÷	Program Days	Program Cost (col. 3 x col.	
		1.00	2.00	col . 2) 3.00	4. 00	4) 5. 00	
	NURSERY (title V & XIX only)	1.00	2. 00	3. 33	1. 00	0.00	42. 00
	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT		I	T		<u> </u>	43. 00
1. 00	CORONARY CARE UNIT						44. 00
1	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)			•			47. 00
	Cost Center Description					1.00	
	Program inpatient ancillary service cost (Wk					0	
	Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS				column 1)	0	
. 00	Pass through costs applicable to Program inp	atient routine	services (from	m Wkst. D, sum	of Parts I and	0	50. 00
. 00	III) Pass through costs applicable to Program inp	atient ancilla	ry services (f	rom Wkst. D, su	m of Parts II	0	51.00
00	and IV) Total Program excludable cost (sum of lines	50 and 51)				0	52.00
	Total Program inpatient operating cost exclu medical education costs (line 49 minus line	ding capital re	elated, non-phy	ysician anesthe	tist, and	0	1
00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
00	Target amount per discharge					48, 100. 75	
	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor	use only)				0. 00 0. 00	1
00	Target amount (line 54 x sum of lines 55, 55	. 01, and 55. 02)				0	56. 00
	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and to	arget amount (line 56 minus l	ine 53)	0 0	
	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	n the cost rep	orting period e	ndi ng 1996,	0.00	1
00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 fro	om prior year	cost report, up	dated by the	0.00	60. 00
00	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x	ser of 50% of	the amount by v	which operating	costs (line	О	61. 00
00	enter zero. (see instructions)		g				
00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instr	uctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dec	ember 31 of the	e cost reportin	g period (See	0	64. 00
00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the (cost reporting	period (See	0	65. 00
00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 nlus line	65)(title XVIII	only). for	0	66. 00
	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	•	•		3,	0	
	(line 12 x line 19)	3		•	3 1		
00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)			•	ung perroa	0	
	Total title V or XIX swing-bed NF inpatient PART III – SKILLED NURSING FACILITY, OTHER N	URSING FACILITY	, AND ICF/IID	ONLY		0	69.00
1	Skilled nursing facility/other nursing facil	-					70.00
	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		THE 70 - TIME	۷)			71. 00
00	Medically necessary private room cost applic	able to Program	•	,			73. 00
1	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•			rt II, column		74. 00 75. 00
00	26, line 45)	no 2)					76 00
1	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	. *					76. 00 77. 00
1	Inpatient routine service cost (line 74 minu	,	arovi don mass:	de)			78.00
	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp	,		*.	s line 79)		79. 00 80. 00
00	Inpatient routine service cost per diem limi	tati on			/		81. 00
1	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (*				82. 00 83. 00
	Program inpatient ancillary services (see in		13)				84. 00
00	Utilization review - physician compensation	(see instruction					85. 00
00	Total Program inpatient operating costs (sum PART IV – COMPUTATION OF OBSERVATION BED PAS		nrough 85)				86.00
	OS O. ATTOM OF ODSERVATION DED TAS)				0	4

0 87.00 0.00 88.00 0 89.00

87.00 Total observation bed days (see instructions)
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)

89.00 Observation bed cost (line 87 x line 88) (see instructions)

Health Financial Systems	CHILDRENS SPECIA	LIZED HOPSITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023		
	_	Title	XVIII	Hospi tal	TEFRA	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(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	795, 049	38, 283, 089	0. 02076	8 0	0	90.00
91.00 Nursing Program cost	0	38, 283, 089	0.00000	0	0	91.00
92.00 Allied health cost	0	38, 283, 089	0.00000	0 0	0	92.00
93 00 All other Medical Education	0	38 283 089	0 00000	ol o	0	93 00

Health Financial Systems	CHILDRENS SPECIALIZED HOPSITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 31-3300		Worksheet D-1
	Component CCN: 31-5239	From 01/01/2023 To 12/31/2023	
	Title XVIII	Skilled Nursing	PPS
		Eacility	

		Title XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description		racirity		
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			17, 199	1. 00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-l Private room days (excluding swing-bed and observation bed day	3 /	ivata room dave	17, 199 0	2. 00 3. 00
3.00	do not complete this line.	ys). IT you have only pr	i vate i ooiii days,	U	3.00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		17, 199	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room)	om days) after December	31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	on days) at tel becember	31 of the cost	O	0.00
7.00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. 00
0.00	reporting period	m daya) aftar Dagambar 2	1 of the cost	0	8. 00
8. 00	Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	ii days) ai tei beceiibei 3	i oi tile cost	U	6.00
9.00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	0	9. 00
40.00	newborn days) (see instructions)				40.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruc-	nly (including private r tions)	oom days)	0	10. 00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days) after	0	11. 00
40.00	December 31 of the cost reporting period (if calendar year, er				40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	X only (including privat	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	X only (including privat	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar ye	ear, enter O on this lin	e)		
14. 00 15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
	SWI NG BED ADJUSTMENT			-	
17. 00					17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost				18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0.00	20. 00
20.00	reporting period			0.00	20.00
21.00	Total general inpatient routine service cost (see instructions			21, 279, 583	
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	er 31 of the cost report	ing period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	g period (line 6	0	23. 00
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	r 31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)				0.4 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 21, 279, 583	26. 00 27. 00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(TITIC 21 IIII III as TITIC 20)		21, 277, 303	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	
29. 00	Private room charges (excluding swing-bed charges)			0	
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 -	÷ line 28)		0. 000000	30. 00 31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	. 11116 20)		0.00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	
34. 00	Average per diem private room charge differential (line 32 min		tions)	0.00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	21, 279, 583	37. 00
	27 minus line 36)	·			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see				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				40.00
41. 00	Total Program general inpatient routine service cost (line 39	+ ITNE 40)			41. 00

al th MPUT	ATION OF INPATIENT OPERATING COST				Period: From 01/01/2023		
			'		To 12/31/2023 Skilled Nursing	5/8/2024 9: 17	
	Coot Conton Donovintion	Total	Total	Average Per	Facility	Program Cost	
	Cost Center Description	Inpatient Cost		Diem (col. 1 col. 2)		(col. 3 x col. 4)	
. 00	NURSERY (title V & XIX only)	1. 00	2. 00	3. 00	4. 00	5. 00	42.0
	Intensive Care Type Inpatient Hospital Units						
. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT						43.0
	BURN INTENSIVE CARE UNIT						45. (
. 00	SURGICAL INTENSIVE CARE UNIT						46.
. 00	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description					1. 00	
	Program inpatient ancillary service cost (Wk					11.00	48.
	Program inpatient cellular therapy acquisiti				column 1)		48.
UÜ	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48.0	ı)(see instru	CTI ONS)			49.
00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sum	of Parts I and		50.
	III)		•				
00	Pass through costs applicable to Program inp and IV)	atient ancillar	y services (f	rom Wkst. D, s	um of Parts II		51.0
00	Total Program excludable cost (sum of lines	50 and 51)					52.
	Total Program inpatient operating cost exclu	iding capital re	lated, non-ph	ysician anesth	etist, and		53.
	medical education costs (line 49 minus line	52)					
00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges						54.
	Target amount per discharge						55.
	Permanent adjustment amount per discharge						55.
	Adjustment amount per discharge (contractor Target amount (line 54 x sum of lines 55, 55						55. 56.
	Difference between adjusted inpatient operat		rget amount (line 56 minus	line 53)		57.
00	Bonus payment (see instructions)	· ·			ŕ		58.
00	Trended costs (lesser of line 53 ÷ line 54,		the cost rep	orting period	endi ng 1996,		59.
00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,		m prior vear	cost report. u	pdated by the		60.
	market basket)			•			
00	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les						61.
	53) are less than expected costs (lines 54 x						
	enter zero. (see instructions)	, ,	3				
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ont (coo instru	ctions)				62.
UU	PROGRAM INPATIENT ROUTINE SWING BED COST	lent (see mstru	Ctrons)				63.
00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of th	e cost reporti	ng period (See		64.
00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	te after Decemb	or 21 of the	cost roporting	pariod (Saa		65.
00	instructions)(title XVIII only)	its after beceilib	er 51 or the	cost reporting	perrou (see		05.
00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	l only); for		66.
00	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	ie costs through	December 31	nf the cost re	norting period		67.
00	(line 12 x line 19)	ic costs till odgi	becember 51	or the cost re	por tring period		07.
00	Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost repo	rting period		68.
00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (line 67 ± lin	e 68)			69.
00	PART III - SKILLED NURSING FACILITY, OTHER N						07.
00	Skilled nursing facility/other nursing facil					21, 279, 583	
00 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ine 70 ÷ line	2)		1, 237. 26 0	1
00	Medically necessary private room cost applic		(line 14 x l	ine 35)		0	1
00	Total Program general inpatient routine serv	ice costs (line	72 + line 73)		0	74.
00	Capital-related cost allocated to inpatient	routine service	costs (from	Worksheet B, Pa	art II, column	0	75.
00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)				0. 00	76.
00	Program capital-related costs (line 9 x line	76)				0.00	1
	Inpatient routine service cost (line 74 minu					0	1
00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp			*.	us line 70)	0	1
00	Inpatient routine service costs for comp		ost iiiiii tatiO	(10 1111111	us 11110 /7)	0. 00	
00	Inpatient routine service cost limitation (I)			0	82.
00	Reasonable inpatient routine service costs (•			0	1

0 84.00

0 85.00

0 86.00

0 87.00 0.00 88.00

84.00

85.00

86.00

PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions)
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)

Program inpatient ancillary services (see instructions)
Utilization review - physician compensation (see instructions)
Total Program inpatient operating costs (sum of lines 83 through 85)

Health Financial Systems	CHILDRENS SPECIA	LIZED HOPSITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (CCN: 31-5239	From 01/01/2023 To 12/31/2023		
		Title	XVIII	Skilled Nursing	PPS	
				Facility		
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	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	H COST					
90.00 Capital-related cost	0	0	0.00000	0 0	0	90. 00
91.00 Nursing Program cost	o	0	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	0	0. 00000	0	0	92.00
93.00 All other Medical Education	0	0	0. 00000	0	0	93. 00

Health Financial Systems	CHILDRENS SPECIALIZED HOPSITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 31-3300	Peri od: From 01/01/2023		
		To 12/31/2023	Date/Time Prep 5/8/2024 9:17	
	Title XIX	Hospi tal	TEFRA	
Cost Center Description	•		1 00	

Description Part All Proviving Components			Title XIX	Hospi tal	5/8/2024 9: 17 TEFRA	am	
PART I - ALL PROVIDER COMPONENTS IMPATTIENT DAYS Inpattent days (including private room days and swing-bed days, excluding newborn) 1.00 Inpattent days (including private room days, excluding swing-bed and newborn days) 1.00 Inpattent days (including private room days, excluding swing-bed and newborn days) 1.00 Inpattent days (including private room days, excluding swing-bed and observation bed days) 1.00 Inpattent days (including private room days) 1.00 Inpattent days (excluding swing-bed and observation bed days) 1.00 Inpattent days (excluding swing-bed and observation bed days) 1.00 Inpattent days (excluding swing-bed and observation bed days) 1.00 Inpattent days (excluding swing-bed and observation bed days) 1.00 Inpattent days (excluding swing-bed and observation bed days) 1.00 Inpattent days (excluding private room days) after December 31 of the cost reporting period (if rollendar year, enter 0 on this line) 1.00 Inpattent days including private room days) through becember 31 of the cost reporting period (if rollendar year, enter 0 on this line) 1.00 Inpattent days including private room days) after Becember 31 of the cost reporting period (if rollendar year, enter 0 on this line) 1.00 Inpattent days including private room days) 1.00 Inpattent days including private room days applicable to the Program (excluding swing-bed and 1,942 Inpattent days including private room days) 1.00 Inpattent days including private room days applicable to the Program (excluding swing-bed and 1,942 Inpattent days including private room days) 1.00 Inpattent days including private room days applicable to the Program (excluding private room days) 1.00 Inpattent days including private room days applicable to title XVIII only (including private room days) 1.00 Inpattent days including private room days applicable to title XVIII only (including private room days) 1.00 Inpattent days including private room days applicable to title XVIII only (including private room days) 1.00 Inpattent days including private room days applicable to		Cost Center Description	THE WAY	noop: tai			
INPATIENT DAYS		PART I - ALL PROVIDER COMPONENTS			1.00		
19,803 1, Impatrient days (Including private room days, excluding saing-bed and newborn days) 19,803 2, 0 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,						1	
Private room days (excluding swing-bed and observation bed days). If you have only private room days. 4. 6 on not complete this line. 4.00 Semi-private room days (excluding swing-bed and observation bed days). 17 you have only private room days. 4. 6 Semi-private room days (excluding private room days). 19.803 4. 6 Semi-private room days (excluding private room days). 19.803 4. 6 Semi-private room days (excluding private room days). 19.803 4. 6 Semi-private from the cost reporting period (if calendary syer, enter 0 on this line). 19.803 19.8							
do not complete this time. 10. Osen private room days (excluding swing-bed and observation bed days) 10. Total swing-bed SNP type inpatient days (including private room days) through December 31 of the cost or sporting period 10. Osen provides the swing-bed SNP type inpatient days (including private room days) after December 31 of the cost or sporting period 10. Osen provides the swing-bed SNP type inpatient days (including private room days) after December 31 of the cost reporting period 10. Osen provides the swing-bed NP type inpatient days (including private room days) after December 31 of the cost reporting period 10. Osen provides the swing-bed NP type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 10. Osen provides the swing-bed NP type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 11. Oswing-bed NP type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 12. Oswing-bed NP type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 13. Oswing-bed NP type inpatient days applicable to titles V or XIX only (including private room days) 14. Office December 31 of the cost reporting period (if callendar year, enter 0 on this line) 15. Oswing-bed NP type inpatient days applicable to titles V or XIX only (including private room days) 16. Oswing-bed NP type inpatient days applicable to title SV or XIX only (including private room days) 17. Oswing-bed SNP type inpatient days applicable to services after December 31 of the cost reporting period (including private room days) 18. Oswing-bed SNP type inpatient days applicable to services after December 31 of the cost reporting period (including private room privat							
4.00 Semi-private room days (excluding swing-bed and observation bed days) 5.00 Total swing-bed SNT type Inpatient days (Including private room days) after December 31 of the cost reporting period (1 cal endar year, enter 0 on this line) 7.00 Total swing-bed NT type inpatient days (Including private room days) after December 31 of the cost reporting period (1 cal endar year, enter 0 on this line) 7.00 Total swing-bed NT type inpatient days (Including private room days) after December 31 of the cost reporting period (1 cal endar year, enter 0 on this line) 7.01 Total swing-bed NT type inpatient days (Including private room days) after December 31 of the cost reporting period (1 cal endar year, enter 0 on this line) 7.02 Total swing-bed NT type inpatient days applicable to the Program (excluding swing-bed and newborn days) SN type inpatient days applicable to the Program (excluding swing-bed and newborn days) SN type inpatient days applicable to this XVIII only (Including private room days) after 0 chrough December 31 of the cost reporting period (see instructions) 7.02 Swing-bed NST type inpatient days applicable to this XVIII only (Including private room days) after 0 chrough December 31 of the cost reporting period (see instructions) 7.03 Swing-bed NST type inpatient days applicable to this XVIII only (Including private room days) after 0 chrough December 31 of the cost reporting period (see instructions) 7.03 Swing-bed NST type inpatient days applicable to this XVIII only (Including private room days) after December 31 of the cost reporting period (including private room days) 7.04 Swing-bed NST type inpatient days applicable to the Program (excluding swing-bed days) 7.05 Swing-bed NST type inpatient days applicable to the Program (excluding swing-bed days) 7.06 Swing-bed NST type inpatient days applicable to services after December 31 of the cost reporting period (Including private room days) 8.01 Swing-bed cost applicable to SWF services applicable to services after December 31 of the cost reporting period	3.00						
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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) 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) 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) Total swing-bed NF type inpatient days applicable to the Program (excluding swing-bed and newborn days) (see Instructions) Total period (if calendar year, enter 0 on this line) Through December 31 of the cost reporting period (see instructions) Through December 31 of the cost reporting period (see instructions) Through December 31 of the cost reporting period (see instructions) Through December 31 of the cost reporting period (if calendar year, enter 0 on this line) Through December 31 of the cost reporting period (if calendar year, enter 0 on this line) Through December 31 of the cost reporting period (if calendar year, enter 0 on this line) Through December 31 of the cost reporting period (if calendar year, enter 0 on this line) Through December 31 of the cost reporting period (if calendar year, enter 0 on this line) Through December 31 of the cost reporting period (if calendar year, enter 0 on this line) Through December 31 of the cost reporting period (if calendar year, enter 0 on this line) Through December 31 of the cost reporting period (if calendar year, enter 0 on this line) Through December 31 of the cost reporting period (if calendar year, enter 0 on this line) Through December 31 of the cost reporting period (in a private room days) applicable to services after December 31 of the cost reporting period (in a private room days) Through December 31 of the cost reporting period (in a private room days) Through December 31 of the cost reporting period (in a private room single-bed NF services applicable to services after D	5.00		om days) through Decembe	r 31 of the cost	0	5. 00	
reporting period (if calendar year, enter 0 on this line) 7.0 Total swing-bed Nr type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.0 Total inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10.0 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newtorn days) (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 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) 12.00 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) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) of through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 15.00 Total nursery days (title V or XIX only) 0 15.00 Total nursery days (title V or XIX only) 0 15.00 Multisery days (title V or XIX only) 0 15.00 Multisery days (title V or XIX only) 0 15.00 Multisery days (title V or XIX only) 0 15.00 Multisery days (title V or XIX only) 0 15.00 Multisery days (title V or XIX only) 0 15.00 Multisery days (title V or XIX only) 0 15.00 Multisery days (title V or XIX only) 0 15.00 Multisery days (title V or XIX only) 0 15.00 Multisery days (title V or XIX only) 0 15.00 Multisery days (title V or XIX only) 0 15.00 Multisery 0 15.00 Multiser	4 00		om days) after December	21 of the cost		4 00	
7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost of reporting period (if calendar year, enter 0 on this line) 10-10 Total inpatient days including private room days) after December 31 of the cost on reporting period (if calendar year, enter 0 on this line) 10-10 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newtorn days) 10-10 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 10-10 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 3fter 11-10 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 3fter 11-10 Swing-bed SMF type inpatient days applicable to titles Vor XIX only (including private room days) 4fter 11-10 Swing-bed SMF type inpatient days applicable to titles Vor XIX only (including private room days) 4fter 11-10 Swing-bed SMF type inpatient days applicable to titles Vor XIX only (including private room days) 4fter 11-10 Swing-bed SMF type inpatient days applicable to titles Vor XIX only (including private room days) 4fter 11-10 Swing-bed SMF type inpatient days applicable to titles Vor XIX only (including private room days) 4fter 11-10 Swing-bed SMF type inpatient days applicable to titles Vor XIX only (including private room days) 4fter December 31 of the cost reporting period (if calendar year, enter 0 on this line) 4fter 11-10 Swing-bed SMF type services applicable to services through December 31 of the cost 11-10 Swing-bed SMF services applicable to services through December 31 of the cost 11-10 Swing-bed SMF services applicable to services after December 31 of the cost 11-10 Swing-bed Cost applicable to SMF type services through December 31 of the cost 11-10 Swing-bed Cost applicable to SMF type services after December 31 of the cost reporting period (line 11-10 Swing-bed cost applicable to SMF type services through December 31 of the cost reporting period (0.00		on days) at tel becember .	of the cost		8.00	
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line)	7.00	Total swing-bed NF type inpatient days (including private roor	m days) through December	31 of the cost	0	7. 00	
reporting period (If calendar year, enter 0 on this line) 1,942 9.0 1,942 9.0 1,943 1.0 1,944 1.0 1,944 1.0 1,945 1	9 00		m days) after December 2	1 of the cost	0	0 00	
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23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average private room per diem charge (line 29 + line 3) 30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Private room cost differential adjustment (line 3 x line 35) 30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 38, 283, 089) 30.00 PRIVATE ROOM DIFFERNTIAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				ing period (line		1	
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7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 RIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 Semi-private room charges (excluding swing-bed and observation bed charges) 90.00 Semi-private room charges (excluding swing-bed charges) 91.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 92.00 Semi-private room charges (excluding swing-bed charges) 93.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 94.00 Average private room per diem charge (line 29 ÷ line 3) 95.00 Average semi-private room per diem charge (line 30 ÷ line 4) 96.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 97.00 Average per diem private room cost differential (line 34 x line 31) 98.00 Average per diem private room cost differential (line 34 x line 31) 99.00 Average per diem private room cost differential (line 34 x line 35) 90.00 Average per diem private room cost differential (line 3 x line 35) 90.00 Average per diem private room cost differential (line 3 x line 35) 90.00 Average per diem private room cost differential (line 3 x line 35) 90.00 Average per diem private room cost differential (line 38 x line 35) 90.00 Average per diem private room cost differential (line 38 x line 35) 90.00 Average per diem private room cost differential (line 38 x line 35) 90.00 Average per diem private room cost differential (line 38 x line 35) 90.00 Average per diem private room cost differential (line 38 x line 35) 90.00 Average per diem private room cost differential (line 38 x line 35)	23.00		31 of the cost reporting	g period (iine 6		23.00	
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 34.00 Average semi-private room per diem charge (line 30 ÷ line 4) 35.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 38, 283, 089) 27.00 Average per diem private room cost differential (line 34 x line 31) 38.283, 089 29.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 39.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 35) 30.00 Private room cost differential adjustment (line 3 x line 35) 30.00 Average per diem private room cost differential (line 32 minus line 36) 30.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	24. 00		r 31 of the cost reporti	ng period (line	0	24. 00	
Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 38, 283, 089) PRAT II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	25. 00	l	31 of the cost reporting	period (line 8	О	25. 00	
27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32. 00 Average private room per diem charge (line 29 ÷ line 3) 33. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 34. 00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 38, 283, 089) PART II - HOSPITAL AND SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					_		
PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 29. 00 Pri vate room charges (excluding swing-bed charges) 0 29. 03 30. 00 Semi-private room charges (excluding swing-bed charges) 0 30. 03 31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 0 .000000 32. 00 Average pri vate room per diem charge (line 29 ÷ line 3) 0 .000 33. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 0 .000 34. 00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 0 .000 35. 00 Average per diem private room cost differential (line 34 x line 31) 0 .000 35. 00 Average per diem private room cost differential (line 3 x line 35) 0 .000 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 38, 283, 089) PART II - HOSPITAL AND SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			(line 21 minus line 26)		1		
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 30.00 Average private room per diem charge (line 29 ÷ line 3) 30.00 Average semi-private room per diem charge (line 30 ÷ line 4) 30.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Private room cost differential adjustment (line 3 x line 35) 30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 38, 283, 089) 30.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	27.00		(TITIE 21 IIITIUS TITIE 20)		30, 203, 009	27.00	
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 38, 283, 089) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	28. 00		d and observation bed ch	arges)	0	28. 00	
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 38, 283, 089) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					1		
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 38, 283, 089) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			1: 00)		-		
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 38, 283, 089) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			÷ IIne 28)			1	
34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 38, 283, 089) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS						1	
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 38, 283, 089 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		, , , , , , , , , , , , , , , , , , , ,	aus line 22)(see instrue	tions)		1	
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 38, 283, 089 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		, , , , , , , , , , , , , , , , , , , ,		LI UIIS)		1	
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 38, 283, 089 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		, , ,	ic 51)			1	
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		,	and private room cost di	fferential (line			
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		27 minus line 36)	,		1, 12, 23,]	
			ICTUENTO			1	
	20.00				1 000 00	20.00	
		, , , , , , , , , , , , , , , , , , , ,	•				
		, , ,	•			1	
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 3,754,274 41.0		, , , , , , , , , , , , , , , , , , , ,	,		-		

COMPUT	ATION OF INPATIENT OPERATING COST		Provi der (eriod: rom 01/01/2023	Worksheet D-1	
				T			
			Ti t	le XIX	Hospi tal	5/8/2024 9: 17 TEFRA	am
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	SDiem (col. 1 ÷ col. 2)		(col. 3 x col. 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
12. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42. 00
13. 00	INTENSIVE CARE UNIT						43. 00
14.00	CORONARY CARE UNIT						44.00
	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
<u> 17. 00</u>	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
	Program inpatient ancillary service cost (Wk					1, 517, 978	1
	Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines				column 1)	0 5, 272, 252	
17.00	PASS THROUGH COST ADJUSTMENTS	41 till ough 40.	or) (see Thisti d	cti ons)		5, 212, 252	47.00
50. 00	Pass through costs applicable to Program inp III)	atient routine	services (fro	m Wkst. D, sum	of Parts I and	77, 971	50. 00
51. 00	Pass through costs applicable to Program inp	atient ancilla	y services (f	rom Wkst. D, su	m of Parts II	57, 587	51. 00
- 00	and IV)	FO F1)				125 550	F2 00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		elated, non-ph	ysician anesthe	tist, and	135, 558 5, 136, 694	1
	medical education costs (line 49 minus line				·		
4. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					31	54.00
55. 00	Target amount per discharge					142, 300. 92	55. 00
	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor	use only)				0. 00 0. 00	1
6. 00	Target amount (line 54 x sum of lines 55, 55	. 01, and 55. 02)				4, 411, 329	1
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and to	arget amount (line 56 minus l	ine 53)	-725, 365 0	1
59. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	n the cost rep	orting period e	ndi ng 1996,	0.00	1
60. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,	or line EE fr	om prior year	cost report up	dated by the	0.00	60.00
JU. UU	market basket)	of Title 55 Tre	om prior year	cost report, up	dated by the	0.00	00.00
51. 00	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les					0	61. 00
	53) are less than expected costs (lines 54 \times						
62. 00	enter zero. (see instructions) Relief payment (see instructions)					142, 116	62. 00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instr	uctions)			4, 689, 003	1
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Door	ombor 21 of th	o cost roportin	a port od (Soo	0	64. 00
34.00	instructions) (title XVIII only)	ts through become	silber 31 Of th	e cost reporting	g perrou (see		04.00
55. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decemb	per 31 of the	cost reporting	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVIII	only); for	0	66. 00
57. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	e costs through	n December 31	of the cost ren	orting period	0	67. 00
77.00	(line 12 x line 19)	ŭ		·	0 .	Į	
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13×1 ine 20)	e costs after l	December 31 of	the cost repor	ting period	0	68. 00
9. 00	Total title V or XIX swing-bed NF inpatient	routine costs	(line 67 + line	e 68)		0	69. 00
70 00	PART III - SKILLED NURSING FACILITY, OTHER N						70.00
	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c						70.00
	Program routine service cost (line 9 x line		. (1: 14)	: 25)			72.00
4.00	Medically necessary private room cost applic Total Program general inpatient routine serv		•	,			73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient	routine service	e costs (from	Worksheet B, Pa	rt II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 \times line	76)					77. 00
	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces	,	orovi den recon	ds)			78. 00 79. 00
	Total Program routine service costs for comp				s line 79)		80.00
31. 00 32. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		1)				81. 00 82. 00
	Reasonable inpatient routine service costs (*				83. 00
84. 00	Program inpatient ancillary services (see in						84. 00
	Utilization review - physician compensation	(coo i mo+	nc)				85 00

Health Financial Systems CH	HILDRENS SPECIA	LIZED HOPSITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023		
		Ti tl	e XIX	Hospi tal	TEFRA	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(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	795, 049	38, 283, 089	0. 02076	8 0	0	90.00
91.00 Nursing Program cost	0	38, 283, 089	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	38, 283, 089	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	38, 283, 089	0. 00000	0	0	93. 00

	LDRENS SPECIALIZED HOPSITAL	•	eu of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 31-3300	Peri od:	Worksheet D-3	
		From 01/01/2023 To 12/31/2023		nared:
		10 12/31/2023	5/8/2024 9: 17	
	Title XIX	Hospi tal	TEFRA	
Cost Center Description	Ratio of Cos	st Inpatient	I npati ent	
	To Charges		Program Costs	
		Charges	(col. 1 x col.	
			2)	
	1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				1
30. 00 03000 ADULTS & PEDI ATRI CS		9, 101, 400		30.00
ANCI LLARY SERVI CE COST CENTERS				1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 1392			
60. 00 06000 LABORATORY	0. 0022	· ·	153	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.0000		1	62. 30
65. 00 06500 RESPI RATORY THERAPY	0. 2484			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 7869	· ·		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 6149	· ·		67.00
68. 00 06800 SPEECH PATHOLOGY	0. 4551	· ·	314, 861	68.00
68. 01 06801 PEDS FEEDING DISORDER RU CARES	0. 4876	17 0	0	68. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1. 4335			71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1. 5658		435, 077	73.00
76. 00 03550 MEDI CAL SERVI CES	4, 515. 1829	41 0	0	76. 00
76. 01 03950 PSYCHI ATRI C	0. 6703	86 5, 607	3, 759	76. 01
76. 02 03020 SEVERE BEHAVI OR	0. 6107	07 0	0	76. 02
76. 97 07697 CARDI AC REHABI LI TATI ON	0.0000	00 0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0.0000	00 0	0	76. 98
76. 99 07699 LI THOTRI PSY	0.0000	00 0	0	76. 99
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0.0000	00 0	0	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0.0000	00 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 5385	05 0	0	1 ,0.00
90. 01 09001 PEDS PRIMARY CARE CLINIC	0.0000	00	0	, , , , , ,
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.0000	00	0	1 , 2 . 00
93. 00 04950 SCHOOL BASED PROGRAMS	0.0000		0	, , , , , ,
02 01 040E1 OTHER OUTDATHENT CERVICE COCT CENTER	0.0000	00 0		00 01

0.000000

2, 731, 905

0 93. 01

0 1, 517, 978 200. 00

93. 99

201. 00 202. 00

93. 01 04951 OTHER OUTPATIENT SERVICE COST CENTER

Net charges (line 200 minus line 201)

202.00

93.01 0495101HER 001PATIENT SERVICE COST CENTER
93.99 09399 PARTIAL HOSPITALIZATION PROGRAM
200.00 Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)

Health Financial Systems	CHILDRENS SPECIALIZED HOPSITAL		In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN:	31-3300	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/8/2024 9:17 am
	T1.11. 10			1

	Title XVIII Hospital	5/8/2024 9: 17 TEFRA	_am
	PART B - MEDICAL AND OTHER HEALTH SERVICES	1.00	
1. 00 2. 00 3. 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructions) OPPS or REH payments	74 10, 006 4, 626	
4. 00 4. 01 5. 00 6. 00	Outlier payment (see instructions) Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instructions) Line 2 times line 5	0 0 0. 961 9, 616	4. 00 4. 01 5. 00 6. 00
7. 00 8. 00 9. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions) Ancillary service other pass through costs including REH direct graduate medical education costs from	48. 11 4, 990 0	7. 00 8. 00
10. 00 11. 00	Wkst. D, Pt. IV, col. 13, line 200 Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)	0 74	10. 00 11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges		
12. 00 13. 00 14. 00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) Total reasonable charges (sum of lines 12 and 13)	138 0 138	
15. 00 16. 00	Customary charges Aggregate amount actually collected from patients liable for payment for services on a charge basis Amounts that would have been realized from patients liable for payment for services on a chargebasis	0	15. 00 16. 00
	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)	0. 000000 138	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	64	
20. 00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
22. 00	Lesser of cost or charges (see instructions) Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instructions) Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	74 0 0 9,616	22. 00 23. 00
25. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions)	0	
26. 00 27. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1, 802 7, 888	26. 00
28. 00 28. 50 29. 00	Direct graduate medical education payments (from Wkst. E-4, line 50) REH facility payment amount (see instructions) ESRD direct medical education costs (from Wkst. E-4, line 36)	0	28. 00 28. 50 29. 00
30. 00 31. 00 32. 00	Subtotal (sum of lines 27, 28, 28.50 and 29) Primary payer payments Subtotal (line 30 minus line 31)	7, 888 0 7, 888	31. 00
33. 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11)	0	
34. 00 35. 00	Adjusted reimbursable bad debts (see instructions)	0 0	35. 00
36. 00 37. 00	Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions)	0 7, 888	1
38. 00	MSP-LCC reconciliation amount from PS&R	0	38. 00
39. 00 39. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)	0	39. 00 39. 50
39. 75 39. 97	N95 respirator payment adjustment amount (see instructions) 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. 99 40. 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)	0 7, 888	39. 99 40. 00
41. 00	Interim payments	2, 767	41. 00
41.01	Interim payments-PARHM Tentative settlement (for contractors use only)	О	41. 01 42. 00
42. 01 43. 00	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions)	4, 963	42. 01 43. 00
43. 01 44. 00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	43. 01
00.00	TO BE COMPLETED BY CONTRACTOR		00.00
	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)	0 0	
92. 00 93. 00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)	0.00	1
	Total (sum of lines 91 and 93)		94.00

Health Financial Systems	CHILDRENS SPECIALIZ	ED HOPSITAL	In Lie	u of Form CMS-	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 31-3300	Peri od:	Worksheet E	
			From 01/01/2023		
			To 12/31/2023	Date/Time Pro	epared:
				5/8/2024 9: 17	<u>7 am </u>
		Title XVIII	Hospi tal	TEFRA	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days					200. 00

In Lieu of Form CMS-2552-10

Period:	Worksheet E-1
From 01/01/2023	Part
To 12/31/2023	Date/Time Prepared:
5/8/2024 9:17 am Health Financial Systems CHILDR ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 31-3300	

Interfim 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						5/8/2024 9: 17	am
1.00			Titl∈	XVIII	Hospi tal	TEFRA	
1.00 Total Interim payments paid to provider 1.00 2.00 3.00 4.00 2.767 1.00 1.00 1.00 1.00 1.00 2.00 3.00 4.00 2.767 1.00 2.00 1.00 1.00 1.00 2.767 1.00 2.00 1.00 1.00 2.767 1.00 2.00 1.00 2.00 2.00 1.00 2.00 1.00 2.00 2.00 1.00 2.0			I npati er	t Part A	Par	t B	
1.00 Total interim payments paid to provider 0 0 2,767 1.00 0 0 0 0 0 0 0 0 0			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
Interfim 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 cost reporting period. If none, write "NoNE" or enter a zero cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			1.00	2.00	3. 00	4.00	
Submitted for to be Submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero	1.00	Total interim payments paid to provider			0	2, 767	1. 00
Services rendered in the cost reporting period. If none, write "NONE" or enter a zero to the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	2.00	Interim payments payable on individual bills, either			0	0	2.00
write "NONE" or enter a zero							
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) Program to Provider							
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) Program to Provider 3.01 3.02 3.03 3.03 3.04 3.05 8 9 Provider to Program 3.50 ADJUSTMENTS TO PROVIDER 0 0 0 3.00 3.03 3.51 5.51 5.52 9 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 0 3.50 3.55 3.54 0 0 0 0 3.55 3.55 0 0 0 0 3.55 3.55 3.54 0 0 0 0 3.55 3.55 3.54 0 0 0 0 3.55 3.55 3.54 0 0 0 0 3.55 3.55 3.54 0 0 0 0 3.55 3.55 3.54 0 0 0 0 3.55 3.55 3.55 0 0 0 0 3.55 3.56 3.50 0 0 0 0 3.55 3.50 3.50 3.50 3.50 3.50 3.50 3.50							
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	3.00						3. 00
payment. If none, write "NONE" or enter a zero. (1)							
Program to Provider							
ADJUSTMENTS TO PROVIDER							
3.02 0	3 01					0	3 01
3.03 0		ADJUSTWIENTS TO TROVIDER					
3.04 0 0 0 3.04 3.05 3.05 3.50 3.							
3.05 Provider to Program							
Provider to Program ADJUSTMENTS TO PROGRAM 0							3. 05
3. 50 ADJUSTMENTS TO PROGRAM 0 0 0 3. 50 3. 51 3. 52 0 0 0 0 3. 53 3. 54 0 0 0 3. 55 3. 50 3. 50 3. 50 3. 50 3. 50 3. 50 3. 50 3. 50 3. 50 3. 50 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) To BE COMPLETED BY CONTRACTOR		Provider to Program				_	
3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 3.50-3.98) 3.50-3.98) 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) To BE COMPLETED BY CONTRACTOR	3.50				0	0	3. 50
3.53 3.54 0	3.51				0	o	3. 51
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 0 0 0 3.54 3.99 3.50-3.98) 0 0 0 2.767 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR	3.52				0	0	3. 52
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	3.53				0	0	3. 53
3.50-3.98 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR					0	0	3. 54
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) TO BE COMPLETED BY CONTRACTOR	3. 99				0	0	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR							
appropriate TO BE COMPLETED BY CONTRACTOR	4. 00				0	2, 767	4. 00
TO BE COMPLETED BY CONTRACTOR S. 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) Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	5 00			1			5 00
Write "NONE" or enter a zero. (1) Program to Provider	5.00						5.00
Program to Provider							
TENTATI VE TO PROVIDER		Program to Provider		l.			
Solution Solution	5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
Provider to Program	5.02				0	o	5. 02
TENTATI VE TO PROGRAM 0	5.03				0	0	5. 03
5.51 0		Provider to Program					
5.52 0		TENTATI VE TO PROGRAM					5. 50
5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00	5. 51				0	0	5. 51
5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00					-	- 1	5. 52
the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00	5. 99	,			0	0	5. 99
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	6. 00						6. 00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	4 01					4.043	4 01
7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00							
Contractor NPR Date Number (Mo/Day/Yr) 0 1.00 2.00						- 1	
Number (Mo/Day/Yr) 0 1.00 2.00	7.00	Total medicale program frability (see instructions)					7.00
0 1.00 2.00							
				0			
	8. 00	Name of Contractor					8. 00

Health Financial Systems	CHILDRENS SPECIALIZED HOPSITAL	In Lieu of Form CMS-2552-10		
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 31-3300	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part I Date/Time Prepared: 5/8/2024 9:17 am	

			10 12/31/2023	5/8/2024 9: 17	
		Title XVIII	Hospi tal	TEFRA	
				1. 00	
	PART I - MEDICARE PART A SERVICES - TEFRA				
1.00	Inpatient hospital services (see instructions)			0	1. 00
1.01	Nursing and allied health managed care payment (see instruction	s)		0	1. 01
2.00	Organ acqui si ti on			0	2. 00
3.00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	3. 00
4.00	Subtotal (sum of lines 1 through 3)			0	4. 00
5.00	Primary payer payments			0	5. 00
6.00	Subtotal (line 4 less line 5).			0	6. 00
7.00	Deducti bl es			0	7. 00
8.00	Subtotal (line 6 minus line 7)			0	8. 00
9.00	Coi nsurance			0	9. 00
10.00	Subtotal (line 8 minus line 9)			0	
	Allowable bad debts (exclude bad debts for professional service:	s) (see instructions)		0	1
	Adjusted reimbursable bad debts (see instructions)			0	12. 00
	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		0	1
14.00	Subtotal (sum of lines 10 and 12)			0	1 00
15. 00	Direct graduate medical education payments (from Wkst. E-4, line	e 49)		0	1
	DO NOT USE THIS LINE				16. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instructions)			0	1
	Recovery of accelerated depreciation.			0	1
	Demonstration payment adjustment amount before sequestration			0	
18. 00	Total amount payable to the provider (see instructions)			0	
18. 01	Sequestration adjustment (see instructions)			0	
18. 02	Demonstration payment adjustment amount after sequestration			0	1
	Interim payments			0	
20.00	Tentative settlement (for contractor use only)			0	
21. 00	Balance due provider/program (line 18 minus lines 18.01, 18.02,			0	
22. 00	Protested amounts (nonallowable cost report items) in accordance §115.2	e with CMS Pub. 15-2,	chapter 1,	0	22. 00

	Financial Systems CHILDRENS SPECIA			u of Form CMS-	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 31-3300	Peri od:	Worksheet E-3	
		Component CCN: 31-5239	From 01/01/2023 To 12/31/2023		nared·
		Compenent Con. 31 3237	10 12/31/2023	5/8/2024 9: 17	
		Title XVIII	Skilled Nursing	PPS	
			Facility Facility		
	DADT VI CALCULATION OF DELADURGEMENT CETTLEMENT ALL	OTHER HEALTH CERVICES FOR T	TITLE WILL DART A	1. 00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL SERVICES	OTHER HEALTH SERVICES FOR I	TILE XVIII PART A	A PPS SNF	
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				1
1. 00	Resource Utilization Group Payment (RUGS)			0	1.00
2.00	Routine service other pass through costs			0	2.00
3.00	Ancillary service other pass through costs			0	3.00
4.00	Subtotal (sum of lines 1 through 3)			0	4. 00
	COMPUTATION OF NET COST OF COVERED SERVICES				1
5.00	Medical and other services (Do not use this line as vaccin	e costs are included in lin	ne 1 of W/S E,		5. 00
	Part B. This line is now shaded.)				
6.00	Deducti bl e			0	6. 00
7.00	Coi nsurance			0	,
8.00	Allowable bad debts (see instructions)			0	
9.00	Reimbursable bad debts for dual eligible beneficiaries (se	e instructions)		0	
10.00	Adjusted reimbursable bad debts (see instructions)			0	1
11.00	Utilization review	40 1437	,	0	1
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus line	s 10 and 11)(see instruction	ons)	0	12.00
	Inpatient primary payer payments			0	1
	Pioneer ACO demonstration payment adjustment (see instruct Recovery of accelerated depreciation.	i ons)		0	
	Demonstration payment adjustment amount before sequestrati	on		0	
	Subtotal (see instructions	011		0	
	Sequestration adjustment (see instructions)			0	
	Domonstration nayment adjustment amount after sequestration	0			

15. 02

15.75

0 16. 00 17. 00

0 18.00 19.00

Demonstration payment adjustment amount after sequestration

16.00 Interim payments
17.00 Tentative settlement (for contractor use only)

Sequestration for non-claims based amounts (see instructions)

18.00 Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)
19.00 Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1,

15. 75

Health Financial Systems	CHILDRENS SPECIALIZED HOPSITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 31-3300	From 01/01/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/8/2024 9:17 am

			To 12/31/2023	Date/Time Prep 5/8/2024 9:17	
		Title XIX	Hospi tal	TEFRA	aiii
		II ti c xi x	Inpati ent	Outpati ent	
			1, 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICE	S FOR TITLES V OR XI		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	TO TON TITLES TON M	,, oz.,,,, ozo		
1.00	Inpatient hospital/SNF/NF services		4, 689, 003		1. 00
2. 00	Medical and other services		1, 221, 222	5, 346, 537	2. 00
3.00	Organ acquisition (certified transplant programs only)		О	., ,	3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		4, 689, 003	5, 346, 537	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)		4, 689, 003	5, 346, 537	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		9, 101, 400		8. 00
9.00	Ancillary service charges		2, 731, 905	8, 259, 833	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)		11, 833, 305	8, 259, 833	12. 00
	CUSTOMARY CHARGES				
13. 00	Amount actually collected from patients liable for payment for ser	rvices on a charge	0	0	13. 00
	basis				
14. 00	Amounts that would have been realized from patients liable for pay		0	0	14. 00
15. 00	a charge basis had such payment been made in accordance with 42 CF	-R 9413. 13(e)	0. 000000	0. 000000	15. 00
16. 00	Ratio of line 13 to line 14 (not to exceed 1.000000) Total customary charges (see instructions)		11, 833, 305	8, 259, 833	16. 00
17. 00	Excess of customary charges over reasonable cost (complete only if	Fline 16 exceeds	7, 144, 302	2, 913, 296	17. 00
17.00	line 4) (see instructions)	Title to exceeds	7, 144, 302	2, 713, 270	17.00
18. 00	Excess of reasonable cost over customary charges (complete only if	Fline 4 exceeds line	0	0	18. 00
10.00	16) (see instructions)	Time 4 exceeds fine	ĭ	O	10.00
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instructi	ons)	o	0	20. 00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		4, 689, 003	5, 346, 537	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be comp	leted for PPS provid	ers.		
22. 00	Other than outlier payments	•	0	0	22. 00
23.00	Outlier payments		O	0	23. 00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
	Routine and Ancillary service other pass through costs		0	0	
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)		4, 689, 003	5, 346, 537	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		1		
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)		4, 689, 003	5, 346, 537	
32. 00	Deducti bl es		0	0	32. 00
	Coinsurance		0	0	33.00
34. 00	Allowable bad debts (see instructions)		0	0	34.00
35. 00	Utilization review		4 (00 000	F 247 F27	35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	1	4, 689, 003	5, 346, 537	36. 00 37. 00
38. 00	D3 ADJUSTMENT Subtotal (line 36 ± line 37)		4, 689, 003	517, 690 5, 864, 227	38.00
	Direct graduate medical education payments (from Wkst. E-4)		4, 009, 003	3, 004, 227	39. 00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)		4, 689, 003	5, 864, 227	40. 00
41. 00	Interim payments		7, 130, 016	5, 864, 227	
41.00	Balance due provider/program (line 40 minus line 41)		-2, 441, 013	337, 781	41.00
43. 00	Protested amounts (nonallowable cost report items) in accordance w	with CMS Pub 15-2	-2, 441, 013	337, 761	43. 00
73.00	chapter 1, §115.2	VI CII ONIO I UD 13-Z,		U	73.00
	1 Fr		'	l	1

	` '	Provider CC	N: 31-3300	Peri od:	worksheet E-4	
MEDI CA	AL EDUCATION COSTS			From 01/01/2023 To 12/31/2023		
		Title	XVIII	Hospi tal	TEFRA	
					1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1. 00	Unweighted resident FTE count for allopathic and osteopathic prending on or before December 31, 1996.	rograms for	cost reporti	ng periods	0.00	1. 00
1. 01	FTE cap adjustment under §131 of the CAA 2021 (see instructions	0.00				
2. 00 2. 26	Unweighted FTE resident cap add-on for new programs per 42 CFR Rural track program FTE cap limitation adjustment after the cap				0. 00 0. 00	1
2. 20	the CAA 2021 (see instructions)	p-barraring v	WITHOUT CIOSEC	duluel 3127 of	0.00	2.20
3. 00	Amount of reduction to Direct GME cap under section 422 of MMA		0.110 70 ()		0.00	•
3. 01	Direct GME cap reduction amount under ACA §5503 in accordance vinstructions for cost reporting periods straddling 7/1/2011)	with 42 CFR	§413.79 (m).	(see	0.00	3. 01
3. 02	Adjustment (increase or decrease) to the hospital's rural track	k FTE limita	ation(s) for	rural track	0.00	3. 02
	programs with a rural track Medicare GME affiliation agreement	in accordar	nce with 413.	75(b) and 87 FR		
4. 00	49075 (August 10, 2022) (see instructions) Adjustment (plus or minus) to the FTE cap for allopathic and os	steopathic r	orograms due	to a Medicare	0.00	4. 00
	GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))		· ·			
4. 01	ACA Section 5503 increase to the Direct GME FTE Cap (see instrustraddling 7/1/2011)	uctions for	cost reporti	ng periods	0.00	4. 01
4. 02	ACA Section 5506 number of additional direct GME FTE cap slots	(see instr	ructions for	cost reporting	0.00	4. 02
1 21	periods straddling 7/1/2011)	to under \$1	0/ of the CA	1 2021 (222	0.00	4 21
4. 21	The amount of increase if the hospital was awarded FTE cap slow instructions)	ts under 912	zo or the CAA	4 2021 (See	0.00	4. 21
5. 00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lines			nus lines 3 and	0.00	5. 00
5. 00	3.01, plus or minus line 3.02, plus or minus line 4, plus lines Unweighted resident FTE count for allopathic and osteopathic pi			vear from vour	5. 95	6. 00
3. 00	records (see instructions)	rograms ron	the current	year from your	3. 73	0.00
7. 00	Enter the lesser of line 5 or line 6		D : 0	011	0.00	7. 00
		+	Primary Care	0ther 2.00	Total 3.00	
3. 00	Weighted FTE count for physicians in an allopathic and osteopa	thi c	2.			8. 00
9. 00	program for the current year. If line 6 is less than 5 enter the amount from line 8, otherwis	se	0.0	0.00	0.00	9. 00
7. 00	multiply line 8 times the result of line 5 divided by the amount		0	0.00	0.00	7.00
	6. For cost reporting periods beginning on or after October 1,	2022, or				
10. 00	if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the current	nt year		0.00		10.00
	Unweighted dental and podiatric resident FTE count for the curr	,				1
10. 01		rent year		0.00		10. 01
11. 00	Total weighted FTE count		0. (0.00		11. 00
			0. (0.00		
11. 00	Total weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost reporting	year (see		0.00		11. 00
11. 00 12. 00 13. 00	Total weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	year (see orting	0. (0.00 0.00 0.00 0.00		11. 00 12. 00 13. 00
11. 00 12. 00	Total weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost reporting year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided by	year (see orting	0.0	0.00 0.00 0.00 0.00 0.00		11. 00 12. 00
11. 00 12. 00 13. 00 14. 00	Total weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost reporting instructions) Rolling average FTE count (sum of lines 11 through 13 divided by Adjustment for residents in initial years of new programs	year (see orting by 3).	0. (0. (00 0.00 00 0.00 00 0.00 00 0.00 00 0.00		11. 00 12. 00 13. 00 14. 00
11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00	Total weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost reporting year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided to adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new productions.	year (see orting by 3).	0. 0 0. 0 0. 0 0. 0 0. 0	00 0.00 00 0.00 00 0.00 00 0.00 00 0.00 00 0.00		11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00
11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00	Total weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost reporting year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided to adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new produstment for residents displaced by program or hospital closu Unweighted adjustment for residents displaced by program or hospital closu	year (see orting by 3).	0. (0. (0. (0. (00 0.00 00 0.00 00 0.00 00 0.00 00 0.00 00 0.00		11. 00 12. 00 13. 00 14. 00 15. 00 15. 01
11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 16. 01	Total weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost reporting year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided to adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new productions.	year (see orting by 3).	0. 0 0. 0 0. 0 0. 0 0. 0	00 0.00 00 0.00 00 0.00 00 0.00 00 0.00 00 0.00 00 0.00		11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00
11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 16. 01 17. 00 18. 00	Total weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost reporting year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided to Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new produstment for residents displaced by program or hospital closs Unweighted adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count Per resident amount	year (see orting by 3).	0. (0. (0. (0. (0. (0. (0. (0. (00 0.00 00 0.00 00 0.00 00 0.00 00 0.00 00 0.00 00 0.00 00 0.00		11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 16. 01 17. 00 18. 00
11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 01	Total weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost reporting instructions) Rolling average FTE count (sum of lines 11 through 13 divided to adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new produstment for residents displaced by program or hospital closu Unweighted adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021	year (see orting by 3).	0. 0 0. 0 0. 0 0. 0 0. 0	00 0.00 00 0.00 00 0.00 00 0.00 00 0.00 00 0.00 00 0.00 00 0.00 00 0.00		11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 01
11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 01	Total weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost reporting year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided to Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new produstment for residents displaced by program or hospital closs Unweighted adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count Per resident amount	year (see orting by 3).	0. (0. (0. (0. (0. (0. (0. (0. (00 0.00 00 0.00 00 0.00 00 0.00 00 0.00 00 0.00 00 0.00 00 0.00		11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 01
11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 01 17. 00 18. 00 18. 01 19. 00	Total weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost reporting instructions) Rolling average FTE count (sum of lines 11 through 13 divided to adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new produstment for residents displaced by program or hospital close Unweighted adjustment for residents displaced by program or hospital close Unweighted adjustment for residents displaced by program or hospital close Unweighted adjustment for residents displaced by program or hospital close Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs	year (see orting by 3). ograms ure spital	0. (0. (0. (0. (0. (0. (0. (00 0.00 00 0.00	0. 1.00	11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 16. 01 17. 00 18. 00 19. 00
11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 01	Total weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost reporting year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided to Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new produstment for residents displaced by program or hospital close Unweighted adjustment for residents displaced by program or hospital close Unweighted adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs	year (see orting by 3). ograms ure spital	0. (0. (0. (0. (0. (0. (0. (00 0.00 00 0.00	0. 1.00	11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 01
11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 01 19. 00	Total weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost reporting instructions) Rolling average FTE count (sum of lines 11 through 13 divided to Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new produstment for residents displaced by program or hospital closs Unweighted adjustment for residents displaced by program or hospital closs Unweighted adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count Per resident amount Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs Additional unweighted allopathic and osteopathic direct GME FTE Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instructions)	year (see orting by 3). ograms ure spital E resident of tions)	0. (0. (0. (0. (0. (0. (0. (00 0.00 00 0.00	0 1.00 0.00 5.95	11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 18. 00 18. 01 19. 00 20. 00
11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 16. 01 17. 00 18. 01 19. 00 20. 00 21. 00 22. 00	Total weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost reporting instructions) Rolling average FTE count (sum of lines 11 through 13 divided to adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new produstment for residents displaced by program or hospital close Unweighted adjustment for residents displaced by program or hospital close Unweighted adjustment for residents displaced by program or hospital close Adjusted rolling average FTE count Per resident amount Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs Additional unweighted allopathic and osteopathic direct GME FTE Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instruct Allowable additional direct GME FTE Resident Count (see instruct	year (see orting by 3). ograms ure spital E resident of tions)	0.0 0.0 0.0 0.0 0.0 0.0 0.0	00 0.00 00 0.00	0 1.00 0.00 5.95 0.00	11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 01 19. 00 20. 00 21. 00 22. 00
11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 16. 01 17. 00 18. 01 19. 00 20. 00 21. 00 22. 00 23. 00	Total weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost reporting instructions) Rolling average FTE count (sum of lines 11 through 13 divided to adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new produstment for residents displaced by program or hospital close Unweighted adjustment for residents displaced by program or hospital close Unweighted adjustment for residents displaced by program or hospital close Adjusted rolling average FTE count Per resident amount Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs Additional unweighted allopathic and osteopathic direct GME FTE Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instruct Allowable additional direct GME FTE Resident Count (see instruct	year (see orting by 3). ograms ure spital E resident of tions)	0.0 0.0 0.0 0.0 0.0 0.0 0.0	00 0.00 00 0.00	0 1.00 0.00 5.95 0.00	11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 18. 00 18. 01 19. 00 20. 00 21. 00 22. 00 23. 00

	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der C	CN: 31-3300	Peri od: From 01/01/2023	Worksheet E-4	ļ
MEDICAL EDUCATION COSTS				To 12/31/2023		
		Title XVIII		Hospi tal	TEFRA	
				rt Managed Care	Total	
			1, 00	2. 00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD		1.00	2.00	0.00	
. 00	Inpatient Days (see instructions) (Title XIX - see S-2 Part I)	X, line		0 0)	26.0
	3. 02, col umn 2)					
. 00			19, 8		II.	27. C
3. 00	Ratio of inpatient days to total inpatient days		0.0000	0. 000000	1	28.0
0. 00	Program direct GME amount			0 0	0	
0. 01	Percent reduction for MA DGME			3. 27	1	29.0
	Reduction for direct GME payments for Medicare Advantage			C	0	
. 00	Net Program direct GME amount				0	31. 0
					1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE	XVIII ONIV	(NIIDSI NG DD	CDAM AND DADAME		
	EDUCATION COSTS)	_ AVIII UNLI	(NUKSING FK	JORAW AND FARAWL	DICAL	
2. 00	Renal dialysis direct medical education costs (from Wkst. B, F	Pt. I. sum c	of col. 20 and	d 23. Lines 74	0	32.0
	and 94)	,		,	_	
3. 00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I	I, col. 8, s	um of lines	74 and 94)	0	33.0
. 00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			0.000000	34. (
	Medicare outpatient ESRD charges (see instructions)				0	35. (
. 00	Medicare outpatient ESRD direct medical education costs (line		5)		0	36. (
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY				
	Part A Reasonable Cost					
	Reasonable cost (see instructions)	`			0	
	Organ acquisition and HSCT acquisition costs (see instructions				0	
	Cost of physicians' services in a teaching hospital (see instr	ructions)			0	
	Primary payer payments (see instructions)			0		
. 00	Total Part A reasonable cost (sum of lines 37 through 39 minus Part B Reasonable Cost	s Title 40)				41.
2. 00					10, 080	12 (
	Primary payer payments (see instructions)				0 10,000	
	Total Part B reasonable cost (line 42 minus line 43)				10, 080	
	Total reasonable cost (sum of lines 41 and 44)				10, 080	
	Ratio of Part A reasonable cost to total reasonable cost (line	e 41 ÷ line	45)		0. 000000	
	Ratio of Part B reasonable cost to total reasonable cost (line				1. 000000	
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PAR					1
	Total program GME payment (line 31)				0	48. (
00 .	Part A Medicare GME payment (line 46 x 48) (title XVIII only)	(see instru	ictions)		0	49. (
	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)				0	50.0

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

Provider CCN: 31-3300 | Period: From 01/01/2023 | To 12/31/2023

Date/Time Prepared: 5/8/2024 9:17 am

OH y)					5/8/2024 9: 17	am
		General Fund		Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4.00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1.00	Cash on hand in banks	1, 163, 106	0	_	_	
2.00	Temporary investments	0	0	_		1
3.00	Notes receivable	0	0	0	0	3. 00
4.00	Accounts receivable	29, 074, 682		0	0	
5.00	Other receivable	74, 909, 903	1	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-5, 693, 352		0	0	
7. 00 8. 00	Inventory Prepaid expenses	1, 056, 911	0	0	0	
9. 00	Other current assets	3, 822, 397	•	0	0	
10. 00	Due from other funds	0	o o	_	ő	10.00
11. 00	Total current assets (sum of lines 1-10)	104, 333, 647	0	0		11. 00
	FIXED ASSETS					
12.00	Land	1, 115, 616	0	0	0	12. 00
13.00	Land improvements	3, 485, 763	0	0		13. 00
14. 00	Accumul ated depreciation	-2, 770, 620	1	_	_	14. 00
15. 00	Bui I di ngs	139, 146, 750	1	0		15.00
16.00	Accumulated depreciation	-49, 987, 264	1	0	0	1
17. 00 18. 00	Leasehold improvements Accumulated depreciation	31, 086, 128 -16, 852, 685	1	_	0	17. 00 18. 00
19. 00	Fi xed equi pment	41, 564, 876	1	_	0	19.00
20. 00	Accumulated depreciation	-28, 855, 957	1	_	0	20.00
21. 00	Automobiles and trucks	20,000,707		_	ő	21.00
22. 00	Accumulated depreciation	0	ō	0	Ō	22. 00
23.00	Maj or movable equipment	67, 868, 766	0	0	0	23. 00
24.00	Accumulated depreciation	-59, 206, 156	0	0	0	24. 00
25. 00	Mi nor equi pment depreci abl e	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	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	_	_	29. 00
30. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	126, 595, 217	'] 0	0	0	30.00
31. 00	Investments	1) 0	0	0	31.00
32. 00	Deposits on Leases			_		32.00
33. 00	Due from owners/officers	0		_	ő	33.00
34. 00	Other assets	51, 615, 360	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	51, 615, 360	0	0	0	35. 00
36.00	Total assets (sum of lines 11, 30, and 35)	282, 544, 224	. 0	0	0	36. 00
	CURRENT LIABILITIES					
37. 00	Accounts payable	2, 881, 594				37. 00
38. 00	Salaries, wages, and fees payable	10, 676, 943	0	0	_	38. 00
39.00	Payroll taxes payable (chart tarm)	1 200 (54	0	0	0	
40. 00 41. 00	Notes and Loans payable (short term) Deferred income	1, 298, 654		0	0	40. 00 41. 00
42. 00	Accel erated payments			0		42.00
43. 00	Due to other funds	8, 877, 471	ĺ	0	0	
44. 00	Other current liabilities	0	o o	Ö	ő	
45.00	Total current liabilities (sum of lines 37 thru 44)	23, 734, 662	. 0	0		1
	LONG TERM LIABILITIES		•			
46.00	Mortgage payable	0	0	0	_	
47. 00	Notes payable	32, 373, 365		_	_	
48. 00	Unsecured Loans	56, 853, 266	1	_		1
49. 00	Other long term liabilities	0	0		_	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	89, 226, 631			_	
51. 00	Total liabilities (sum of lines 45 and 50)	112, 961, 293	0	0	0	51.00
52. 00	CAPITAL ACCOUNTS General fund balance	169, 582, 931				52.00
53. 00	Specific purpose fund	109, 302, 931	0			53.00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			o o		55. 00
56. 00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant]	0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
	repl acement, and expansion		1			
59. 00	Total fund balances (sum of lines 52 thru 58)	169, 582, 931		0	0	
60. 00	Total liabilities and fund balances (sum of lines 51 and	282, 544, 224	0	0	0	60.00
	[59]	I	I	I	I	I

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 31-3300

					To	om 01/01/2023 12/31/2023	Date/Time Prep 5/8/2024 9:17	
		Genera	l Fund	Speci al	Pur	pose Fund	Endowment Fund	
		1.00	0.00	2.00		4.00	F 00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) NET TRANSFER OF EQUITY INT IN TRNA OF UNCONS FDN CONTRIBUTED CAPITAL CONTRIBUTED CAPITAL-UR Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	1.00 -1,158,051 -2,275,351 7,439,674 3,689,889 0 0 0 0 0 0	2. 00 165, 565, 604 -3, 678, 834 161, 886, 770 7, 696, 161 169, 582, 931		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4.00 0 0		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)		169, 582, 931			0		19. 00
	15 (********************************	Endowment Fund	PI ant	Fund				
		6.00	7. 00	8.00				
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) NET TRANSFER OF EQUITY INT IN TRNA OF UNCONS FDN CONTRIBUTED CAPITAL CONTRIBUTED CAPITAL-UR	0	0 0 0 0 0		0			1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0	0 0 0 0 0		0 0 0			10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

Health Financial Systems CHIL STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 31-3300

			10	12/31/2023	5/8/2024 9:17	
	Cost Center Description	In	pati ent	Outpati ent	Total	diii
			1. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES	<u> </u>	<u> </u>			
	General Inpatient Routine Services					
1.00	Hospi tal	8	33, 690, 905		83, 690, 905	1.00
2.00	SUBPROVI DER - I PF					2.00
3.00	SUBPROVI DER - I RF					3.00
4.00	SUBPROVI DER					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	2	27, 532, 750		27, 532, 750	7. 00
8.00	NURSING FACILITY	1	11, 666, 140		11, 666, 140	8. 00
9.00	OTHER LONG TERM CARE					9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	12	22, 889, 795		122, 889, 795	10. 00
	Intensive Care Type Inpatient Hospital Services					
11. 00	INTENSIVE CARE UNIT					11. 00
12. 00	CORONARY CARE UNIT					12. 00
13. 00	BURN INTENSIVE CARE UNIT					13. 00
14. 00	SURGI CAL INTENSIVE CARE UNIT					14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)					15. 00
16. 00	Total intensive care type inpatient hospital services (sum of I	ines	0		0	16. 00
17 00	11-15)	1.0	22 000 705		100 000 705	17 00
17. 00	Total inpatient routine care services (sum of lines 10 and 16) Ancillary services		22, 889, 795 48, 218, 189	112 142 104	122, 889, 795 160, 380, 293	17. 00 18. 00
18. 00 19. 00	Outpatient services	4	10, 210, 109	112, 162, 104	100, 360, 293	19. 00
20. 00	RURAL HEALTH CLINIC		o	0	0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21. 00
22. 00	HOME HEALTH AGENCY		O	o _l	o _l	22. 00
23. 00	AMBULANCE SERVICES					23. 00
24. 00	CMHC					24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)					25. 00
26. 00	HOSPI CE					26. 00
27. 00	OTHER (SPECIFY)		0	0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	o Wkst. 17	71, 107, 984	112, 162, 104	283, 270, 088	28. 00
	G-3, line 1)			, , , ,		
	PART II - OPERATING EXPENSES		<u> </u>			
29.00	Operating expenses (per Wkst. A, column 3, line 200)			189, 549, 882		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	T + 1 + 1 + 1		0	_		41. 00
42. 00	Total deductions (sum of lines 37-41)	(+		100 540 000		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		189, 549, 882		43. 00
	to Wkst. G-3, line 4)	1	1	I		

	Financial Systems CHILDRENS SPECIAL ENT OF REVENUES AND EXPENSES	CHILDRENS SPECIALIZED HOPSITAL Provider CCN: 31-3300		u of Form CMS-2 Worksheet G-3	
OTTTE	EIN OF REVEROES AND EAR ENGES	11001461 65.11 61 6566	Peri od: From 01/01/2023 To 12/31/2023		pared:
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, li			283, 270, 088	
2.00	Less contractual allowances and discounts on patients' accou	ınts		118, 143, 110	
3.00	Net patient revenues (line 1 minus line 2)			165, 126, 978	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	2 43)		189, 549, 882	
5.00	Net income from service to patients (line 3 minus line 4)			-24, 422, 904	5.00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	
7.00	Income from investments			1, 077, 849	
8.00	Revenues from telephone and other miscellaneous communication	on services		0	
9. 00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			11, 497	
11. 00	Rebates and refunds of expenses			0	
12.00	Parking lot receipts			0	
13.00	Revenue from Laundry and Linen service			0	
14.00	Revenue from meals sold to employees and guests			172, 157	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			52, 672	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			13, 571	21.00
22. 00	Rental of hospital space			371, 324	22. 00
23. 00	Governmental appropriations			16, 805, 784	23.00
24. 00	MISC			855, 139	24. 0
24. 01	FOUNDATION NET ASSETS RELEASED			902, 136	24. 0
	CHRONIC PAIN PROGRAM			481, 941	
	COVI D-19 PHE Funding			0	
	Total other income (sum of lines 6-24)			20, 744, 070	
	Total (line 5 plus line 25)			-3, 678, 834	
27. 00	OTHER EXPENSES (SPECIFY)			0	27. 0
28. 00	Total other expenses (sum of line 27 and subscripts)			0	

0 28.00 -3, 678, 834 29.00

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)