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: 09-30-2028

ASPEN HILLS HEALTHCARE CENTER	Period:	Run Date Time:	5/25/2026 2:55
	From: 01/01/2025	MCRIF32	**2552-10**
Provider CCN: 31-4023	To: 12/31/2025	Version:	25.3.181.0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT
CERTIFICATION AND SETTLEMENT SUMMARY

Worksheet S
Parts I, II & III

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: — Time:
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. [ ] Initial Report for this Provider CCN
9. [ ] Final Report for this Provider CCN
10. NPR Date: _____
11. Contractor 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 OF 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 ASPEN HILLS HEALTHCARE CENTER, 31-4023 {Provider Name(s) and Number(s)} for the cost reporting period beginning 01/01/2025 and ending 12/31/2025 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	*Avi Maierovits*		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:	AVI MAIEROVITS			2
3	Signatory Title:	CONTROLLER			3
4	Signature Date:	(Dated when report is electronically signed.)			4

PART III - SETTLEMENT SUMMARY

			Title XVIII				
		Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
1.00	HOSPITAL	0	-445	0	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	354,547	0		0	7.00
200.00	TOTAL	**0**	**354,102**	**0**	**0**	**0**	200.00

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Worksheet S-2
Part I

PART I - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX IDENTIFICATION DATA

Hospital and Hospital Health Care Complex Address:

1.00	Street:	600 PEMBERTON-BROWNS MILL ROAD	P.O. Box:						1.00
2.00	City:	LISBON	State:	NJ	ZIP Code:	08060	County	BURLINGTON	2.00

Hospital and Hospital-Based Component Identification:

							Payment System (P, T, O, or N)			
	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
3.00	Hospital	ASPEN HILLS HEALTHCARE CENTER	314023	15804	4 - Psychiatric	11/29/1995	N	P	T	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	ASPEN HILLS HEALTHCARE CENTER	315260	15804		04/04/1988	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
20.00	Cost Reporting Period (mm/dd/yyyy)	From: 01/01/2025	To: 12/31/2025							20.00
21.00	Type of Control (see instructions)	4 - Proprietary, Corporation								21.00

Inpatient PPS Information

		1.00	2.00	3.00	
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 redesignation from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015 or FY2025? 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
22.05	Did this hospital receive a geographic reclassification from urban to rural in accordance with 42 CFR 412.103? Enter in column 1, "Y" for yes or "N" for no. If column 1 is Y, enter the effective date of the geographic reclassification in column 2.	N			22.05
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.	2	N		23.00

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Worksheet S-2
Part I

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid days	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 Status	Date of Geographic Reclassification	
		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
			1.00	
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
		Beginning:	Ending:	
		1.00	2.00	
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

Prospective Payment System (PPS)-Capital

		V	XVIII	XIX	
		1.00	2.00	3.00	
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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Worksheet S-2
Part I

Teaching Hospitals

		V	XVIII	XIX	
		1.00	2.00	3.00	
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
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

ACA Provisions Affecting the Health Resources and Services Administration (HRSA)

		1.00	
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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Worksheet S-2
Part I

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.

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
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

Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

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

Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)

		1.00	
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

Inpatient Psychiatric Facility PPS

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

Inpatient Rehabilitation Facility PPS

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Worksheet S-2
Part I

Long Term Care Hospital PPS

		1.00	
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

Title V and XIX Services

		V	XIX	
		1.00	2.00	
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	N	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	Y	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	10.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	5.80	97.00
		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	N	98.06

Rural Providers

		1.00	2.00	
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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Worksheet S-2
Part I

		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	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.		N			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.		0			118.00
			Premiums	Losses	Insurance	
			1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:		0	0	0	118.01
				1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.			N		118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.			N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.			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
124.00	Did the hospital incur cost, either directly or through a contract with an outside supplier, to establish and maintain access to no less than a 6-month buffer stock of one or more essential medicines according to 42 CFR 412.113(g)? Enter "Y" for yes or "N" for no.			N		124.00
Certified Transplant Center Information						
				1.00	2.00	
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						
				1.00	2.00	
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)			Y		140.00

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:		Contractor's Name:		Contractor's Number:	141.00
142.00	Street:		P.O. Box:			142.00
143.00	City:		State:		Zip Code:	143.00

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Worksheet S-2
Part I

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

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)

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
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

Multicampus

							1.00	
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

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

						1.00	
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

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HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Worksheet S-2
Part II

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

		Y/N	Date		
		1.00	2.00		
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)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	06/15/2025	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00

			Part A		Part B		
			Y/N	Date	Y/N	Date	
			1.00	2.00	3.00	4.00	
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, in columns 2 and 4, from the PS&R used to prepare this cost report, enter the "Paid Claims Verified Current As Of" date, if present, or the paid-through date.(see instructions)		Y	05/11/2026	Y	05/11/2026	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, in columns 2 and 4, enter the "Paid Claims Verified Current As Of" date, if present, or the paid-through date. (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
		Description	Y/N	Date	Y/N	Date	
		0	1.00	2.00	3.00	4.00	
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

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HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Worksheet S-2
Part II

COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

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

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

		1.00	2.00	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.	CHRIS	GUILBAULT	CONSULTANT	41.00
42.00	Enter the employer/company name of the cost report preparer.	HEALTH CARE RESOURCES			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	609-987-1440	CHRIS.GUILBAULT@HCRNJ.NET		43.00

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Worksheet S-3
Part I

						I/P Days / O/P Visits / Trips				
	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
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	30	10,950	0.00	0	1,413	0	10,095	1.00
2.00	HMO and other (see instructions)						0	0		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	0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0		0	0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		**30**	**10,950**	**0.00**	**0**	**1,413**	**0**	**10,095**	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)		**30**	**10,950**	**0.00**	**0**	**1,413**	**0**	**10,095**	14.00
15.00	CAH visits					0	0	0	0	15.00
15.10	REH hours and visits				0.00	0	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	44.00	204	74,460		0	8,473	49,091	68,031	19.00
20.00	NURSING FACILITY									20.00
21.00	OTHER LONG TERM CARE									21.00
22.00	HOME HEALTH AGENCY									22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)									23.00
24.00	HOSPICE									24.00
24.10	HOSPICE (non-distinct part)	30.00							0	24.10
25.00	CMHC - CMHC									25.00
26.00	RURAL HEALTH CLINIC									26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	0	0	0	26.25
27.00	Total (sum of lines 14-26)		**234**							27.00
28.00	Observation Bed Days					0		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	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									34.00

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Worksheet S-3
Part I

		Full Time Equivalents			Discharges					
	Component	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients		
		9.00	10.00	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	64	0	2,234		1.00
2.00	HMO and other (see instructions)					0	0			2.00
3.00	HMO IPF Subprovider						0			3.00
4.00	HMO IRF Subprovider						0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF									5.00
6.00	Hospital Adults & Peds. Swing Bed NF									6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)									7.00
8.00	INTENSIVE CARE UNIT									8.00
9.00	CORONARY CARE UNIT									9.00
10.00	BURN INTENSIVE CARE UNIT									10.00
11.00	SURGICAL INTENSIVE CARE UNIT									11.00
12.00	OTHER SPECIAL CARE (SPECIFY)									12.00
13.00	NURSERY									13.00
14.00	Total (see instructions)	**0.00**	**48.30**	**0.00**	**0**	**64**	**0**	**2,234**		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	148.90	0.00						19.00
20.00	NURSING FACILITY									20.00
21.00	OTHER LONG TERM CARE									21.00
22.00	HOME HEALTH AGENCY									22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)									23.00
24.00	HOSPICE									24.00
24.10	HOSPICE (non-distinct part)									24.10
25.00	CMHC - CMHC									25.00
26.00	RURAL HEALTH CLINIC									26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00	0.00	0.00						26.25
27.00	Total (sum of lines 14-26)	**0.00**	**197.20**	**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

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HOSPITAL WAGE INDEX INFORMATION

Worksheet S-3
Part II

PART II - WAGE DATA

		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	
SALARIES								
1.00	Total salaries (see instructions)	200.00	12,339,358	0	12,339,358	410,102.00	30.09	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	5,673,943	0	5,673,943	194,097.00	29.23	9.00
10.00	Excluded area salaries (see instructions)		0	0	0	0.00	0.00	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor: Direct Patient Care		44,065	0	44,065	964.00	45.71	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		0	0	0	0.00	0.00	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
15.01	Home office Physicians Part A - Administrative		0	0	0	0.00	0.00	15.01
15.02	Home office contract Physicians Part A - Administrative		0	0	0	0.00	0.00	15.02
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)		1,507,119	0	1,507,119			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		421,021	0	421,021			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)		0	0	0			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
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	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	1,699,763	0	1,699,763	38,793.00	43.82	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	327,281	0	327,281	12,883.00	25.40	30.00
31.00	Laundry & Linen Service	8.00	64,126	0	64,126	4,193.00	15.29	31.00
32.00	Housekeeping	9.00	581,114	0	581,114	35,225.00	16.50	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	106,418	0	106,418	2,048.00	51.96	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00

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HOSPITAL WAGE INDEX INFORMATION

Worksheet S-3
Part II

PART II - WAGE DATA

		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	
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	384,137	0	384,137	6,737.00	57.02	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	285,470	0	285,470	7,842.00	36.40	42.00
43.00	Other General Service	18.00	522,730	0	522,730	25,178.00	20.76	43.00

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HOSPITAL WAGE INDEX INFORMATION

Worksheet S-3
Part III

PART III - HOSPITAL WAGE INDEX SUMMARY

		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	
1.00	Net salaries (see instructions)		12,339,358	0	12,339,358	410,102.00	30.09	1.00
2.00	Excluded area salaries (see instructions)		5,673,943	0	5,673,943	194,097.00	29.23	2.00
3.00	Subtotal salaries (line 1 minus line 2)		**6,665,415**	**0**	**6,665,415**	**216,005.00**	**30.86**	3.00
4.00	Subtotal other wages & related costs (see inst.)		44,065	0	44,065	964.00	45.71	4.00
5.00	Subtotal wage-related costs (see inst.)		1,507,119	0	1,507,119	0.00	22.61	5.00
6.00	Total (sum of lines 3 thru 5)		**8,216,599**	**0**	**8,216,599**	**216,969.00**	**37.87**	6.00
7.00	Total overhead cost (see instructions)		3,971,039	0	3,971,039	132,899.00	29.88	7.00

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HOSPITAL WAGE RELATED COSTS

Worksheet S-3
Part IV

PART IV - WAGE RELATED COSTS

Part A - Core List

		Amount Reported	
		1.00	
RETIREMENT COST			
1.00	401K Employer Contributions	13,679	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)	615,712	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	223,004	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	918,797	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	156,948	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)	**1,928,140**	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

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HOSPITAL CONTRACT LABOR AND BENEFIT COST

Worksheet S-3
Part V

PART V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

		Contract Labor	Benefit Cost	
		1.00	2.00	
1.00	Total facility's contract labor and benefit cost	1,924,001	1,307,625	1.00
2.00	Hospital	44,065	421,020	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY	1,879,936	886,605	8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I			17.00
18.00	Other	0	0	18.00

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES **Worksheet A**

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	Adjustments (See A-8)	Net Expenses For Allocation	
			1.00	2.00	3.00	4.00	5.00	6.00	7.00	
GENERAL SERVICE COST CENTERS										
1.00	00100	CAP REL COSTS-BLDG & FIXT		10,147,207	**10,147,207**	0	**10,147,207**	-7,796,396	**2,350,811**	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,939,675	**1,939,675**	0	**1,939,675**	0	**1,939,675**	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,699,763	4,806,683	**6,506,446**	0	**6,506,446**	-959,861	**5,546,585**	5.00
7.00	00700	OPERATION OF PLANT	327,281	1,042,941	**1,370,222**	0	**1,370,222**	0	**1,370,222**	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	64,126	96,513	**160,639**	0	**160,639**	0	**160,639**	8.00
9.00	00900	HOUSEKEEPING	581,114	114,170	**695,284**	0	**695,284**	0	**695,284**	9.00
10.00	01000	DIETARY	106,418	1,636,592	**1,743,010**	0	**1,743,010**	0	**1,743,010**	10.00
13.00	01300	NURSING ADMINISTRATION	384,137	0	**384,137**	0	**384,137**	0	**384,137**	13.00
17.00	01700	SOCIAL SERVICE	285,470	0	**285,470**	0	**285,470**	0	**285,470**	17.00
18.00	01850	PATIENT ACTIVITIES	522,730	25,490	**548,220**	0	**548,220**	0	**548,220**	18.00
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	2,694,376	912,843	**3,607,219**	0	**3,607,219**	0	**3,607,219**	30.00
44.00	04400	SKILLED NURSING FACILITY	5,673,943	1,460,409	**7,134,352**	0	**7,134,352**	0	**7,134,352**	44.00
ANCILLARY SERVICE COST CENTERS										
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	48,426	**48,426**	0	**48,426**	0	**48,426**	54.00
60.00	06000	LABORATORY	0	71,054	**71,054**	0	**71,054**	0	**71,054**	60.00
64.00	06400	INTRAVENOUS THERAPY	0	7,725	**7,725**	0	**7,725**	0	**7,725**	64.00
66.00	06600	PHYSICAL THERAPY	0	414,441	**414,441**	0	**414,441**	0	**414,441**	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	443,363	**443,363**	0	**443,363**	0	**443,363**	67.00
68.00	06800	SPEECH PATHOLOGY	0	195,064	**195,064**	0	**195,064**	0	**195,064**	68.00
69.00	06900	ELECTROCARDIOLOGY	0	561	**561**	0	**561**	0	**561**	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	750	**750**	0	**750**	0	**750**	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	347,144	**347,144**	0	**347,144**	0	**347,144**	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	**0**	0	**0**	0	**0**	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	**0**	0	**0**	0	**0**	78.00
OUTPATIENT SERVICE COST CENTERS										
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART								92.00
OTHER REIMBURSABLE COST CENTERS										
95.00	09500	AMBULANCE SERVICES	0	0	**0**	0	**0**	0	**0**	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	**0**	0	**0**	0	**0**	102.00
SPECIAL PURPOSE COST CENTERS										
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	**12,339,358**	**23,711,051**	**36,050,409**	**0**	**36,050,409**	**-8,756,257**	**27,294,152**	118.00
NONREIMBURSABLE COST CENTERS										
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	**0**	0	**0**	0	**0**	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	**0**	0	**0**	0	**0**	192.00
194.00	07950	SPACE RENTED TO PHYSICIAN PRACTICE	0	0	**0**	0	**0**	0	**0**	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	**12,339,358**	**23,711,051**	**36,050,409**	**0**	**36,050,409**	**-8,756,257**	**27,294,152**	200.00

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RECLASSIFICATIONS **Worksheet A-6**

	Increases				Decreases					
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	10.00	
A - DEFAULT										
1.00		0.00	0	0		0.00	0	0	0	1.00
	Totals		**0**	**0**			**0**	**0**		
500.00	**TOTAL RECLASSIFICATIONS (sum of columns 4 and 5 must equal sum of columns 8 and 9)**		**0**	**0**			**0**	**0**		500.00

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
(2) Transfer the amounts in columns 4, 5, 8 and 9 to Worksheet A, column 4, line as appropriate.

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RECONCILIATION OF CAPITAL COSTS CENTERS

Worksheet A-7
Part I

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

	Description	Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	Land	0	0	0	**0**	0	**0**	0	1.00
2.00	Land Improvements	0	0	0	**0**	0	**0**	0	2.00
3.00	Buildings and Fixtures	4,378,566	237,239	0	**237,239**	2,255,174	**2,360,631**	0	3.00
4.00	Building Improvements	0	0	0	**0**	0	**0**	0	4.00
5.00	Fixed Equipment	0	0	0	**0**	0	**0**	0	5.00
6.00	Movable Equipment	1,168,162	109,200	0	**109,200**	910,128	**367,234**	0	6.00
7.00	HIT designated Assets	0	0	0	**0**	0	**0**	0	7.00
8.00	Subtotal (sum of lines 1-7)	**5,546,728**	**346,439**	**0**	**346,439**	**3,165,302**	**2,727,865**	**0**	8.00
9.00	Reconciling Items	0	0	0	**0**	0	**0**	0	9.00
10.00	Total (line 8 minus line 9)	**5,546,728**	**346,439**	**0**	**346,439**	**3,165,302**	**2,727,865**	**0**	10.00

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2

	Description	SUMMARY OF CAPITAL: Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		9.00	10.00	11.00	12.00	13.00	14.00	15.00	
1.00	CAP REL COSTS-BLDG & FIXT	221,516	9,925,691	0	0	0	0	**10,147,207**	1.00
3.00	Total (sum of lines 1-2)	**221,516**	**9,925,691**	**0**	**0**	**0**	**0**	**10,147,207**	3.00

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS

	Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
1.00	CAP REL COSTS-BLDG & FIXT	2,727,865	0	2,727,865	1.000000	0	0	0	**0**	1.00
3.00	Total (sum of lines 1-2)	**2,727,865**	**0**	**2,727,865**	**1.000000**	**0**	**0**	**0**	**0**	3.00

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS

	Description	SUMMARY OF CAPITAL: Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		9.00	10.00	11.00	12.00	13.00	14.00	15.00	
1.00	CAP REL COSTS-BLDG & FIXT	793,595	68,607	338,430	95,312	371,652	683,215	**2,350,811**	1.00
3.00	Total (sum of lines 1-2)	**793,595**	**68,607**	**338,430**	**95,312**	**371,652**	**683,215**	**2,350,811**	3.00

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ADJUSTMENTS TO EXPENSES **Worksheet A-8**

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Description (1)	Basis/Code (2)	Amount	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	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-1,539	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	0			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-8,012,196			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	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	*** Cost Center Deleted ***	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	PROMOTIONAL ADS	A	-65,522	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	CREDIT LOSS & WRITEOFFS	A	-427,000	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	CONTROLLER FEES	A	-150,000	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	LEGAL DEDUCTIBLES	A	-100,000	ADMINISTRATIVE & GENERAL	5.00	0	36.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		**-8,756,257**				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.

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

Worksheet A-8-1

A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	1.00	CAP REL COSTS-BLDG & FIXT	RENT	0	9,857,084	**-9,857,084**	10	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	DEPRECIATION	572,079	0	**572,079**	9	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST	338,430	0	**338,430**	11	3.00
3.01	1.00	CAP REL COSTS-BLDG & FIXT	FEES	7,121	0	**7,121**	14	3.01
3.02	1.00	CAP REL COSTS-BLDG & FIXT	MORTGAGE INSURANCE	95,312	0	**95,312**	12	3.02
3.03	1.00	CAP REL COSTS-BLDG & FIXT	REAL ESTATE TAX	371,652	0	**371,652**	13	3.03
3.04	1.00	CAP REL COSTS-BLDG & FIXT	PROPERTY INSURANCE	676,094	0	**676,094**	14	3.04
3.05	0.00			0	0	**0**	0	3.05
3.06	10.00	DIETARY	PURCHASING	672,787	672,787	**0**	0	3.06
3.07	5.00	ADMINISTRATIVE & GENERAL	CORPORATE SERVICES	1,444,200	1,660,000	**-215,800**	0	3.07
3.08	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSURANCE	790,291	790,291	**0**	0	3.08
4.00	44.00	SKILLED NURSING FACILITY	NURSING AGENCY	9,576	9,576	**0**	0	4.00
5.00	**TOTALS (sum of lines 1 through 4) Transfer column 6, line 5, to Worksheet A-8, column 2, line 12.**			**4,977,542**	**12,989,738**	**-8,012,196**		5.00

* The amounts on lines 1 through 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 have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1.00	2.00	3.00	4.00	5.00	6.00	
6.00	B	ASPEN HILLS HEATHCARE CTR LLC	100.00	OCEAN HEALTHCARE OPER PTR LLC	100.00	REALTY	6.00
7.00	B	ASPEN HILLS HEALTHCARE CTR LLC	100.00	OCEAN DIETARY	100.00	PURCHASING	7.00
8.00	B	ASPEN HILLS HEALTHCARE CTR LLC	100.00	DYNAMIC HEALTH	100.00	CORPORATE SERVICES	8.00
9.00	B	ASPEN HILLS HEALTHCARE CTR LLC	100.00	OCEAN HEALTHCARE HEALTH FUND	100.00	HEALTH INSURANCE	9.00
10.00			0.00		0.00		10.00

(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.
G. Other (financial or non-financial) specify:

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COST ALLOCATION - GENERAL SERVICE COSTS

Worksheet B
Part I

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
		0	1.00	4.00	4A	5.00	7.00	
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT	2,350,811	**2,350,811**					1.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	1,939,675	0	**1,939,675**				4.00
5.00	ADMINISTRATIVE & GENERAL	5,546,585	554,983	267,193	6,368,761	**6,368,761**		5.00
7.00	OPERATION OF PLANT	1,370,222	166,462	51,447	1,588,131	483,357	**2,071,488**	7.00
8.00	LAUNDRY & LINEN SERVICE	160,639	40,398	10,080	211,117	64,255	51,360	8.00
9.00	HOUSEKEEPING	695,284	38,727	91,348	825,359	251,203	49,236	9.00
10.00	DIETARY	1,743,010	212,216	16,728	1,971,954	600,176	269,800	10.00
13.00	NURSING ADMINISTRATION	384,137	0	60,384	444,521	135,293	0	13.00
17.00	SOCIAL SERVICE	285,470	7,777	44,874	338,121	102,909	9,887	17.00
18.00	PATIENT ACTIVITIES	548,220	0	82,170	630,390	191,863	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	3,607,219	130,709	423,540	4,161,468	1,266,568	166,176	30.00
44.00	SKILLED NURSING FACILITY	7,134,352	1,000,179	891,911	9,026,442	2,747,243	1,271,575	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	RADIOLOGY-DIAGNOSTIC	48,426	0	0	48,426	14,739	0	54.00
60.00	LABORATORY	71,054	0	0	71,054	21,626	0	60.00
64.00	INTRAVENOUS THERAPY	7,725	0	0	7,725	2,351	0	64.00
66.00	PHYSICAL THERAPY	414,441	63,071	0	477,512	145,334	80,185	66.00
67.00	OCCUPATIONAL THERAPY	443,363	27,937	0	471,300	143,443	35,517	67.00
68.00	SPEECH PATHOLOGY	195,064	0	0	195,064	59,369	0	68.00
69.00	ELECTROCARDIOLOGY	561	0	0	561	171	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	750	0	0	750	228	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	347,144	0	0	347,144	105,655	0	73.00
77.00	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	0	77.00
78.00	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
92.00	OBSERVATION BEDS (NON-DISTINCT PART							92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	AMBULANCE SERVICES	0	0	0	0	0	0	95.00
102.00	OPIOID TREATMENT PROGRAM	0	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	**27,294,152**	**2,242,459**	**1,939,675**	**27,185,800**	**6,335,783**	**1,933,736**	118.00
NONREIMBURSABLE COST CENTERS								
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,132	0	2,132	649	2,710	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	0	192.00
194.00	SPACE RENTED TO PHYSICIAN PRACTICE	0	106,220	0	106,220	32,329	135,042	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)	**27,294,152**	**2,350,811**	**1,939,675**	**27,294,152**	**6,368,761**	**2,071,488**	202.00

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COST ALLOCATION - GENERAL SERVICE COSTS

Worksheet B
Part I

	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	SOCIAL SERVICE	OTHER GENERAL SERVICE PATIENT ACTIVITIES	
		8.00	9.00	10.00	13.00	17.00	18.00	
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT							1.00
4.00	EMPLOYEE BENEFITS DEPARTMENT							4.00
5.00	ADMINISTRATIVE & GENERAL							5.00
7.00	OPERATION OF PLANT							7.00
8.00	LAUNDRY & LINEN SERVICE	**326,732**						8.00
9.00	HOUSEKEEPING	0	**1,125,798**					9.00
10.00	DIETARY	0	165,449	**3,007,379**				10.00
13.00	NURSING ADMINISTRATION	0	0	0	**579,814**			13.00
17.00	SOCIAL SERVICE	0	6,063	0	0	**456,980**		17.00
18.00	PATIENT ACTIVITIES	0	0	0	0	0	**822,253**	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	42,218	101,904	388,596	164,620	253,659	317,863	30.00
44.00	SKILLED NURSING FACILITY	284,514	779,768	2,618,783	415,194	203,321	504,390	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	0	0	0	0	60.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
66.00	PHYSICAL THERAPY	0	49,172	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	21,780	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
77.00	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	0	77.00
78.00	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
92.00	OBSERVATION BEDS (NON-DISTINCT PART							92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	AMBULANCE SERVICES	0	0	0	0	0	0	95.00
102.00	OPIOID TREATMENT PROGRAM	0	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	**326,732**	**1,124,136**	**3,007,379**	**579,814**	**456,980**	**822,253**	118.00
NONREIMBURSABLE COST CENTERS								
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,662	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	0	192.00
194.00	SPACE RENTED TO PHYSICIAN PRACTICE	0	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	**326,732**	**1,125,798**	**3,007,379**	**579,814**	**456,980**	**822,253**	202.00

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COST ALLOCATION - GENERAL SERVICE COSTS

Worksheet B
Part I

	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
4.00	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	ADMINISTRATIVE & GENERAL					5.00
7.00	OPERATION OF PLANT					7.00
8.00	LAUNDRY & LINEN SERVICE					8.00
9.00	HOUSEKEEPING					9.00
10.00	DIETARY					10.00
13.00	NURSING ADMINISTRATION					13.00
17.00	SOCIAL SERVICE					17.00
18.00	PATIENT ACTIVITIES					18.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	**6,863,072**	0	**6,863,072**		30.00
44.00	SKILLED NURSING FACILITY	**17,851,230**	0	**17,851,230**		44.00
ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	**63,165**	0	**63,165**		54.00
60.00	LABORATORY	**92,680**	0	**92,680**		60.00
64.00	INTRAVENOUS THERAPY	**10,076**	0	**10,076**		64.00
66.00	PHYSICAL THERAPY	**752,203**	0	**752,203**		66.00
67.00	OCCUPATIONAL THERAPY	**672,040**	0	**672,040**		67.00
68.00	SPEECH PATHOLOGY	**254,433**	0	**254,433**		68.00
69.00	ELECTROCARDIOLOGY	**732**	0	**732**		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	**978**	0	**978**		71.00
73.00	DRUGS CHARGED TO PATIENTS	**452,799**	0	**452,799**		73.00
77.00	ALLOGENEIC HSCT ACQUISITION	**0**	0	**0**		77.00
78.00	CAR T-CELL IMMUNOTHERAPY	**0**	0	**0**		78.00
OUTPATIENT SERVICE COST CENTERS						
92.00	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	**0**	0	**0**		95.00
102.00	OPIOID TREATMENT PROGRAM	**0**	0	**0**		102.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	**27,013,408**	**0**	**27,013,408**		118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	**7,153**	0	**7,153**		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	**0**	0	**0**		192.00
194.00	SPACE RENTED TO PHYSICIAN PRACTICE	**273,591**	0	**273,591**		194.00
200.00	Cross Foot Adjustments	**0**	0	**0**		200.00
201.00	Negative Cost Centers	**0**	0	**0**		201.00
202.00	TOTAL (sum lines 118 through 201)	**27,294,152**	**0**	**27,294,152**		202.00

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ALLOCATION OF CAPITAL RELATED COSTS

Worksheet B
Part II

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
		0	1.00	2A	4.00	5.00	7.00	
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT							1.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	**0**			4.00
5.00	ADMINISTRATIVE & GENERAL	0	554,983	554,983	0	**554,983**		5.00
7.00	OPERATION OF PLANT	0	166,462	166,462	0	42,120	**208,582**	7.00
8.00	LAUNDRY & LINEN SERVICE	0	40,398	40,398	0	5,599	5,172	8.00
9.00	HOUSEKEEPING	0	38,727	38,727	0	21,890	4,958	9.00
10.00	DIETARY	0	212,216	212,216	0	52,300	27,167	10.00
13.00	NURSING ADMINISTRATION	0	0	0	0	11,790	0	13.00
17.00	SOCIAL SERVICE	0	7,777	7,777	0	8,968	996	17.00
18.00	PATIENT ACTIVITIES	0	0	0	0	16,719	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	0	130,709	130,709	0	110,370	16,733	30.00
44.00	SKILLED NURSING FACILITY	0	1,000,179	1,000,179	0	239,400	128,035	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	1,284	0	54.00
60.00	LABORATORY	0	0	0	0	1,884	0	60.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	205	0	64.00
66.00	PHYSICAL THERAPY	0	63,071	63,071	0	12,665	8,074	66.00
67.00	OCCUPATIONAL THERAPY	0	27,937	27,937	0	12,500	3,576	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	5,173	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	15	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	20	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	9,207	0	73.00
77.00	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	0	77.00
78.00	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
92.00	OBSERVATION BEDS (NON-DISTINCT PART							92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	AMBULANCE SERVICES	0	0	0	0	0	0	95.00
102.00	OPIOID TREATMENT PROGRAM	0	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	**0**	**2,242,459**	**2,242,459**	**0**	**552,109**	**194,711**	118.00
NONREIMBURSABLE COST CENTERS								
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,132	2,132	0	57	273	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	0	192.00
194.00	SPACE RENTED TO PHYSICIAN PRACTICE	0	106,220	106,220	0	2,817	13,598	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)	**0**	**2,350,811**	**2,350,811**	**0**	**554,983**	**208,582**	202.00

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ALLOCATION OF CAPITAL RELATED COSTS

Worksheet B
Part II

	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	SOCIAL SERVICE	OTHER GENERAL SERVICE PATIENT ACTIVITIES	
		8.00	9.00	10.00	13.00	17.00	18.00	
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT							1.00
4.00	EMPLOYEE BENEFITS DEPARTMENT							4.00
5.00	ADMINISTRATIVE & GENERAL							5.00
7.00	OPERATION OF PLANT							7.00
8.00	LAUNDRY & LINEN SERVICE	**51,169**						8.00
9.00	HOUSEKEEPING	0	**65,575**					9.00
10.00	DIETARY	0	9,637	**301,320**				10.00
13.00	NURSING ADMINISTRATION	0	0	0	**11,790**			13.00
17.00	SOCIAL SERVICE	0	353	0	0	**18,094**		17.00
18.00	PATIENT ACTIVITIES	0	0	0	0	0	**16,719**	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	6,612	5,936	38,935	3,347	10,044	6,463	30.00
44.00	SKILLED NURSING FACILITY	44,557	45,419	262,385	8,443	8,050	10,256	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	0	0	0	0	60.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
66.00	PHYSICAL THERAPY	0	2,864	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	1,269	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
77.00	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	0	77.00
78.00	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
92.00	OBSERVATION BEDS (NON-DISTINCT PART							92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	AMBULANCE SERVICES	0	0	0	0	0	0	95.00
102.00	OPIOID TREATMENT PROGRAM	0	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	**51,169**	**65,478**	**301,320**	**11,790**	**18,094**	**16,719**	118.00
NONREIMBURSABLE COST CENTERS								
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	97	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	0	192.00
194.00	SPACE RENTED TO PHYSICIAN PRACTICE	0	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	**51,169**	**65,575**	**301,320**	**11,790**	**18,094**	**16,719**	202.00

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ALLOCATION OF CAPITAL RELATED COSTS

Worksheet B
Part II

	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
4.00	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	ADMINISTRATIVE & GENERAL					5.00
7.00	OPERATION OF PLANT					7.00
8.00	LAUNDRY & LINEN SERVICE					8.00
9.00	HOUSEKEEPING					9.00
10.00	DIETARY					10.00
13.00	NURSING ADMINISTRATION					13.00
17.00	SOCIAL SERVICE					17.00
18.00	PATIENT ACTIVITIES					18.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	**329,149**	0	**329,149**		30.00
44.00	SKILLED NURSING FACILITY	**1,746,724**	0	**1,746,724**		44.00
ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	**1,284**	0	**1,284**		54.00
60.00	LABORATORY	**1,884**	0	**1,884**		60.00
64.00	INTRAVENOUS THERAPY	**205**	0	**205**		64.00
66.00	PHYSICAL THERAPY	**86,674**	0	**86,674**		66.00
67.00	OCCUPATIONAL THERAPY	**45,282**	0	**45,282**		67.00
68.00	SPEECH PATHOLOGY	**5,173**	0	**5,173**		68.00
69.00	ELECTROCARDIOLOGY	**15**	0	**15**		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	**20**	0	**20**		71.00
73.00	DRUGS CHARGED TO PATIENTS	**9,207**	0	**9,207**		73.00
77.00	ALLOGENEIC HSCT ACQUISITION	**0**	0	**0**		77.00
78.00	CAR T-CELL IMMUNOTHERAPY	**0**	0	**0**		78.00
OUTPATIENT SERVICE COST CENTERS						
92.00	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	**0**	0	**0**		95.00
102.00	OPIOID TREATMENT PROGRAM	**0**	0	**0**		102.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	**2,225,617**	**0**	**2,225,617**		118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	**2,559**	0	**2,559**		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	**0**	0	**0**		192.00
194.00	SPACE RENTED TO PHYSICIAN PRACTICE	**122,635**	0	**122,635**		194.00
200.00	Cross Foot Adjustments	**0**	0	**0**		200.00
201.00	Negative Cost Centers	**0**	0	**0**		201.00
202.00	TOTAL (sum lines 118 through 201)	**2,350,811**	**0**	**2,350,811**		202.00

ASPEN HILLS HEALTHCARE CENTER	Period:	Run Date Time: 5/25/2026 2:55
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COST ALLOCATION - STATISTICAL BASIS **Worksheet B-1**

	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	
		1.00	4.00	5A	5.00	7.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT	**178,646**						1.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	0	**12,339,358**					4.00
5.00	ADMINISTRATIVE & GENERAL	42,175	1,699,763	**-6,368,761**	**20,925,391**			5.00
7.00	OPERATION OF PLANT	12,650	327,281	0	1,588,131	**123,821**		7.00
8.00	LAUNDRY & LINEN SERVICE	3,070	64,126	0	211,117	3,070	**78,126**	8.00
9.00	HOUSEKEEPING	2,943	581,114	0	825,359	2,943	0	9.00
10.00	DIETARY	16,127	106,418	0	1,971,954	16,127	0	10.00
13.00	NURSING ADMINISTRATION	0	384,137	0	444,521	0	0	13.00
17.00	SOCIAL SERVICE	591	285,470	0	338,121	591	0	17.00
18.00	PATIENT ACTIVITIES	0	522,730	0	630,390	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	9,933	2,694,376	0	4,161,468	9,933	10,095	30.00
44.00	SKILLED NURSING FACILITY	76,007	5,673,943	0	9,026,442	76,007	68,031	44.00
ANCILLARY SERVICE COST CENTERS								
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	48,426	0	0	54.00
60.00	LABORATORY	0	0	0	71,054	0	0	60.00
64.00	INTRAVENOUS THERAPY	0	0	0	7,725	0	0	64.00
66.00	PHYSICAL THERAPY	4,793	0	0	477,512	4,793	0	66.00
67.00	OCCUPATIONAL THERAPY	2,123	0	0	471,300	2,123	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	195,064	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	561	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	750	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	347,144	0	0	73.00
77.00	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	0	77.00
78.00	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
92.00	OBSERVATION BEDS (NON-DISTINCT PART							92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	AMBULANCE SERVICES	0	0	0	0	0	0	95.00
102.00	OPIOID TREATMENT PROGRAM	0	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	**170,412**	**12,339,358**	**-6,368,761**	**20,817,039**	**115,587**	**78,126**	118.00
NONREIMBURSABLE COST CENTERS								
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	162	0	0	2,132	162	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	0	192.00
194.00	SPACE RENTED TO PHYSICIAN PRACTICE	8,072	0	0	106,220	8,072	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)	2,350,811	1,939,675		6,368,761	2,071,488	326,732	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	13.159046	0.157194		0.304356	16.729699	4.182116	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)		0		554,983	208,582	51,169	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)		0.000000		0.026522	1.684545	0.654955	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

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COST ALLOCATION - STATISTICAL BASIS **Worksheet B-1**

	Cost Center Description	HOUSEKEEPING (ADJUSTED SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	SOCIAL SERVICE (ACTUAL)	OTHER GENERAL SERVICE PATIENT ACTIVITIES (TIME SPENT)		
		9.00	10.00	13.00	17.00	18.00		
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT							1.00
4.00	EMPLOYEE BENEFITS DEPARTMENT							4.00
5.00	ADMINISTRATIVE & GENERAL							5.00
7.00	OPERATION OF PLANT							7.00
8.00	LAUNDRY & LINEN SERVICE							8.00
9.00	HOUSEKEEPING	**109,736**						9.00
10.00	DIETARY	16,127	**234,378**					10.00
13.00	NURSING ADMINISTRATION	0	0	**296,105**				13.00
17.00	SOCIAL SERVICE	591	0	0	**285,470**			17.00
18.00	PATIENT ACTIVITIES	0	0	0	0	**548,221**		18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	9,933	30,285	84,070	158,458	211,929		30.00
44.00	SKILLED NURSING FACILITY	76,007	204,093	212,035	127,012	336,292		44.00
ANCILLARY SERVICE COST CENTERS								
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0		54.00
60.00	LABORATORY	0	0	0	0	0		60.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0		64.00
66.00	PHYSICAL THERAPY	4,793	0	0	0	0		66.00
67.00	OCCUPATIONAL THERAPY	2,123	0	0	0	0		67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0		68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0		71.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0		73.00
77.00	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0		77.00
78.00	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0		78.00
OUTPATIENT SERVICE COST CENTERS								
92.00	OBSERVATION BEDS (NON-DISTINCT PART							92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	AMBULANCE SERVICES	0	0	0	0	0		95.00
102.00	OPIOID TREATMENT PROGRAM	0	0	0	0	0		102.00
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	**109,574**	**234,378**	**296,105**	**285,470**	**548,221**		118.00
NONREIMBURSABLE COST CENTERS								
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	162	0	0	0	0		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0		192.00
194.00	SPACE RENTED TO PHYSICIAN PRACTICE	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)	1,125,798	3,007,379	579,814	456,980	822,253		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	10.259149	12.831319	1.958136	1.600799	1.499857		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	65,575	301,320	11,790	18,094	16,719		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.597571	1.285616	0.039817	0.063383	0.030497		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

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COMPUTATION OF RATIO OF COSTS TO CHARGES

Worksheet C
Part I

Title XVIII Hospital PPS

				Costs			Charges			
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	Inpatient	Outpatient	Total (col. 6 + col. 7)	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	ADULTS & PEDIATRICS	**6,863,072**		**6,863,072**	0	**6,863,072**	8,898,084		**8,898,084**	30.00
44.00	SKILLED NURSING FACILITY	**17,851,230**		**17,851,230**	0	**17,851,230**	29,152,432		**29,152,432**	44.00
ANCILLARY SERVICE COST CENTERS										
54.00	RADIOLOGY-DIAGNOSTIC	**63,165**		**63,165**	0	**63,165**	63,954	0	**63,954**	54.00
60.00	LABORATORY	**92,680**		**92,680**	0	**92,680**	93,370	0	**93,370**	60.00
64.00	INTRAVENOUS THERAPY	**10,076**		**10,076**	0	**10,076**	11,043	0	**11,043**	64.00
66.00	PHYSICAL THERAPY	**752,203**	0	**752,203**	0	**752,203**	778,467	0	**778,467**	66.00
67.00	OCCUPATIONAL THERAPY	**672,040**	0	**672,040**	0	**672,040**	832,793	0	**832,793**	67.00
68.00	SPEECH PATHOLOGY	**254,433**	0	**254,433**	0	**254,433**	366,399	0	**366,399**	68.00
69.00	ELECTROCARDIOLOGY	**732**		**732**	0	**732**	1,529	0	**1,529**	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	**978**		**978**	0	**978**	6,938	0	**6,938**	71.00
73.00	DRUGS CHARGED TO PATIENTS	**452,799**		**452,799**	0	**452,799**	518,495	0	**518,495**	73.00
77.00	ALLOGENEIC HSCT ACQUISITION	**0**		**0**	0	**0**	0	0	**0**	77.00
78.00	CAR T-CELL IMMUNOTHERAPY	**0**		**0**	0	**0**	0	0	**0**	78.00
OUTPATIENT SERVICE COST CENTERS										
92.00	OBSERVATION BEDS (NON-DISTINCT PART	**0**		**0**		**0**	0	0	**0**	92.00
OTHER REIMBURSABLE COST CENTERS										
95.00	AMBULANCE SERVICES	**0**		**0**	0	**0**	0	0	**0**	95.00
102.00	OPIOID TREATMENT PROGRAM	**0**		**0**		**0**	0	0	**0**	102.00
200.00	Subtotal (see instructions)	**27,013,408**	**0**	**27,013,408**	**0**	**27,013,408**	**40,723,504**	**0**	**40,723,504**	200.00
201.00	Less Observation Beds	**0**		**0**		**0**				201.00
202.00	Total (see instructions)	**27,013,408**	**0**	**27,013,408**	**0**	**27,013,408**	**40,723,504**	**0**	**40,723,504**	202.00

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COMPUTATION OF RATIO OF COSTS TO CHARGES

Worksheet C
Part I

Title XVIII Hospital PPS

	Cost Center Description	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		9.00	10.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS				30.00
44.00	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS					
54.00	RADIOLOGY-DIAGNOSTIC	0.987663	0.000000	0.987663	54.00
60.00	LABORATORY	0.992610	0.000000	0.992610	60.00
64.00	INTRAVENOUS THERAPY	0.912433	0.000000	0.912433	64.00
66.00	PHYSICAL THERAPY	0.966262	0.000000	0.966262	66.00
67.00	OCCUPATIONAL THERAPY	0.806971	0.000000	0.806971	67.00
68.00	SPEECH PATHOLOGY	0.694415	0.000000	0.694415	68.00
69.00	ELECTROCARDIOLOGY	0.478744	0.000000	0.478744	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.140963	0.000000	0.140963	71.00
73.00	DRUGS CHARGED TO PATIENTS	0.873295	0.000000	0.873295	73.00
77.00	ALLOGENEIC HSCT ACQUISITION	0.000000	0.000000	0.000000	77.00
78.00	CAR T-CELL IMMUNOTHERAPY	0.000000	0.000000	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS					
92.00	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0.000000	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES	0.000000	0.000000	0.000000	95.00
102.00	OPIOID TREATMENT PROGRAM				102.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

ASPEN HILLS HEALTHCARE CENTER	Period:	Run Date Time: 5/25/2026 2:55
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COMPUTATION OF RATIO OF COSTS TO CHARGES

Worksheet C
Part I

Title XIX Hospital TEFRA

				Costs			Charges			
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	Inpatient	Outpatient	Total (col. 6 + col. 7)	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	ADULTS & PEDIATRICS	**6,863,072**		**6,863,072**	0	**6,863,072**	8,898,084		**8,898,084**	30.00
44.00	SKILLED NURSING FACILITY	**17,851,230**		**17,851,230**	0	**17,851,230**	29,152,432		**29,152,432**	44.00
ANCILLARY SERVICE COST CENTERS										
54.00	RADIOLOGY-DIAGNOSTIC	**63,165**		**63,165**	0	**63,165**	63,954	0	**63,954**	54.00
60.00	LABORATORY	**92,680**		**92,680**	0	**92,680**	93,370	0	**93,370**	60.00
64.00	INTRAVENOUS THERAPY	**10,076**		**10,076**	0	**10,076**	11,043	0	**11,043**	64.00
66.00	PHYSICAL THERAPY	**752,203**	0	**752,203**	0	**752,203**	778,467	0	**778,467**	66.00
67.00	OCCUPATIONAL THERAPY	**672,040**	0	**672,040**	0	**672,040**	832,793	0	**832,793**	67.00
68.00	SPEECH PATHOLOGY	**254,433**	0	**254,433**	0	**254,433**	366,399	0	**366,399**	68.00
69.00	ELECTROCARDIOLOGY	**732**		**732**	0	**732**	1,529	0	**1,529**	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	**978**		**978**	0	**978**	6,938	0	**6,938**	71.00
73.00	DRUGS CHARGED TO PATIENTS	**452,799**		**452,799**	0	**452,799**	518,495	0	**518,495**	73.00
77.00	ALLOGENEIC HSCT ACQUISITION	**0**		**0**	0	**0**	0	0	**0**	77.00
78.00	CAR T-CELL IMMUNOTHERAPY	**0**		**0**	0	**0**	0	0	**0**	78.00
OUTPATIENT SERVICE COST CENTERS										
92.00	OBSERVATION BEDS (NON-DISTINCT PART	**0**		**0**		**0**	0	0	**0**	92.00
OTHER REIMBURSABLE COST CENTERS										
95.00	AMBULANCE SERVICES	**0**		**0**	0	**0**	0	0	**0**	95.00
102.00	OPIOID TREATMENT PROGRAM	**0**		**0**		**0**	0	0	**0**	102.00
200.00	Subtotal (see instructions)	**27,013,408**	**0**	**27,013,408**	**0**	**27,013,408**	**40,723,504**	**0**	**40,723,504**	200.00
201.00	Less Observation Beds	**0**		**0**		**0**				201.00
202.00	Total (see instructions)	**27,013,408**	**0**	**27,013,408**	**0**	**27,013,408**	**40,723,504**	**0**	**40,723,504**	202.00

ASPEN HILLS HEALTHCARE CENTER	Period:	Run Date Time: 5/25/2026 2:55
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COMPUTATION OF RATIO OF COSTS TO CHARGES

Worksheet C
Part I

Title XIX Hospital TEFRA

	Cost Center Description	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		9.00	10.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS				30.00
44.00	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS					
54.00	RADIOLOGY-DIAGNOSTIC	0.987663	0.987663	0.000000	54.00
60.00	LABORATORY	0.992610	0.992610	0.000000	60.00
64.00	INTRAVENOUS THERAPY	0.912433	0.912433	0.000000	64.00
66.00	PHYSICAL THERAPY	0.966262	0.966262	0.000000	66.00
67.00	OCCUPATIONAL THERAPY	0.806971	0.806971	0.000000	67.00
68.00	SPEECH PATHOLOGY	0.694415	0.694415	0.000000	68.00
69.00	ELECTROCARDIOLOGY	0.478744	0.478744	0.000000	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.140963	0.140963	0.000000	71.00
73.00	DRUGS CHARGED TO PATIENTS	0.873295	0.873295	0.000000	73.00
77.00	ALLOGENEIC HSCT ACQUISITION	0.000000	0.000000	0.000000	77.00
78.00	CAR T-CELL IMMUNOTHERAPY	0.000000	0.000000	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS					
92.00	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0.000000	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES	0.000000	0.000000	0.000000	95.00
102.00	OPIOID TREATMENT PROGRAM				102.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

ASPEN HILLS HEALTHCARE CENTER	Period:	Run Date Time: 5/25/2026 2:55
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Worksheet C
Part II

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	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)	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS										
54.00	RADIOLOGY-DIAGNOSTIC	**63,165**	1,284	**61,881**	128	3,589	**59,448**	**63,954**	0.929543	54.00
60.00	LABORATORY	**92,680**	1,884	**90,796**	188	5,266	**87,226**	**93,370**	0.934197	60.00
64.00	INTRAVENOUS THERAPY	**10,076**	205	**9,871**	21	573	**9,482**	**11,043**	0.858643	64.00
66.00	PHYSICAL THERAPY	**752,203**	86,674	**665,529**	8,667	38,601	**704,935**	**778,467**	0.905543	66.00
67.00	OCCUPATIONAL THERAPY	**672,040**	45,282	**626,758**	4,528	36,352	**631,160**	**832,793**	0.757883	67.00
68.00	SPEECH PATHOLOGY	**254,433**	5,173	**249,260**	517	14,457	**239,459**	**366,399**	0.653547	68.00
69.00	ELECTROCARDIOLOGY	**732**	15	**717**	2	42	**688**	**1,529**	0.449967	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	**978**	20	**958**	2	56	**920**	**6,938**	0.132603	71.00
73.00	DRUGS CHARGED TO PATIENTS	**452,799**	9,207	**443,592**	921	25,728	**426,150**	**518,495**	0.821898	73.00
77.00	ALLOGENEIC HSCT ACQUISITION	**0**	0	**0**	0	0	**0**	**0**	0.000000	77.00
78.00	CAR T-CELL IMMUNOTHERAPY	**0**	0	**0**	0	0	**0**	**0**	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS										
92.00	OBSERVATION BEDS (NON-DISTINCT PART	**0**	0	**0**	0	0	**0**	**0**	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS										
95.00	AMBULANCE SERVICES	**0**	0	**0**	0	0	**0**	**0**	0.000000	95.00
102.00	OPIOID TREATMENT PROGRAM	**0**	0	**0**	0	0	**0**	**0**	0.000000	102.00
200.00	Subtotal (sum of lines 50 thru 199)	**2,299,106**	**149,744**	**2,149,362**	**14,974**	**124,664**	**2,159,468**	**2,672,988**		200.00
201.00	Less Observation Beds	**0**	0	**0**	0	0	**0**	**0**		201.00
202.00	Total (line 200 minus line 201)	**2,299,106**	**149,744**	**2,149,362**	**14,974**	**124,664**	**2,159,468**	**2,672,988**		202.00

ASPEN HILLS HEALTHCARE CENTER	Period:	Run Date Time:	5/25/2026 2:55
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Provider CCN: 31-4023	To: 12/31/2025	Version:	25.3.181.0

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Worksheet D
Part I

Title XVIII Hospital PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	ADULTS & PEDIATRICS	**329,149**	0	**329,149**	**10,095**	32.61	1,413	**46,078**	30.00
44.00	SKILLED NURSING FACILITY	**1,746,724**		**1,746,724**	**68,031**	25.68	8,473	**217,587**	44.00
200.00	Total (lines 30 through 199)	**2,075,873**		**2,075,873**	**78,126**		**9,886**	**263,665**	200.00

ASPEN HILLS HEALTHCARE CENTER	Period:	Run Date Time: 5/25/2026 2:55
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Provider CCN: 31-4023	To: 12/31/2025	Version: 25.3.181.0

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Worksheet D
Part II

Title XVIII Hospital PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
54.00	RADIOLOGY-DIAGNOSTIC	**1,284**	**63,954**	0.020077	3,872	**78**	54.00
60.00	LABORATORY	**1,884**	**93,370**	0.020178	3,458	**70**	60.00
64.00	INTRAVENOUS THERAPY	**205**	**11,043**	0.018564	0	**0**	64.00
66.00	PHYSICAL THERAPY	**86,674**	**778,467**	0.111339	794	**88**	66.00
67.00	OCCUPATIONAL THERAPY	**45,282**	**832,793**	0.054374	90	**5**	67.00
68.00	SPEECH PATHOLOGY	**5,173**	**366,399**	0.014118	0	**0**	68.00
69.00	ELECTROCARDIOLOGY	**15**	**1,529**	0.009810	561	**6**	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	**20**	**6,938**	0.002883	0	**0**	71.00
73.00	DRUGS CHARGED TO PATIENTS	**9,207**	**518,495**	0.017757	115,862	**2,057**	73.00
77.00	ALLOGENEIC HSCT ACQUISITION	**0**	**0**	0.000000	0	**0**	77.00
78.00	CAR T-CELL IMMUNOTHERAPY	**0**	**0**	0.000000	0	**0**	78.00
OUTPATIENT SERVICE COST CENTERS							
92.00	OBSERVATION BEDS (NON-DISTINCT PART	**0**	**0**	0.000000	0	**0**	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	**149,744**	**2,672,988**		**124,637**	**2,304**	200.00

ASPEN HILLS HEALTHCARE CENTER	Period:	Run Date Time: 5/25/2026 2:55
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Worksheet D
Part III

Title XVIII Hospital PPS

	Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
		1A	1.00	2A	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	ADULTS & PEDIATRICS	0	0	0	0	0	0	**0**	30.00
44.00	SKILLED NURSING FACILITY	0	0	0	0			**0**	44.00
200.00	Total (lines 30 through 199)	**0**	**0**	**0**	**0**	**0**		**0**	200.00

	Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
		6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	**10,095**	0.00	1,413	**0**		30.00
44.00	SKILLED NURSING FACILITY	**68,031**	0.00	8,473	**0**		44.00
200.00	Total (lines 30 through 199)	**78,126**		**9,886**	**0**		200.00

ASPEN HILLS HEALTHCARE CENTER	Period:	Run Date Time: 5/25/2026 2:55
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Worksheet D
Part IV

Title XVIII Hospital PPS

	Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	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)	
		1.00	2A	2.00	3A	3.00	4.00	5.00	6.00	
ANCILLARY SERVICE COST CENTERS										
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	**0**	**0**	54.00
60.00	LABORATORY	0	0	0	0	0	0	**0**	**0**	60.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	0	**0**	**0**	64.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	0	**0**	**0**	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	0	**0**	**0**	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	0	**0**	**0**	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	0	**0**	**0**	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	**0**	**0**	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	**0**	**0**	73.00
77.00	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	0	**0**	**0**	77.00
78.00	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	0	**0**	**0**	78.00
OUTPATIENT SERVICE COST CENTERS										
92.00	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	0	**0**	**0**	92.00
OTHER REIMBURSABLE COST CENTERS										
95.00	AMBULANCE SERVICES									95.00
200.00	Total (lines 50 through 199)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	200.00

ASPEN HILLS HEALTHCARE CENTER	Period:	Run Date Time: 5/25/2026 2:55
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Worksheet D
Part IV

Title XVIII Hospital PPS

	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	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)		
		7.00	8.00	9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS										
54.00	RADIOLOGY-DIAGNOSTIC	**63,954**	0.000000	0.000000	3,872	**0**	0	**0**		54.00
60.00	LABORATORY	**93,370**	0.000000	0.000000	3,458	**0**	0	**0**		60.00
64.00	INTRAVENOUS THERAPY	**11,043**	0.000000	0.000000	0	**0**	0	**0**		64.00
66.00	PHYSICAL THERAPY	**778,467**	0.000000	0.000000	794	**0**	0	**0**		66.00
67.00	OCCUPATIONAL THERAPY	**832,793**	0.000000	0.000000	90	**0**	0	**0**		67.00
68.00	SPEECH PATHOLOGY	**366,399**	0.000000	0.000000	0	**0**	0	**0**		68.00
69.00	ELECTROCARDIOLOGY	**1,529**	0.000000	0.000000	561	**0**	0	**0**		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	**6,938**	0.000000	0.000000	0	**0**	0	**0**		71.00
73.00	DRUGS CHARGED TO PATIENTS	**518,495**	0.000000	0.000000	115,862	**0**	0	**0**		73.00
77.00	ALLOGENEIC HSCT ACQUISITION	**0**	0.000000	0.000000	0	**0**	0	**0**		77.00
78.00	CAR T-CELL IMMUNOTHERAPY	**0**	0.000000	0.000000	0	**0**	0	**0**		78.00
OUTPATIENT SERVICE COST CENTERS										
92.00	OBSERVATION BEDS (NON-DISTINCT PART	**0**	0.000000	0.000000	0	**0**	0	**0**		92.00
OTHER REIMBURSABLE COST CENTERS										
95.00	AMBULANCE SERVICES									95.00
200.00	Total (lines 50 through 199)	**2,672,988**			**124,637**	**0**	**0**	**0**		200.00

ASPEN HILLS HEALTHCARE CENTER	Period:	Run Date Time: 5/25/2026 2:55
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Component CCN: 315260

Worksheet D
Part IV

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	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)	
		1.00	2A	2.00	3A	3.00	4.00	5.00	6.00	
ANCILLARY SERVICE COST CENTERS										
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	**0**	**0**	54.00
60.00	LABORATORY	0	0	0	0	0	0	**0**	**0**	60.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	0	**0**	**0**	64.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	0	**0**	**0**	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	0	**0**	**0**	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	0	**0**	**0**	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	0	**0**	**0**	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	**0**	**0**	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	**0**	**0**	73.00
77.00	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	0	**0**	**0**	77.00
78.00	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	0	**0**	**0**	78.00
OUTPATIENT SERVICE COST CENTERS										
92.00	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	0	**0**	**0**	92.00
OTHER REIMBURSABLE COST CENTERS										
95.00	AMBULANCE SERVICES									95.00
200.00	Total (lines 50 through 199)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	200.00

ASPEN HILLS HEALTHCARE CENTER	Period:	Run Date Time: 5/25/2026 2:55
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Component CCN: 315260

Worksheet D
Part IV

Title XVIII Skilled Nursing Facility PPS

	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	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)		
		7.00	8.00	9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS										
54.00	RADIOLOGY-DIAGNOSTIC	**63,954**	0.000000	0.000000	4,375	**0**	0	**0**		54.00
60.00	LABORATORY	**93,370**	0.000000	0.000000	37,766	**0**	0	**0**		60.00
64.00	INTRAVENOUS THERAPY	**11,043**	0.000000	0.000000	0	**0**	0	**0**		64.00
66.00	PHYSICAL THERAPY	**778,467**	0.000000	0.000000	338,687	**0**	0	**0**		66.00
67.00	OCCUPATIONAL THERAPY	**832,793**	0.000000	0.000000	360,332	**0**	0	**0**		67.00
68.00	SPEECH PATHOLOGY	**366,399**	0.000000	0.000000	201,995	**0**	0	**0**		68.00
69.00	ELECTROCARDIOLOGY	**1,529**	0.000000	0.000000	0	**0**	0	**0**		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	**6,938**	0.000000	0.000000	0	**0**	0	**0**		71.00
73.00	DRUGS CHARGED TO PATIENTS	**518,495**	0.000000	0.000000	402,633	**0**	0	**0**		73.00
77.00	ALLOGENEIC HSCT ACQUISITION	**0**	0.000000	0.000000	0	**0**	0	**0**		77.00
78.00	CAR T-CELL IMMUNOTHERAPY	**0**	0.000000	0.000000	0	**0**	0	**0**		78.00
OUTPATIENT SERVICE COST CENTERS										
92.00	OBSERVATION BEDS (NON-DISTINCT PART	**0**	0.000000	0.000000	0	**0**	0	**0**		92.00
OTHER REIMBURSABLE COST CENTERS										
95.00	AMBULANCE SERVICES									95.00
200.00	Total (lines 50 through 199)	**2,672,988**			**1,345,788**	**0**	**0**	**0**		200.00

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Worksheet D
Part I

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)	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	ADULTS & PEDIATRICS	**329,149**	0	**329,149**	**10,095**	32.61	0	**0**	30.00
44.00	SKILLED NURSING FACILITY	**1,746,724**		**1,746,724**	**68,031**	25.68	49,091	**1,260,657**	44.00
200.00	Total (lines 30 through 199)	**2,075,873**		**2,075,873**	**78,126**		**49,091**	**1,260,657**	200.00

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Worksheet D
Part II

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	RADIOLOGY-DIAGNOSTIC	**1,284**	**63,954**	0.020077	0	**0**	54.00
60.00	LABORATORY	**1,884**	**93,370**	0.020178	0	**0**	60.00
64.00	INTRAVENOUS THERAPY	**205**	**11,043**	0.018564	0	**0**	64.00
66.00	PHYSICAL THERAPY	**86,674**	**778,467**	0.111339	0	**0**	66.00
67.00	OCCUPATIONAL THERAPY	**45,282**	**832,793**	0.054374	0	**0**	67.00
68.00	SPEECH PATHOLOGY	**5,173**	**366,399**	0.014118	0	**0**	68.00
69.00	ELECTROCARDIOLOGY	**15**	**1,529**	0.009810	0	**0**	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	**20**	**6,938**	0.002883	0	**0**	71.00
73.00	DRUGS CHARGED TO PATIENTS	**9,207**	**518,495**	0.017757	0	**0**	73.00
77.00	ALLOGENEIC HSCT ACQUISITION	**0**	**0**	0.000000	0	**0**	77.00
78.00	CAR T-CELL IMMUNOTHERAPY	**0**	**0**	0.000000	0	**0**	78.00
OUTPATIENT SERVICE COST CENTERS							
92.00	OBSERVATION BEDS (NON-DISTINCT PART	**0**	**0**	0.000000	0	**0**	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	**149,744**	**2,672,988**		**0**	**0**	200.00

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Worksheet D
Part III

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	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
		1A	1.00	2A	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	ADULTS & PEDIATRICS	0	0	0	0	0	0	**0**	30.00
44.00	SKILLED NURSING FACILITY	0	0	0	0			**0**	44.00
200.00	Total (lines 30 through 199)	**0**	**0**	**0**	**0**	**0**		**0**	200.00

	Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
		6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	**10,095**	0.00	0	**0**		30.00
44.00	SKILLED NURSING FACILITY	**68,031**	0.00	49,091	**0**		44.00
200.00	Total (lines 30 through 199)	**78,126**		**49,091**	**0**		200.00

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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Worksheet D
Part IV

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	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)	
		1.00	2A	2.00	3A	3.00	4.00	5.00	6.00	
ANCILLARY SERVICE COST CENTERS										
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	**0**	**0**	54.00
60.00	LABORATORY	0	0	0	0	0	0	**0**	**0**	60.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	0	**0**	**0**	64.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	0	**0**	**0**	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	0	**0**	**0**	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	0	**0**	**0**	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	0	**0**	**0**	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	**0**	**0**	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	**0**	**0**	73.00
77.00	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	0	**0**	**0**	77.00
78.00	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	0	**0**	**0**	78.00
OUTPATIENT SERVICE COST CENTERS										
92.00	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	0	**0**	**0**	92.00
OTHER REIMBURSABLE COST CENTERS										
95.00	AMBULANCE SERVICES									95.00
200.00	Total (lines 50 through 199)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	200.00

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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Worksheet D
Part IV

Title XIX Hospital TEFRA

	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	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)		
		7.00	8.00	9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS										
54.00	RADIOLOGY-DIAGNOSTIC	**63,954**	0.000000	0.000000	0	**0**	0	**0**		54.00
60.00	LABORATORY	**93,370**	0.000000	0.000000	0	**0**	0	**0**		60.00
64.00	INTRAVENOUS THERAPY	**11,043**	0.000000	0.000000	0	**0**	0	**0**		64.00
66.00	PHYSICAL THERAPY	**778,467**	0.000000	0.000000	0	**0**	0	**0**		66.00
67.00	OCCUPATIONAL THERAPY	**832,793**	0.000000	0.000000	0	**0**	0	**0**		67.00
68.00	SPEECH PATHOLOGY	**366,399**	0.000000	0.000000	0	**0**	0	**0**		68.00
69.00	ELECTROCARDIOLOGY	**1,529**	0.000000	0.000000	0	**0**	0	**0**		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	**6,938**	0.000000	0.000000	0	**0**	0	**0**		71.00
73.00	DRUGS CHARGED TO PATIENTS	**518,495**	0.000000	0.000000	0	**0**	0	**0**		73.00
77.00	ALLOGENEIC HSCT ACQUISITION	**0**	0.000000	0.000000	0	**0**	0	**0**		77.00
78.00	CAR T-CELL IMMUNOTHERAPY	**0**	0.000000	0.000000	0	**0**	0	**0**		78.00
OUTPATIENT SERVICE COST CENTERS										
92.00	OBSERVATION BEDS (NON-DISTINCT PART	**0**	0.000000	0.000000	0	**0**	0	**0**		92.00
OTHER REIMBURSABLE COST CENTERS										
95.00	AMBULANCE SERVICES									95.00
200.00	Total (lines 50 through 199)	**2,672,988**			**0**	**0**	**0**	**0**		200.00

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COMPUTATION OF INPATIENT OPERATING COST **Worksheet D-1**

Title XVIII Hospital PPS

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

		1.00	
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	10,095	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	10,095	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)	10,095	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)	**1,413**	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)	**6,863,072**	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)	**6,863,072**	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)	**6,863,072**	37.00

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COMPUTATION OF INPATIENT OPERATING COST **Worksheet D-1**

Title XVIII Hospital PPS

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS

						1.00	
38.00	Adjusted general inpatient routine service cost per diem (see instructions)					679.85	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)					960,628	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)					**960,628**	41.00
		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
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					109,547	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)					**1,070,175**	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)	46,078	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	2,304	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	**48,382**	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	**1,021,793**	53.00

TARGET AMOUNT AND LIMIT COMPUTATION

54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
55.03	CAR T-cell amount paid as an interim payment	0	55.03
56.00	Target amount ((line 54 x sum of lines 55, 55.01, and 55.02) plus line 55.03)	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

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COMPUTATION OF INPATIENT OPERATING COST **Worksheet D-1**

Title XVIII Hospital PPS

PART III - SNF, NF, AND ICF/IID ONLY

		1.00	
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

		1.00	
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 OBSERVATION BED PASS THROUGH COST

		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	
90.00	Capital-related cost	329,149	6,863,072	0.047959	0	**0**	90.00
91.00	Nursing Program cost	0	6,863,072	0.000000	0	**0**	91.00
92.00	Allied health cost	0	6,863,072	0.000000	0	**0**	92.00
93.00	All other Medical Education	0	6,863,072	0.000000	0	**0**	93.00

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COMPUTATION OF INPATIENT OPERATING COST — Component CCN: 315260 — **Worksheet D-1**

Title XVIII — Skilled Nursing Facility — PPS

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

		1.00	
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	68,031	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	68,031	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)	68,031	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)	**8,473**	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	**17,851,230**	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	**0**	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	**17,851,230**	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	**17,851,230**	37.00

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COMPUTATION OF INPATIENT OPERATING COST — Component CCN: 315260 — **Worksheet D-1**

Title XVIII — Skilled Nursing Facility — PPS

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS

						1.00	
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
		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
						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
55.03	CAR T-cell amount paid as an interim payment						55.03
56.00	Target amount ((line 54 x sum of lines 55, 55.01, and 55.02) plus line 55.03)						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

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COMPUTATION OF INPATIENT OPERATING COST — Component CCN: 315260 — **Worksheet D-1**

Title XVIII — Skilled Nursing Facility — PPS

PART III - SNF, NF, AND ICF/IID ONLY

		1.00	
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	17,851,230	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	262.40	71.00
72.00	Program routine service cost (line 9 x line 71)	2,223,315	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)	**2,223,315**	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)	2,223,315	83.00
84.00	Program inpatient ancillary services (see instructions)	1,151,730	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)	**3,375,045**	86.00

PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		1.00	
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 OBSERVATION BED PASS THROUGH COST

		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	
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

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COMPUTATION OF INPATIENT OPERATING COST **Worksheet D-1**

Title XIX Hospital TEFRA

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

		1.00	
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	10,095	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	10,095	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)	10,095	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)	**6,863,072**	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)	**6,863,072**	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)	**6,863,072**	37.00

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COMPUTATION OF INPATIENT OPERATING COST **Worksheet D-1**

Title XIX Hospital TEFRA

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS

						1.00	
38.00	Adjusted general inpatient routine service cost per diem (see instructions)					679.85	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
		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
						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	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
55.03	CAR T-cell amount paid as an interim payment	0	55.03
56.00	Target amount ((line 54 x sum of lines 55, 55.01, and 55.02) plus line 55.03)	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

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COMPUTATION OF INPATIENT OPERATING COST **Worksheet D-1**

Title XIX Hospital TEFRA

PART III - SNF, NF, AND ICF/IID ONLY

		1.00	
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

		1.00	
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 OBSERVATION BED PASS THROUGH COST

		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	
90.00	Capital-related cost	329,149	6,863,072	0.047959	0	**0**	90.00
91.00	Nursing Program cost	0	6,863,072	0.000000	0	**0**	91.00
92.00	Allied health cost	0	6,863,072	0.000000	0	**0**	92.00
93.00	All other Medical Education	0	6,863,072	0.000000	0	**0**	93.00

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Worksheet D-3

Title XVIII Hospital PPS

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		2,260,800		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	RADIOLOGY-DIAGNOSTIC	0.987663	3,872	3,824	54.00
60.00	LABORATORY	0.992610	3,458	3,432	60.00
64.00	INTRAVENOUS THERAPY	0.912433	0	0	64.00
66.00	PHYSICAL THERAPY	0.966262	794	767	66.00
67.00	OCCUPATIONAL THERAPY	0.806971	90	73	67.00
68.00	SPEECH PATHOLOGY	0.694415	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.478744	561	269	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.140963	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	0.873295	115,862	101,182	73.00
77.00	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
OUTPATIENT SERVICE COST CENTERS					
92.00	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		**124,637**	**109,547**	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)		**124,637**		202.00

ASPEN HILLS HEALTHCARE CENTER	Period:	Run Date Time: 5/25/2026 2:55
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT — Component CCN: 315260 — **Worksheet D-3**

Title XVIII — Skilled Nursing Facility — PPS

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
54.00	RADIOLOGY-DIAGNOSTIC	0.987663	4,375	4,321	54.00
60.00	LABORATORY	0.992610	37,766	37,487	60.00
64.00	INTRAVENOUS THERAPY	0.912433	0	0	64.00
66.00	PHYSICAL THERAPY	0.966262	338,687	327,260	66.00
67.00	OCCUPATIONAL THERAPY	0.806971	360,332	290,777	67.00
68.00	SPEECH PATHOLOGY	0.694415	201,995	140,268	68.00
69.00	ELECTROCARDIOLOGY	0.478744	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.140963	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	0.873295	402,633	351,617	73.00
77.00	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
OUTPATIENT SERVICE COST CENTERS					
92.00	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		**1,345,788**	**1,151,730**	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		**1,345,788**		202.00

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Worksheet E-1
Part I

Title XVIII Hospital PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,336,615		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		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	12/04/2025	5,617		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)		5,617		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		**1,342,232**		**0**	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		**0**		**0**	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		445		0	6.02
7.00	Total Medicare program liability (see instructions)		**1,341,787**		**0**	7.00

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

(1) On lines 3, 5, and 6, where an amount is due "Provider to Program", show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED — Component CCN: 315260 — **Worksheet E-1 Part I**

Title XVIII — Skilled Nursing Facility — PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		5,862,572		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	07/30/2025	29,623		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)		29,623		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)		**5,892,195**		**0**	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		**0**		**0**	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		354,547		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		**6,246,742**		**0**	7.00

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

(1) On lines 3, 5, and 6, where an amount is due "Provider to Program", show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

ASPEN HILLS HEALTHCARE CENTER	Period:	Run Date Time: 5/25/2026 2:55
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CALCULATION OF REIMBURSEMENT SETTLEMENT

Worksheet E-3
Part II

Title XVIII Hospital PPS

PART II - MEDICARE PART A SERVICES - IPF PPS

		1.00	
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1,414,168	1.00
2.00	Net IPF PPS Outlier Payments	0	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	27.657534	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	**1,414,168**	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	**1,414,168**	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	**1,414,168**	18.00
19.00	Deductibles	76,964	19.00
20.00	Subtotal (line 18 minus line 19)	**1,337,204**	20.00
21.00	Coinsurance	4,609	21.00
22.00	Subtotal (line 20 minus line 21)	**1,332,595**	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	56,269	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	36,575	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	33,189	25.00
26.00	Subtotal (sum of lines 22 and 24)	**1,369,170**	26.00
27.00	Direct graduate medical education payments (see instructions)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.98	Recovery of accelerated depreciation.	0	30.98
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	**1,369,170**	31.00
31.01	Sequestration adjustment (see instructions)	27,383	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	1,342,232	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	-445	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
TO BE COMPLETED BY CONTRACTOR			
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	**0**	53.00
FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)			
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0.000000	99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0.000000	99.01

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CALCULATION OF REIMBURSEMENT SETTLEMENT — Component CCN: 315260 — **Worksheet E-3 Part VI**

Title XVIII — Skilled Nursing Facility — PPS

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	
1.00	Resource Utilization Group Payment (RUGS)	7,087,284	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)	**7,087,284**	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	1,349,903	7.00
8.00	Allowable bad debts (see instructions)	979,508	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	400,206	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	636,680	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)	**6,374,061**	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	NET MSP PAYMENTS	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	**6,374,061**	15.00
15.01	Sequestration adjustment (see instructions)	114,585	15.01
15.02	Demonstration payment adjustment amount after sequestration	0	15.02
15.75	Sequestration for non-claims based amounts (see instructions)	12,734	15.75
16.00	Interim payments	5,892,195	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)	**354,547**	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

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

Worksheet G

	Assets (Omit Cents)	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	1,879,471	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	8,780,952	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-707,784	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	174,258	0	0	0	8.00
9.00	Other current assets	0	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)	**10,126,897**	**0**	**0**	**0**	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	2,360,631	0	0	0	15.00
16.00	Accumulated depreciation	-1,234,909	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	367,233	0	0	0	23.00
24.00	Accumulated depreciation	-248,787	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)	**1,244,168**	**0**	**0**	**0**	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	13,056	0	0	0	32.00
33.00	Due from owners/officers	21,340	0	0	0	33.00
34.00	Other assets	877,588	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	911,984	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	**12,283,049**	**0**	**0**	**0**	36.00

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

	Liabilities and Fund Balances (Omit cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT LIABILITIES						
37.00	Accounts payable	2,556,169	0	0	0	37.00
38.00	Salaries, wages, and fees payable	320,024	0	0	0	38.00
39.00	Payroll taxes payable	181,598	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	20,499	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	**3,078,290**	**0**	**0**	**0**	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	1,218,676	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	1,218,676	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	**4,296,966**	**0**	**0**	**0**	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	7,986,083				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)	**7,986,083**	**0**	**0**	**0**	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	**12,283,049**	**0**	**0**	**0**	60.00

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STATEMENT OF CHANGES IN FUND BALANCES **Worksheet G-1**

		General Fund		Special Purpose Fund		Endowment Fund		Plant Fund		
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
1.00	Fund balances at beginning of period		6,222,569		0		0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,763,514							2.00
3.00	Total (sum of line 1 and line 2)		**7,986,083**		**0**		**0**		**0**	3.00
4.00	Additions (credit adjustments) (specify)	0		0		0		0		4.00
5.00		0		0		0		0		5.00
6.00		0		0		0		0		6.00
7.00		0		0		0		0		7.00
8.00		0		0		0		0		8.00
9.00		0		0		0		0		9.00
10.00	Total additions (sum of line 4-9)		**0**		**0**		**0**		**0**	10.00
11.00	Subtotal (line 3 plus line 10)		**7,986,083**		**0**		**0**		**0**	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0		0		12.00
13.00		0		0		0		0		13.00
14.00		0		0		0		0		14.00
15.00		0		0		0		0		15.00
16.00		0		0		0		0		16.00
17.00		0		0		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		**0**		**0**		**0**		**0**	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		**7,986,083**		**0**		**0**		**0**	19.00

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	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4023	To: 12/31/2025	Version: 25.3.181.0

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Worksheet G-2
Parts I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
General Inpatient Routine Services					
1.00	Hospital	8,898,084		8,898,084	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	29,152,432		29,152,432	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	**38,050,516**		**38,050,516**	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)	**38,050,516**		**38,050,516**	17.00
18.00	Ancillary services	2,669,188	0	2,669,188	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	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	MISCELLANEOUS REVENUE	516,560	0	516,560	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	**41,236,264**	**0**	**41,236,264**	28.00

ASPEN HILLS HEALTHCARE CENTER	Period:	Run Date Time: 5/25/2026 2:55
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4023	To: 12/31/2025	Version: 25.3.181.0

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Worksheet G-2
Parts I & II

PART II - OPERATING EXPENSES

		1.00	2.00	
29.00	Operating expenses (per Wkst. A, column 3, line 200)		**36,050,409**	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)		**36,050,409**	43.00

ASPEN HILLS HEALTHCARE CENTER	Period:	Run Date Time: 5/25/2026 2:55
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4023	To: 12/31/2025	Version: 25.3.181.0

STATEMENT OF REVENUES AND EXPENSES **Worksheet G-3**

	Description		
		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	41,236,264	1.00
2.00	Less contractual allowances and discounts on patients' accounts	3,497,142	2.00
3.00	Net patient revenues (line 1 minus line 2)	37,739,122	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	36,050,409	4.00
5.00	Net income from service to patients (line 3 minus line 4)	**1,688,713**	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	73,262	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS REVENUE	1,539	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	**74,801**	25.00
26.00	Total (line 5 plus line 25)	**1,763,514**	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)	**1,763,514**	29.00

MARTIN FRIEDMAN CPA PC
CERTIFIED PUBLIC ACCOUNTANTS

ASPEN HILLS HEALTHCARE CENTER LLC

Financial Statements

Year Ended December 31, 2025

Aspen Hills Healthcare Center LLC

Year Ended December 31, 2025

TABLE OF CONTENTS

MARTIN FRIEDMAN CPA PC
CERTIFIED PUBLIC ACCOUNTANTS

INDEPENDENT AUDITOR'S REPORT

To the Members,
Aspen Hills Healthcare Center LLC:

Opinion

We have audited the accompanying financial statements of Aspen Hills Healthcare Center LLC, which comprise the balance sheet as of December 31, 2025, and the related statement of operations, members' equity, and cash flows for the year then ended, and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Aspen Hills Healthcare Center LLC as of December 31, 2025, and the results of its operations and its cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of Aspen Hills Healthcare Center LLC and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about Aspen Hills Healthcare Center LLC's ability to continue as a going concern within one year after the date that the financial statements are available to be issued.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with generally accepted auditing standards will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements, including omissions, are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

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MARTIN FRIEDMAN CPA PC
CERTIFIED PUBLIC ACCOUNTANTS

Independent Auditor's Report Continued

In performing an audit in accordance with generally accepted auditing standards, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Aspen Hills Healthcare Center LLC's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about Aspen Hills Healthcare Center LLC's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control related matters that we identified during the audit.

Martin Friedman CPA, PC

MARTIN FRIEDMAN, C.P.A. P.C.
Certified Public Accountants

Brooklyn, NY

June 4, 2026

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Aspen Hills Healthcare Center LLC
Balance Sheet
December 31, 2025

Assets		
Cash	$ 1,879,469	
Accounts Receivable	8,073,167	
(Net of Allowance for Credit Losses of $707,784)		
Prepaid Expenses	174,258	
Total Current Assets		$ 10,126,894
Leasehold Improvements	2,360,631	
Furniture & Equipment	367,233	
	2,727,864	
Less: Accum. Depreciation & Amortization	1,483,696	
Total Fixed Assets		1,244,168
Right-of-Use Asset	31,992,152	
Security Deposits	13,056	
Goodwill	850,000	
Intangible Assets (Net)	27,587	
Total Other Assets		32,882,795
Total Assets		**$ 44,253,857**
Liabilities and Equity		
Accounts Payable	$ 1,804,596	
Lease Liabilities	1,016,625	
Withholding Taxes Payable	15,587	
Accrued Payroll	315,253	
Accrued Expenses & Taxes	917,583	
Exchanges	30,673	
Due To Third Party Payors	1,191,932	
Total Current Liabilities		$ 5,292,249
Lease Liabilities	30,975,527	
Total Long Term Liabilities		30,975,527
Members' Equity		7,986,081
Total Liabilities & Members' Equity		**$ 44,253,857**

See accompanying notes to the financial statements.

Aspen Hills Healthcare Center LLC
Statement of Operations
For the year ended December 31, 2025

Total Revenue From Patients		$ 37,739,122
Operating Expenses:		
Payroll	$ 12,339,358	
Employee Benefits	1,939,676	
Professional Care	3,986,063	
Dietary & Housekeeping	1,847,275	
Plant & Maintenance	11,275,303	
General & Administrative	4,662,736	
Total Operating Expenses		36,050,411
Income From Operations		1,688,711
Other Income		74,801
Net Income		**$ 1,763,512**

See accompanying notes to the financial statements.

Aspen Hills Healthcare Center LLC
Statement of Members' Equity
For the year ended December 31, 2025

Members' Equity:		
Balance as of Beginning of Period	$	6,222,569
Net Income for the Period		1,763,512
Total Members' Equity - End of Period	**$**	**7,986,081**

See accompanying notes to the financial statements.

Aspen Hills Healthcare Center LLC
Statement of Cash Flows
For the year ended December 31, 2025

Cash Flows From Operating Activities:		
Net Income		$ 1,763,512
Adjustments to reconcile Net Income to Net Cash Provided by Operating Activities:		
Depreciation & Amortization		233,775
Allowance for Credit Losses		104,241
(Increase) Decrease In:		
Accounts Receivable	$ (2,594,313)	
Prepaid Expenses	(40,413)	
Increase (Decrease) In:		
Accounts Payable	288,580	
Accrued Payroll & Withholding Taxes	(365,899)	
Accrued Expenses & Taxes	635,258	
Exchanges	139,157	
Total Adjustments		(1,937,630)
Net Cash Provided By Operating Activities		163,898
Cash Flows From Investing Activities:		
Capital Expenditures	(346,439)	
Net Cash Used In Investing Activities		(346,439)
Net Change In Cash		(182,541)
Cash - Beginning of Period		2,062,010
Cash - End of Period		**$ 1,879,469**

See accompanying notes to the financial statements.

Aspen Hills Healthcare Center LLC
Notes to the Financial Statements

1) **Organization**:

Aspen Hills Healthcare Center LLC ("the Facility"), a limited liability company, is licensed by the New Jersey State Department of Health to run and operate a 204 bed skilled nursing facility and a 30 bed psychiatric hospital located in Pemberton, New Jersey. The Facility began operations August 14, 2012.

2) **Summary of Significant Accounting Policies:**

The accounting policies that affect the significant elements of the financial statements are summarized below.

Method of Accounting -

The Facility maintains its books and prepares its financial statements on the accrual basis of accounting.

Cash -

For purposes of the statement of cash flows, cash includes time deposits, certificates of deposits, and all highly liquid debt instruments with original maturities of six months or less. The Facility maintains cash at financial institutions which periodically exceeds federally insured amounts during the year.

Fixed Assets -

Fixed assets are stated at cost. Depreciation and amortization for assets are computed using the straight-line method over the estimated useful lives of the assets.

Leasehold Improvements	10 years
Furniture & Equipment	5 years

Use of Estimates -

The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Advertising -

Advertising costs are expensed as incurred and included in general and administrative expenses. Advertising expense for the year was $158,480.

Income Taxes -

The Facility is treated as a partnership for income tax purposes, and as such each member is taxed separately on their distributive share of the Facility's income whether or not that income is actually distributed.

3) **Accounts Receivable:**

The Facility grants credit, without collateral, to its patients, the majority of whom are insured under the third-party payor agreements. The amount of receivables from patients and third-party payors at December 31, 2025 was as follows:

Medicaid Patients	$	2,232,638
Medicare Patients		1,613,058
HMO Patients		2,560,452
Private Patients and Other		2,374,803
Less: Allowance for Credit Losses		(707,784)
Total	**$**	**8,073,16**

Management provides for probable uncollectible amounts through a charge to earnings and a credit to a valuation allowance based on the current expected credit loss (CECL) model. Credit losses that are expected to occur in the future are recognized at the time the receivable is recorded. The Facility uses a pooled approach to group together receivables with similar risk characteristics into portfolios categorized by major payor class. Estimated credit losses are calculated based on historical loss data for each portfolio as well as current and forecasted economic conditions. Management periodically reviews the allowance to ensure it accurately reflects the expected credit losses. Any adjustments that are needed are recognized currently as credit loss expense. Balances that are still outstanding after management has used reasonable collection efforts are written off through a charge to the valuation allowance and a credit to accounts receivable.

Allowance for Credit Losses

Balance, January 1, 2025	$	603,544
Provision for expected credit losses		427,000
Write-offs charged against the allowance		(322,760)
Balance December 31, 2025	**$**	**707,784**

4) **Uncertainty in Income Taxes:**

Management has determined that there are no material uncertain tax positions that require recognition or disclosure in the financial statements. Periods ended December 31, 2022 and subsequent remain subject to examination by applicable taxing authorities.

5) **Compensated Absences:**

The Facility recognizes a liability for compensated absences when the employees have earned the right to the leave through their service, the leave is expected to be used in the future, and the amount can be reasonably estimated. Compensated absences include accrued vacation, sick leave and personal time off. The liability is calculated based on the employee's current pay rate and number of remaining unused days. As of December 31, 2025, the liability for compensated absences amounted to $195,159, which is included in the total accrued payroll liability of $315,253.

6) **Right-of-Use Asset and Lease Liability:**

The Facility's operating lease right-of-use assets and lease liabilities were for a building lease.

The Facility occupies premises pursuant to a 38-year, non-arm's-length lease from Ocean Healthcare Operating Partners LLC (related through common ownership) expiring in 2050. The lease, as amended in November 2015, provides for monthly rental payments of $137,528. Rent expense for the year ended December 31, 2025 was $9,925,691.

The Facility determines the present value of the remaining lease payments using the US Treasury risk-free rate at the time of adoption of the Standard, which was 2.01%. The Facility does not have any variable lease payments, residual value guarantees, or material lease incentives.

The Facility has not recognized any material impairments of its operating lease right-of-use asset as of December 31, 2025. As of December 31, 2025, the Facility's operating lease liability and corresponding asset was $31,992,152 of which $1,016,625 of the liability was considered short term.

The Facility's future minimum lease payments for the next five years and thereafter, as of December 31, 2025, were as follows:

2026	$ 1,650,336
2027	1,650,336
2028	1,650,336
2029	1,650,336
2030	1,650,336
Thereafter	33,969,416

The future minimum lease payments include only the remaining non-cancelable lease payments under the operating leases with a term of more than 12 months as of December 31, 2025.

7) **Patient Care Revenue Recognition:**

Resident services revenue is recognized at the amount the Facility expects to receive in exchange for providing care to residents. This revenue includes amounts due from residents, third-party payors (such as health insurers and government programs), and incorporates variable considerations for potential retroactive adjustments resulting from audits and reviews. Typically, the Facility bills residents and third-party payors a few days after services are provided or when the resident no longer requires care. Revenue is recognized as performance obligations are fulfilled.

Performance obligations are identified based on the nature of the services provided. For obligations satisfied over time, revenue is recognized based on the Percentage of Completion method actual charges incurred relative to the total expected charges. This approach is believed to accurately reflect the transfer of services throughout the performance obligation period, particularly for residents receiving post-acute care services in our Facility.

7) **Patient Care Revenue Recognition (cont.):**

Revenue for performance obligations fulfilled at a specific point in time is generally recognized when goods are provided to residents in a retail setting (e.g., personal care services and additional meals not included in the resident contract) and when no further goods or services are required.

The transaction price is determined based on standard charges for services rendered, adjusted for contractual allowances given to third-party payors, discounts for uninsured residents per the Facility's charity care policy, and implicit price concessions for uninsured residents. Estimates for contractual adjustments and discounts are based on contractual agreements, Facility policies, and historical data.

Agreements with major third-party payors typically stipulate payments at amounts lower than established charges. A summary of the payment arrangements with key payors includes:

- Medicare: Certain in-resident post-acute care services are reimbursed at predetermined rates per service, influenced by clinical and diagnostic factors. Other services are reimbursed based on cost-reimbursement methodologies, with physician services paid according to established fee schedules. Medicare revenue primarily consists of fixed regional rates adjusted for patient acuity, subject to audit verification.

- Medicaid: Under the current statewide pricing methodology, Medicaid revenue is based on the rate in effect as of July 1, 2014. The State has made statewide adjustments in some years, but the rates are not subject to audit.

  New Jersey implemented a managed care Medicaid formula in January 2014, requiring Medicaid patients to enroll in managed long-term care plans. The state's executive budget mandates that managed care companies pay rates no less than the current Medicaid methodology, with New Jersey Department of Health calculating these rates annually.

- Other: Payment agreements with various commercial insurance carriers, health maintenance organizations, and preferred provider organizations typically provide for payment based on predetermined rates per service, discounts from standard charges, and daily rates.

Compliance with government regulations, particularly concerning Medicare and Medicaid, is complex and can be subject to interpretation. Facilities may receive requests for information and notices of alleged noncompliance, leading to potential settlement agreements. Future regulatory reviews may result in fines, penalties, or exclusion from programs. The Facility believes they are currently in compliance with all applicable laws and regulations.

Settlements for retroactive adjustments due to audits or investigations are considered variable considerations and are included in the transaction price estimation for resident services. These settlements are estimated based on agreements with payors, relevant correspondence, and historical settlement activities. Adjustments are made in subsequent periods as new information becomes available or when cases are settled.

7) **Patient Care Revenue Recognition (cont.):**

Residents covered by third-party payors are generally responsible for deductibles and coinsurance, which can vary. The Facility also serves uninsured residents and offers discounts as required by policy or law. Estimates of transaction prices for these residents are based on historical data and market conditions. Initial transaction price estimates are calculated by reducing standard charges by contractual adjustments, discounts, and implicit price concessions.

Changes to transaction price estimates are recorded as adjustments to resident service revenue in the period of change. Adverse changes in residents' ability to pay are recorded as bad debt expense.

Revenue from residents' deductibles and coinsurance is included in the preceding categories based on the primary payor.

Revenues are recorded based on current billings of the estimated net realizable amounts from patients, third-party payers and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payers. Certain adjustments may be made in subsequent periods as a result of audits or appeals. Such adjustments, if any, will be reflected in revenues in the period in which they are received.

8) **Nursing Home/Hospital Provider Tax:**

All New Jersey facilities were assessed a provider assessment tax of $14.67 for each private and Medicaid patient day. The nursing home provider tax for the year ended December 31, 2025 was $851,476. Concurrently with the tax assessment, the State prospectively calculated a revenue add-on to the Medicaid rate.

All New Jersey psychiatric hospitals were charged a fee calculated as a percentage of revenue. The fee paid by the Facility in 2025 was $683,741.

9) **Subsequent Events:**

The Facility has evaluated subsequent events through June 4, 2026, the date which the financial statements were available to be issued. No significant subsequent events have been identified by management.

MARTIN FRIEDMAN CPA PC
CERTIFIED PUBLIC ACCOUNTANTS

INDEPENDENT AUDITOR'S REPORT
ON ADDITIONAL INFORMATION

To the Members,
Aspen Hills Healthcare Center LLC:

Our report on our audit of the basic financial statements of Aspen Hills Healthcare Center LLC for 2025 appears on page 1. That audit was conducted for the purpose of forming an opinion on the basic financial statements taken as a whole. The supplementary information on page 13 is presented for purposes of additional analysis and is not a required part of the basic financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the basic financial statements taken as a whole.

Martin Friedman CPA, PC

MARTIN FRIEDMAN C.P.A. P.C.
Certified Public Accountants

Brooklyn, NY

June 4, 2026

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Aspen Hills Healthcare Center LLC
Supplementary Schedules
For the year ended December 31, 2025

Revenue From Patients:		
Private & HMO	$ 6,821,023	
Medicaid	22,766,400	
Medicare	8,151,699	
Total Revenue From Patients		$ 37,739,122
Other Income:		
Interest	73,262	
Other	1,539	
Total Other Income		74,801
Total Revenue		**$ 37,813,923**