This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 09-30-2025

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 31-3300	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/8/2024 9:17 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/8/2024 Time: 9:17 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by 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	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	Richard Henwood		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Richard Henwood			2
3	Signatory Title	VP CORPORATE REIMBURSEMENT			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	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 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/8/2024 9:17 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 150 PROVIDENCE ROAD	PO Box:			1.00
2.00	City: MOUNTAINSIDE	State: NJ	Zip Code: 07094	County: UNION	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	CHILDRENS SPECIALIZED HOPSITAL	313300	35084	7	01/01/1970	N	T	T	3.00
4.00	Subprovider - IPF (combined)									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	CHILDRENS SPECIALIZED HOSPITAL	315239	35084		10/06/1986	N	P	N	9.00
10.00	Hospital-Based NF	CHILDRENS SPECIALIIZED HOSPITAL	315239	35084		10/06/1986	N		N	10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2023	12/31/2023	20.00
21.00	Type of Control (see instructions)	2		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/8/2024 9:17 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/8/2024 9:17 am

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	3.73	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	PEDIATRICS	2000	0.00	2.03	0.000000	67.00
67.01		FAMILY MEDICINE	1350	0.00	0.19	0.000000	67.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 31-3300	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/8/2024 9:17 am

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/8/2024 9:17 am

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

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

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

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

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

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	518,563	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	Y	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	Y	N	123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	H53560	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: RWJBARNABAS HEALTH	Contractor's Name: NOVITAS SOLUTIONS	Contractor's Number: 12001	141.00
142.00	Street: 95 OLD SHORT HILLS	PO Box:		142.00
143.00	City: WEST ORANGE	State: NJ	Zip Code: 07052	143.00

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

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

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

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

			1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act			
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)		0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II Date/Time Prepared: 5/8/2024 9:17 am

		Y/N	Date	
		1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE			
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	04/07/2024	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	03/28/2024	Y	03/28/2024	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II Date/Time Prepared: 5/8/2024 9:17 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
	Provider-Based Physicians		
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RICHARD	HENWOOD	41.00
42.00	Enter the employer/company name of the cost report preparer.	RWJBARNABAS HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	732 923-8074	RICH.HENWOOD@RWJBH.ORG	43.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I Date/Time Prepared: 5/8/2024 9:17 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	68	24,820	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		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	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	48	17,520		0	19.00
20.00	NURSING FACILITY	45.00	26	9,490		0	20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		142				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/8/2024 9:17 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	0	1,942	19,803			1.00
2.00	HMO and other (see instructions)	0	7,894				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	0	1,942	19,803			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	1,942	19,803	5.95	1,174.92	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits	0	0	0			15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	16,462	17,199	0.00	104.18	19.00
20.00	NURSING FACILITY		6,624	7,300	0.00	0.00	20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				5.95	1,279.10	27.00
28.00	Observation Bed Days		0	0			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/8/2024 9:17 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	0	31	533	1.00
2.00	HMO and other (see instructions)			0	223		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	0	31	533	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY	0.00					20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part II Date/Time Prepared: 5/8/2024 9:17 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	110,095,738	0	110,095,738	0.00	0.00	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	7,559,931	675,140	8,235,071	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		3,475,360	45,346	3,520,706	0.00	0.00	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		0	0	0	0.00	0.00	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		5,063,674	0	5,063,674	144,346.59	35.08	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		0	0	0			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		1,109,390	0	1,109,390			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		920,930	0	920,930			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part II Date/Time Prepared: 5/8/2024 9:17 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	-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 contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	955,885	2,217	958,102	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,587,540	1,665	1,589,205	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,431,369	1,024	1,432,393	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
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 Records Library	16.00	969,075	691	969,766	0.00	0.00	41.00
42.00	Social Service	17.00	793,224	-605,867	187,357	0.00	0.00	42.00
43.00	Other General Service	18.00	433,475	-491,088	-57,613	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part III Date/Time Prepared: 5/8/2024 9:17 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		110,095,738	0	110,095,738	0.00	0.00	1.00
2.00	Excluded area salaries (see instructions)		11,035,291	720,486	11,755,777	0.00	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)		99,060,447	-720,486	98,339,961	0.00	0.00	3.00
4.00	Subtotal other wages & related costs (see inst.)		5,063,674	0	5,063,674	144,346.59	35.08	4.00
5.00	Subtotal wage-related costs (see inst.)		920,930	0	920,930	0.00	0.94	5.00
6.00	Total (sum of lines 3 thru 5)		105,045,051	-720,486	104,324,565	144,346.59	722.74	6.00
7.00	Total overhead cost (see instructions)		26,035,745	-5,516,649	20,519,096	0.00	0.00	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part IV | Date/Time Prepared: 5/8/2024 9:17 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	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. Noncumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	0	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
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)		25.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/8/2024 9:17 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		10,292,455	10,292,455	-4,972,828	5,319,627	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	1,616,181	1,616,181	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	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	00700	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	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,587,540	795,701	2,383,241	6,190	2,389,431	9.00
10.00	01000	DIETARY	1,431,369	1,083,371	2,514,740	27,762	2,542,502	10.00
13.00	01300	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	01600	MEDICAL RECORDS & LIBRARY	969,075	200,088	1,169,163	5,216	1,174,379	16.00
17.00	01700	SOCIAL SERVICE	793,224	8,740	801,964	-598,090	203,874	17.00
18.00	01080	INSERVICE EDUCATION	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	0	21.00
22.00	02200	I&R SERVICES-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	18,795,008	2,209,471	21,004,479	30.00
44.00	04400	SKILLED NURSING FACILITY	7,559,931	465,956	8,025,887	755,125	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	RADIOLOGY-DIAGNOSTIC	0	0	0	0	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	0	62.30
65.00	06500	RESPIRATORY THERAPY	3,266,737	420,718	3,687,455	42,127	3,729,582	65.00
66.00	06600	PHYSICAL THERAPY	5,250,851	163,467	5,414,318	1,503,619	6,917,937	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,762,063	77,013	5,839,076	1,660,063	7,499,139	67.00
68.00	06800	SPEECH PATHOLOGY	5,717,860	98,735	5,816,595	1,289,574	7,106,169	68.00
68.01	06801	PEDS FEEDING DISORDER RU CARES	768,967	10,863	779,830	132,021	911,851	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,574,937	2,574,937	0	2,574,937	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	657,375	657,375	0	657,375	73.00
76.00	03550	MEDICAL SERVICES	10,254,894	398,996	10,653,890	-4,788,513	5,865,377	76.00
76.01	03950	PSYCHIATRIC	4,345,494	284,108	4,629,602	1,712,495	6,342,097	76.01
76.02	03020	SEVERE BEHAVIOR	1,292,243	421,369	1,713,612	200,239	1,913,851	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	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	CLINIC	6,594,302	122,910	6,717,212	5,057,042	11,774,254	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	11,844,503	515,089	12,359,592	601,116	12,960,708	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	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,451,902	1,451,902	-1,451,902	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	108,986,348	78,790,688	187,777,036	-22,575	187,754,461	118.00
		NONREIMBURSABLE COST CENTERS						
191.00	19100	RESEARCH	1,109,390	663,456	1,772,846	22,575	1,795,421	191.00
194.00	07950	CHILD CARE CENTER (MEDICAL DAY CARE	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	110,095,738	79,454,144	189,549,882	0	189,549,882	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/8/2024 9:17 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	5,319,627		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	1,616,181		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-807,892	18,102,260		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	916,714	48,217,589		5.00
7.00	00700	OPERATION OF PLANT	-424,433	3,138,012		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0		8.00
9.00	00900	HOUSEKEEPING	0	2,389,431		9.00
10.00	01000	DIETARY	-185,728	2,356,774		10.00
13.00	01300	NURSING ADMINISTRATION	0	320,179		13.00
15.00	01500	PHARMACY	0	1,994,797		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-52,672	1,121,707		16.00
17.00	01700	SOCIAL SERVICE	0	203,874		17.00
18.00	01080	INSERVICE EDUCATION	0	30,143		18.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	1,002,306		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-924,359	20,080,120		30.00
44.00	04400	SKILLED NURSING FACILITY	0	8,781,012		44.00
45.00	04500	NURSING FACILITY	0	3,347,082		45.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	1,720		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	3,729,582		65.00
66.00	06600	PHYSICAL THERAPY	0	6,917,937		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,499,139		67.00
68.00	06800	SPEECH PATHOLOGY	0	7,106,169		68.00
68.01	06801	PEDS FEEDING DISORDER RU CARES	0	911,851		68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,574,937		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	657,375		73.00
76.00	03550	MEDICAL SERVICES	-4,043,218	1,822,159		76.00
76.01	03950	PSYCHIATRIC	-1,447,668	4,894,429		76.01
76.02	03020	SEVERE BEHAVIOR	0	1,913,851		76.02
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-3,736,826	8,037,428		90.00
90.01	09001	PEDS PRIMARY CARE CLINIC	0	0		90.01
92.00	09200	OBSERVATION 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		93.01
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0		93.99
		OTHER REIMBURSABLE COST CENTERS				
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-26,086,342	161,668,119		118.00
		NONREIMBURSABLE COST CENTERS				
191.00	19100	RESEARCH	0	1,795,421		191.00
194.00	07950	CHILD CARE CENTER (MEDICAL DAY CARE	0	0		194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-26,086,342	163,463,540		200.00

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		Increases			
	Cost Center	Line #	Salary	Other	
	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 BEHAVIOR	76.02	3,782	0	5.00
6.00	CLINIC	90.00	122,324	0	6.00
7.00	CLINIC	90.00	66,124	0	7.00
	0		1,137,143	0	
	B - INTEREST				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,451,902	1.00
	0		0	1,451,902	
	C - TUITION REIMBURSMENT				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	79,497	1.00
2.00	NURSING ADMINISTRATION	13.00	0	0	2.00
3.00	PHARMACY	15.00	0	5,250	3.00
4.00	ADULTS & PEDIATRICS	30.00	0	59,810	4.00
5.00	SKILLED NURSING FACILITY	44.00	0	25,755	5.00
6.00	PHYSICAL THERAPY	66.00	0	5,250	6.00
7.00	OCCUPATIONAL THERAPY	67.00	0	5,250	7.00
8.00	SPEECH PATHOLOGY	68.00	0	2,364	8.00
9.00	MEDICAL SERVICES	76.00	0	7,655	9.00
10.00	PSYCHIATRIC	76.01	0	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
	0		0	272,890	
	D - MME				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,616,181	1.00
	0		0	1,616,181	
	E - MALPRACTICE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,494	1.00
2.00	DIETARY	10.00	0	107	2.00
3.00	NURSING ADMINISTRATION	13.00	0	3,858	3.00
4.00	PHARMACY	15.00	0	11,625	4.00
5.00	SOCIAL SERVICE	17.00	0	3,252	5.00
6.00	ADULTS & PEDIATRICS	30.00	0	101,384	6.00
7.00	SKILLED NURSING FACILITY	44.00	0	42,137	7.00
8.00	NURSING FACILITY	45.00	0	15,230	8.00
9.00	RESPIRATORY THERAPY	65.00	0	20,714	9.00
10.00	PHYSICAL THERAPY	66.00	0	32,677	10.00
11.00	OCCUPATIONAL THERAPY	67.00	0	38,493	11.00
12.00	SPEECH PATHOLOGY	68.00	0	37,185	12.00
13.00	PEDS FEEDING DISORDER RU CARES	68.01	0	5,071	13.00
14.00	MEDICAL SERVICES	76.00	0	76,618	14.00
15.00	PSYCHIATRIC	76.01	0	27,769	15.00
16.00	SEVERE BEHAVIOR	76.02	0	7,899	16.00
17.00	CLINIC	90.00	0	13,399	17.00
18.00	CLINIC	90.00	0	7,835	18.00
19.00	SCHOOL BASED PROGRAMS	93.00	0	65,404	19.00
20.00	RESEARCH	191.00	0	4,412	20.00
	0		0	518,563	
	F - OUTPATIENT SITE DIRECTORS				
1.00	ADMINISTRATIVE & GENERAL	5.00	312,060	0	1.00
2.00	PHYSICAL THERAPY	66.00	154,033	0	2.00
3.00	OCCUPATIONAL THERAPY	67.00	209,228	0	3.00
4.00	SPEECH PATHOLOGY	68.00	183,491	0	4.00
5.00	PEDS FEEDING DISORDER RU CARES	68.01	26,469	0	5.00
6.00	PSYCHIATRIC	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	0	8.00
9.00	CLINIC	90.00	49,851	0	9.00
	0		1,253,351	0	
	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	PHYSICAL THERAPY	66.00	0	0	3.00
4.00	OCCUPATIONAL THERAPY	67.00	143,827	0	4.00
5.00	SPEECH PATHOLOGY	68.00	135,377	0	5.00
6.00	PSYCHIATRIC	76.01	154,270	0	6.00
	0		433,474	0	

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		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	H - MEDICAL DIRECTOR				
1.00	MEDICAL SERVICES	76.00	186,088	0	1.00
2.00	CLINIC	90.00	169,562	0	2.00
3.00	CLINIC	90.00	70,278	0	3.00
	0		425,928	0	
	I - PHARMACY STAFF RECLASS				
1.00	SKILLED NURSING FACILITY	44.00	100,380	0	1.00
	0		100,380	0	
	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	HOUSEKEEPING	9.00	0	4,525	3.00
4.00	DIETARY	10.00	0	26,631	4.00
5.00	NURSING ADMINISTRATION	13.00	0	27,873	5.00
6.00	PHARMACY	15.00	0	4,525	6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	4,525	7.00
8.00	SOCIAL SERVICE	17.00	0	4,525	8.00
9.00	INSERVICE EDUCATION	18.00	0	15,248	9.00
10.00	ADULTS & PEDIATRICS	30.00	0	221,804	10.00
11.00	SKILLED NURSING FACILITY	44.00	0	12,093	11.00
12.00	NURSING FACILITY	45.00	0	42,548	12.00
13.00	RESPIRATORY THERAPY	65.00	0	20,945	13.00
14.00	PHYSICAL THERAPY	66.00	0	103,987	14.00
15.00	OCCUPATIONAL THERAPY	67.00	0	84,088	15.00
16.00	SPEECH PATHOLOGY	68.00	0	92,272	16.00
17.00	PEDS FEEDING DISORDER RU CARES	68.01	0	0	17.00
18.00	MEDICAL SERVICES	76.00	0	21,914	18.00
19.00	PSYCHIATRIC	76.01	0	98,408	19.00
20.00	SEVERE BEHAVIOR	76.02	0	0	20.00
21.00	CLINIC	90.00	0	6,788	21.00
22.00	SCHOOL BASED PROGRAMS	93.00	0	421,045	22.00
23.00	RESEARCH	191.00	0	18,163	23.00
	0		0	1,464,148	
	L - LEASES				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,370,414	1.00
2.00	NURSING FACILITY	45.00	0	283,131	2.00
3.00	PHYSICAL THERAPY	66.00	0	893,531	3.00
4.00	OCCUPATIONAL THERAPY	67.00	0	752,365	4.00
5.00	SPEECH PATHOLOGY	68.00	0	432,499	5.00
6.00	PEDS FEEDING DISORDER RU CARES	68.01	0	74,520	6.00
7.00	MEDICAL SERVICES	76.00	0	14,685	7.00
8.00	PSYCHIATRIC	76.01	0	315,221	8.00
9.00	SEVERE BEHAVIOR	76.02	0	74,520	9.00
10.00	CLINIC	90.00	0	500,308	10.00
12.00	SCHOOL BASED PROGRAMS	93.00	0	97,355	12.00
	0		0	4,808,549	
	M - PHYSICIAN RECLASS				
1.00	ADULTS & PEDIATRICS	30.00	763,448	0	1.00
2.00	SKILLED NURSING FACILITY	44.00	141,057	0	2.00
3.00	PSYCHIATRIC	76.01	750,562	0	3.00
4.00	CLINIC	90.00	2,809,167	0	4.00
5.00	CLINIC	90.00	633,901	0	5.00
	0		5,098,135	0	
	N - THERAPY SCHEDULING				
1.00	PHYSICAL THERAPY	66.00	311,646	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	424,195	0	2.00
3.00	SPEECH PATHOLOGY	68.00	403,951	0	3.00
4.00	PSYCHIATRIC	76.01	240,885	0	4.00
5.00	SEVERE BEHAVIOR	76.02	41,602	0	5.00
6.00	PEDS FEEDING DISORDER RU CARES	68.01	25,444	0	6.00
7.00	CLINIC	90.00	348,419	0	7.00
8.00	CLINIC	90.00	61,103	0	8.00
	0		1,857,245	0	
	O - INSERVICE EDUCATION				
1.00	ADMINISTRATIVE & GENERAL	5.00	11,109	0	1.00
2.00	OPERATION OF PLANT	7.00	2,217	0	2.00
3.00	HOUSEKEEPING	9.00	1,665	0	3.00
4.00	DIETARY	10.00	1,024	0	4.00
5.00	NURSING ADMINISTRATION	13.00	290	0	5.00
6.00	PHARMACY	15.00	828	0	6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	691	0	7.00

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		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
8.00	SOCIAL SERVICE	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	RESPIRATORY THERAPY	65.00	468	0	12.00
13.00	PHYSICAL THERAPY	66.00	2,495	0	13.00
14.00	OCCUPATIONAL 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 CARES	68.01	517	0	16.00
17.00	MEDICAL SERVICES	76.00	2,662	0	17.00
18.00	PSYCHIATRIC	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	0	
500.00	Grand Total: Increases		10,969,488	10,132,233	500.00

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		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - NURSING ADMINISTRATION					
1.00	NURSING ADMINISTRATION	13.00	1,137,143	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
	0		1,137,143	0		
	B - INTEREST					
1.00	INTEREST EXPENSE	113.00	0	1,451,902	9	1.00
	0		0	1,451,902		
	C - TUITION REIMBURSMENT					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	272,890	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
11.00		0.00	0	0	0	11.00
12.00		0.00	0	0	0	12.00
13.00		0.00	0	0	0	13.00
14.00		0.00	0	0	0	14.00
	0		0	272,890		
	D - MME					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,616,181	9	1.00
	0		0	1,616,181		
	E - MALPRACTICE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	518,563	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
11.00		0.00	0	0	0	11.00
12.00		0.00	0	0	0	12.00
13.00		0.00	0	0	0	13.00
14.00		0.00	0	0	0	14.00
15.00		0.00	0	0	0	15.00
16.00		0.00	0	0	0	16.00
17.00		0.00	0	0	0	17.00
18.00		0.00	0	0	0	18.00
19.00		0.00	0	0	0	19.00
20.00		0.00	0	0	0	20.00
	0		0	518,563		
	F - OUTPATIENT SITE DIRECTORS					
1.00	ADMINISTRATIVE & GENERAL	5.00	1,253,351	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
	0		1,253,351	0		
	G - THERAPY LEADS RECLASS					
1.00	INSERVICE EDUCATION	18.00	433,474	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
	0		433,474	0		

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		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	H - MEDICAL DIRECTOR						
1.00	ADMINISTRATIVE & GENERAL	5.00	425,928	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		425,928	0			
	I - PHARMACY STAFF RECLASS						
1.00	PHARMACY	15.00	100,380	0	0		1.00
	0		100,380	0			
	J - INCENTIVES RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,464,148	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
	0		0	1,464,148			
	L - LEASES						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,808,549	9		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
12.00		0.00	0	0	0		12.00
	0		0	4,808,549			
	M - PHYSICIAN RECLASS						
1.00	MEDICAL SERVICES	76.00	5,098,135	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	0		5,098,135	0			
	N - THERAPY SCHEDULING						
1.00	ADMINISTRATIVE & GENERAL	5.00	1,857,245	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
	0		1,857,245	0			
	O - INSERVICE EDUCATION						
1.00	INSERVICE EDUCATION	18.00	57,614	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00

RECLASSIFICATIONS | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/8/2024 9:17 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
	0		57,614	0			
	P - SOCIAL SERVICE						
1.00	SOCIAL SERVICE	17.00	606,218	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		606,218	0			
500.00	Grand Total: Decreases		10,969,488	10,132,233			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I Date/Time Prepared: 5/8/2024 9:17 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,075,800	0	0	0	0	1.00
2.00	Land Improvements	3,485,763	0	0	0	0	2.00
3.00	Buildings and Fixtures	144,309,475	0	0	0	0	3.00
4.00	Building Improvements	16,277,251	0	0	0	0	4.00
5.00	Fixed Equipment	38,025,960	0	0	0	0	5.00
6.00	Movable Equipment	65,899,073	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	269,073,322	0	0	0	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	269,073,322	0	0	0	0	10.00

		Ending Balance	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
3.00	Buildings and Fixtures	144,309,475	0	3.00
4.00	Building Improvements	16,277,251	0	4.00
5.00	Fixed Equipment	38,025,960	0	5.00
6.00	Movable Equipment	65,899,073	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	269,073,322	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	269,073,322	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part II Date/Time Prepared: 5/8/2024 9:17 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	10,292,455	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	10,292,455	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	10,292,455	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	10,292,455	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part III Date/Time Prepared: 5/8/2024 9:17 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	10,292,455	0	10,292,455	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	10,292,455	0	10,292,455	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	5,319,627	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,616,181	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	6,935,808	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	5,319,627	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,616,181	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	6,935,808	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/8/2024 9:17 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	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)	B	-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)	B	-424,433	OPERATION OF PLANT	7.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-5,306,261			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	1,327,575			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-185,728	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others	B	0	OPERATION OF PLANT	7.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-52,672	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)	B	0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	B	-154,945	ADMINISTRATIVE & GENERAL	5.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MARKETING COST	A	-2,119	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/8/2024 9:17 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
34.00	AUTISM GRANT	B	-530,473	PSYCHIATRIC	76.01	0	34.00
35.00	MISC OTHER OPERATING REVENUE	B	-242,300	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	CEC GRANT	B	-680,439	MEDICAL SERVICES	76.00	0	36.00
37.00	CHGME REV	B	-58,669	ADULTS & PEDIATRICS	30.00	0	37.00
38.00	NURSE PRACTITIONER SALARIES	A	-3,362,779	MEDICAL SERVICES	76.00	0	38.00
39.00	NURSE PRAC BENEFITS	A	-807,892	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.00
40.00	PHYSICIAN PART C	A	-60,423	ADULTS & PEDIATRICS	30.00	0	40.00
41.00	PHYSICIAN PART C	A	-108,004	CLINIC	90.00	0	41.00
43.00	PHYSICIAN PART C	A	-1,798	PSYCHIATRIC	76.01	0	43.00
44.00	PEDIATRIC PRACTICE	B	-2,530	CLINIC	90.00	0	44.00
45.00	CEPHALON DRUG TRIAL	B	-40,695	PSYCHIATRIC	76.01	0	45.00
46.00	SCHOOL BASED PROGRAM GRANTS	B	-15,380,260	SCHOOL BASED PROGRAMS	93.00	0	46.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-26,086,342				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 5/8/2024 9:17 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	12,194,946	10,867,371	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			12,194,946	10,867,371	5.00

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

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 31-3300	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8-1 Date/Time Prepared: 5/8/2024 9:17 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	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 lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate.Positive amounts increase cost and negative amounts decrease cost.For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

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

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

6.00	HEALTHCARE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 5/8/2024 9:17 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	958,096	763,448	194,648	211,500	1,503	1.00
2.00	76.01	AGGREGATE-PSYCHIATRIC	1,017,871	812,562	205,309	211,500	1,408	2.00
3.00	90.00	AGGREGATE-CLINIC	3,466,855	2,809,167	657,688	211,500	5,013	3.00
4.00	90.00	AGGREGATE-CLINIC	917,685	633,901	283,784	211,500	2,444	4.00
5.00	0.00		0	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	0	10.00
200.00			6,360,507	5,019,078	1,341,429		10,368	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	152,829	7,641	0	0	0	1.00
2.00	76.01	AGGREGATE-PSYCHIATRIC	143,169	7,158	0	0	0	2.00
3.00	90.00	AGGREGATE-CLINIC	509,735	25,487	0	0	0	3.00
4.00	90.00	AGGREGATE-CLINIC	248,513	12,426	0	0	0	4.00
5.00	0.00		0	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	0	10.00
200.00			1,054,246	52,712	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	152,829	41,819	805,267		1.00
2.00	76.01	AGGREGATE-PSYCHIATRIC	0	143,169	62,140	874,702		2.00
3.00	90.00	AGGREGATE-CLINIC	0	509,735	147,953	2,957,120		3.00
4.00	90.00	AGGREGATE-CLINIC	0	248,513	35,271	669,172		4.00
5.00	0.00		0	0	0	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		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	1,054,246	287,183	5,306,261		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/8/2024 9:17 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	5,319,627	5,319,627				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,616,181		1,616,181			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	18,102,260	65,384	19,865	18,187,509		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	48,217,589	2,019,069	613,424	2,907,213	53,757,295	5.00
7.00	00700	OPERATION OF PLANT	3,138,012	263,580	80,079	154,495	3,636,166	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	26,362	8,009	0	34,371	8.00
9.00	00900	HOUSEKEEPING	2,389,431	37,629	11,432	253,715	2,692,207	9.00
10.00	01000	DIETARY	2,356,774	158,305	48,095	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	16,997	286,486	2,354,224	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,121,707	69,038	20,975	155,155	1,366,875	16.00
17.00	01700	SOCIAL SERVICE	203,874	21,969	6,674	30,523	263,040	17.00
18.00	01080	INSERVICE EDUCATION	30,143	7,526	2,286	2,430	42,385	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	1,002,306	0	0	0	1,002,306	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,080,120	0	0	3,182,005	23,262,125	30.00
44.00	04400	SKILLED NURSING FACILITY	8,781,012	693,121	210,580	1,331,220	11,015,933	44.00
45.00	04500	NURSING FACILITY	3,347,082	0	0	409,152	3,756,234	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,088	634	0	2,722	54.00
60.00	06000	LABORATORY	1,720	0	0	0	1,720	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	3,729,582	4,350	1,322	523,932	4,259,186	65.00
66.00	06600	PHYSICAL THERAPY	6,917,937	680,418	206,721	927,569	8,732,645	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,499,139	430,890	130,911	1,055,518	9,116,458	67.00
68.00	06800	SPEECH PATHOLOGY	7,106,169	144,732	43,972	1,041,104	8,335,977	68.00
68.01	06801	PEDS FEEDING DISORDER RU CARES	911,851	0	0	8,273	920,124	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,574,937	0	0	0	2,574,937	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	657,375	0	0	0	657,375	73.00
76.00	03550	MEDICAL SERVICES	1,822,159	9,222	2,802	847,247	2,681,430	76.00
76.01	03950	PSYCHIATRIC	4,894,429	344,712	104,728	880,674	6,224,543	76.01
76.02	03020	SEVERE BEHAVIOR	1,913,851	0	0	16,093	1,929,944	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	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	CLINIC	8,037,428	212,987	64,709	1,757,615	10,072,739	90.00
90.01	09001	PEDS PRIMARY CARE CLINIC	0	0	0	0	0	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.00	04950	SCHOOL BASED PROGRAMS	-2,419,552	72,301	21,966	1,962,606	-362,679	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	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	161,668,119	5,319,627	1,616,181	18,007,820	161,488,430	118.00
		NONREIMBURSABLE COST CENTERS						
191.00	19100	RESEARCH	1,795,421	0	0	179,689	1,975,110	191.00
194.00	07950	CHILD CARE CENTER (MEDICAL DAY CARE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	163,463,540	5,319,627	1,616,181	18,187,509	163,463,540	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/8/2024 9:17 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	53,757,295					5.00
7.00	00700	OPERATION OF PLANT	1,775,893	5,412,059				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	16,787	48,013	99,171			8.00
9.00	00900	HOUSEKEEPING	1,314,866	68,533	1,267	4,076,873		9.00
10.00	01000	DIETARY	1,365,326	288,315	5,330	221,966	4,676,461	10.00
13.00	01300	NURSING ADMINISTRATION	177,104	0	0	0	0	13.00
15.00	01500	PHARMACY	1,149,796	101,889	1,884	78,441	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	667,578	125,737	2,325	96,801	0	16.00
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
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	489,523	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,361,112	0	0	0	2,090,379	30.00
44.00	04400	SKILLED NURSING FACILITY	5,380,149	1,262,354	23,339	971,854	1,815,504	44.00
45.00	04500	NURSING FACILITY	1,834,533	0	0	0	770,578	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,329	3,803	70	2,928	0	54.00
60.00	06000	LABORATORY	840	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,080,174	7,923	146	6,100	0	65.00
66.00	06600	PHYSICAL THERAPY	4,264,998	1,239,222	22,911	954,044	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,452,451	784,764	14,509	604,169	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,071,266	263,595	4,873	202,935	0	68.00
68.01	06801	PEDS FEEDING DISORDER RU CARES	449,386	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,257,592	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	321,060	0	0	0	0	73.00
76.00	03550	MEDICAL SERVICES	1,309,602	16,797	311	12,931	0	76.00
76.01	03950	PSYCHIATRIC	3,040,048	627,811	11,607	483,335	0	76.01
76.02	03020	SEVERE BEHAVIOR	942,579	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	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	CLINIC	4,919,496	387,906	7,172	298,638	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	131,679	2,434	101,376	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	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	52,792,657	5,412,059	99,171	4,076,873	4,676,461	118.00
		NONREIMBURSABLE COST CENTERS						
191.00	19100	RESEARCH	964,638	0	0	0	0	191.00
194.00	07950	CHILD CARE CENTER (MEDICAL DAY CARE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	53,757,295	5,412,059	99,171	4,076,873	4,676,461	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/8/2024 9:17 am

		Cost Center Description	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE INSERVICE EDUCATION	
			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	HOUSEKEEPING						9.00
10.00	01000	DIETARY						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	INSERVICE EDUCATION	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 & PEDIATRICS	259,069	0	1,310,404	0	0	30.00
44.00	04400	SKILLED NURSING FACILITY	188,905	0	474,456	123,333	23,756	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	372	72	54.00
60.00	06000	LABORATORY	0	0	0	0	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	774	149	65.00
66.00	06600	PHYSICAL THERAPY	0	0	158,152	121,074	23,321	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	135,559	76,673	14,769	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	45,186	25,754	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	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,686,234	0	0	0	73.00
76.00	03550	MEDICAL SERVICES	0	0	0	1,641	316	76.00
76.01	03950	PSYCHIATRIC	0	0	45,186	61,338	11,815	76.01
76.02	03020	SEVERE BEHAVIOR	0	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	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	CLINIC	91,754	0	90,373	37,899	7,300	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	0	0	12,865	2,478	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	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	539,728	3,686,234	2,259,316	463,062	88,937	118.00
		NONREIMBURSABLE COST CENTERS						
191.00	19100	RESEARCH	0	0	0	0	0	191.00
194.00	07950	CHILD CARE CENTER (MEDICAL DAY CARE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	539,728	3,686,234	2,259,316	463,062	88,937	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/8/2024 9:17 am

		Cost Center Description	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION						13.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
18.00	01080	INSERVICE EDUCATION						18.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		1,491,829				22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	776,429	39,059,518	-776,429	38,283,089	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	21,279,583	0	21,279,583	44.00
45.00	04500	NURSING FACILITY	0	0	6,361,345	0	6,361,345	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	11,296	0	11,296	54.00
60.00	06000	LABORATORY	0	0	2,560	0	2,560	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	6,354,452	0	6,354,452	65.00
66.00	06600	PHYSICAL THERAPY	0	465,858	15,982,225	-465,858	15,516,367	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	15,199,352	0	15,199,352	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	12,954,547	0	12,954,547	68.00
68.01	06801	PEDS FEEDING DISORDER RU CARES	0	0	1,369,510	0	1,369,510	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	3,832,529	0	3,832,529	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	4,664,669	0	4,664,669	73.00
76.00	03550	MEDICAL SERVICES	0	0	4,023,028	0	4,023,028	76.00
76.01	03950	PSYCHIATRIC	0	0	10,505,683	0	10,505,683	76.01
76.02	03020	SEVERE BEHAVIOR	0	0	2,872,523	0	2,872,523	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	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	CLINIC	0	249,542	16,162,819	-249,542	15,913,277	90.00
90.01	09001	PEDS PRIMARY CARE CLINIC	0	0	0	0	0	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04950	SCHOOL BASED PROGRAMS	0	0	-111,847	0	-111,847	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	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,491,829	160,523,792	-1,491,829	159,031,963	118.00
		NONREIMBURSABLE COST CENTERS						
191.00	19100	RESEARCH	0	0	2,939,748	0	2,939,748	191.00
194.00	07950	CHILD CARE CENTER (MEDICAL DAY CARE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,491,829	163,463,540	-1,491,829	161,971,711	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/8/2024 9:17 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	65,384	19,865	85,249	85,249	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	2,019,069	613,424	2,632,493	13,627	5.00
7.00	00700	OPERATION OF PLANT	0	263,580	80,079	343,659	724	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	26,362	8,009	34,371	0	8.00
9.00	00900	HOUSEKEEPING	0	37,629	11,432	49,061	1,189	9.00
10.00	01000	DIETARY	0	158,305	48,095	206,400	1,089	10.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	199	13.00
15.00	01500	PHARMACY	0	55,944	16,997	72,941	1,343	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	69,038	20,975	90,013	727	16.00
17.00	01700	SOCIAL SERVICE	0	21,969	6,674	28,643	143	17.00
18.00	01080	INSERVICE EDUCATION	0	7,526	2,286	9,812	11	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 & PEDIATRICS	0	0	0	0	14,913	30.00
44.00	04400	SKILLED NURSING FACILITY	0	693,121	210,580	903,701	6,240	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	1,918	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,088	634	2,722	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	4,350	1,322	5,672	2,456	65.00
66.00	06600	PHYSICAL THERAPY	0	680,418	206,721	887,139	4,348	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	430,890	130,911	561,801	4,948	67.00
68.00	06800	SPEECH PATHOLOGY	0	144,732	43,972	188,704	4,880	68.00
68.01	06801	PEDS FEEDING DISORDER RU CARES	0	0	0	0	39	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	MEDICAL SERVICES	0	9,222	2,802	12,024	3,971	76.00
76.01	03950	PSYCHIATRIC	0	344,712	104,728	449,440	4,128	76.01
76.02	03020	SEVERE BEHAVIOR	0	0	0	0	75	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	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	CLINIC	0	212,987	64,709	277,696	8,239	90.00
90.01	09001	PEDS PRIMARY CARE CLINIC	0	0	0	0	0	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04950	SCHOOL BASED PROGRAMS	0	72,301	21,966	94,267	9,200	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	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	5,319,627	1,616,181	6,935,808	84,407	118.00
		NONREIMBURSABLE COST CENTERS						
191.00	19100	RESEARCH	0	0	0	0	842	191.00
194.00	07950	CHILD CARE CENTER (MEDICAL DAY CARE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	5,319,627	1,616,181	6,935,808	85,249	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/8/2024 9:17 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	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	HOUSEKEEPING	64,723	5,468	499	120,940		9.00
10.00	01000	DIETARY	67,207	23,003	2,098	6,585	306,382	10.00
13.00	01300	NURSING ADMINISTRATION	8,718	0	0	0	0	13.00
15.00	01500	PHARMACY	56,598	8,129	741	2,327	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	32,861	10,032	915	2,872	0	16.00
17.00	01700	SOCIAL SERVICE	6,324	3,192	291	914	0	17.00
18.00	01080	INSERVICE EDUCATION	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 & PEDIATRICS	559,198	0	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	RADIOLOGY-DIAGNOSTIC	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	RESPIRATORY THERAPY	102,395	632	58	181	0	65.00
66.00	06600	PHYSICAL THERAPY	209,942	98,871	9,016	28,302	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	219,169	62,612	5,710	17,923	0	67.00
68.00	06800	SPEECH PATHOLOGY	200,405	21,031	1,918	6,020	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	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,804	0	0	0	0	73.00
76.00	03550	MEDICAL SERVICES	64,464	1,340	122	384	0	76.00
76.01	03950	PSYCHIATRIC	149,644	50,090	4,568	14,338	0	76.01
76.02	03020	SEVERE BEHAVIOR	46,398	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	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	CLINIC	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	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,598,636	431,800	39,028	120,940	306,382	118.00
		NONREIMBURSABLE COST CENTERS						
191.00	19100	RESEARCH	47,484	0	0	0	0	191.00
194.00	07950	CHILD CARE CENTER (MEDICAL DAY CARE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,646,120	431,800	39,028	120,940	306,382	202.00

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		Cost Center Description	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE INSERVICE EDUCATION	
			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	HOUSEKEEPING						9.00
10.00	01000	DIETARY						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	INSERVICE EDUCATION	0	0	0	114	12,463	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 & PEDIATRICS	4,280	0	79,705	0	0	30.00
44.00	04400	SKILLED NURSING FACILITY	3,121	0	28,858	10,523	3,329	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	32	10	54.00
60.00	06000	LABORATORY	0	0	0	0	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	PHYSICAL THERAPY	0	0	9,619	10,330	3,268	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	8,245	6,541	2,070	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	2,748	2,197	695	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	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	142,079	0	0	0	73.00
76.00	03550	MEDICAL SERVICES	0	0	0	140	44	76.00
76.01	03950	PSYCHIATRIC	0	0	2,748	5,233	1,656	76.01
76.02	03020	SEVERE BEHAVIOR	0	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	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	CLINIC	1,516	0	5,497	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						92.00
93.00	04950	SCHOOL BASED PROGRAMS	0	0	0	1,098	347	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	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,917	142,079	137,420	39,507	12,463	118.00
		NONREIMBURSABLE COST CENTERS						
191.00	19100	RESEARCH	0	0	0	0	0	191.00
194.00	07950	CHILD CARE CENTER (MEDICAL DAY CARE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	8,917	142,079	137,420	39,507	12,463	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/8/2024 9:17 am

		Cost Center Description	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION						13.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
18.00	01080	INSERVICE EDUCATION						18.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		24,096				22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS			795,049	0	795,049	30.00
44.00	04400	SKILLED NURSING FACILITY			1,478,279	0	1,478,279	44.00
45.00	04500	NURSING FACILITY			142,707	0	142,707	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC			3,247	0	3,247	54.00
60.00	06000	LABORATORY			41	0	41	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS			0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY			111,481	0	111,481	65.00
66.00	06600	PHYSICAL THERAPY			1,260,835	0	1,260,835	66.00
67.00	06700	OCCUPATIONAL THERAPY			889,019	0	889,019	67.00
68.00	06800	SPEECH PATHOLOGY			428,598	0	428,598	68.00
68.01	06801	PEDS FEEDING DISORDER RU CARES			22,160	0	22,160	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT			61,904	0	61,904	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS			157,883	0	157,883	73.00
76.00	03550	MEDICAL SERVICES			82,489	0	82,489	76.00
76.01	03950	PSYCHIATRIC			681,845	0	681,845	76.01
76.02	03020	SEVERE BEHAVIOR			46,473	0	46,473	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	76.99
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			581,993	0	581,993	90.00
90.01	09001	PEDS PRIMARY CARE CLINIC			0	0	0	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04950	SCHOOL BASED PROGRAMS			119,383	0	119,383	93.00
93.01	04951	OTHER OUTPATIENT SERVICE COST CENTER			0	0	0	93.01
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM			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
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	6,863,386	0	6,863,386	118.00
		NONREIMBURSABLE COST CENTERS						
191.00	19100	RESEARCH			48,326	0	48,326	191.00
194.00	07950	CHILD CARE CENTER (MEDICAL DAY CARE			0	0	0	194.00
200.00		Cross Foot Adjustments	0	24,096	24,096	0	24,096	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	24,096	6,935,808	0	6,935,808	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/8/2024 9:17 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	122,284					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
5.00	00500	ADMINISTRATIVE & GENERAL	46,413	46,413	18,242,827	-53,757,295	110,068,924	5.00
7.00	00700	OPERATION OF PLANT	6,059	6,059	969,460	0	3,636,166	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	606	606	0	0	34,371	8.00
9.00	00900	HOUSEKEEPING	865	865	1,592,065	0	2,692,207	9.00
10.00	01000	DIETARY	3,639	3,639	1,458,000	0	2,795,524	10.00
13.00	01300	NURSING ADMINISTRATION	0	0	266,344	0	362,624	13.00
15.00	01500	PHARMACY	1,286	1,286	1,797,705	0	2,354,224	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,587	1,587	973,600	0	1,366,875	16.00
17.00	01700	SOCIAL SERVICE	505	505	191,531	0	263,040	17.00
18.00	01080	INSERVICE EDUCATION	173	173	15,248	0	42,385	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	1,002,306	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	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
45.00	04500	NURSING FACILITY	0	0	2,567,439	0	3,756,234	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	48	48	0	0	2,722	54.00
60.00	06000	LABORATORY	0	0	0	0	1,720	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	100	100	3,287,682	0	4,259,186	65.00
66.00	06600	PHYSICAL THERAPY	15,641	15,641	5,820,517	0	8,732,645	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,905	9,905	6,623,401	0	9,116,458	67.00
68.00	06800	SPEECH PATHOLOGY	3,327	3,327	6,532,951	0	8,335,977	68.00
68.01	06801	PEDS FEEDING DISORDER RU CARES	0	0	51,913	0	920,124	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	2,574,937	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	657,375	73.00
76.00	03550	MEDICAL SERVICES	212	212	5,316,495	0	2,681,430	76.00
76.01	03950	PSYCHIATRIC	7,924	7,924	5,526,251	0	6,224,543	76.01
76.02	03020	SEVERE BEHAVIOR	0	0	100,985	0	1,929,944	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	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	CLINIC	4,896	4,896	11,029,071	0	10,072,739	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	1,662	1,662	12,315,398	362,679	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	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	122,284	122,284	112,999,273	-53,394,616	108,093,814	118.00
		NONREIMBURSABLE COST CENTERS						
191.00	19100	RESEARCH	0	0	1,127,553	0	1,975,110	191.00
194.00	07950	CHILD CARE CENTER (MEDICAL DAY CARE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,319,627	1,616,181	18,187,509		53,757,295	202.00
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, Part II)			85,249		2,646,120	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000747		0.024041	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/8/2024 9:17 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (SQUARE FEET)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
			7.00	8.00	9.00	10.00	13.00	
		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	68,309					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	606	67,703				8.00
9.00	00900	HOUSEKEEPING	865	865	66,838			9.00
10.00	01000	DIETARY	3,639	3,639	3,639	44,302		10.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	100	13.00
15.00	01500	PHARMACY	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
17.00	01700	SOCIAL SERVICE	505	505	505	0	0	17.00
18.00	01080	INSERVICE EDUCATION	173	173	173	0	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	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	19,803	48	30.00
44.00	04400	SKILLED NURSING FACILITY	15,933	15,933	15,933	17,199	35	44.00
45.00	04500	NURSING FACILITY	0	0	0	7,300	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	48	48	48	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	100	100	100	0	0	65.00
66.00	06600	PHYSICAL THERAPY	15,641	15,641	15,641	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,905	9,905	9,905	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,327	3,327	3,327	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	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	MEDICAL SERVICES	212	212	212	0	0	76.00
76.01	03950	PSYCHIATRIC	7,924	7,924	7,924	0	0	76.01
76.02	03020	SEVERE BEHAVIOR	0	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	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	CLINIC	4,896	4,896	4,896	0	17	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	1,662	1,662	1,662	0	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	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	68,309	67,703	66,838	44,302	100	118.00
		NONREIMBURSABLE COST CENTERS						
191.00	19100	RESEARCH	0	0	0	0	0	191.00
194.00	07950	CHILD CARE CENTER (MEDICAL DAY CARE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,412,059	99,171	4,076,873	4,676,461	539,728	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	79.229077	1.464795	60.996334	105.558688	5,397.280000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	431,800	39,028	120,940	306,382	8,917	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	6.321275	0.576459	1.809450	6.915760	89.170000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/8/2024 9:17 am

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (SQUARE FEET)	OTHER GENERAL SERVICE INSERVICE EDUCATION (SQUARE FEET)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	
			15.00	16.00	17.00	18.00	21.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION						13.00
15.00	01500	PHARMACY	100					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	100				16.00
17.00	01700	SOCIAL SERVICE	0	0	59,821			17.00
18.00	01080	INSERVICE EDUCATION	0	0	173	59,648		18.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	2,200	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	58	0	0	1,145	30.00
44.00	04400	SKILLED NURSING FACILITY	0	21	15,933	15,933	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	48	48	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	100	100	0	65.00
66.00	06600	PHYSICAL THERAPY	0	7	15,641	15,641	687	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	6	9,905	9,905	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	2	3,327	3,327	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	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	100	0	0	0	0	73.00
76.00	03550	MEDICAL SERVICES	0	0	212	212	0	76.00
76.01	03950	PSYCHIATRIC	0	2	7,924	7,924	0	76.01
76.02	03020	SEVERE BEHAVIOR	0	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	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	CLINIC	0	4	4,896	4,896	368	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	0	1,662	1,662	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	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	100	59,821	59,648	2,200	118.00
		NONREIMBURSABLE COST CENTERS						
191.00	19100	RESEARCH	0	0	0	0	0	191.00
194.00	07950	CHILD CARE CENTER (MEDICAL DAY CARE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,686,234	2,259,316	463,062	88,937	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	36,862.340000	22,593.160000	7.740793	1.491031	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	142,079	137,420	39,507	12,463	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1,420.790000	1,374.200000	0.660420	0.208942	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/8/2024 9:17 am

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
			22.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
13.00	01300	NURSING ADMINISTRATION			13.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
18.00	01080	INSERVICE EDUCATION			18.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	2,200		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	1,145		30.00
44.00	04400	SKILLED NURSING FACILITY	0		44.00
45.00	04500	NURSING FACILITY	0		45.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
60.00	06000	LABORATORY	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		62.30
65.00	06500	RESPIRATORY THERAPY	0		65.00
66.00	06600	PHYSICAL THERAPY	687		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
68.01	06801	PEDS FEEDING DISORDER RU CARES	0		68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
76.00	03550	MEDICAL SERVICES	0		76.00
76.01	03950	PSYCHIATRIC	0		76.01
76.02	03020	SEVERE BEHAVIOR	0		76.02
76.97	07697	CARDIAC REHABILITATION	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		76.98
76.99	07699	LITHOTRIPSY	0		76.99
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		78.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	368		90.00
90.01	09001	PEDS PRIMARY CARE CLINIC	0		90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.00	04950	SCHOOL BASED PROGRAMS	0		93.00
93.01	04951	OTHER OUTPATIENT SERVICE COST CENTER	0		93.01
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		93.99
		OTHER REIMBURSABLE COST CENTERS			
102.00	10200	OPIOID TREATMENT PROGRAM	0		102.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,200		118.00
		NONREIMBURSABLE COST CENTERS			
191.00	19100	RESEARCH	0		191.00
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
202.00		Cost to be allocated (per Wkst. B, Part I)	1,491,829		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	678.104091		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	24,096		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	10.952727		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/8/2024 9:17 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	38,283,089		38,283,089	0	38,283,089	30.00
44.00	04400	SKILLED NURSING FACILITY	21,279,583		21,279,583	0	21,279,583	44.00
45.00	04500	NURSING FACILITY	6,361,345		6,361,345	0	6,361,345	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,296		11,296	0	11,296	54.00
60.00	06000	LABORATORY	2,560		2,560	0	2,560	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	6,354,452	0	6,354,452	0	6,354,452	65.00
66.00	06600	PHYSICAL THERAPY	15,516,367	0	15,516,367	0	15,516,367	66.00
67.00	06700	OCCUPATIONAL 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	68.00
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	MEDICAL SERVICES	4,023,028		4,023,028	0	4,023,028	76.00
76.01	03950	PSYCHIATRIC	10,505,683		10,505,683	0	10,505,683	76.01
76.02	03020	SEVERE BEHAVIOR	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	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	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	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	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	200.00
201.00		Less Observation Beds	0		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 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/8/2024 9:17 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	83,690,905		83,690,905			30.00
44.00	04400	SKILLED NURSING FACILITY	27,532,750		27,532,750			44.00
45.00	04500	NURSING FACILITY	11,666,140		11,666,140			45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	51,956	29,150	81,106	0.139275	0.139275	54.00
60.00	06000	LABORATORY	1,019,744	96,218	1,115,962	0.002294	0.002294	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	25,558,408	20,331	25,578,739	0.248427	0.248427	65.00
66.00	06600	PHYSICAL THERAPY	4,222,603	15,494,645	19,717,248	0.786944	0.786944	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
68.01	06801	PEDS FEEDING DISORDER RU CARES	0	2,808,575	2,808,575	0.487617	0.487617	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,177,588	495,921	2,673,509	1.433520	1.433520	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,648,942	330,040	2,978,982	1.565860	1.565860	73.00
76.00	03550	MEDICAL SERVICES	891	0	891	4,515.182941	4,515.182941	76.00
76.01	03950	PSYCHIATRIC	350,872	15,320,228	15,671,100	0.670386	0.670386	76.01
76.02	03020	SEVERE BEHAVIOR	0	4,703,600	4,703,600	0.610707	0.610707	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0.000000	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	29,550,842	29,550,842	0.538505	0.538505	90.00
90.01	09001	PEDS PRIMARY CARE CLINIC	0	0	0	0.000000	0.000000	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00
93.00	04950	SCHOOL BASED PROGRAMS	0	0	0	0.000000	0.000000	93.00
93.01	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.01
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000	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)	169,155,902	111,791,316	280,947,218			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	169,155,902	111,791,316	280,947,218			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/8/2024 9:17 am

Title XVIII | Hospital | TEFRA

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.139275		54.00
60.00	06000	LABORATORY	0.002294		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	0.248427		65.00
66.00	06600	PHYSICAL THERAPY	0.786944		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.614935		67.00
68.00	06800	SPEECH PATHOLOGY	0.455187		68.00
68.01	06801	PEDS FEEDING DISORDER RU CARES	0.487617		68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.433520		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.565860		73.00
76.00	03550	MEDICAL SERVICES	4,515.182941		76.00
76.01	03950	PSYCHIATRIC	0.670386		76.01
76.02	03020	SEVERE BEHAVIOR	0.610707		76.02
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000		78.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.538505		90.00
90.01	09001	PEDS PRIMARY CARE CLINIC	0.000000		90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04950	SCHOOL BASED PROGRAMS	0.000000		93.00
93.01	04951	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.01
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000		93.99
		OTHER REIMBURSABLE COST CENTERS			
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/8/2024 9:17 am

Title XIX | Hospital | TEFRA

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	38,283,089		38,283,089	41,819	38,324,908	30.00
44.00	04400	SKILLED NURSING FACILITY	21,279,583		21,279,583	0	21,279,583	44.00
45.00	04500	NURSING FACILITY	6,361,345		6,361,345	0	6,361,345	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,296		11,296	0	11,296	54.00
60.00	06000	LABORATORY	2,560		2,560	0	2,560	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	6,354,452	0	6,354,452	0	6,354,452	65.00
66.00	06600	PHYSICAL THERAPY	15,516,367	0	15,516,367	0	15,516,367	66.00
67.00	06700	OCCUPATIONAL 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	68.00
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	MEDICAL SERVICES	4,023,028		4,023,028	0	4,023,028	76.00
76.01	03950	PSYCHIATRIC	10,505,683		10,505,683	62,140	10,567,823	76.01
76.02	03020	SEVERE BEHAVIOR	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	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	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	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	15,913,277		15,913,277	183,224	16,096,501	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	287,183	159,430,993	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	159,143,810	0	159,143,810	287,183	159,430,993	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/8/2024 9:17 am

Title XIX | Hospital | TEFRA

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	83,690,905		83,690,905			30.00
44.00	04400	SKILLED NURSING FACILITY	27,532,750		27,532,750			44.00
45.00	04500	NURSING FACILITY	11,666,140		11,666,140			45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	51,956	29,150	81,106	0.139275	0.139275	54.00
60.00	06000	LABORATORY	1,019,744	96,218	1,115,962	0.002294	0.002294	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	25,558,408	20,331	25,578,739	0.248427	0.248427	65.00
66.00	06600	PHYSICAL THERAPY	4,222,603	15,494,645	19,717,248	0.786944	0.786944	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
68.01	06801	PEDS FEEDING DISORDER RU CARES	0	2,808,575	2,808,575	0.487617	0.487617	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,177,588	495,921	2,673,509	1.433520	1.433520	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,648,942	330,040	2,978,982	1.565860	1.565860	73.00
76.00	03550	MEDICAL SERVICES	891	0	891	4,515.182941	4,515.182941	76.00
76.01	03950	PSYCHIATRIC	350,872	15,320,228	15,671,100	0.670386	0.670386	76.01
76.02	03020	SEVERE BEHAVIOR	0	4,703,600	4,703,600	0.610707	0.610707	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0.000000	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	29,550,842	29,550,842	0.538505	0.538505	90.00
90.01	09001	PEDS PRIMARY CARE CLINIC	0	0	0	0.000000	0.000000	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00
93.00	04950	SCHOOL BASED PROGRAMS	0	0	0	0.000000	0.000000	93.00
93.01	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.01
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000	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)	169,155,902	111,791,316	280,947,218			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	169,155,902	111,791,316	280,947,218			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/8/2024 9:17 am

Title XIX | Hospital | TEFRA

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	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	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
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	MEDICAL SERVICES	0.000000		76.00
76.01	03950	PSYCHIATRIC	0.000000		76.01
76.02	03020	SEVERE BEHAVIOR	0.000000		76.02
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000		78.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	PEDS PRIMARY CARE CLINIC	0.000000		90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04950	SCHOOL BASED PROGRAMS	0.000000		93.00
93.01	04951	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.01
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000		93.99
		OTHER REIMBURSABLE COST CENTERS			
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part II Date/Time Prepared: 5/8/2024 9:17 am

Title XIX | Hospital | TEFRA

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,296	3,247	8,049	0	0	54.00
60.00	06000	LABORATORY	2,560	41	2,519	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	6,354,452	111,481	6,242,971	0	0	65.00
66.00	06600	PHYSICAL THERAPY	15,516,367	1,260,835	14,255,532	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	15,199,352	889,019	14,310,333	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	12,954,547	428,598	12,525,949	0	0	68.00
68.01	06801	PEDS FEEDING DISORDER RU CARES	1,369,510	22,160	1,347,350	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,832,529	61,904	3,770,625	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,664,669	157,883	4,506,786	0	0	73.00
76.00	03550	MEDICAL SERVICES	4,023,028	82,489	3,940,539	0	0	76.00
76.01	03950	PSYCHIATRIC	10,505,683	681,845	9,823,838	0	0	76.01
76.02	03020	SEVERE BEHAVIOR	2,872,523	46,473	2,826,050	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	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	CLINIC	15,913,277	581,993	15,331,284	0	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	0	0	0	0	0	92.00
93.00	04950	SCHOOL BASED PROGRAMS	0	119,383	-119,383	0	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	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	93,219,793	4,447,351	88,772,442	0	0	200.00
201.00		Less Observation Beds	0	0	0	0	0	201.00
202.00		Total (line 200 minus line 201)	93,219,793	4,447,351	88,772,442	0	0	202.00

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

Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part II | Date/Time Prepared: 5/8/2024 9:17 am

Title XIX | Hospital | TEFRA

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,296	81,106	0.139275		54.00
60.00	06000	LABORATORY	2,560	1,115,962	0.002294		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	6,354,452	25,578,739	0.248427		65.00
66.00	06600	PHYSICAL THERAPY	15,516,367	19,717,248	0.786944		66.00
67.00	06700	OCCUPATIONAL 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 FEEDING DISORDER RU CARES	1,369,510	2,808,575	0.487617		68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,832,529	2,673,509	1.433520		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,664,669	2,978,982	1.565860		73.00
76.00	03550	MEDICAL SERVICES	4,023,028	891	4,515.182941		76.00
76.01	03950	PSYCHIATRIC	10,505,683	15,671,100	0.670386		76.01
76.02	03020	SEVERE BEHAVIOR	2,872,523	4,703,600	0.610707		76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000		76.98
76.99	07699	LITHOTRIPSY	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 IMMUNOTHERAPY	0	0	0.000000		78.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	15,913,277	29,550,842	0.538505		90.00
90.01	09001	PEDS PRIMARY CARE CLINIC	0	0	0.000000		90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	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	0.000000		93.01
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000		93.99
		OTHER REIMBURSABLE COST CENTERS					
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0.000000		102.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)	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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part I Date/Time Prepared: 5/8/2024 9:17 am

Title XVIII | Hospital | TEFRA

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	795,049	0	795,049	19,803	40.15	30.00
44.00	SKILLED NURSING FACILITY	1,478,279		1,478,279	17,199	85.95	44.00
45.00	NURSING FACILITY	142,707		142,707	7,300	19.55	45.00
200.00	Total (lines 30 through 199)	2,416,035		2,416,035	44,302		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
		6.00	7.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/8/2024 9:17 am

Title XVIII | Hospital | TEFRA

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,247	81,106	0.040034	0	0	54.00
60.00	06000	LABORATORY	41	1,115,962	0.000037	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	111,481	25,578,739	0.004358	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,260,835	19,717,248	0.063946	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	889,019	24,717,021	0.035968	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	428,598	28,459,848	0.015060	0	0	68.00
68.01	06801	PEDS FEEDING DISORDER RU CARES	22,160	2,808,575	0.007890	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	61,904	2,673,509	0.023155	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	157,883	2,978,982	0.052999	0	0	73.00
76.00	03550	MEDICAL SERVICES	82,489	891	92.580247	0	0	76.00
76.01	03950	PSYCHIATRIC	681,845	15,671,100	0.043510	0	0	76.01
76.02	03020	SEVERE BEHAVIOR	46,473	4,703,600	0.009880	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	581,993	29,550,842	0.019695	0	0	90.00
90.01	09001	PEDS PRIMARY CARE CLINIC	0	0	0.000000	0	0	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00
93.00	04950	SCHOOL BASED PROGRAMS	0	0	0.000000	0	0	93.00
93.01	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.01
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0	93.99
200.00		Total (lines 50 through 199)	4,327,968	158,057,423		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part III Date/Time Prepared: 5/8/2024 9:17 am

Title XVIII | Hospital | TEFRA

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
45.00	04500	NURSING FACILITY	0	0	0	0		45.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	19,803	0.00	0	30.00
44.00	04400	SKILLED NURSING FACILITY		0	17,199	0.00	0	44.00
45.00	04500	NURSING FACILITY		0	7,300	0.00	0	45.00
200.00		Total (lines 30 through 199)		0	44,302		0	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
45.00	04500	NURSING FACILITY	0	45.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/8/2024 9:17 am

Title XVIII | Hospital | TEFRA

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	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	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	PEDS FEEDING DISORDER RU CARES	0	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	MEDICAL SERVICES	0	0	0	0	0	76.00
76.01	03950	PSYCHIATRIC	0	0	0	0	0	76.01
76.02	03020	SEVERE BEHAVIOR	0	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	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	CLINIC	0	0	0	0	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	0		0		0	92.00
93.00	04950	SCHOOL BASED PROGRAMS	0	0	0	0	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
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/8/2024 9:17 am

Title XVIII | Hospital | TEFRA

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	81,106	0.000000	54.00
60.00	06000	LABORATORY	0	0	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	PHYSICAL THERAPY	0	0	0	19,717,248	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	24,717,021	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	28,459,848	0.000000	68.00
68.01	06801	PEDS FEEDING DISORDER RU CARES	0	0	0	2,808,575	0.000000	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,673,509	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,978,982	0.000000	73.00
76.00	03550	MEDICAL SERVICES	0	0	0	891	0.000000	76.00
76.01	03950	PSYCHIATRIC	0	0	0	15,671,100	0.000000	76.01
76.02	03020	SEVERE BEHAVIOR	0	0	0	4,703,600	0.000000	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	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						
90.00	09000	CLINIC	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	0	0	0	0	0.000000	92.00
93.00	04950	SCHOOL BASED PROGRAMS	0	0	0	0	0.000000	93.00
93.01	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0.000000	93.01
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
200.00		Total (lines 50 through 199)	0	0	0	158,057,423		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/8/2024 9:17 am

Title XVIII | Hospital | TEFRA

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
68.01	06801	PEDS FEEDING DISORDER RU CARES	0.000000	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	126	0	73.00
76.00	03550	MEDICAL SERVICES	0.000000	0	0	0	0	76.00
76.01	03950	PSYCHIATRIC	0.000000	0	0	0	0	76.01
76.02	03020	SEVERE BEHAVIOR	0.000000	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	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						
90.00	09000	CLINIC	0.000000	0	0	18,215	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	93.01
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
200.00		Total (lines 50 through 199)		0	0	18,341	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/8/2024 9:17 am

Title XVIII | Hospital | TEFRA

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.139275	0	0	0	0	54.00
60.00	06000	LABORATORY	0.002294	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.248427	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.786944	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.614935	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.455187	0	0	0	0	68.00
68.01	06801	PEDS FEEDING DISORDER RU CARES	0.487617	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.433520	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.565860	126	0	0	197	73.00
76.00	03550	MEDICAL SERVICES	4,515.182941	0	0	0	0	76.00
76.01	03950	PSYCHIATRIC	0.670386	0	0	0	0	76.01
76.02	03020	SEVERE BEHAVIOR	0.610707	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	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						
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	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	93.01
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
200.00		Subtotal (see instructions)		18,341	0	138	10,006	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		18,341	0	138	10,006	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/8/2024 9:17 am

Title XVIII | Hospital | TEFRA

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
68.01	06801	PEDS FEEDING DISORDER RU CARES	0	0		68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03550	MEDICAL SERVICES	0	0		76.00
76.01	03950	PSYCHIATRIC	0	0		76.01
76.02	03020	SEVERE BEHAVIOR	0	0		76.02
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	74		90.00
90.01	09001	PEDS PRIMARY CARE CLINIC	0	0		90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.00	04950	SCHOOL BASED PROGRAMS	0	0		93.00
93.01	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.01
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0		93.99
200.00		Subtotal (see instructions)	0	74		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	74		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 31-3300 | Component CCN: 31-5239 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/8/2024 9:17 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	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	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	PEDS FEEDING DISORDER RU CARES	0	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	MEDICAL SERVICES	0	0	0	0	0	76.00
76.01	03950	PSYCHIATRIC	0	0	0	0	0	76.01
76.02	03020	SEVERE BEHAVIOR	0	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	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	CLINIC	0	0	0	0	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	0		0		0	92.00
93.00	04950	SCHOOL BASED PROGRAMS	0	0	0	0	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
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 31-3300 | Component CCN: 31-5239 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/8/2024 9:17 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	81,106	0.000000	54.00
60.00	06000	LABORATORY	0	0	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	PHYSICAL THERAPY	0	0	0	19,717,248	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	24,717,021	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	28,459,848	0.000000	68.00
68.01	06801	PEDS FEEDING DISORDER RU CARES	0	0	0	2,808,575	0.000000	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,673,509	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,978,982	0.000000	73.00
76.00	03550	MEDICAL SERVICES	0	0	0	891	0.000000	76.00
76.01	03950	PSYCHIATRIC	0	0	0	15,671,100	0.000000	76.01
76.02	03020	SEVERE BEHAVIOR	0	0	0	4,703,600	0.000000	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	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						
90.00	09000	CLINIC	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	0	0	0	0	0.000000	92.00
93.00	04950	SCHOOL BASED PROGRAMS	0	0	0	0	0.000000	93.00
93.01	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0.000000	93.01
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
200.00		Total (lines 50 through 199)	0	0	0	158,057,423		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 31-3300 | Component CCN: 31-5239 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/8/2024 9:17 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
68.01	06801	PEDS FEEDING DISORDER RU CARES	0.000000	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
76.00	03550	MEDICAL SERVICES	0.000000	0	0	0	0	76.00
76.01	03950	PSYCHIATRIC	0.000000	0	0	0	0	76.01
76.02	03020	SEVERE BEHAVIOR	0.000000	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	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						
90.00	09000	CLINIC	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	93.01
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part I Date/Time Prepared: 5/8/2024 9:17 am

Title XIX | Hospital | TEFRA

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	795,049	0	795,049	19,803	40.15	30.00
44.00	SKILLED NURSING FACILITY	1,478,279		1,478,279	17,199	85.95	44.00
45.00	NURSING FACILITY	142,707		142,707	7,300	19.55	45.00
200.00	Total (lines 30 through 199)	2,416,035		2,416,035	44,302		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	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				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/8/2024 9:17 am

Title XIX | Hospital | TEFRA

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,247	81,106	0.040034	12,102	484	54.00
60.00	06000	LABORATORY	41	1,115,962	0.000037	66,908	2	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	111,481	25,578,739	0.004358	1,084,478	4,726	65.00
66.00	06600	PHYSICAL THERAPY	1,260,835	19,717,248	0.063946	249,663	15,965	66.00
67.00	06700	OCCUPATIONAL THERAPY	889,019	24,717,021	0.035968	239,398	8,611	67.00
68.00	06800	SPEECH PATHOLOGY	428,598	28,459,848	0.015060	691,718	10,417	68.00
68.01	06801	PEDS FEEDING DISORDER RU CARES	22,160	2,808,575	0.007890	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	61,904	2,673,509	0.023155	104,179	2,412	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	157,883	2,978,982	0.052999	277,852	14,726	73.00
76.00	03550	MEDICAL SERVICES	82,489	891	92.580247	0	0	76.00
76.01	03950	PSYCHIATRIC	681,845	15,671,100	0.043510	5,607	244	76.01
76.02	03020	SEVERE BEHAVIOR	46,473	4,703,600	0.009880	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	581,993	29,550,842	0.019695	0	0	90.00
90.01	09001	PEDS PRIMARY CARE CLINIC	0	0	0.000000	0	0	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00
93.00	04950	SCHOOL BASED PROGRAMS	0	0	0.000000	0	0	93.00
93.01	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.01
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0	93.99
200.00		Total (lines 50 through 199)	4,327,968	158,057,423		2,731,905	57,587	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part III Date/Time Prepared: 5/8/2024 9:17 am

Title XIX | Hospital | TEFRA

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
45.00	04500	NURSING FACILITY	0	0	0	0		45.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	19,803	0.00	1,942	30.00
44.00	04400	SKILLED NURSING FACILITY		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		25,028	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
45.00	04500	NURSING FACILITY	0	45.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/8/2024 9:17 am

Title XIX | Hospital | TEFRA

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	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	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	PEDS FEEDING DISORDER RU CARES	0	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	MEDICAL SERVICES	0	0	0	0	0	76.00
76.01	03950	PSYCHIATRIC	0	0	0	0	0	76.01
76.02	03020	SEVERE BEHAVIOR	0	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	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	CLINIC	0	0	0	0	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	0		0		0	92.00
93.00	04950	SCHOOL BASED PROGRAMS	0	0	0	0	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
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/8/2024 9:17 am

Title XIX | Hospital | TEFRA

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	81,106	0.000000	54.00
60.00	06000	LABORATORY	0	0	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	PHYSICAL THERAPY	0	0	0	19,717,248	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	24,717,021	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	28,459,848	0.000000	68.00
68.01	06801	PEDS FEEDING DISORDER RU CARES	0	0	0	2,808,575	0.000000	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,673,509	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,978,982	0.000000	73.00
76.00	03550	MEDICAL SERVICES	0	0	0	891	0.000000	76.00
76.01	03950	PSYCHIATRIC	0	0	0	15,671,100	0.000000	76.01
76.02	03020	SEVERE BEHAVIOR	0	0	0	4,703,600	0.000000	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	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						
90.00	09000	CLINIC	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	0	0	0	0	0.000000	92.00
93.00	04950	SCHOOL BASED PROGRAMS	0	0	0	0	0.000000	93.00
93.01	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0.000000	93.01
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
200.00		Total (lines 50 through 199)	0	0	0	158,057,423		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/8/2024 9:17 am

Title XIX | Hospital | TEFRA

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	12,102	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	66,908	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	1,084,478	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	249,663	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	239,398	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	691,718	0	0	0	68.00
68.01	06801	PEDS FEEDING DISORDER RU CARES	0.000000	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	104,179	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	277,852	0	0	0	73.00
76.00	03550	MEDICAL SERVICES	0.000000	0	0	0	0	76.00
76.01	03950	PSYCHIATRIC	0.000000	5,607	0	0	0	76.01
76.02	03020	SEVERE BEHAVIOR	0.000000	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	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						
90.00	09000	CLINIC	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	93.01
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
200.00		Total (lines 50 through 199)		2,731,905	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/8/2024 9:17 am

Title XIX | Hospital | TEFRA

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.139275	0	0	0	0	54.00
60.00	06000	LABORATORY	0.002294	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.248427	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.786944	0	15,513	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.614935	0	19,466	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.455187	0	16,868	0	0	68.00
68.01	06801	PEDS FEEDING DISORDER RU CARES	0.487617	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.433520	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.565860	0	0	0	0	73.00
76.00	03550	MEDICAL SERVICES	4,515.182941	0	0	0	0	76.00
76.01	03950	PSYCHIATRIC	0.670386	0	6,783,691	0	0	76.01
76.02	03020	SEVERE BEHAVIOR	0.610707	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	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						
90.00	09000	CLINIC	0.538505	0	1,424,295	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	93.01
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
200.00		Subtotal (see instructions)		0	8,259,833	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	8,259,833	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/8/2024 9:17 am

Title XIX | Hospital | TEFRA

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	12,208	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	11,970	0		67.00
68.00	06800	SPEECH PATHOLOGY	7,678	0		68.00
68.01	06801	PEDS FEEDING DISORDER RU CARES	0	0		68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03550	MEDICAL SERVICES	0	0		76.00
76.01	03950	PSYCHIATRIC	4,547,691	0		76.01
76.02	03020	SEVERE BEHAVIOR	0	0		76.02
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	766,990	0		90.00
90.01	09001	PEDS PRIMARY CARE CLINIC	0	0		90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.00	04950	SCHOOL BASED PROGRAMS	0	0		93.00
93.01	04951	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.01
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0		93.99
200.00		Subtotal (see instructions)	5,346,537	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,346,537	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/8/2024 9:17 am

Title XVIII | Hospital | TEFRA

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	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 reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	38,283,089	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	38,283,089	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	38,283,089	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,933.20	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	0	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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/8/2024 9:17 am

Title XVIII | Hospital | TEFRA

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	0	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	48,100.75	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/8/2024 9:17 am

Title XVIII | Hospital | TEFRA

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	795,049	38,283,089	0.020768	0	0	90.00
91.00	Nursing Program cost	0	38,283,089	0.000000	0	0	91.00
92.00	Allied health cost	0	38,283,089	0.000000	0	0	92.00
93.00	All other Medical Education	0	38,283,089	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 31-3300 Component CCN: 31-5239	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/8/2024 9:17 am
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	17,199	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	17,199	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)	17,199	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	21,279,583	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	21,279,583	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	21,279,583	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1

Component CCN: 31-5239 | Date/Time Prepared: 5/8/2024 9:17 am

Title XVIII | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)		48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
55.01	Permanent adjustment amount per discharge		55.01
55.02	Adjustment amount per discharge (contractor use only)		55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)		59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)		60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	21,279,583	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	1,237.26	71.00
72.00	Program routine service cost (line 9 x line 71)	0	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	0	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	0	83.00
84.00	Program inpatient ancillary services (see instructions)	0	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	0	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 31-3300 Component CCN: 31-5239	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/8/2024 9:17 am
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/8/2024 9:17 am

Title XIX | Hospital | TEFRA

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	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 reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,942	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	38,283,089	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	38,283,089	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	38,283,089	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,933.20	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,754,274	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3,754,274	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/8/2024 9:17 am

Title XIX | Hospital | TEFRA

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,517,978	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	5,272,252	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	77,971	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	57,587	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	135,558	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	5,136,694	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	31	54.00
55.00	Target amount per discharge	142,300.92	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	4,411,329	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	-725,365	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	142,116	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	4,689,003	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/8/2024 9:17 am

Title XIX | Hospital | TEFRA

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	795,049	38,283,089	0.020768	0	0	90.00
91.00	Nursing Program cost	0	38,283,089	0.000000	0	0	91.00
92.00	Allied health cost	0	38,283,089	0.000000	0	0	92.00
93.00	All other Medical Education	0	38,283,089	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/8/2024 9:17 am

Title XIX | Hospital | TEFRA

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		9,101,400		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.139275	12,102	1,686	54.00
60.00	06000	LABORATORY	0.002294	66,908	153	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.248427	1,084,478	269,414	65.00
66.00	06600	PHYSICAL THERAPY	0.786944	249,663	196,471	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.614935	239,398	147,214	67.00
68.00	06800	SPEECH PATHOLOGY	0.455187	691,718	314,861	68.00
68.01	06801	PEDS FEEDING DISORDER RU CARES	0.487617	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.433520	104,179	149,343	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.565860	277,852	435,077	73.00
76.00	03550	MEDICAL SERVICES	4,515.182941	0	0	76.00
76.01	03950	PSYCHIATRIC	0.670386	5,607	3,759	76.01
76.02	03020	SEVERE BEHAVIOR	0.610707	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.538505	0	0	90.00
90.01	09001	PEDS PRIMARY CARE CLINIC	0.000000	0	0	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
93.00	04950	SCHOOL BASED PROGRAMS	0.000000	0	0	93.00
93.01	04951	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.01
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	93.99
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,731,905	1,517,978	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		2,731,905		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 31-3300	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/8/2024 9:17 am
	Title XVIII	Hospital	TEFRA

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	74	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	10,006	2.00
3.00	OPPS or REH payments	4,626	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.961	5.00
6.00	Line 2 times line 5	9,616	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	48.11	7.00
8.00	Transitional corridor payment (see instructions)	4,990	8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	74	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	138	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	138	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	138	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	64	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	74	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	9,616	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,802	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	7,888	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount (see instructions)		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	7,888	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	7,888	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	7,888	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	7,888	40.00
41.00	Interim payments	2,767	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	4,963	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 31-3300	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/8/2024 9:17 am
	Title XVIII	Hospital	TEFRA

		1.00	
	MEDICARE PART B ANCILLARY COSTS		
200.00	Part B Combined Billed Days	0	200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/8/2024 9:17 am

Title XVIII | Hospital | TEFRA

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		2,767	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		0		2,767	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		4,963	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		7,730	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 31-3300	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part I Date/Time Prepared: 5/8/2024 9:17 am
	Title XVIII	Hospital	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 instructions)	0	1.01
2.00	Organ acquisition	0	2.00
3.00	Cost of physicians' services in a teaching hospital (see instructions)	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	Deductibles	0	7.00
8.00	Subtotal (line 6 minus line 7)	0	8.00
9.00	Coinsurance	0	9.00
10.00	Subtotal (line 8 minus line 9)	0	10.00
11.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	11.00
12.00	Adjusted reimbursable bad debts (see instructions)	0	12.00
13.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	13.00
14.00	Subtotal (sum of lines 10 and 12)	0	14.00
15.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	15.00
16.00	DO NOT USE THIS LINE		16.00
17.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	17.00
17.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	17.50
17.98	Recovery of accelerated depreciation.	0	17.98
17.99	Demonstration payment adjustment amount before sequestration	0	17.99
18.00	Total amount payable to the provider (see instructions)	0	18.00
18.01	Sequestration adjustment (see instructions)	0	18.01
18.02	Demonstration payment adjustment amount after sequestration	0	18.02
19.00	Interim payments	0	19.00
20.00	Tentative settlement (for contractor use only)	0	20.00
21.00	Balance due provider/program (line 18 minus lines 18.01, 18.02, 19, and 20)	0	21.00
22.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	22.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 31-3300 Component CCN: 31-5239	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VI Date/Time Prepared: 5/8/2024 9:17 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
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		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	0	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	0	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.98	Recovery of accelerated depreciation.	0	14.98
14.99	Demonstration payment adjustment amount before sequestration	0	14.99
15.00	Subtotal (see instructions	0	15.00
15.01	Sequestration adjustment (see instructions)	0	15.01
15.02	Demonstration payment adjustment amount after sequestration	0	15.02
15.75	Sequestration for non-claims based amounts (see instructions)	0	15.75
16.00	Interim payments	0	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 31-3300	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/8/2024 9:17 am
	Title XIX	Hospital	TEFRA

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	4,689,003		1.00
2.00	Medical and other services		5,346,537	2.00
3.00	Organ acquisition (certified transplant programs only)	0		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 services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	11,833,305	8,259,833	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	7,144,302	2,913,296	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	4,689,003	5,346,537	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	4,689,003	5,346,537	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	4,689,003	5,346,537	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	4,689,003	5,346,537	36.00
37.00	D3 ADJUSTMENT	0	517,690	37.00
38.00	Subtotal (line 36 ± line 37)	4,689,003	5,864,227	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	4,689,003	5,864,227	40.00
41.00	Interim payments	7,130,016	5,526,446	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-2,441,013	337,781	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 31-3300	Period: From 01/01/2023 To 12/31/2023	Worksheet E-4 Date/Time Prepared: 5/8/2024 9:17 am
	Title XVIII	Hospital	TEFRA

				1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
1.01	FTE cap adjustment under §131 of the CAA 2021 (see instructions)			0.00	1.01
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
2.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)			0.00	2.26
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
3.02	Adjustment (increase or decrease) to the hospital's rural track FTE limitation(s) for rural track programs with a rural track Medicare GME affiliation agreement in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)			0.00	3.02
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
4.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)			0.00	4.21
5.00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lines 2.26 through 2.49, minus lines 3 and 3.01, plus or minus line 3.02, plus or minus line 4, plus lines 4.01 through 4.27			0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			5.95	6.00
7.00	Enter the lesser of line 5 or line 6			0.00	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	2.12	3.06	5.18	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6. For cost reporting periods beginning on or after October 1, 2022, or if Worksheet S-2, Part I, line 68, is "Y", see instructions.	0.00	0.00	0.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.00	0.00		17.00
18.00	Per resident amount	0.00	0.00		18.00
18.01	Per resident amount under §131 of the CAA 2021	0.00	0.00		18.01
19.00	Approved amount for resident costs	0	0	0	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			5.95	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			0	25.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-4 | Date/Time Prepared: 5/8/2024 9:17 am

Title XVIII | Hospital | TEFRA

		Inpatient Part A	Managed Care	Total	
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	0	0		26.00
27.00	Total Inpatient Days (see instructions)	19,803	19,803		27.00
28.00	Ratio of inpatient days to total inpatient days	0.000000	0.000000		28.00
29.00	Program direct GME amount	0	0	0	29.00
29.01	Percent reduction for MA DGME		3.27		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		0	0	30.00
31.00	Net Program direct GME amount			0	31.00
				1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			0	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
	Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)			0	37.00
38.00	Organ acquisition and HSCT acquisition costs (see instructions)			0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)			0	39.00
40.00	Primary payer payments (see instructions)			0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			0	41.00
	Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)			10,080	42.00
43.00	Primary payer payments (see instructions)			0	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			10,080	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			10,080	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.000000	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			1.000000	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)			0	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			0	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			0	50.00

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 | Worksheet G | Date/Time Prepared: 5/8/2024 9:17 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1,163,106	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	29,074,682	0	0	0	4.00
5.00	Other receivable	74,909,903	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-5,693,352	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	1,056,911	0	0	0	8.00
9.00	Other current assets	3,822,397	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	104,333,647	0	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	0	13.00
14.00	Accumulated depreciation	-2,770,620	0	0	0	14.00
15.00	Buildings	139,146,750	0	0	0	15.00
16.00	Accumulated depreciation	-49,987,264	0	0	0	16.00
17.00	Leasehold improvements	31,086,128	0	0	0	17.00
18.00	Accumulated depreciation	-16,852,685	0	0	0	18.00
19.00	Fixed equipment	41,564,876	0	0	0	19.00
20.00	Accumulated depreciation	-28,855,957	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	67,868,766	0	0	0	23.00
24.00	Accumulated depreciation	-59,206,156	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	126,595,217	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	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	0	0	0	37.00
38.00	Salaries, wages, and fees payable	10,676,943	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,298,654	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	8,877,471	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	23,734,662	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	32,373,365	0	0	0	47.00
48.00	Unsecured loans	56,853,266	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	89,226,631	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	112,961,293	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	169,582,931				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	169,582,931	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	282,544,224	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 5/8/2024 9:17 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		165,565,604		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-3,678,834				2.00
3.00	Total (sum of line 1 and line 2)		161,886,770		0		3.00
4.00	NET TRANSFER OF EQUITY	-1,158,051		0		0	4.00
5.00	INT IN TRNA OF UNCONS FDN	-2,275,351		0		0	5.00
6.00	CONTRIBUTED CAPITAL	7,439,674		0		0	6.00
7.00	CONTRIBUTED CAPITAL-UR	3,689,889		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		7,696,161		0		10.00
11.00	Subtotal (line 3 plus line 10)		169,582,931		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		169,582,931		0		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	NET TRANSFER OF EQUITY		0			4.00
5.00	INT IN TRNA OF UNCONS FDN		0			5.00
6.00	CONTRIBUTED CAPITAL		0			6.00
7.00	CONTRIBUTED CAPITAL-UR		0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/8/2024 9:17 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	83,690,905		83,690,905	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	27,532,750		27,532,750	7.00
8.00	NURSING FACILITY	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)	122,889,795		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	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	122,889,795		122,889,795	17.00
18.00	Ancillary services	48,218,189	112,162,104	160,380,293	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	171,107,984	112,162,104	283,270,088	28.00
	PART II - OPERATING EXPENSES				
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		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		189,549,882		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 31-3300 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-3 | Date/Time Prepared: 5/8/2024 9:17 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	283,270,088	1.00
2.00	Less contractual allowances and discounts on patients' accounts	118,143,110	2.00
3.00	Net patient revenues (line 1 minus line 2)	165,126,978	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	189,549,882	4.00
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	6.00
7.00	Income from investments	1,077,849	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	11,497	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	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	24.00
24.01	FOUNDATION NET ASSETS RELEASED	902,136	24.01
24.02	CHRONIC PAIN PROGRAM	481,941	24.02
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	20,744,070	25.00
26.00	Total (line 5 plus line 25)	-3,678,834	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-3,678,834	29.00