

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0090	Period: From 01/01/2024 To 12/31/2024	Worksheet S Parts I-III Date/Time Prepared: 4/14/2025 10:55 am
--	-----------------------	---	---

PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report 2. ☐ Manually prepared cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report 4. ☒ Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.		Date: 4/14/2025 Time: 10:55 am
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FRANCISCAN HEALTH - DYER (15-0090) for the cost reporting period beginning 01/01/2024 and ending 12/31/2024 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	Pamela Ott	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	Pamela Ott		2
3	Signatory Title	CFO		3
4	Date	(Dated when report is electronica		4

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	-393,599	-1,267	0	1.00
2.00	SUBPROVIDER - IPF	0	1,510	15	0	2.00
3.00	SUBPROVIDER - IRF	0	-147,109	2	0	3.00
5.00	SWING BED - SNF	0	0	0	0	5.00
6.00	SWING BED - NF	0			0	6.00
9.00	HOME HEALTH AGENCY I	0	0	1	0	9.00
200.00	TOTAL	0	-539,198	-1,249	0	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 15-0090		Period: From 01/01/2024 To 12/31/2024		Worksheet S-2 Part I Date/Time Prepared: 4/14/2025 10:55 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 24 JOLIET STREET			PO Box:				1.00	
2.00	City: DYER			State: IN		Zip Code: 46311-1799		County: LAKE	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00
								8.00	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			FRANCISCAN HEALTH - DYER	150090	23844	1	07/01/1966	N
4.00	Subprovider - IPF			PRANCISCAN HEALTH -	15S090	22384	4	01/01/2024	N
5.00	Subprovider - IRF			DYER- PSYCH					
				FRANCISCAN HEALTH - DYER	15T090	23844	5	01/01/2002	N
				-REHAB					
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA			ST. MARGARET HOME CARE	157145	23844		01/01/2023	N
13.00	Separately Certified ASC								P
14.00	Hospital-Based Hospice								N
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2024	12/31/2024	20.00
21.00	Type of Control (see instructions)						1		21.00
						1.00	2.00	3.00	
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic 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
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet S-2
Part I
Date/Time Prepared:
4/14/2025 10:55 am

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	54	29	254	225	3,699	84	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	73		25.00
					Urban/Rural St	Date of Geogra	
					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.					2		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.					2		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					1		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					01/01/2024	12/31/2024	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)					Y	Y	40.00
					V	XVIII	XIX
					1.00	2.00	3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					Y	Y	
57.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.					Y		
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0090	Period: From 01/01/2024 To 12/31/2024	Worksheet S-2 Part I Date/Time Prepared: 4/14/2025 10:55 am	
			V 1.00	XVIII 2.00	XIX 3.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	Y	Y		60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1	60.01
60.02	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.01	1	60.02
60.03	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.02	1	60.03
		Y/N	IME	Direct GME	
		1.00	2.00	3.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N		0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count
		1.00	2.00	3.00	4.00
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	61.20
					1.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during this cost reporting period of HRSA THC program. (see instructions)				62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings					
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N			63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet S-2
Part I
Date/Time Prepared:
4/14/2025 10:55 am

			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	6.96	0.000000	64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	6.96	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0090	Period: From 01/01/2024 To 12/31/2024	Worksheet S-2 Part I Date/Time Prepared: 4/14/2025 10:55 am	
				1.00	
68.00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?				68.00
				1.00	2.00 3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			Y	70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N N 0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			Y	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)			N N 0	76.00
				1.00	
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87.00
			Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
			1.00	2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.		N	0	88.00
			Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge
			1.00	2.00	3.00
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.		0.00		0 89.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	97.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0090	Period: From 01/01/2024 To 12/31/2024	Worksheet S-2 Part I Date/Time Prepared: 4/14/2025 10:55 am
		V 1.00	XIX 2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06
Rural Providers				
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		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)	N		107.00
107.01	If this facility is a REH (line 3, column 4, is "12"), is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no. (see instructions)			107.01
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00
		Physical 1.00	Occupational 2.00	Speech 3.00
		Respiratory 4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N
				1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N		110.00
				1.00
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
				1.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2		118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0090	Period: From 01/01/2024 To 12/31/2024	Worksheet S-2 Part I Date/Time Prepared: 4/14/2025 10:55 am
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	574,932	0	232,860
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.04	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		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.			124.00
Certified Transplant Center Information				
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	158014	140.00
		1.00	2.00	3.00
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.				
141.00	Name: FRANCISCAN ALLIANCE, INC	Contractor's Name: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 08101	141.00
142.00	Street: 1515 DRAGOON TRAIL	PO Box: -		142.00
143.00	City: MISHAWAKA	State: IN	Zip Code: 46546	143.00
				1.00
144.00	Are provider based physicians' costs included in Worksheet A?		Y	144.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0090		Period: From 01/01/2024 To 12/31/2024		Worksheet S-2 Part I Date/Time Prepared: 4/14/2025 10:55 am	
		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	
		Part A 1.00		Part B 2.00		Title V 3.00	
						Title XIX 4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N		N		155.00	
156.00	Subprovider - IPF	N		N		156.00	
157.00	Subprovider - IRF	N		N		157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N		N		159.00	
160.00	HOME HEALTH AGENCY	N		N		160.00	
161.00	CMHC	N		N		161.00	
		1.00					
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N				165.00	
		Name 0		County 1.00		State 2.00	
				Zip Code 3.00		CBSA 4.00	
						FTE/Campus 5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00 166.00	
		1.00					
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y				167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00				169.00	
		Beginning 1.00		Ending 2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					170.00	
		1.00		2.00			
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N				0 171.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0090		Period: From 01/01/2024 To 12/31/2024		Worksheet S-2 Part II Date/Time Prepared: 4/14/2025 10:55 am	
		Y/N	Date				
		1.00	2.00				
PART II - HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE							
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		04/15/2025		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.				Y		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)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, in columns 2 and 4, enter the "Paid Claims Verified Current As Of" date, if present, or the paid-through date. (see instructions)	Y	02/28/2025	Y	02/28/2025		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet S-2
Part II
Date/Time Prepared:
4/14/2025 10:55 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	If	Y		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.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	HALL	JAMES		41.00
42.00	Enter the employer/company name of the cost report preparer	FRANCISCAN ALLIANCE INC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(614) 565-2739	JAMES.HALL@FRANCISCANALLIANCE.ORG		43.00

Health Financial Systems

FRANCISCAN HEALTH - DYER

In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0090	Period: From 01/01/2024 To 12/31/2024	Worksheet S-2 Part II Date/Time Prepared: 4/14/2025 10:55 am
		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.	REIMBURSEMENT ANALYST		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet S-3
Part I
Date/Time Prepared:
4/14/2025 10:55 am

Component						4/14/2023 10:55 am	
		Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips	
						Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	81	31,970	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		81	31,970	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	12	4,724	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	NEONATAL INTENSIVE CARE UNIT	35.00	4	1,962	0.00	0	12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		97	38,656	0.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
16.00	SUBPROVIDER - IPF	40.00	50	18,300		0	16.00
17.00	SUBPROVIDER - IRF	41.00	15	5,490		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		162				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet S-3
Part I
Date/Time Prepared:
4/14/2025 10:55 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	6,560	77	18,869			1.00
2.00	HMO and other (see instructions)	5,983	3,699				2.00
3.00	HMO IPF Subprovider	503	0				3.00
4.00	HMO IRF Subprovider	801	73				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	6,560	77	18,869			7.00
8.00	INTENSIVE CARE UNIT	774	265	2,388			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	NEONATAL INTENSIVE CARE UNIT	0	78	249			12.00
13.00	NURSERY		142	616			13.00
14.00	Total (see instructions)	7,334	562	22,122	6.96	711.36	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits	0	0	0			15.10
16.00	SUBPROVIDER - IPF	523	3,598	7,616	0.00	51.94	16.00
17.00	SUBPROVIDER - IRF	2,297	0	3,697	0.00	20.24	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	22,892	0	57,210	0.00	67.54	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				6.96	851.08	27.00
28.00	Observation Bed Days		0	2,337			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	84	168			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet S-3
Part I
Date/Time Prepared:
4/14/2025 10:55 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	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	1,584	123	4,439	1.00
2.00 HMO and other (see instructions)			1,067	1,088		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				8		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 NEONATAL INTENSIVE CARE UNIT						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,584	123	4,439	14.00
15.00 CAH visits						15.00
15.10 REH hours and visits						15.10
16.00 SUBPROVIDER - IPF	0.00	0	78	700	1,632	16.00
17.00 SUBPROVIDER - IRF	0.00	0	181	0	295	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01
34.00 Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet S-3
Part II
Date/Time Prepared:
4/14/2025 10:55 am

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	76,769,295	0	76,769,295	1,777,049.96	43.20
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		87,525	0	87,525	633.50	138.16
4.01	Physicians - Part A - Teaching		79,923	0	79,923	2,400.00	33.30
5.00	Physician and Non Physician-Part B		2,442,036	0	2,442,036	7,389.00	330.50
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	60,392	0	60,392	2,080.00	29.03
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		17,818,876	-51,326	17,767,550	317,406.84	55.98
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,590,454	0	2,590,454	27,797.00	93.19
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		180,625	0	180,625	1,445.00	125.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		13,599,907	0	13,599,907	312,144.00	43.57
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
15.01	Home office Physicians Part A - Administrative		0	0	0	0.00	0.00
15.02	Home office contract Physicians Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		16,414,444	0	16,414,444		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		4,416,308	0	4,416,308		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		16,761	0	16,761		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		412,405	0	412,405		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		3,460,543	0	3,460,543		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet S-3
Part II
Date/Time Prepared:
4/14/2025 10:55 am

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	395,440	0	395,440	12,109.90	32.65	26.00
27.00	Administrative & General	5.00	4,758,915	0	4,758,915	97,704.93	48.71	27.00
28.00	Administrative & General under contract (see inst.)		894,328	0	894,328	5,421.45	164.96	28.00
29.00	Maintenance & Repairs	6.00	2,003,911	0	2,003,911	46,648.31	42.96	29.00
30.00	Operation of Plant	7.00	330,656	0	330,656	9,495.40	34.82	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	2,171,757	0	2,171,757	103,823.23	20.92	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,355,562	-781,115	574,447	24,358.97	23.58	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	781,115	781,115	33,122.55	23.58	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,718,396	0	2,718,396	46,687.59	58.23	38.00
39.00	Central Services and Supply	14.00	413,203	0	413,203	16,791.38	24.61	39.00
40.00	Pharmacy	15.00	2,346,455	59,214	2,405,669	41,427.59	58.07	40.00
41.00	Medical Records & Medical Records Library	16.00	187,609	0	187,609	5,344.00	35.11	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet S-3
Part III
Date/Time Prepared:
4/14/2025 10:55 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	75,081,272	0	75,081,272	1,770,602.41	42.40	1.00
2.00	Excluded area salaries (see instructions)	17,818,876	-51,326	17,767,550	317,406.84	55.98	2.00
3.00	Subtotal salaries (line 1 minus line 2)	57,262,396	51,326	57,313,722	1,453,195.57	39.44	3.00
4.00	Subtotal other wages & related costs (see inst.)	16,370,986	0	16,370,986	341,386.00	47.95	4.00
5.00	Subtotal wage-related costs (see inst.)	19,891,748	0	19,891,748	0.00	34.71	5.00
6.00	Total (sum of lines 3 thru 5)	93,525,130	51,326	93,576,456	1,794,581.57	52.14	6.00
7.00	Total overhead cost (see instructions)	17,576,232	59,214	17,635,446	442,935.30	39.81	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 15-0090	Period: From 01/01/2024 To 12/31/2024	Worksheet S-3 Part IV Date/Time Prepared: 4/14/2025 10:55 am
			Amount Reported	
			1.00	
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		1,943,966	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)		3,380,956	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)		7,886,474	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		302,766	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		28,827	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)		286,637	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		1,037,974	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		6,040,885	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		0	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		20,908,485	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet S-3
Part V
Date/Time Prepared:
4/14/2025 10:55 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	2,590,454	20,908,485	1.00
2.00	Hospital	2,590,454	20,908,485	2.00
3.00	SUBPROVIDER - IPF	0	0	3.00
4.00	SUBPROVIDER - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			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

HOME HEALTH AGENCY STATISTICAL DATA				Provider CCN: 15-0090 Component CCN: 15-7145		Period: From 01/01/2024 To 12/31/2024		Worksheet S-4 Date/Time Prepared: 4/14/2025 10:55 am		
						Home Health Agency I		PPS		
						1.00				
0.00	County							0.00		
				Title V	Title XVIII	Title XIX	Other	Total		
				1.00	2.00	3.00	4.00	5.00		
HOME HEALTH AGENCY STATISTICAL DATA										
1.00	Home Health Aide Hours			0	0	0	0	0	1.00	
2.00	Unduplicated Census Count (see instructions)			0.00	1,544.00	0.00	0.00	57,210.00	2.00	
				Number of Employees (Full Time Equivalent)						
				Enter the number of hours in your normal work week			Staff	Contract	Total	
				0			1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES										
3.00	Administrator and Assistant Administrator(s)			40.00		0.00	0.00	0.00	3.00	
4.00	Director(s) and Assistant Director(s)					1.49	0.00	1.49	4.00	
5.00	Other Administrative Personnel					20.74	0.00	20.74	5.00	
6.00	Direct Nursing Service					21.92	0.00	21.92	6.00	
7.00	Nursing Supervisor					3.29	0.00	3.29	7.00	
8.00	Physical Therapy Service					13.47	0.79	14.26	8.00	
9.00	Physical Therapy Supervisor					0.00	0.00	0.00	9.00	
10.00	Occupational Therapy Service					1.65	0.43	2.08	10.00	
11.00	Occupational Therapy Supervisor					0.00	0.00	0.00	11.00	
12.00	Speech Pathology Service					0.26	0.12	0.38	12.00	
13.00	Speech Pathology Supervisor					0.00	0.00	0.00	13.00	
14.00	Medical Social Service					0.04	0.00	0.04	14.00	
15.00	Medical Social Service Supervisor					0.00	0.00	0.00	15.00	
16.00	Home Health Aide					1.32	0.00	1.32	16.00	
17.00	Home Health Aide Supervisor					0.00	0.00	0.00	17.00	
18.00	HOME HEALTH THERAPY ASSISTANT					3.20	0.47	3.67	18.00	
								CBSA Data		
								1.00		
HOME HEALTH AGENCY CBSA CODES										
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.							5	19.00	
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).							16984	20.00	
20.01								23844	20.01	
20.02								33140	20.02	
20.03								43780	20.03	
20.04								99915	20.04	
				Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)		
				Without Outliers	With Outliers					
				1.00	2.00	3.00	4.00	5.00		
PPS ACTIVITY DATA										
21.00	Skilled Nursing Visits			7,956	1,728	194	18	9,896	21.00	
22.00	Skilled Nursing Visit Charges			3,174,444	689,472	77,406	6,783	3,948,105	22.00	
23.00	Physical Therapy Visits			8,708	1,675	87	25	10,495	23.00	
24.00	Physical Therapy Visit Charges			3,605,112	693,450	36,018	8,694	4,343,274	24.00	
25.00	Occupational Therapy Visits			898	532	0	5	1,435	25.00	
26.00	Occupational Therapy Visit Charges			371,772	220,248	0	1,656	593,676	26.00	
27.00	Speech Pathology Visits			65	61	0	0	126	27.00	
28.00	Speech Pathology Visit Charges			26,910	25,254	0	0	52,164	28.00	
29.00	Medical Social Service Visits			5	1	0	0	6	29.00	
30.00	Medical Social Service Visit Charges			2,400	480	0	0	2,880	30.00	
31.00	Home Health Aide Visits			651	275	2	6	934	31.00	
32.00	Home Health Aide Visit Charges			125,643	53,075	386	1,158	180,262	32.00	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)			18,283	4,272	283	54	22,892	33.00	
34.00	Other Charges			0	0	0	0	0	34.00	
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)			7,306,281	1,681,979	113,810	18,291	9,120,361	35.00	
36.00	Total Number of Episodes (standard/non outlier)			2,509		192	6	2,707	36.00	
37.00	Total Number of Outlier Episodes				276		2	278	37.00	
38.00	Total Non-Routine Medical Supply Charges			171,669	49,799	3,942	462	225,872	38.00	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 15-0090	Period: From 01/01/2024 To 12/31/2024	Worksheet S-10 Parts I & II Date/Time Prepared: 4/14/2025 10:55 am
				1.00
PART I - HOSPITAL AND HOSPITAL COMPLEX DATA				
Uncompensated and Indigent Care Cost-to-Charge Ratio				
1.00	Cost to charge ratio (see instructions)		0.221070	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		21,948,530	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		136,561,409	6.00
7.00	Medicaid cost (line 1 times line 6)		30,189,631	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)		8,241,101	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)		0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		8,241,101	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	12,521,341	2,086,569	14,607,910
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,768,093	1,875,976	4,644,069
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (see instructions)	2,768,093	1,875,976	4,644,069
				1.00
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
25.01	Charges for insured patients' liability (see instructions)		270,362	25.01
26.00	Bad debt amount (see instructions)		6,165,487	26.00
27.00	Medicare reimbursable bad debts (see instructions)		323,490	27.00
27.01	Medicare allowable bad debts (see instructions)		497,677	27.01
28.00	Non-Medicare bad debt amount (see instructions)		5,667,810	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)		1,427,170	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)		6,071,239	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		14,312,340	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 15-0090	Period: From 01/01/2024 To 12/31/2024	Worksheet S-10 Parts I & II Date/Time Prepared: 4/14/2025 10:55 am	
				1.00	
PART II - HOSPITAL DATA					
Uncompensated and Indigent Care Cost-to-Charge Ratio					
1.00	Cost to charge ratio (see instructions)		0.193963		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?				4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid				5.00
6.00	Medicaid charges				6.00
7.00	Medicaid cost (line 1 times line 6)				7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)				8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP				9.00
10.00	Stand-alone CHIP charges				10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)				11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)				12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)				13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)				14.00
15.00	State or local indigent care program cost (line 1 times line 14)				15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)				16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care				17.00
18.00	Government grants, appropriations or transfers for support of hospital operations				18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)				19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
Uncompensated care cost (see instructions for each line)					
20.00	Charity care charges and uninsured discounts (see instructions)	12,022,452	1,912,321	13,934,773	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,331,911	1,694,399	4,026,310	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (see instructions)	2,331,911	1,694,399	4,026,310	23.00
				1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0		25.00
25.01	Charges for insured patients' liability (see instructions)		270,362		25.01
26.00	Bad debt amount (see instructions)		6,165,487		26.00
27.00	Medicare reimbursable bad debts (see instructions)		323,490		27.00
27.01	Medicare allowable bad debts (see instructions)		497,677		27.01
28.00	Non-Medicare bad debt amount (see instructions)		5,667,810		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)		1,273,532		29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)		5,299,842		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		5,299,842		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0090

Period:

From 01/01/2024

To 12/31/2024

Worksheet A

Date/Time Prepared:
4/14/2025 10:55 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	7,938,527	7,938,527	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	4,055,803	4,055,803	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	395,440	20,949,478	21,344,918	-784	21,344,134	4.00
5.04	00593	ADMINISTRATIVE & GENERAL	4,758,915	44,210,529	48,969,444	-3,489,505	45,479,939	5.04
6.00	00600	MAINTENANCE & REPAIRS	2,003,911	10,855,273	12,859,184	-4,842,875	8,016,309	6.00
7.00	00700	OPERATION OF PLANT	330,656	772,750	1,103,406	415,657	1,519,063	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	888,936	888,936	0	888,936	8.00
9.00	00900	HOUSEKEEPING	2,171,757	445,707	2,617,464	-16,844	2,600,620	9.00
10.00	01000	DIETARY	1,355,562	1,204,717	2,560,279	-1,479,997	1,080,282	10.00
11.00	01100	CAFETERIA	0	0	0	1,468,933	1,468,933	11.00
13.00	01300	NURSING ADMINISTRATION	2,718,396	1,665,003	4,383,399	-148,622	4,234,777	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	413,203	679,979	1,093,182	-330,223	762,959	14.00
15.00	01500	PHARMACY	2,346,455	4,436,763	6,783,218	-4,231,649	2,551,569	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	187,609	130,128	317,737	0	317,737	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	60,392	81	60,473	0	60,473	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	79,923	124,769	204,692	0	204,692	22.00
23.00	02300	PARAMED ED PRGM - EMERGENCY MEDICINE	524	13,867	14,391	6,924	21,315	23.00
23.01	02301	PARAMED ED PRGM- LAB	96,164	17,441	113,605	199,262	312,867	23.01
23.02	02302	PARAMED ED PRGM- PHARMACY	129,463	12,385	141,848	-59,214	82,634	23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,835,464	2,218,904	16,054,368	-3,605,537	12,448,831	30.00
31.00	03100	INTENSIVE CARE UNIT	2,190,049	870,578	3,060,627	-470,402	2,590,225	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	1,022,341	878,439	1,900,780	-62,741	1,838,039	35.00
40.00	04000	SUBPROVIDER - IPF	4,890,562	1,774,084	6,664,646	-44,438	6,620,208	40.00
41.00	04100	SUBPROVIDER - IRF	1,731,007	100,996	1,832,003	-85,303	1,746,700	41.00
43.00	04300	NURSERY	0	0	0	410,985	410,985	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,456,062	8,861,256	10,317,318	-7,449,358	2,867,960	50.00
50.01	05001	OUTPATIENT SURGERY	832,008	281,720	1,113,728	-317,541	796,187	50.01
51.00	05100	RECOVERY ROOM	495,926	50,008	545,934	-47,173	498,761	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,698,761	1,698,761	52.00
53.00	05300	ANESTHESIOLOGY	39,501	4,958,632	4,998,133	-252,941	4,745,192	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,884,657	2,113,492	3,998,149	-1,135,147	2,863,002	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	1,132,346	897,487	2,029,833	-885,865	1,143,968	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	323,071	383,419	706,490	-340,813	365,677	56.00
60.00	06000	LABORATORY	0	7,624,089	7,624,089	-324,919	7,299,170	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	441,187	441,187	0	441,187	63.00
65.00	06500	RESPIRATORY THERAPY	2,072,943	424,462	2,497,405	-293,903	2,203,502	65.00
66.00	06600	PHYSICAL THERAPY	3,937,418	834,173	4,771,591	-519,595	4,251,996	66.00
67.00	06700	OCCUPATIONAL THERAPY	618,221	1,660	619,881	-883	618,998	67.00
68.00	06800	SPEECH PATHOLOGY	476,320	210,609	686,929	-15,796	671,133	68.00
69.00	06900	ELECTROCARDIOLOGY	920,704	248,892	1,169,596	-258,588	911,008	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	269,433	71,438	340,871	-46,837	294,034	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	13,762,852	13,762,852	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,711,093	4,711,093	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,653,054	4,653,054	73.00
76.00	03630	ULTRA SOUND	503,433	110,268	613,701	-84,952	528,749	76.00
76.01	03951	PAIN CLINIC	727,242	519,105	1,246,347	-111,286	1,135,061	76.01
76.02	03952	CATH LAB	2,180,825	7,085,224	9,266,049	-6,959,221	2,306,828	76.02
76.03	03953	ACTIVITY THERAPEUTIC	1,537,445	9,926	1,547,371	0	1,547,371	76.03
76.04	03954	WOUND CARE CENTER	546,795	85,404	632,199	-81,196	551,003	76.04
76.05	03340	BARIATRIC CLINIC	0	0	0	0	0	76.05
76.06	03030	HEALTHY LIVING CENTER	0	0	0	0	0	76.06
76.07	03950	CV RESOURCE CENTER	0	0	0	0	0	76.07
76.08	03955	ANCILLARY OTHER	0	0	0	0	0	76.08
76.09	03956	LACTATION CLINIC	0	0	0	0	0	76.09
76.10	03957	ANCILLARY OTHER	0	0	0	0	0	76.10
76.11	03958	ANCILLARY OTHER	0	0	0	0	0	76.11
76.12	03959	ANTICOAGULATION CLINIC	530,907	90,635	621,542	-75,598	545,944	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	4,595,089	1,043,455	5,638,544	-915,012	4,723,532	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	7,787,554	1,372,031	9,159,585	-420,666	8,738,919	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 15-0090		Period: From 01/01/2024 To 12/31/2024		Worksheet A Date/Time Prepared: 4/14/2025 10:55 am	
Cost Center Description				Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
				1.00	2.00	3.00	4.00	5.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE			-83,025	-83,025	83,025		0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)		73,585,693	129,886,354	203,472,047	-548	203,471,499	118.00
NONREIMBURSABLE COST CENTERS									
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		43,316	92,477	135,793	0	135,793	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		308,350	-264,857	43,493	548	44,041	192.00
192.01	19201	WORKING WELL		0	0	0	0	0	192.01
192.02	19202	PHYSICIANS' PRIVATE OFFICES		0	0	0	0	0	192.02
192.03	19203	MISC		0	0	0	0	0	192.03
194.00	07950	RESIDENTIAL		2,831,624	155,527	2,987,151	0	2,987,151	194.00
194.01	07954	FITNESS CENTER		0	0	0	0	0	194.01
194.02	07952	INFUSION PHARMACY		0	0	0	0	0	194.02
194.03	07953	CENTER OF HOPE		312	1,125	1,437	0	1,437	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)		76,769,295	129,870,626	206,639,921	0	206,639,921	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024

Worksheet A

Date/Time Prepared:
4/14/2025 10:55 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,398,843	9,337,370	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	4,055,803	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,165,712	20,178,422	4.00
5.04	00593	ADMINISTRATIVE & GENERAL	-8,536,339	36,943,600	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	8,016,309	6.00
7.00	00700	OPERATION OF PLANT	-287,798	1,231,265	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	888,936	8.00
9.00	00900	HOUSEKEEPING	-55	2,600,565	9.00
10.00	01000	DIETARY	-233	1,080,049	10.00
11.00	01100	CAFETERIA	-439,491	1,029,442	11.00
13.00	01300	NURSING ADMINISTRATION	-1,424,032	2,810,745	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	762,959	14.00
15.00	01500	PHARMACY	289,291	2,840,860	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	880,875	1,198,612	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	60,473	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	-149,617	55,075	22.00
23.00	02300	PARAMED ED PRGM - EMERGENCY MEDICINE	0	21,315	23.00
23.01	02301	PARAMED ED PRGM- LAB	-30,019	282,848	23.01
23.02	02302	PARAMED ED PRGM- PHARMACY	-250	82,384	23.02
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-488,649	11,960,182	30.00
31.00	03100	INTENSIVE CARE UNIT	-12	2,590,213	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	-798,331	1,039,708	35.00
40.00	04000	SUBPROVIDER - IPF	-1,902,187	4,718,021	40.00
41.00	04100	SUBPROVIDER - IRF	-14	1,746,686	41.00
43.00	04300	NURSERY	0	410,985	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-57	2,867,903	50.00
50.01	05001	OUTPATIENT SURGERY	0	796,187	50.01
51.00	05100	RECOVERY ROOM	40	498,801	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,698,761	52.00
53.00	05300	ANESTHESIOLOGY	-4,680,400	64,792	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-22	2,862,980	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	0	1,143,968	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	365,677	56.00
60.00	06000	LABORATORY	0	7,299,170	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	441,187	63.00
65.00	06500	RESPIRATORY THERAPY	-3,658	2,199,844	65.00
66.00	06600	PHYSICAL THERAPY	-2,289	4,249,707	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	618,998	67.00
68.00	06800	SPEECH PATHOLOGY	-462	670,671	68.00
69.00	06900	ELECTROCARDIOLOGY	0	911,008	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	294,034	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	13,762,852	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,711,093	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,653,054	73.00
76.00	03630	ULTRA SOUND	0	528,749	76.00
76.01	03951	PAIN CLINIC	-403,270	731,791	76.01
76.02	03952	CATH LAB	0	2,306,828	76.02
76.03	03953	ACTIVITY THERAPEUTIC	-287,134	1,260,237	76.03
76.04	03954	WOUND CARE CENTER	-102	550,901	76.04
76.05	03340	BARIATRIC CLINIC	0	0	76.05
76.06	03030	HEALTHY LIVING CENTER	0	0	76.06
76.07	03950	CV RESOURCE CENTER	0	0	76.07
76.08	03955	ANCILLARY OTHER	0	0	76.08
76.09	03956	LACTATION CLINIC	0	0	76.09
76.10	03957	ANCILLARY OTHER	0	0	76.10
76.11	03958	ANCILLARY OTHER	0	0	76.11
76.12	03959	ANTICOAGULATION CLINIC	-1,779	544,165	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	78.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-293,667	4,429,865	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	-50	8,738,869	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-18,326,580	185,144,919	118.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024

Worksheet A

Date/Time Prepared:
4/14/2025 10:55 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	135,793	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	44,041	192.00
192.01	19201	WORKING WELL	0	0	192.01
192.02	19202	PHYSICIANS' PRIVATE OFFICES	0	0	192.02
192.03	19203	MISC	0	0	192.03
194.00	07950	RESIDENTIAL	0	2,987,151	194.00
194.01	07954	FITNESS CENTER	0	0	194.01
194.02	07952	INFUSION PHARMACY	0	0	194.02
194.03	07953	CENTER OF HOPE	0	1,437	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-18,326,580	188,313,341	200.00

RECLASSIFICATIONS

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024

Worksheet A-6

Date/Time Prepared:
4/14/2025 10:55 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	7,114,113	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,883,699	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
20.00		0.00	0	0	20.00	
21.00		0.00	0	0	21.00	
22.00		0.00	0	0	22.00	
23.00		0.00	0	0	23.00	
24.00		0.00	0	0	24.00	
25.00		0.00	0	0	25.00	
26.00		0.00	0	0	26.00	
27.00		0.00	0	0	27.00	
28.00		0.00	0	0	28.00	
29.00		0.00	0	0	29.00	
30.00		0.00	0	0	30.00	
31.00		0.00	0	0	31.00	
32.00		0.00	0	0	32.00	
33.00		0.00	0	0	33.00	
34.00		0.00	0	0	34.00	
	0		0	10,997,812		
B - INTEREST CAPITALIZED						
1.00	INTEREST EXPENSE	113.00	0	83,025	1.00	
	0		0	83,025		
C - DIETARY						
1.00	CAFETERIA	11.00	781,115	687,818	1.00	
	0		781,115	687,818		
D - INSURANCE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	664,948	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	180,379	2.00	
	0		0	845,327		
E - PATIENT TRANSPORT						
1.00	ADULTS & PEDIATRICS	30.00	18,848	63	1.00	
2.00	RADIOLOGY-DIAGNOSTIC	54.00	105,162	354	2.00	
3.00	RADIOISOTOPE	56.00	31,960	108	3.00	
4.00	ELECTROCARDIOLOGY	69.00	7,373	25	4.00	
5.00	ULTRA SOUND	76.00	13,112	44	5.00	
6.00	CATH LAB	76.02	6,962	23	6.00	
7.00	EMERGENCY	91.00	11,703	39	7.00	
8.00	PHYSICIANS' PRIVATE OFFICES	192.00	546	2	8.00	
	0		195,666	658		
F - CHARGEABLE MED SUPPLIES & IMPLANTS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	13,762,852	1.00	
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	4,711,093	2.00	
3.00	LABORATORY	60.00	0	22,238	3.00	
4.00	SPEECH PATHOLOGY	68.00	0	11,951	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	

RECLASSIFICATIONS

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024

Worksheet A-6

Date/Time Prepared:
4/14/2025 10:55 am

Increases					
Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00		
16.00	0.00	0	0		16.00
17.00	0.00	0	0		17.00
18.00	0.00	0	0		18.00
19.00	0.00	0	0		19.00
20.00	0.00	0	0		20.00
21.00	0.00	0	0		21.00
22.00	0.00	0	0		22.00
23.00	0.00	0	0		23.00
24.00	0.00	0	0		24.00
25.00	0.00	0	0		25.00
26.00	0.00	0	0		26.00
27.00	0.00	0	0		27.00
28.00	0.00	0	0		28.00
0		0	18,508,134		
G - DRUGS CHARGED TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,653,054	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	61	2.00
3.00	RESPIRATORY THERAPY	65.00	0	2,154	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
0			0	4,655,269	
H - PARAMEDICAL					
1.00	PARAMED ED PRGM - EMERGENCY MEDICINE	23.00	7,342	0	1.00
2.00	PARAMED ED PRGM- LAB	23.01	0	199,635	2.00
3.00	PHARMACY	15.00	59,214	0	3.00
0			66,556	199,635	
I - NURSERY					
1.00	NEONATAL INTENSIVE CARE UNIT	35.00	4,552	107	1.00
2.00	NURSERY	43.00	390,543	20,442	2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	1,659,205	39,556	3.00
0			2,054,300	60,105	
J - OPEN					
1.00		0.00	0	0	1.00
0			0	0	
K - LEASES AND RENT					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	242,491	1.00
2.00	OPERATION OF PLANT	7.00	0	432,148	2.00
3.00	OPERATING ROOM	50.00	0	165,840	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
0			0	840,479	
L - OPEN					
1.00		0.00	0	0	1.00
0			0	0	
500.00	Grand Total: Increases		3,097,637	36,878,262	500.00

RECLASSIFICATIONS

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet A-6
Date/Time Prepared:
4/14/2025 10:55 am

		Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
	A - DEPRECIATION							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	784	9		1.00	
2.00	ADMINISTRATIVE & GENERAL	5.04	0	2,554,465	9		2.00	
3.00	MAINTENANCE & REPAIRS	6.00	0	4,840,647	0		3.00	
4.00	OPERATION OF PLANT	7.00	0	16,491	0		4.00	
5.00	HOUSEKEEPING	9.00	0	16,844	0		5.00	
6.00	DIETARY	10.00	0	11,064	0		6.00	
7.00	NURSING ADMINISTRATION	13.00	0	49,364	0		7.00	
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	164,377	0		8.00	
9.00	PHARMACY	15.00	0	24,922	0		9.00	
10.00	PARAMED ED PRGM- LAB	23.01	0	373	0		10.00	
11.00	ADULTS & PEDIATRICS	30.00	0	290,653	0		11.00	
12.00	INTENSIVE CARE UNIT	31.00	0	78,066	0		12.00	
13.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	8,340	0		13.00	
14.00	SUBPROVIDER - IPF	40.00	0	31,106	0		14.00	
15.00	SUBPROVIDER - IRF	41.00	0	22,443	0		15.00	
16.00	OPERATING ROOM	50.00	0	748,699	0		16.00	
17.00	OUTPATIENT SURGERY	50.01	0	27,907	0		17.00	
18.00	RECOVERY ROOM	51.00	0	35,682	0		18.00	
19.00	ANESTHESIOLOGY	53.00	0	633	0		19.00	
20.00	RADIOLOGY-DIAGNOSTIC	54.00	0	996,052	0		20.00	
21.00	RADIOLOGY-SPECIAL PROCEDURES	54.01	0	71,326	0		21.00	
22.00	RADIOISOTOPE	56.00	0	149,760	0		22.00	
23.00	LABORATORY	60.00	0	147,522	0		23.00	
24.00	RESPIRATORY THERAPY	65.00	0	88,947	0		24.00	
25.00	PHYSICAL THERAPY	66.00	0	71,855	0		25.00	
26.00	SPEECH PATHOLOGY	68.00	0	27,747	0		26.00	
27.00	ELECTROCARDIOLOGY	69.00	0	168,125	0		27.00	
28.00	ELECTROENCEPHALOGRAPHY	70.00	0	24,664	0		28.00	
29.00	ULTRA SOUND	76.00	0	71,226	0		29.00	
30.00	PAIN CLINIC	76.01	0	16,350	0		30.00	
31.00	CATH LAB	76.02	0	142,646	0		31.00	
32.00	WOUND CARE CENTER	76.04	0	15,238	0		32.00	
33.00	EMERGENCY	91.00	0	62,574	0		33.00	
34.00	HOME HEALTH AGENCY	101.00	0	20,920	0		34.00	
	0		0	10,997,812				
B - INTEREST CAPITALIZED								
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	83,025	11		1.00	
	0		0	83,025				
C - DIETARY								
1.00	DIETARY	10.00	781,115	687,818	0		1.00	
	0		781,115	687,818				
D - INSURANCE								
1.00	ADMINISTRATIVE & GENERAL	5.04	0	845,327	12		1.00	
2.00		0.00	0	0	12		2.00	
	0		0	845,327				
E - PATIENT TRANSPORT								
1.00	EMERGENCY	91.00	195,666	658	0		1.00	
2.00		0.00	0	0	0		2.00	
3.00		0.00	0	0	0		3.00	
4.00		0.00	0	0	0		4.00	
5.00		0.00	0	0	0		5.00	
6.00		0.00	0	0	0		6.00	
7.00		0.00	0	0	0		7.00	
8.00		0.00	0	0	0		8.00	
	0		195,666	658				
F - CHARGEABLE MED SUPPLIES & IMPLANTS								
1.00	NURSING ADMINISTRATION	13.00	0	96,159	0		1.00	
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	165,907	0		2.00	
3.00	PHARMACY	15.00	0	43,000	0		3.00	
4.00	PARAMED ED PRGM - EMERGENCY MEDICINE	23.00	0	418	0		4.00	
5.00	ADULTS & PEDIATRICS	30.00	0	1,029,523	0		5.00	
6.00	INTENSIVE CARE UNIT	31.00	0	344,062	0		6.00	
7.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	31,948	0		7.00	
8.00	SUBPROVIDER - IPF	40.00	0	13,270	0		8.00	
9.00	SUBPROVIDER - IRF	41.00	0	57,147	0		9.00	
10.00	OPERATING ROOM	50.00	0	6,836,907	0		10.00	
11.00	OUTPATIENT SURGERY	50.01	0	284,468	0		11.00	
12.00	RECOVERY ROOM	51.00	0	9,939	0		12.00	
13.00	ANESTHESIOLOGY	53.00	0	195,218	0		13.00	
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	241,653	0		14.00	
15.00	RADIOLOGY-SPECIAL PROCEDURES	54.01	0	812,560	0		15.00	
16.00	RADIOISOTOPE	56.00	0	7,357	0		16.00	

RECLASSIFICATIONS

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024

Worksheet A-6

Date/Time Prepared:
4/14/2025 10:55 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
17.00	RESPIRATORY THERAPY	65.00	0	207,110	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	13,689	0		18.00
19.00	OCCUPATIONAL THERAPY	67.00	0	883	0		19.00
20.00	ELECTROCARDIOLOGY	69.00	0	97,735	0		20.00
21.00	ELECTROENCEPHALOGRAPHY	70.00	0	22,173	0		21.00
22.00	ULTRA SOUND	76.00	0	26,846	0		22.00
23.00	PAIN CLINIC	76.01	0	94,407	0		23.00
24.00	CATH LAB	76.02	0	6,818,296	0		24.00
25.00	WOUND CARE CENTER	76.04	0	54,100	0		25.00
26.00	ANTICOAGULATION CLINIC	76.12	0	75,598	0		26.00
27.00	EMERGENCY	91.00	0	624,885	0		27.00
28.00	HOME HEALTH AGENCY	101.00	0	302,876	0		28.00
0			0	18,508,134			
G - DRUGS CHARGED TO PATIENTS							
1.00	NURSING ADMINISTRATION	13.00	0	92	0		1.00
2.00	PHARMACY	15.00	0	4,160,625	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	73,836	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	43,383	0		4.00
5.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	135	0		5.00
6.00	SUBPROVIDER - IPF	40.00	0	62	0		6.00
7.00	SUBPROVIDER - IRF	41.00	0	4,166	0		7.00
8.00	OPERATING ROOM	50.00	0	29,592	0		8.00
9.00	OUTPATIENT SURGERY	50.01	0	5,166	0		9.00
10.00	RECOVERY ROOM	51.00	0	1,552	0		10.00
11.00	ANESTHESIOLOGY	53.00	0	57,090	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,958	0		12.00
13.00	RADIOLOGY-SPECIAL PROCEDURES	54.01	0	1,979	0		13.00
14.00	RADIOISOTOPE	56.00	0	215,764	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	186	0		15.00
16.00	ELECTROCARDIOLOGY	69.00	0	126	0		16.00
17.00	ULTRA SOUND	76.00	0	36	0		17.00
18.00	PAIN CLINIC	76.01	0	529	0		18.00
19.00	CATH LAB	76.02	0	5,264	0		19.00
20.00	WOUND CARE CENTER	76.04	0	11,562	0		20.00
21.00	EMERGENCY	91.00	0	35,629	0		21.00
22.00	HOME HEALTH AGENCY	101.00	0	5,537	0		22.00
0			0	4,655,269			
H - PARAMEDICAL							
1.00	EMERGENCY	91.00	7,342	0	0		1.00
2.00	LABORATORY	60.00	0	199,635	0		2.00
3.00	PARAMED ED PRGM- PHARMACY	23.02	59,214	0	0		3.00
0			66,556	199,635			
I - NURSERY							
1.00	ADULTS & PEDIATRICS	30.00	2,039,517	47,911	0		1.00
2.00	NEONATAL INTENSIVE CARE UNIT	35.00	14,783	12,194	0		2.00
3.00		0.00	0	0	0		3.00
0			2,054,300	60,105			
J - OPEN							
1.00		0.00	0	0	0		1.00
0			0	0			
K - LEASES AND RENT							
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	8,275	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.04	0	89,713	10		2.00
3.00	MAINTENANCE & REPAIRS	6.00	0	2,228	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	3,007	0		4.00
5.00	PHARMACY	15.00	0	62,316	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	143,008	0		6.00
7.00	INTENSIVE CARE UNIT	31.00	0	4,891	0		7.00
8.00	SUBPROVIDER - IRF	41.00	0	1,547	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	433,865	0		9.00
10.00	WOUND CARE CENTER	76.04	0	296	0		10.00
11.00	HOME HEALTH AGENCY	101.00	0	91,333	0		11.00
0			0	840,479			
L - OPEN							
1.00		0.00	0	0	0		1.00
0			0	0			
500.00	Grand Total: Decreases		3,097,637	36,878,262			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet A-7
Part I
Date/Time Prepared:
4/14/2025 10:55 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	694,364	0	0	0	0	1.00	
2.00	Land Improvements	10,382,022	11,595	0	11,595	0	2.00	
3.00	Buildings and Fixtures	76,043,442	818,274	0	818,274	0	3.00	
4.00	Building Improvements	178,989	0	0	0	0	4.00	
5.00	Fixed Equipment	121,061,281	2,146,643	0	2,146,643	0	5.00	
6.00	Movable Equipment	57,204,912	185,598	0	185,598	812,475	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	265,565,010	3,162,110	0	3,162,110	812,475	8.00	
9.00	Reconciling Items	1,660,614	384,687	0	384,687	0	9.00	
10.00	Total (line 8 minus line 9)	263,904,396	2,777,423	0	2,777,423	812,475	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	694,364	0					1.00
2.00	Land Improvements	10,393,617	0					
3.00	Buildings and Fixtures	76,861,716	0					
4.00	Building Improvements	178,989	0					
5.00	Fixed Equipment	123,207,924	0					
6.00	Movable Equipment	56,578,035	0					
7.00	HIT designated Assets	0	0					
8.00	Subtotal (sum of lines 1-7)	267,914,645	0					
9.00	Reconciling Items	2,045,301	0					
10.00	Total (line 8 minus line 9)	265,869,344	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet A-7
Part II
Date/Time Prepared:
4/14/2025 10:55 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet A-7
Part III
Date/Time Prepared:
4/14/2025 10:55 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	211,336,609	0	211,336,609	0.788821	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	56,578,036	0	56,578,036	0.211179	0	2.00
3.00	Total (sum of lines 1-2)	267,914,645	0	267,914,645	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	8,512,956	242,491	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,883,699	-8,275	2.00
3.00	Total (sum of lines 1-2)	0	0	0	12,396,655	234,216	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	-83,025	664,948	0	0	9,337,370	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	180,379	0	0	4,055,803	2.00
3.00	Total (sum of lines 1-2)	-83,025	845,327	0	0	13,393,173	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024

Worksheet A-8

Date/Time Prepared:
4/14/2025 10:55 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		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	-10,889,513			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	654,180			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-414,168	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-25,323	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	RENTAL INCOME	B	-121,294	ADMINISTRATIVE & GENERAL	5.04	0	33.00
33.01	RENTAL INCOME	B	-287,760	OPERATION OF PLANT	7.00	0	33.01
34.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024

Worksheet A-8

Date/Time Prepared:
4/14/2025 10:55 am

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
35.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.00
36.00 FALL OUT ACCOUNTS	A	6,312	ADMINISTRATIVE & GENERAL	5.04	0	36.00
37.00 ADVERTISING EXPENSE	A	-4	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37.00
37.01 ADVERTISING EXPENSE	A	-926	ADMINISTRATIVE & GENERAL	5.04	0	37.01
37.02 ADVERTISING EXPENSE	A	-1,132	ADULTS & PEDIATRICS	30.00	0	37.02
37.03 ADVERTISING EXPENSE	A	-43	NEONATAL INTENSIVE CARE UNIT	35.00	0	37.03
37.04 ADVERTISING EXPENSE	A	-1,966	SUBPROVIDER - IPF	40.00	0	37.04
37.05 ADVERTISING EXPENSE	A	40	RECOVERY ROOM	51.00	0	37.05
37.06 ADVERTISING EXPENSE	A	-38	OPERATION OF PLANT	7.00	0	37.06
37.07 ADVERTISING EXPENSE	A	-1,833	NURSING ADMINISTRATION	13.00	0	37.07
37.08 ADVERTISING EXPENSE	A	-250	PARAMED ED PRGM- PHARMACY	23.02	0	37.08
37.09 ADVERTISING EXPENSE	A	-57	OPERATING ROOM	50.00	0	37.09
37.10 ADVERTISING EXPENSE	A	-1,639	PHYSICAL THERAPY	66.00	0	37.10
37.11 ADVERTISING EXPENSE	A	-462	SPEECH PATHOLOGY	68.00	0	37.11
37.12 ADVERTISING EXPENSE	A	-102	WOUND CARE CENTER	76.04	0	37.12
37.13 ADVERTISING EXPENSE	A	-595	EMERGENCY	91.00	0	37.13
37.14 ADVERTISING EXPENSE	A	-50	HOME HEALTH AGENCY	101.00	0	37.14
38.00 OUTSOURCED STAFF	B	0		0.00	0	38.00
39.00 GIFTS/DONATIONS	A	0		0.00	0	39.00
40.00 NON PATIENT BILLING	B	-111,411	EMERGENCY	91.00	0	40.00
41.00 340B PRESCRIPTION DRUG PROGRAM	B	-25,635	PHARMACY	15.00	0	41.00
42.00 HAF FEES	A	-4,732,050	ADMINISTRATIVE & GENERAL	5.04	0	42.00
43.00 UNNECESSARY BORROWING	A	0		0.00	0	43.00
44.00 LOBBYING EXPENSE	A	-7,412	ADMINISTRATIVE & GENERAL	5.04	0	44.00
45.00 PENSION ADJSUTMENT - PENDING HO INFO	A	-1,145,661	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.00
46.00 DISCOUNTS EARNED/REBATES	B	-954,620	ADMINISTRATIVE & GENERAL	5.04	0	46.00
47.00 OTHER OPERATING REVENUE	B	-931	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	47.00
47.01 OTHER OPERATING REVENUE	B	-73,086	ADMINISTRATIVE & GENERAL	5.04	0	47.01
47.02 OTHER OPERATING REVENUE	B	-76,642	ADULTS & PEDIATRICS	30.00	0	47.02
47.03 OTHER OPERATING REVENUE	B	-55	HOUSEKEEPING	9.00	0	47.03
47.04 OTHER OPERATING REVENUE	B	-23	DIETARY	10.00	0	47.04
47.05 OTHER OPERATING REVENUE	B	-15	RADIOLOGY-DIAGNOSTIC	54.00	0	47.05
47.06 OTHER OPERATING REVENUE	B	-30	PHARMACY	15.00	0	47.06
47.07 OTHER OPERATING REVENUE	B	-11	SUBPROVIDER - IPF	40.00	0	47.07
47.08 OTHER OPERATING REVENUE	B	-200	PHYSICAL THERAPY	66.00	0	47.08
47.09 OTHER OPERATING REVENUE	B	-11,155	EMERGENCY	91.00	0	47.09
47.10 OTHER OPERATING REVENUE	B	-12	INTENSIVE CARE UNIT	31.00	0	47.10
47.11 OTHER OPERATING REVENUE	B	-14	SUBPROVIDER - IRF	41.00	0	47.11
47.12 OTHER OPERATING REVENUE	B	-6	RESPIRATORY THERAPY	65.00	0	47.12
47.13 OTHER OPERATING REVENUE	B	-5	PAIN CLINIC	76.01	0	47.13
48.00 PROGRAM FEES	B	-5,444	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	48.00
48.01 PROGRAM FEES	B	-2,744	ADMINISTRATIVE & GENERAL	5.04	0	48.01
48.02 PROGRAM FEES	B	-22,891	ADULTS & PEDIATRICS	30.00	0	48.02
48.03 PROGRAM FEES	B	-450	PHYSICAL THERAPY	66.00	0	48.03
49.00 DUES/FEES/EDUCATION	B	-13,672	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	49.00
49.01 DUES/FEES/EDUCATION	B	-25,546	ADMINISTRATIVE & GENERAL	5.04	0	49.01
49.02 DUES/FEES/EDUCATION	B	-210	DIETARY	10.00	0	49.02
49.03 DUES/FEES/EDUCATION	B	-7	RADIOLOGY-DIAGNOSTIC	54.00	0	49.03
49.04 DUES/FEES/EDUCATION	B	-30,019	PARAMED ED PRGM- LAB	23.01	0	49.04
49.05 DUES/FEES/EDUCATION	B	0		0.00	0	49.05
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-18,326,580				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

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

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024

Worksheet A-8-1

Date/Time Prepared:
4/14/2025 10:55 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL	1,398,843	0	1.00
2.00	5.04	ADMINISTRATIVE & GENERAL	A&G	27,588,912	29,529,406	2.00
3.00	16.00	MEDICAL RECORDS & LIBRARY	HIM	880,875	0	3.00
4.00	15.00	PHARMACY	COVP/PHARMACY	314,956	0	4.00
4.01	0.00			0	0	4.01
4.02	0.00			0	0	4.02
4.03	0.00			0	0	4.03
4.04	0.00			0	0	4.04
4.05	0.00			0	0	4.05
4.06	0.00			0	0	4.06
4.07	0.00			0	0	4.07
4.08	0.00			0	0	4.08
4.09	0.00			0	0	4.09
4.10	0.00			0	0	4.10
4.11	0.00			0	0	4.11
4.12	0.00			0	0	4.12
4.13	0.00			0	0	4.13
4.14	0.00			0	0	4.14
4.15	0.00			0	0	4.15
4.16	0.00			0	0	4.16
4.17	0.00			0	0	4.17
4.18	0.00			0	0	4.18
4.19	0.00			0	0	4.19
4.20	0.00			0	0	4.20
4.21	0.00			0	0	4.21
4.22	0.00			0	0	4.22
4.23	0.00			0	0	4.23
4.24	0.00			0	0	4.24
4.25	0.00			0	0	4.25
4.26	0.00			0	0	4.26
4.27	0.00			0	0	4.27
4.28	0.00			0	0	4.28
4.29	0.00			0	0	4.29
4.30	0.00			0	0	4.30
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			30,183,586	29,529,406	5.00

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

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

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

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

6.00	B	FRANCISCAN ALLI	100.00	FRANCISCAN ALLI	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024

Worksheet A-8-1

Date/Time Prepared:
4/14/2025 10:55 am

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
				Name	Percentage of Ownership
	1.00	2.00	3.00	4.00	5.00

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

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

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

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024

Worksheet A-8-1

Date/Time Prepared:
4/14/2025 10:55 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	1,398,843	9		1.00
2.00	-1,940,494	0		2.00
3.00	880,875	0		3.00
4.00	314,956	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
4.15	0	0		4.15
4.16	0	0		4.16
4.17	0	0		4.17
4.18	0	0		4.18
4.19	0	0		4.19
4.20	0	0		4.20
4.21	0	0		4.21
4.22	0	0		4.22
4.23	0	0		4.23
4.24	0	0		4.24
4.25	0	0		4.25
4.26	0	0		4.26
4.27	0	0		4.27
4.28	0	0		4.28
4.29	0	0		4.29
4.30	0	0		4.30
5.00	654,180			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024

Worksheet A-8-2

Date/Time Prepared:
4/14/2025 10:55 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.04	AGGREGATE-ADMINISTRATIVE & GENERAL	684,479	684,479	0	0	211,500	1.00
2.00	13.00	AGGREGATE-NURSING ADMINISTRATION	1,422,199	1,422,199	0	0	211,500	2.00
3.00	22.00	AGGREGATE-I&R SERVICES-OTHER PRGM CO	149,617	149,617	0	0	197,500	3.00
4.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	387,984	387,984	0	0	197,500	4.00
5.00	35.00	AGGREGATE-NEONATAL INTENSIVE CARE UN	798,288	798,288	0	0	237,100	5.00
6.00	40.00	AGGREGATE-SUBPROVIDER - IPF	1,900,210	1,900,210	0	0	181,300	6.00
7.00	53.00	AGGREGATE-ANESTHESIOLOGY	4,680,400	4,680,400	0	0	239,400	7.00
8.00	65.00	AGGREGATE-RESPIRATORY THERAPY	3,652	3,652	0	0	211,500	8.00
9.00	76.01	AGGREGATE-PAIN CLINIC	403,265	403,265	0	0	211,500	9.00
10.00	76.03	AGGREGATE-ACTIVITY THERAPEUTIC	287,134	287,134	0	0	211,500	10.00
11.00	76.12	AGGREGATE-ANTICOAGULATION CLINIC	1,779	1,779	0	0	260,300	11.00
12.00	91.00	AGGREGATE-EMERGENCY	170,506	170,506	0	0	211,500	12.00
200.00			10,889,513	10,889,513	0	0	2,582,100	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.04	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	13.00	AGGREGATE-NURSING ADMINISTRATION	0	0	0	0	0	2.00
3.00	22.00	AGGREGATE-I&R SERVICES-OTHER PRGM CO	0	0	0	0	0	3.00
4.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	4.00
5.00	35.00	AGGREGATE-NEONATAL INTENSIVE CARE UN	0	0	0	0	0	5.00
6.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	0	0	0	6.00
7.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	0	0	7.00
8.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	0	0	8.00
9.00	76.01	AGGREGATE-PAIN CLINIC	0	0	0	0	0	9.00
10.00	76.03	AGGREGATE-ACTIVITY THERAPEUTIC	0	0	0	0	0	10.00
11.00	76.12	AGGREGATE-ANTICOAGULATION CLINIC	0	0	0	0	0	11.00
12.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	12.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.04	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	684,479		1.00
2.00	13.00	AGGREGATE-NURSING ADMINISTRATION	0	0	0	1,422,199		2.00
3.00	22.00	AGGREGATE-I&R SERVICES-OTHER PRGM CO	0	0	0	149,617		3.00
4.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	387,984		4.00
5.00	35.00	AGGREGATE-NEONATAL INTENSIVE CARE UN	0	0	0	798,288		5.00
6.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	0	1,900,210		6.00
7.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	4,680,400		7.00
8.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	3,652		8.00
9.00	76.01	AGGREGATE-PAIN CLINIC	0	0	0	403,265		9.00
10.00	76.03	AGGREGATE-ACTIVITY THERAPEUTIC	0	0	0	287,134		10.00
11.00	76.12	AGGREGATE-ANTICOAGULATION CLINIC	0	0	0	1,779		11.00
12.00	91.00	AGGREGATE-EMERGENCY	0	0	0	170,506		12.00
200.00			0	0	0	10,889,513		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet B
Part I
Date/Time Prepared:
4/14/2025 10:55 am

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	9,337,370				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	4,055,803	4,055,803			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	20,178,422	38,435	933	20,217,790	4.00
5.04	00593	ADMINISTRATIVE & GENERAL	36,943,600	694,537	118,155	1,259,785	5.04
6.00	00600	MAINTENANCE & REPAIRS	8,016,309	1,405,334	172,345	530,477	6.00
7.00	00700	OPERATION OF PLANT	1,231,265	398,531	12,306	87,532	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	888,936	0	0	0	8.00
9.00	00900	HOUSEKEEPING	2,600,565	106,601	18,437	574,910	9.00
10.00	01000	DIETARY	1,080,049	94,040	12,851	152,068	10.00
11.00	01100	CAFETERIA	1,029,442	135,758	0	206,778	11.00
13.00	01300	NURSING ADMINISTRATION	2,810,745	14,361	58,744	719,617	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	762,959	121,081	167,283	109,384	14.00
15.00	01500	PHARMACY	2,840,860	63,438	5,625	636,831	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,198,612	96,651	0	49,664	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	60,473	0	0	15,987	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	55,075	0	0	21,157	22.00
23.00	02300	PARAMED ED PRGM - EMERGENCY MEDICINE	21,315	791	0	2,082	23.00
23.01	02301	PARAMED ED PRGM- LAB	282,848	34,043	444	25,457	23.01
23.02	02302	PARAMED ED PRGM- PHARMACY	82,384	4,154	0	18,596	23.02
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	11,960,182	1,446,777	269,736	3,127,651	30.00
31.00	03100	INTENSIVE CARE UNIT	2,590,213	196,447	92,699	579,752	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	1,039,708	10,820	9,932	267,927	35.00
40.00	04000	SUBPROVIDER - IPF	4,718,021	523,825	36,414	1,294,634	40.00
41.00	04100	SUBPROVIDER - IRF	1,746,686	117,461	14,955	458,234	41.00
43.00	04300	NURSERY	410,985	22,709	1,421	103,385	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,867,903	326,152	789,658	385,450	50.00
50.01	05001	OUTPATIENT SURGERY	796,187	316,697	32,926	220,250	50.01
51.00	05100	RECOVERY ROOM	498,801	109,805	42,324	131,282	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,698,761	99,222	5,523	439,226	52.00
53.00	05300	ANESTHESIOLOGY	64,792	0	753	10,457	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,862,980	465,906	1,062,554	526,747	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	1,143,968	30,503	84,824	299,756	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	365,677	97,541	91,622	93,984	56.00
60.00	06000	LABORATORY	7,299,170	102,605	175,552	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	441,187	56,001	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	2,199,844	42,332	105,848	548,752	65.00
66.00	06600	PHYSICAL THERAPY	4,249,707	28,722	41,121	1,042,317	66.00
67.00	06700	OCCUPATIONAL THERAPY	618,998	10,998	0	163,656	67.00
68.00	06800	SPEECH PATHOLOGY	670,671	0	30,431	126,092	68.00
69.00	06900	ELECTROCARDIOLOGY	911,008	75,327	201,981	245,681	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	294,034	104,089	29,350	71,325	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,762,852	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,711,093	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,653,054	0	0	0	73.00
76.00	03630	ULTRA SOUND	528,749	45,279	84,760	136,740	76.00
76.01	03951	PAIN CLINIC	731,791	243,763	14,400	192,516	76.01
76.02	03952	CATH LAB	2,306,828	178,782	151,574	579,153	76.02
76.03	03953	ACTIVITY THERAPEUTIC	1,260,237	112,871	0	406,994	76.03
76.04	03954	WOUND CARE CENTER	550,901	125,887	17,519	144,748	76.04
76.05	03340	BARIATRIC CLINIC	0	0	0	0	76.05
76.06	03030	HEALTHY LIVING CENTER	0	0	0	0	76.06
76.07	03950	CV RESOURCE CENTER	0	0	0	0	76.07
76.08	03955	ANCILLARY OTHER	0	0	0	0	76.08
76.09	03956	LACTATION CLINIC	0	0	0	0	76.09
76.10	03957	ANCILLARY OTHER	0	0	0	0	76.10
76.11	03958	ANCILLARY OTHER	0	0	0	0	76.11
76.12	03959	ANTICOAGULATION CLINIC	544,165	8,704	0	140,542	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	4,429,865	317,330	72,944	1,165,774	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	8,738,869	26,863	577	2,061,529	101.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet B
Part I
Date/Time Prepared:
4/14/2025 10:55 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	185,144,919	8,451,173	4,028,521	19,374,879	183,388,529	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	135,793	15,746	3,932	11,467	166,938	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	44,041	270,943	2,099	81,771	398,854	192.00
192.01	19201	WORKING WELL	0	0	0	0	0	192.01
192.02	19202	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.02
192.03	19203	MISC	0	0	0	0	0	192.03
194.00	07950	RESIDENTIAL	2,987,151	599,508	21,251	749,590	4,357,500	194.00
194.01	07954	FITNESS CENTER	0	0	0	0	0	194.01
194.02	07952	INFUSION PHARMACY	0	0	0	0	0	194.02
194.03	07953	CENTER OF HOPE	1,437	0	0	83	1,520	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	188,313,341	9,337,370	4,055,803	20,217,790	188,313,341	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet B
Part I
Date/Time Prepared:
4/14/2025 10:55 am

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.04	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.04	00593	ADMINISTRATIVE & GENERAL	39,016,077					5.04
6.00	00600	MAINTENANCE & REPAIRS	2,645,837	12,770,302				6.00
7.00	00700	OPERATION OF PLANT	452,007	706,948	2,888,589			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	232,307	0	0	1,121,243		8.00
9.00	00900	HOUSEKEEPING	862,526	189,097	45,280	0	4,397,416	9.00
10.00	01000	DIETARY	349,924	166,816	39,944	0	61,777	10.00
11.00	01100	CAFETERIA	358,540	240,819	57,665	0	89,183	11.00
13.00	01300	NURSING ADMINISTRATION	941,698	25,475	6,100	0	9,434	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	303,329	214,783	51,430	0	79,541	14.00
15.00	01500	PHARMACY	926,877	112,532	26,946	0	41,674	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	351,471	171,447	41,053	0	63,492	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	19,981	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	19,922	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM - EMERGENCY MEDICINE	6,321	1,404	336	0	520	23.00
23.01	02301	PARAMED ED PRGM- LAB	89,582	60,389	14,460	0	22,364	23.01
23.02	02302	PARAMED ED PRGM- PHARMACY	27,475	7,369	1,764	0	2,729	23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,391,569	2,566,412	614,531	584,127	950,425	30.00
31.00	03100	INTENSIVE CARE UNIT	903,973	348,474	83,443	79,677	129,051	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	347,149	19,194	4,596	8,408	7,108	35.00
40.00	04000	SUBPROVIDER - IPF	1,717,701	929,205	222,500	254,111	344,114	40.00
41.00	04100	SUBPROVIDER - IRF	610,818	208,362	49,892	123,352	77,163	41.00
43.00	04300	NURSERY	140,727	40,283	9,646	29,795	14,918	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,141,798	578,556	138,536	0	214,258	50.00
50.01	05001	OUTPATIENT SURGERY	356,994	561,783	134,520	0	208,046	50.01
51.00	05100	RECOVERY ROOM	204,416	194,782	46,641	0	72,134	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	586,095	176,009	42,146	41,773	65,182	52.00
53.00	05300	ANESTHESIOLOGY	19,862	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,285,275	826,463	197,898	0	306,066	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	407,428	54,108	12,956	0	20,038	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	169,558	173,026	41,431	0	64,077	56.00
60.00	06000	LABORATORY	1,980,190	182,009	43,582	0	67,404	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	129,931	99,338	23,787	0	36,788	63.00
65.00	06500	RESPIRATORY THERAPY	757,017	75,092	17,981	0	27,809	65.00
66.00	06600	PHYSICAL THERAPY	1,401,222	50,950	12,200	0	18,868	66.00
67.00	06700	OCCUPATIONAL THERAPY	207,406	19,510	4,672	0	7,225	67.00
68.00	06800	SPEECH PATHOLOGY	216,171	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	374,748	133,621	31,996	0	49,484	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	130,351	184,641	44,213	0	68,378	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,596,660	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,231,155	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,215,987	0	0	0	0	73.00
76.00	03630	ULTRA SOUND	207,896	80,320	19,233	0	29,745	76.00
76.01	03951	PAIN CLINIC	309,016	432,408	103,541	0	160,135	76.01
76.02	03952	CATH LAB	840,529	317,139	75,939	0	117,447	76.02
76.03	03953	ACTIVITY THERAPEUTIC	465,196	200,221	47,943	0	74,148	76.03
76.04	03954	WOUND CARE CENTER	219,271	223,310	53,472	0	82,699	76.04
76.05	03340	BARIATRIC CLINIC	0	0	0	0	0	76.05
76.06	03030	HEALTHY LIVING CENTER	0	0	0	0	0	76.06
76.07	03950	CV RESOURCE CENTER	0	0	0	0	0	76.07
76.08	03955	ANCILLARY OTHER	0	0	0	0	0	76.08
76.09	03956	LACTATION CLINIC	0	0	0	0	0	76.09
76.10	03957	ANCILLARY OTHER	0	0	0	0	0	76.10
76.11	03958	ANCILLARY OTHER	0	0	0	0	0	76.11
76.12	03959	ANTICOAGULATION CLINIC	181,210	15,439	3,697	0	5,718	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	1,564,305	562,906	134,789	0	208,462	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	2,829,650	47,652	11,410	0	17,647	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	37,729,071	11,198,292	2,512,169	1,121,243	3,815,251	118.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet B
Part I
Date/Time Prepared:
4/14/2025 10:55 am

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.04	6.00	7.00	8.00	9.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	43,626	27,931	6,688	0	10,344	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	104,233	480,621	115,085	0	177,989	192.00
192.01	19201	WORKING WELL	0	0	0	0	0	192.01
192.02	19202	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.02
192.03	19203	MISC	0	0	0	0	0	192.03
194.00	07950	RESIDENTIAL	1,138,750	1,063,458	254,647	0	393,832	194.00
194.01	07954	FITNESS CENTER	0	0	0	0	0	194.01
194.02	07952	INFUSION PHARMACY	0	0	0	0	0	194.02
194.03	07953	CENTER OF HOPE	397	0	0	0	0	194.03
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)	39,016,077	12,770,302	2,888,589	1,121,243	4,397,416	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet B
Part I
Date/Time Prepared:
4/14/2025 10:55 am

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.04	00593	ADMINISTRATIVE & GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,957,469					10.00
11.00	01100	CAFETERIA	0	2,118,185				11.00
13.00	01300	NURSING ADMINISTRATION	0	62,838	4,649,012			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	24,828	9	1,834,627		14.00
15.00	01500	PHARMACY	0	56,565	0	27,051	4,738,399	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,776	0	3,602	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	2,803	0	249	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	3,838	0	1,630	0	22.00
23.00	02300	PARAMED ED PRGM - EMERGENCY MEDICINE	0	33	0	17,589	0	23.00
23.01	02301	PARAMED ED PRGM- LAB	0	2,837	0	2,467	0	23.01
23.02	02302	PARAMED ED PRGM- PHARMACY	0	6,174	0	0	0	23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,065,485	410,336	1,475,054	176,577	0	30.00
31.00	03100	INTENSIVE CARE UNIT	143,859	73,050	413,866	18,084	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	27,832	158,772	6,272	0	35.00
40.00	04000	SUBPROVIDER - IPF	458,827	158,448	322,310	39,496	0	40.00
41.00	04100	SUBPROVIDER - IRF	222,721	63,372	254,616	20,680	0	41.00
43.00	04300	NURSERY	0	6,374	26,873	3,639	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	46,119	97,156	119,064	0	50.00
50.01	05001	OUTPATIENT SURGERY	0	21,391	121,947	30,662	0	50.01
51.00	05100	RECOVERY ROOM	0	12,614	55,022	3,836	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	66,577	26,030	106,639	15,565	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,903	0	2,049	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	65,541	2,101	50,149	0	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	0	30,435	92,129	29,890	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	8,877	0	729	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	68,578	0	36,519	0	65.00
66.00	06600	PHYSICAL THERAPY	0	117,000	9,718	50,561	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	19,255	0	437	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	11,980	0	585,068	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	30,702	65,528	39,930	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	8,376	0	1,556	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	4,738,399	73.00
76.00	03630	ULTRA SOUND	0	14,917	1,088	37,405	0	76.00
76.01	03951	PAIN CLINIC	0	22,059	117,708	8,459	0	76.01
76.02	03952	CATH LAB	0	56,031	225,576	265,921	0	76.02
76.03	03953	ACTIVITY THERAPEUTIC	0	51,525	1,726	3,181	0	76.03
76.04	03954	WOUND CARE CENTER	0	18,555	75,555	6,506	0	76.04
76.05	03340	BARIATRIC CLINIC	0	0	0	0	0	76.05
76.06	03030	HEALTHY LIVING CENTER	0	0	0	0	0	76.06
76.07	03950	CV RESOURCE CENTER	0	0	0	0	0	76.07
76.08	03955	ANCILLARY OTHER	0	0	0	0	0	76.08
76.09	03956	LACTATION CLINIC	0	0	0	0	0	76.09
76.10	03957	ANCILLARY OTHER	0	0	0	0	0	76.10
76.11	03958	ANCILLARY OTHER	0	0	0	0	0	76.11
76.12	03959	ANTICOAGULATION CLINIC	0	15,084	0	2,956	0	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	170,027	516,660	59,684	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	204,534	392,593	145,678	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,957,469	1,929,637	4,532,646	1,813,141	4,738,399	118.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet B
Part I
Date/Time Prepared:
4/14/2025 10:55 am

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,636	0	163	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	25,429	3,555	0	0	192.00
192.01	19201	WORKING WELL	0	0	0	0	0	192.01
192.02	19202	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.02
192.03	19203	MISC	0	0	0	0	0	192.03
194.00	07950	RESIDENTIAL	0	160,483	112,811	21,323	0	194.00
194.01	07954	FITNESS CENTER	0	0	0	0	0	194.01
194.02	07952	INFUSION PHARMACY	0	0	0	0	0	194.02
194.03	07953	CENTER OF HOPE	0	0	0	0	0	194.03
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)	1,957,469	2,118,185	4,649,012	1,834,627	4,738,399	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet B
Part I
Date/Time Prepared:
4/14/2025 10:55 am

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		PARAMED ED PRGM - EMERGENCY MEDICINE	
					SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS APPRV		
			16.00	17.00	21.00	22.00	23.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.04	00593	ADMINISTRATIVE & GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,983,768					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	99,493			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		101,622		22.00
23.00	02300	PARAMED ED PRGM - EMERGENCY MEDICINE	0	0			50,391	23.00
23.01	02301	PARAMED ED PRGM- LAB	0	0				23.01
23.02	02302	PARAMED ED PRGM- PHARMACY	0	0				23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	139,234	0	68,650	70,119	0	30.00
31.00	03100	INTENSIVE CARE UNIT	26,280	0	0	0	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	3,575	0	0	0	0	35.00
40.00	04000	SUBPROVIDER - IPF	51,939	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	17,746	0	0	0	0	41.00
43.00	04300	NURSERY	2,431	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	204,913	0	0	0	0	50.00
50.01	05001	OUTPATIENT SURGERY	10,276	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	43,440	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,491	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	47,012	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	238,133	0	0	0	0	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	28,824	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	27,898	0	0	0	0	56.00
60.00	06000	LABORATORY	195,497	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	5,534	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	32,795	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	67,658	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	30,114	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	22,566	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	69,979	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	13,041	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	132,547	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	48,486	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	100,389	0	0	0	0	73.00
76.00	03630	ULTRA SOUND	36,181	0	0	0	0	76.00
76.01	03951	PAIN CLINIC	27,422	0	0	0	0	76.01
76.02	03952	CATH LAB	124,081	0	0	0	0	76.02
76.03	03953	ACTIVITY THERAPEUTIC	13,700	0	0	0	0	76.03
76.04	03954	WOUND CARE CENTER	7,835	0	0	0	0	76.04
76.05	03340	BARIATRIC CLINIC	0	0	0	0	0	76.05
76.06	03030	HEALTHY LIVING CENTER	0	0	0	0	0	76.06
76.07	03950	CV RESOURCE CENTER	0	0	0	0	0	76.07
76.08	03955	ANCILLARY OTHER	0	0	0	0	0	76.08
76.09	03956	LACTATION CLINIC	0	0	0	0	0	76.09
76.10	03957	ANCILLARY OTHER	0	0	0	0	0	76.10
76.11	03958	ANCILLARY OTHER	0	0	0	0	0	76.11
76.12	03959	ANTICOAGULATION CLINIC	3,828	0	0	0	0	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	173,550	0	30,843	31,503	50,391	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
101.00	10100	HOME HEALTH AGENCY	26,373	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet B
Part I
Date/Time Prepared:
4/14/2025 10:55 am

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		PARAMED ED PRGM - EMERGENCY MEDICINE	
				SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS APPRV		
				21.00	22.00		
		16.00	17.00			23.00	
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,983,768	0	99,493	101,622	50,391
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	WORKING WELL	0	0	0	0	192.01
192.02	19202	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.02
192.03	19203	MISC	0	0	0	0	192.03
194.00	07950	RESIDENTIAL	0	0	0	0	194.00
194.01	07954	FITNESS CENTER	0	0	0	0	194.01
194.02	07952	INFUSION PHARMACY	0	0	0	0	194.02
194.03	07953	CENTER OF HOPE	0	0	0	0	194.03
200.00		Cross Foot Adjustments			0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,983,768	0	99,493	101,622	50,391

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet B
Part I
Date/Time Prepared:
4/14/2025 10:55 am

Cost Center Description			PARAMED ED PRGM- LAB	PARAMED ED PRGM- PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			23.01	23.02	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.04	00593	ADMINISTRATIVE & GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV						22.00
23.00	02300	PARAMED ED PRGM - EMERGENCY MEDICINE						23.00
23.01	02301	PARAMED ED PRGM- LAB	534,891					23.01
23.02	02302	PARAMED ED PRGM- PHARMACY		150,645				23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	29,316,865	-138,769	29,178,096	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	5,678,868	0	5,678,868	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	1,911,293	0	1,911,293	35.00
40.00	04000	SUBPROVIDER - IPF	0	0	11,071,545	0	11,071,545	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	3,986,058	0	3,986,058	41.00
43.00	04300	NURSERY	0	0	813,186	0	813,186	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	6,909,563	0	6,909,563	50.00
50.01	05001	OUTPATIENT SURGERY	0	0	2,811,679	0	2,811,679	50.01
51.00	05100	RECOVERY ROOM	0	0	1,415,097	0	1,415,097	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	3,379,239	0	3,379,239	52.00
53.00	05300	ANESTHESIOLOGY	0	0	147,828	0	147,828	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	7,889,813	0	7,889,813	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	0	0	2,234,859	0	2,234,859	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	1,134,420	0	1,134,420	56.00
60.00	06000	LABORATORY	534,891	0	10,580,900	0	10,580,900	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	792,566	0	792,566	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	3,912,567	0	3,912,567	65.00
66.00	06600	PHYSICAL THERAPY	0	0	7,090,044	0	7,090,044	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	1,082,271	0	1,082,271	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1,662,979	0	1,662,979	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	2,229,985	0	2,229,985	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	949,354	0	949,354	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	17,492,059	0	17,492,059	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	5,990,734	0	5,990,734	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	150,645	10,858,474	0	10,858,474	73.00
76.00	03630	ULTRA SOUND	0	0	1,222,313	0	1,222,313	76.00
76.01	03951	PAIN CLINIC	0	0	2,363,218	0	2,363,218	76.01
76.02	03952	CATH LAB	0	0	5,239,000	0	5,239,000	76.02
76.03	03953	ACTIVITY THERAPEUTIC	0	0	2,637,742	0	2,637,742	76.03
76.04	03954	WOUND CARE CENTER	0	0	1,526,258	0	1,526,258	76.04
76.05	03340	BARIATRIC CLINIC	0	0	0	0	0	76.05
76.06	03030	HEALTHY LIVING CENTER	0	0	0	0	0	76.06
76.07	03950	CV RESOURCE CENTER	0	0	0	0	0	76.07
76.08	03955	ANCILLARY OTHER	0	0	0	0	0	76.08
76.09	03956	LACTATION CLINIC	0	0	0	0	0	76.09
76.10	03957	ANCILLARY OTHER	0	0	0	0	0	76.10
76.11	03958	ANCILLARY OTHER	0	0	0	0	0	76.11
76.12	03959	ANTICOAGULATION CLINIC	0	0	921,343	0	921,343	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	9,489,033	-62,346	9,426,687	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	14,503,375	0	14,503,375	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet B
Part I
Date/Time Prepared:
4/14/2025 10:55 am

Cost Center Description			PARAMED ED PRGM- LAB	PARAMED ED PRGM- PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			23.01	23.02	24.00	25.00	26.00	
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	534,891	150,645	179,244,528	-201,115	179,043,413	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	258,326	0	258,326	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,305,766	0	1,305,766	192.00
192.01	19201	WORKING WELL	0	0	0	0	0	192.01
192.02	19202	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.02
192.03	19203	MISC	0	0	0	0	0	192.03
194.00	07950	RESIDENTIAL	0	0	7,502,804	0	7,502,804	194.00
194.01	07954	FITNESS CENTER	0	0	0	0	0	194.01
194.02	07952	INFUSION PHARMACY	0	0	0	0	0	194.02
194.03	07953	CENTER OF HOPE	0	0	1,917	0	1,917	194.03
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	534,891	150,645	188,313,341	-201,115	188,112,226	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet B
Part II
Date/Time Prepared:
4/14/2025 10:55 am

Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	38,435	933	39,368	39,368	4.00
5.04	00593	ADMINISTRATIVE & GENERAL	0	694,537	118,155	812,692	2,451	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	1,405,334	172,345	1,577,679	1,032	6.00
7.00	00700	OPERATION OF PLANT	0	398,531	12,306	410,837	170	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	106,601	18,437	125,038	1,118	9.00
10.00	01000	DIETARY	0	94,040	12,851	106,891	296	10.00
11.00	01100	CAFETERIA	0	135,758	0	135,758	402	11.00
13.00	01300	NURSING ADMINISTRATION	0	14,361	58,744	73,105	1,400	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	121,081	167,283	288,364	213	14.00
15.00	01500	PHARMACY	0	63,438	5,625	69,063	1,239	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	96,651	0	96,651	97	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	31	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	41	22.00
23.00	02300	PARAMED ED PRGM - EMERGENCY MEDICINE	0	791	0	791	4	23.00
23.01	02301	PARAMED ED PRGM- LAB	0	34,043	444	34,487	50	23.01
23.02	02302	PARAMED ED PRGM- PHARMACY	0	4,154	0	4,154	36	23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	1,446,777	269,736	1,716,513	6,121	30.00
31.00	03100	INTENSIVE CARE UNIT	0	196,447	92,699	289,146	1,128	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	10,820	9,932	20,752	521	35.00
40.00	04000	SUBPROVIDER - IPF	0	523,825	36,414	560,239	2,519	40.00
41.00	04100	SUBPROVIDER - IRF	0	117,461	14,955	132,416	891	41.00
43.00	04300	NURSERY	0	22,709	1,421	24,130	201	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	326,152	789,658	1,115,810	750	50.00
50.01	05001	OUTPATIENT SURGERY	0	316,697	32,926	349,623	428	50.01
51.00	05100	RECOVERY ROOM	0	109,805	42,324	152,129	255	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	99,222	5,523	104,745	854	52.00
53.00	05300	ANESTHESIOLOGY	0	0	753	753	20	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	465,906	1,062,554	1,528,460	1,025	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	0	30,503	84,824	115,327	583	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	97,541	91,622	189,163	183	56.00
60.00	06000	LABORATORY	0	102,605	175,552	278,157	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	56,001	0	56,001	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	42,332	105,848	148,180	1,068	65.00
66.00	06600	PHYSICAL THERAPY	0	28,722	41,121	69,843	2,028	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	10,998	0	10,998	318	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	30,431	30,431	245	68.00
69.00	06900	ELECTROCARDIOLOGY	0	75,327	201,981	277,308	478	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	104,089	29,350	133,439	139	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03630	ULTRA SOUND	0	45,279	84,760	130,039	266	76.00
76.01	03951	PAIN CLINIC	0	243,763	14,400	258,163	375	76.01
76.02	03952	CATH LAB	0	178,782	151,574	330,356	1,127	76.02
76.03	03953	ACTIVITY THERAPEUTIC	0	112,871	0	112,871	792	76.03
76.04	03954	WOUND CARE CENTER	0	125,887	17,519	143,406	282	76.04
76.05	03340	BARIATRIC CLINIC	0	0	0	0	0	76.05
76.06	03030	HEALTHY LIVING CENTER	0	0	0	0	0	76.06
76.07	03950	CV RESOURCE CENTER	0	0	0	0	0	76.07
76.08	03955	ANCILLARY OTHER	0	0	0	0	0	76.08
76.09	03956	LACTATION CLINIC	0	0	0	0	0	76.09
76.10	03957	ANCILLARY OTHER	0	0	0	0	0	76.10
76.11	03958	ANCILLARY OTHER	0	0	0	0	0	76.11
76.12	03959	ANTICOAGULATION CLINIC	0	8,704	0	8,704	273	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	317,330	72,944	390,274	2,268	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	26,863	577	27,440	4,011	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet B
Part II
Date/Time Prepared:
4/14/2025 10:55 am

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	8,451,173	4,028,521	12,479,694	37,729
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,746	3,932	19,678	22
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	270,943	2,099	273,042	159
192.01	19201	WORKING WELL	0	0	0	0	0
192.02	19202	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.03	19203	MISC	0	0	0	0	0
194.00	07950	RESIDENTIAL	0	599,508	21,251	620,759	1,458
194.01	07954	FITNESS CENTER	0	0	0	0	0
194.02	07952	INFUSION PHARMACY	0	0	0	0	0
194.03	07953	CENTER OF HOPE	0	0	0	0	0
200.00		Cross Foot Adjustments				0	0
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	0	9,337,370	4,055,803	13,393,173	39,368

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet B
Part II
Date/Time Prepared:
4/14/2025 10:55 am

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.04	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.04	00593	ADMINISTRATIVE & GENERAL	815,143					5.04
6.00	00600	MAINTENANCE & REPAIRS	55,280	1,633,991				6.00
7.00	00700	OPERATION OF PLANT	9,444	90,456	510,907			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,854	0	0	4,854		8.00
9.00	00900	HOUSEKEEPING	18,021	24,195	8,009	0	176,381	9.00
10.00	01000	DIETARY	7,311	21,344	7,065	0	2,478	10.00
11.00	01100	CAFETERIA	7,491	30,813	10,199	0	3,577	11.00
13.00	01300	NURSING ADMINISTRATION	19,675	3,260	1,079	0	378	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,337	27,482	9,096	0	3,190	14.00
15.00	01500	PHARMACY	19,365	14,399	4,766	0	1,672	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,343	21,937	7,261	0	2,547	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	417	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	416	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM - EMERGENCY MEDICINE	132	180	59	0	21	23.00
23.01	02301	PARAMED ED PRGM- LAB	1,872	7,727	2,558	0	897	23.01
23.02	02302	PARAMED ED PRGM- PHARMACY	574	943	312	0	109	23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	91,733	328,377	108,693	2,529	38,123	30.00
31.00	03100	INTENSIVE CARE UNIT	18,887	44,588	14,759	345	5,176	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	7,253	2,456	813	36	285	35.00
40.00	04000	SUBPROVIDER - IPF	35,888	118,894	39,354	1,100	13,802	40.00
41.00	04100	SUBPROVIDER - IRF	12,762	26,660	8,825	534	3,095	41.00
43.00	04300	NURSERY	2,940	5,154	1,706	129	598	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	23,856	74,028	24,503	0	8,594	50.00
50.01	05001	OUTPATIENT SURGERY	7,459	71,882	23,793	0	8,345	50.01
51.00	05100	RECOVERY ROOM	4,271	24,923	8,249	0	2,893	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,245	22,521	7,454	181	2,614	52.00
53.00	05300	ANESTHESIOLOGY	415	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,853	105,748	35,002	0	12,276	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	8,512	6,923	2,292	0	804	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	3,543	22,139	7,328	0	2,570	56.00
60.00	06000	LABORATORY	41,372	23,289	7,708	0	2,704	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,715	12,711	4,207	0	1,476	63.00
65.00	06500	RESPIRATORY THERAPY	15,816	9,608	3,180	0	1,115	65.00
66.00	06600	PHYSICAL THERAPY	29,276	6,519	2,158	0	757	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,333	2,496	826	0	290	67.00
68.00	06800	SPEECH PATHOLOGY	4,516	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	7,830	17,097	5,659	0	1,985	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,723	23,625	7,820	0	2,743	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	75,145	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,723	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,406	0	0	0	0	73.00
76.00	03630	ULTRA SOUND	4,344	10,277	3,402	0	1,193	76.00
76.01	03951	PAIN CLINIC	6,456	55,328	18,313	0	6,423	76.01
76.02	03952	CATH LAB	17,561	40,579	13,431	0	4,711	76.02
76.03	03953	ACTIVITY THERAPEUTIC	9,719	25,619	8,480	0	2,974	76.03
76.04	03954	WOUND CARE CENTER	4,581	28,573	9,458	0	3,317	76.04
76.05	03340	BARIATRIC CLINIC	0	0	0	0	0	76.05
76.06	03030	HEALTHY LIVING CENTER	0	0	0	0	0	76.06
76.07	03950	CV RESOURCE CENTER	0	0	0	0	0	76.07
76.08	03955	ANCILLARY OTHER	0	0	0	0	0	76.08
76.09	03956	LACTATION CLINIC	0	0	0	0	0	76.09
76.10	03957	ANCILLARY OTHER	0	0	0	0	0	76.10
76.11	03958	ANCILLARY OTHER	0	0	0	0	0	76.11
76.12	03959	ANTICOAGULATION CLINIC	3,786	1,976	654	0	229	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	32,683	72,025	23,840	0	8,361	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	59,120	6,097	2,018	0	708	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	788,254	1,432,848	444,329	4,854	153,030	118.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet B
Part II
Date/Time Prepared:
4/14/2025 10:55 am

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.04	6.00	7.00	8.00	9.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	911	3,574	1,183	0	415	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,178	61,497	20,355	0	7,139	192.00
192.01	19201	WORKING WELL	0	0	0	0	0	192.01
192.02	19202	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.02
192.03	19203	MISC	0	0	0	0	0	192.03
194.00	07950	RESIDENTIAL	23,792	136,072	45,040	0	15,797	194.00
194.01	07954	FITNESS CENTER	0	0	0	0	0	194.01
194.02	07952	INFUSION PHARMACY	0	0	0	0	0	194.02
194.03	07953	CENTER OF HOPE	8	0	0	0	0	194.03
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)	815,143	1,633,991	510,907	4,854	176,381	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet B
Part II
Date/Time Prepared:
4/14/2025 10:55 am

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.04	00593	ADMINISTRATIVE & GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	145,385					10.00
11.00	01100	CAFETERIA	0	188,240				11.00
13.00	01300	NURSING ADMINISTRATION	0	5,584	104,481			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,206	0	336,888		14.00
15.00	01500	PHARMACY	0	5,027	0	4,967	120,498	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	691	0	661	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	249	0	46	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	341	0	299	0	22.00
23.00	02300	PARAMED ED PRGM - EMERGENCY MEDICINE	0	3	0	3,230	0	23.00
23.01	02301	PARAMED ED PRGM- LAB	0	252	0	453	0	23.01
23.02	02302	PARAMED ED PRGM- PHARMACY	0	549	0	0	0	23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	79,135	36,467	33,151	32,424	0	30.00
31.00	03100	INTENSIVE CARE UNIT	10,685	6,492	9,301	3,321	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	2,473	3,568	1,152	0	35.00
40.00	04000	SUBPROVIDER - IPF	34,078	14,081	7,244	7,253	0	40.00
41.00	04100	SUBPROVIDER - IRF	16,542	5,632	5,722	3,797	0	41.00
43.00	04300	NURSERY	0	566	604	668	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	4,099	2,183	21,863	0	50.00
50.01	05001	OUTPATIENT SURGERY	0	1,901	2,741	5,630	0	50.01
51.00	05100	RECOVERY ROOM	0	1,121	1,237	704	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,945	2,313	2,397	2,858	0	52.00
53.00	05300	ANESTHESIOLOGY	0	258	0	376	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,825	47	9,209	0	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	0	2,705	2,070	5,489	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	789	0	134	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	6,094	0	6,706	0	65.00
66.00	06600	PHYSICAL THERAPY	0	10,398	218	9,284	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,711	0	80	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,065	0	107,435	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,728	1,473	7,332	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	744	0	286	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	120,498	73.00
76.00	03630	ULTRA SOUND	0	1,326	24	6,869	0	76.00
76.01	03951	PAIN CLINIC	0	1,960	2,645	1,553	0	76.01
76.02	03952	CATH LAB	0	4,979	5,070	48,830	0	76.02
76.03	03953	ACTIVITY THERAPEUTIC	0	4,579	39	584	0	76.03
76.04	03954	WOUND CARE CENTER	0	1,649	1,698	1,195	0	76.04
76.05	03340	BARIATRIC CLINIC	0	0	0	0	0	76.05
76.06	03030	HEALTHY LIVING CENTER	0	0	0	0	0	76.06
76.07	03950	CV RESOURCE CENTER	0	0	0	0	0	76.07
76.08	03955	ANCILLARY OTHER	0	0	0	0	0	76.08
76.09	03956	LACTATION CLINIC	0	0	0	0	0	76.09
76.10	03957	ANCILLARY OTHER	0	0	0	0	0	76.10
76.11	03958	ANCILLARY OTHER	0	0	0	0	0	76.11
76.12	03959	ANTICOAGULATION CLINIC	0	1,340	0	543	0	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	15,110	11,611	10,960	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	18,177	8,823	26,751	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	145,385	171,484	101,866	332,942	120,498	118.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet B
Part II
Date/Time Prepared:
4/14/2025 10:55 am

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	234	0	30	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,260	80	0	0	192.00
192.01	19201	WORKING WELL	0	0	0	0	0	192.01
192.02	19202	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.02
192.03	19203	MISC	0	0	0	0	0	192.03
194.00	07950	RESIDENTIAL	0	14,262	2,535	3,916	0	194.00
194.01	07954	FITNESS CENTER	0	0	0	0	0	194.01
194.02	07952	INFUSION PHARMACY	0	0	0	0	0	194.02
194.03	07953	CENTER OF HOPE	0	0	0	0	0	194.03
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)	145,385	188,240	104,481	336,888	120,498	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet B
Part II
Date/Time Prepared:
4/14/2025 10:55 am

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		PARAMED ED PRGM - EMERGENCY MEDICINE	
					SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS APPRV		
			16.00	17.00	21.00	22.00	23.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.04	00593	ADMINISTRATIVE & GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	137,188					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	743			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		1,097		22.00
23.00	02300	PARAMED ED PRGM - EMERGENCY MEDICINE	0	0			4,420	23.00
23.01	02301	PARAMED ED PRGM- LAB	0	0				23.01
23.02	02302	PARAMED ED PRGM- PHARMACY	0	0				23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,608	0				30.00
31.00	03100	INTENSIVE CARE UNIT	1,813	0				31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	247	0				35.00
40.00	04000	SUBPROVIDER - IPF	3,584	0				40.00
41.00	04100	SUBPROVIDER - IRF	1,225	0				41.00
43.00	04300	NURSERY	168	0				43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	14,141	0				50.00
50.01	05001	OUTPATIENT SURGERY	709	0				50.01
51.00	05100	RECOVERY ROOM	2,998	0				51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	724	0				52.00
53.00	05300	ANESTHESIOLOGY	3,244	0				53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,725	0				54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	1,989	0				54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0				55.00
56.00	05600	RADIOISOTOPE	1,925	0				56.00
60.00	06000	LABORATORY	13,491	0				60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	382	0				63.00
65.00	06500	RESPIRATORY THERAPY	2,263	0				65.00
66.00	06600	PHYSICAL THERAPY	4,669	0				66.00
67.00	06700	OCCUPATIONAL THERAPY	2,078	0				67.00
68.00	06800	SPEECH PATHOLOGY	1,557	0				68.00
69.00	06900	ELECTROCARDIOLOGY	4,829	0				69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	900	0				70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,147	0				71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,346	0				72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,928	0				73.00
76.00	03630	ULTRA SOUND	2,497	0				76.00
76.01	03951	PAIN CLINIC	1,892	0				76.01
76.02	03952	CATH LAB	8,563	0				76.02
76.03	03953	ACTIVITY THERAPEUTIC	945	0				76.03
76.04	03954	WOUND CARE CENTER	541	0				76.04
76.05	03340	BARIATRIC CLINIC	0	0				76.05
76.06	03030	HEALTHY LIVING CENTER	0	0				76.06
76.07	03950	CV RESOURCE CENTER	0	0				76.07
76.08	03955	ANCILLARY OTHER	0	0				76.08
76.09	03956	LACTATION CLINIC	0	0				76.09
76.10	03957	ANCILLARY OTHER	0	0				76.10
76.11	03958	ANCILLARY OTHER	0	0				76.11
76.12	03959	ANTICOAGULATION CLINIC	264	0				76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0				77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0				78.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	11,976	0				91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
101.00	10100	HOME HEALTH AGENCY	1,820	0				101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0				102.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet B
Part II
Date/Time Prepared:
4/14/2025 10:55 am

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		PARAMED ED PRGM - EMERGENCY MEDICINE	
					SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS APPRV		
					21.00	22.00		
			16.00	17.00			23.00	
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	137,188	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0				192.00
192.01	19201	WORKING WELL	0	0				192.01
192.02	19202	PHYSICIANS' PRIVATE OFFICES	0	0				192.02
192.03	19203	MISC	0	0				192.03
194.00	07950	RESIDENTIAL	0	0				194.00
194.01	07954	FITNESS CENTER	0	0				194.01
194.02	07952	INFUSION PHARMACY	0	0				194.02
194.03	07953	CENTER OF HOPE	0	0				194.03
200.00		Cross Foot Adjustments			743	1,097	4,420	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	137,188	0	743	1,097	4,420	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet B
Part II
Date/Time Prepared:
4/14/2025 10:55 am

Cost Center Description			PARAMED ED PRGM- LAB	PARAMED ED PRGM- PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			23.01	23.02	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.04	00593	ADMINISTRATIVE & GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV						22.00
23.00	02300	PARAMED ED PRGM - EMERGENCY MEDICINE						23.00
23.01	02301	PARAMED ED PRGM- LAB	48,296					23.01
23.02	02302	PARAMED ED PRGM- PHARMACY		6,677				23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS			2,482,874	0	2,482,874	30.00
31.00	03100	INTENSIVE CARE UNIT			405,641	0	405,641	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT			39,556	0	39,556	35.00
40.00	04000	SUBPROVIDER - IPF			838,036	0	838,036	40.00
41.00	04100	SUBPROVIDER - IRF			218,101	0	218,101	41.00
43.00	04300	NURSERY			36,864	0	36,864	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM			1,289,827	0	1,289,827	50.00
50.01	05001	OUTPATIENT SURGERY			472,511	0	472,511	50.01
51.00	05100	RECOVERY ROOM			198,780	0	198,780	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM			163,851	0	163,851	52.00
53.00	05300	ANESTHESIOLOGY			5,066	0	5,066	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC			1,741,170	0	1,741,170	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES			146,694	0	146,694	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC			0	0	0	55.00
56.00	05600	RADIOISOTOPE			227,774	0	227,774	56.00
60.00	06000	LABORATORY			366,721	0	366,721	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.			77,492	0	77,492	63.00
65.00	06500	RESPIRATORY THERAPY			194,030	0	194,030	65.00
66.00	06600	PHYSICAL THERAPY			135,150	0	135,150	66.00
67.00	06700	OCCUPATIONAL THERAPY			23,130	0	23,130	67.00
68.00	06800	SPEECH PATHOLOGY			145,249	0	145,249	68.00
69.00	06900	ELECTROCARDIOLOGY			326,719	0	326,719	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY			172,419	0	172,419	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT			84,292	0	84,292	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS			29,069	0	29,069	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS			152,832	0	152,832	73.00
76.00	03630	ULTRA SOUND			160,237	0	160,237	76.00
76.01	03951	PAIN CLINIC			353,108	0	353,108	76.01
76.02	03952	CATH LAB			475,207	0	475,207	76.02
76.03	03953	ACTIVITY THERAPEUTIC			166,602	0	166,602	76.03
76.04	03954	WOUND CARE CENTER			194,700	0	194,700	76.04
76.05	03340	BARIATRIC CLINIC			0	0	0	76.05
76.06	03030	HEALTHY LIVING CENTER			0	0	0	76.06
76.07	03950	CV RESOURCE CENTER			0	0	0	76.07
76.08	03955	ANCILLARY OTHER			0	0	0	76.08
76.09	03956	LACTATION CLINIC			0	0	0	76.09
76.10	03957	ANCILLARY OTHER			0	0	0	76.10
76.11	03958	ANCILLARY OTHER			0	0	0	76.11
76.12	03959	ANTICOAGULATION CLINIC			17,769	0	17,769	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION			0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY			0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY			579,108	0	579,108	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY			154,965	0	154,965	101.00
102.00	10200	OPIOID TREATMENT PROGRAM			0	0	0	102.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet B
Part II
Date/Time Prepared:
4/14/2025 10:55 am

Cost Center Description			PARAMED ED PRGM- LAB	PARAMED ED PRGM- PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			23.01	23.02	24.00	25.00	26.00	
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	12,075,544	0	12,075,544	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN			26,047	0	26,047	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES			366,710	0	366,710	192.00
192.01	19201	WORKING WELL			0	0	0	192.01
192.02	19202	PHYSICIANS' PRIVATE OFFICES			0	0	0	192.02
192.03	19203	MISC			0	0	0	192.03
194.00	07950	RESIDENTIAL			863,631	0	863,631	194.00
194.01	07954	FITNESS CENTER			0	0	0	194.01
194.02	07952	INFUSION PHARMACY			0	0	0	194.02
194.03	07953	CENTER OF HOPE			8	0	8	194.03
200.00		Cross Foot Adjustments	48,296	6,677	61,233	0	61,233	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	48,296	6,677	13,393,173	0	13,393,173	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024

Worksheet B-1

Date/Time Prepared:
4/14/2025 10:55 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A.04	5.04	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	472,033					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,408,216				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,943	784	76,373,855			4.00
5.04	00593	ADMINISTRATIVE & GENERAL	35,111	99,289	4,758,915	-39,016,077	149,297,264	5.04
6.00	00600	MAINTENANCE & REPAIRS	71,044	144,827	2,003,911	0	10,124,465	6.00
7.00	00700	OPERATION OF PLANT	20,147	10,341	330,656	0	1,729,634	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	888,936	8.00
9.00	00900	HOUSEKEEPING	5,389	15,493	2,171,757	0	3,300,513	9.00
10.00	01000	DIETARY	4,754	10,799	574,447	0	1,339,008	10.00
11.00	01100	CAFETERIA	6,863	0	781,115	0	1,371,978	11.00
13.00	01300	NURSING ADMINISTRATION	726	49,364	2,718,396	0	3,603,467	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,121	140,573	413,203	0	1,160,707	14.00
15.00	01500	PHARMACY	3,207	4,727	2,405,669	0	3,546,754	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,886	0	187,609	0	1,344,927	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	60,392	0	76,460	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	79,923	0	76,232	22.00
23.00	02300	PARAMED ED PRGM - EMERGENCY MEDICINE	40	0	7,866	0	24,188	23.00
23.01	02301	PARAMED ED PRGM- LAB	1,721	373	96,164	0	342,792	23.01
23.02	02302	PARAMED ED PRGM- PHARMACY	210	0	70,249	0	105,134	23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	73,139	226,667	11,814,795	0	16,804,346	30.00
31.00	03100	INTENSIVE CARE UNIT	9,931	77,898	2,190,049	0	3,459,111	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	547	8,346	1,012,110	0	1,328,387	35.00
40.00	04000	SUBPROVIDER - IPF	26,481	30,600	4,890,562	0	6,572,894	40.00
41.00	04100	SUBPROVIDER - IRF	5,938	12,567	1,731,007	0	2,337,336	41.00
43.00	04300	NURSERY	1,148	1,194	390,543	0	538,500	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	16,488	663,574	1,456,062	0	4,369,163	50.00
50.01	05001	OUTPATIENT SURGERY	16,010	27,669	832,008	0	1,366,060	50.01
51.00	05100	RECOVERY ROOM	5,551	35,566	495,926	0	782,212	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,016	4,641	1,659,205	0	2,242,732	52.00
53.00	05300	ANESTHESIOLOGY	0	633	39,501	0	76,002	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,553	892,898	1,989,819	0	4,918,187	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	1,542	71,280	1,132,346	0	1,559,051	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	4,931	76,993	355,031	0	648,824	56.00
60.00	06000	LABORATORY	5,187	147,522	0	0	7,577,327	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,831	0	0	0	497,188	63.00
65.00	06500	RESPIRATORY THERAPY	2,140	88,947	2,072,943	0	2,896,776	65.00
66.00	06600	PHYSICAL THERAPY	1,452	34,555	3,937,418	0	5,361,867	66.00
67.00	06700	OCCUPATIONAL THERAPY	556	0	618,221	0	793,652	67.00
68.00	06800	SPEECH PATHOLOGY	0	25,572	476,320	0	827,194	68.00
69.00	06900	ELECTROCARDIOLOGY	3,808	169,731	928,077	0	1,433,997	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,262	24,664	269,433	0	498,798	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	13,762,852	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	4,711,093	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	4,653,054	73.00
76.00	03630	ULTRA SOUND	2,289	71,226	516,545	0	795,528	76.00
76.01	03951	PAIN CLINIC	12,323	12,101	727,242	0	1,182,470	76.01
76.02	03952	CATH LAB	9,038	127,372	2,187,787	0	3,216,337	76.02
76.03	03953	ACTIVITY THERAPEUTIC	5,706	0	1,537,445	0	1,780,102	76.03
76.04	03954	WOUND CARE CENTER	6,364	14,722	546,795	0	839,055	76.04
76.05	03340	BARIATRIC CLINIC	0	0	0	0	0	76.05
76.06	03030	HEALTHY LIVING CENTER	0	0	0	0	0	76.06
76.07	03950	CV RESOURCE CENTER	0	0	0	0	0	76.07
76.08	03955	ANCILLARY OTHER	0	0	0	0	0	76.08
76.09	03956	LACTATION CLINIC	0	0	0	0	0	76.09
76.10	03957	ANCILLARY OTHER	0	0	0	0	0	76.10
76.11	03958	ANCILLARY OTHER	0	0	0	0	0	76.11
76.12	03959	ANTICOAGULATION CLINIC	440	0	530,907	0	693,411	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	16,042	61,297	4,403,784	0	5,985,913	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	1,358	485	7,787,554	0	10,827,838	101.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024

Worksheet B-1

Date/Time Prepared:
4/14/2025 10:55 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A.04	5.04	
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	427,233	3,385,290	73,189,707	-39,016,077	144,372,452	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	796	3,304	43,316	0	166,938	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,697	1,764	308,896	0	398,854	192.00
192.01	19201	WORKING WELL	0	0	0	0	0	192.01
192.02	19202	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.02
192.03	19203	MISC	0	0	0	0	0	192.03
194.00	07950	RESIDENTIAL	30,307	17,858	2,831,624	0	4,357,500	194.00
194.01	07954	FITNESS CENTER	0	0	0	0	0	194.01
194.02	07952	INFUSION PHARMACY	0	0	0	0	0	194.02
194.03	07953	CENTER OF HOPE	0	0	312	0	1,520	194.03
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)	9,337,370	4,055,803	20,217,790		39,016,077	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	19.781181	1.190008	0.264721		0.261331	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			39,368		815,143	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000515		0.005460	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024

Worksheet B-1

Date/Time Prepared:
4/14/2025 10:55 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUND)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT ME ALS)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.04	00593	ADMINISTRATIVE & GENERAL					5.04
6.00	00600	MAINTENANCE & REPAIRS	363,935				6.00
7.00	00700	OPERATION OF PLANT	20,147	343,788			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	578,892		8.00
9.00	00900	HOUSEKEEPING	5,389	5,389	0	338,399	9.00
10.00	01000	DIETARY	4,754	4,754	0	4,754	192,169 10.00
11.00	01100	CAFETERIA	6,863	6,863	0	6,863	0 11.00
13.00	01300	NURSING ADMINISTRATION	726	726	0	726	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,121	6,121	0	6,121	0 14.00
15.00	01500	PHARMACY	3,207	3,207	0	3,207	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,886	4,886	0	4,886	0 16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0 17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0 21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0 22.00
23.00	02300	PARAMED ED PRGM - EMERGENCY MEDICINE	40	40	0	40	0 23.00
23.01	02301	PARAMED ED PRGM- LAB	1,721	1,721	0	1,721	0 23.01
23.02	02302	PARAMED ED PRGM- PHARMACY	210	210	0	210	0 23.02
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	73,139	73,139	301,582	73,139	104,601 30.00
31.00	03100	INTENSIVE CARE UNIT	9,931	9,931	41,137	9,931	14,123 31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	547	547	4,341	547	0 35.00
40.00	04000	SUBPROVIDER - IPF	26,481	26,481	131,196	26,481	45,044 40.00
41.00	04100	SUBPROVIDER - IRF	5,938	5,938	63,686	5,938	21,865 41.00
43.00	04300	NURSERY	1,148	1,148	15,383	1,148	0 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	16,488	16,488	0	16,488	0 50.00
50.01	05001	OUTPATIENT SURGERY	16,010	16,010	0	16,010	0 50.01
51.00	05100	RECOVERY ROOM	5,551	5,551	0	5,551	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,016	5,016	21,567	5,016	6,536 52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,553	23,553	0	23,553	0 54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	1,542	1,542	0	1,542	0 54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0 55.00
56.00	05600	RADIOISOTOPE	4,931	4,931	0	4,931	0 56.00
60.00	06000	LABORATORY	5,187	5,187	0	5,187	0 60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,831	2,831	0	2,831	0 63.00
65.00	06500	RESPIRATORY THERAPY	2,140	2,140	0	2,140	0 65.00
66.00	06600	PHYSICAL THERAPY	1,452	1,452	0	1,452	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	556	556	0	556	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	3,808	3,808	0	3,808	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,262	5,262	0	5,262	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00	03630	ULTRA SOUND	2,289	2,289	0	2,289	0 76.00
76.01	03951	PAIN CLINIC	12,323	12,323	0	12,323	0 76.01
76.02	03952	CATH LAB	9,038	9,038	0	9,038	0 76.02
76.03	03953	ACTIVITY THERAPEUTIC	5,706	5,706	0	5,706	0 76.03
76.04	03954	WOUND CARE CENTER	6,364	6,364	0	6,364	0 76.04
76.05	03340	BARIATRIC CLINIC	0	0	0	0	0 76.05
76.06	03030	HEALTHY LIVING CENTER	0	0	0	0	0 76.06
76.07	03950	CV RESOURCE CENTER	0	0	0	0	0 76.07
76.08	03955	ANCILLARY OTHER	0	0	0	0	0 76.08
76.09	03956	LACTATION CLINIC	0	0	0	0	0 76.09
76.10	03957	ANCILLARY OTHER	0	0	0	0	0 76.10
76.11	03958	ANCILLARY OTHER	0	0	0	0	0 76.11
76.12	03959	ANTICOAGULATION CLINIC	440	440	0	440	0 76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0 77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0 78.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	16,042	16,042	0	16,042	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	1,358	1,358	0	1,358	0 101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0 102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024

Worksheet B-1

Date/Time Prepared:
4/14/2025 10:55 am

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUND)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT ME ALS)	
			6.00	7.00	8.00	9.00	10.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	319,135	298,988	578,892	293,599	192,169	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	796	796	0	796	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,697	13,697	0	13,697	0	192.00
192.01	19201	WORKING WELL	0	0	0	0	0	192.01
192.02	19202	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.02
192.03	19203	MISC	0	0	0	0	0	192.03
194.00	07950	RESIDENTIAL	30,307	30,307	0	30,307	0	194.00
194.01	07954	FITNESS CENTER	0	0	0	0	0	194.01
194.02	07952	INFUSION PHARMACY	0	0	0	0	0	194.02
194.03	07953	CENTER OF HOPE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	12,770,302	2,888,589	1,121,243	4,397,416	1,957,469	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	35.089513	8.402239	1.936878	12.994767	10.186185	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,633,991	510,907	4,854	176,381	145,385	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.489788	1.486111	0.008385	0.521222	0.756548	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024

Worksheet B-1

Date/Time Prepared:
4/14/2025 10:55 am

Cost Center Description			CAFETERIA (HOURS WORK ED)	NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQ UISI)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.04	00593	ADMINISTRATIVE & GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	63,473					11.00
13.00	01300	NURSING ADMINISTRATION	1,883	495,639				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	744	1	596,425			14.00
15.00	01500	PHARMACY	1,695	0	8,794	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	233	0	1,171	0	809,896,351	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	84	0	81	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	115	0	530	0	0	22.00
23.00	02300	PARAMED ED PRGM - EMERGENCY MEDICINE	1	0	5,718	0	0	23.00
23.01	02301	PARAMED ED PRGM- LAB	85	0	802	0	0	23.01
23.02	02302	PARAMED ED PRGM- PHARMACY	185	0	0	0	0	23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,296	157,258	57,404	0	56,853,355	30.00
31.00	03100	INTENSIVE CARE UNIT	2,189	44,123	5,879	0	10,730,712	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	834	16,927	2,039	0	1,459,593	35.00
40.00	04000	SUBPROVIDER - IPF	4,748	34,362	12,840	0	21,208,140	40.00
41.00	04100	SUBPROVIDER - IRF	1,899	27,145	6,723	0	7,246,222	41.00
43.00	04300	NURSERY	191	2,865	1,183	0	992,544	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,382	10,358	38,707	0	83,672,272	50.00
50.01	05001	OUTPATIENT SURGERY	641	13,001	9,968	0	4,195,834	50.01
51.00	05100	RECOVERY ROOM	378	5,866	1,247	0	17,737,755	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	780	11,369	5,060	0	4,283,604	52.00
53.00	05300	ANESTHESIOLOGY	87	0	666	0	19,196,412	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,964	224	16,303	0	97,101,635	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	912	9,822	9,717	0	11,769,730	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	266	0	237	0	11,391,704	56.00
60.00	06000	LABORATORY	0	0	0	0	79,827,118	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	2,259,766	63.00
65.00	06500	RESPIRATORY THERAPY	2,055	0	11,872	0	13,391,240	65.00
66.00	06600	PHYSICAL THERAPY	3,506	1,036	16,437	0	27,626,946	66.00
67.00	06700	OCCUPATIONAL THERAPY	577	0	142	0	12,296,468	67.00
68.00	06800	SPEECH PATHOLOGY	359	0	190,202	0	9,214,326	68.00
69.00	06900	ELECTROCARDIOLOGY	920	6,986	12,981	0	28,574,403	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	251	0	506	0	5,325,229	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	54,123,089	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	19,798,241	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	100	40,991,736	73.00
76.00	03630	ULTRA SOUND	447	116	12,160	0	14,773,801	76.00
76.01	03951	PAIN CLINIC	661	12,549	2,750	0	11,197,366	76.01
76.02	03952	CATH LAB	1,679	24,049	86,449	0	50,666,069	76.02
76.03	03953	ACTIVITY THERAPEUTIC	1,544	184	1,034	0	5,594,002	76.03
76.04	03954	WOUND CARE CENTER	556	8,055	2,115	0	3,199,460	76.04
76.05	03340	BARIATRIC CLINIC	0	0	0	0	0	76.05
76.06	03030	HEALTHY LIVING CENTER	0	0	0	0	0	76.06
76.07	03950	CV RESOURCE CENTER	0	0	0	0	0	76.07
76.08	03955	ANCILLARY OTHER	0	0	0	0	0	76.08
76.09	03956	LACTATION CLINIC	0	0	0	0	0	76.09
76.10	03957	ANCILLARY OTHER	0	0	0	0	0	76.10
76.11	03958	ANCILLARY OTHER	0	0	0	0	0	76.11
76.12	03959	ANTICOAGULATION CLINIC	452	0	961	0	1,562,933	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	5,095	55,082	19,403	0	70,865,822	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	6,129	41,855	47,359	0	10,768,824	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024

Worksheet B-1

Date/Time Prepared:
4/14/2025 10:55 am

Cost Center Description		CAFETERIA (HOURS WORK ED)	NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQ UI SI)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	
		11.00	13.00	14.00	15.00	16.00	
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	57,823	483,233	589,440	100	809,896,351
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	79	0	53	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	762	379	0	0	192.00
192.01	19201	WORKING WELL	0	0	0	0	192.01
192.02	19202	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.02
192.03	19203	MISC	0	0	0	0	192.03
194.00	07950	RESIDENTIAL	4,809	12,027	6,932	0	194.00
194.01	07954	FITNESS CENTER	0	0	0	0	194.01
194.02	07952	INFUSION PHARMACY	0	0	0	0	194.02
194.03	07953	CENTER OF HOPE	0	0	0	0	194.03
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)	2,118,185	4,649,012	1,834,627	4,738,399	1,983,768
203.00		Unit cost multiplier (Wkst. B, Part I)	33.371434	9.379835	3.076040	47,383.990000	0.002449
204.00		Cost to be allocated (per Wkst. B, Part II)	188,240	104,481	336,888	120,498	137,188
205.00		Unit cost multiplier (Wkst. B, Part II)	2.965670	0.210801	0.564846	1,204.980000	0.000169
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024

Worksheet B-1

Date/Time Prepared:
4/14/2025 10:55 am

Cost Center Description			INTERNS & RESIDENTS			PARAMED ED PRGM - EMERGENCY MEDICINE (ASSIGNED TIME)	PARAMED ED PRGM- LAB (ASSIGNED TIME)		
			SOCIAL SERVICE (GROSS CHARGES)	SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)				
			17.00	21.00	22.00	23.00	23.01		
	GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00	
5.04	00593	ADMINISTRATIVE & GENERAL						5.04	
6.00	00600	MAINTENANCE & REPAIRS						6.00	
7.00	00700	OPERATION OF PLANT						7.00	
8.00	00800	LAUNDRY & LINEN SERVICE						8.00	
9.00	00900	HOUSEKEEPING						9.00	
10.00	01000	DIETARY						10.00	
11.00	01100	CAFETERIA						11.00	
13.00	01300	NURSING ADMINISTRATION						13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00	
15.00	01500	PHARMACY						15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00	
17.00	01700	SOCIAL SERVICE	809,896,351					17.00	
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	100				21.00	
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0		100			22.00	
23.00	02300	PARAMED ED PRGM - EMERGENCY MEDICINE	0			100		23.00	
23.01	02301	PARAMED ED PRGM- LAB	0				100	23.01	
23.02	02302	PARAMED ED PRGM- PHARMACY	0					23.02	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	56,853,355	69	69	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	10,730,712	0	0	0	0	31.00	
35.00	02060	NEONATAL INTENSIVE CARE UNIT	1,459,593	0	0	0	0	35.00	
40.00	04000	SUBPROVIDER - IPF	21,208,140	0	0	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	7,246,222	0	0	0	0	41.00	
43.00	04300	NURSERY	992,544	0	0	0	0	43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	83,672,272	0	0	0	0	50.00	
50.01	05001	OUTPATIENT SURGERY	4,195,834	0	0	0	0	50.01	
51.00	05100	RECOVERY ROOM	17,737,755	0	0	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,283,604	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	19,196,412	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	97,101,635	0	0	0	0	54.00	
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	11,769,730	0	0	0	0	54.01	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00	
56.00	05600	RADIOISOTOPE	11,391,704	0	0	0	0	56.00	
60.00	06000	LABORATORY	79,827,118	0	0	0	100	60.00	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,259,766	0	0	0	0	63.00	
65.00	06500	RESPIRATORY THERAPY	13,391,240	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	27,626,946	0	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	12,296,468	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	9,214,326	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	28,574,403	0	0	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	5,325,229	0	0	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	54,123,089	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,798,241	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	40,991,736	0	0	0	0	73.00	
76.00	03630	ULTRA SOUND	14,773,801	0	0	0	0	76.00	
76.01	03951	PAIN CLINIC	11,197,366	0	0	0	0	76.01	
76.02	03952	CATH LAB	50,666,069	0	0	0	0	76.02	
76.03	03953	ACTIVITY THERAPEUTIC	5,594,002	0	0	0	0	76.03	
76.04	03954	WOUND CARE CENTER	3,199,460	0	0	0	0	76.04	
76.05	03340	BARIATRIC CLINIC	0	0	0	0	0	76.05	
76.06	03030	HEALTHY LIVING CENTER	0	0	0	0	0	76.06	
76.07	03950	CV RESOURCE CENTER	0	0	0	0	0	76.07	
76.08	03955	ANCILLARY OTHER	0	0	0	0	0	76.08	
76.09	03956	LACTATION CLINIC	0	0	0	0	0	76.09	
76.10	03957	ANCILLARY OTHER	0	0	0	0	0	76.10	
76.11	03958	ANCILLARY OTHER	0	0	0	0	0	76.11	
76.12	03959	ANTICOAGULATION CLINIC	1,562,933	0	0	0	0	76.12	
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00	
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00	
	OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	70,865,822	31	31	100	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024

Worksheet B-1

Date/Time Prepared:
4/14/2025 10:55 am

Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM - EMERGENCY MEDICINE (ASSIGNED TIME)	PARAMED ED PRGM- LAB (ASSIGNED TIME)	
			SOCIAL SERVICE (GROSS CHARGES)	SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
			17.00	21.00	22.00	23.00	23.01
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	10,768,824	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	809,896,351	100	100	100	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	WORKING WELL	0	0	0	0	192.01
192.02	19202	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.02
192.03	19203	MISC	0	0	0	0	192.03
194.00	07950	RESIDENTIAL	0	0	0	0	194.00
194.01	07954	FITNESS CENTER	0	0	0	0	194.01
194.02	07952	INFUSION PHARMACY	0	0	0	0	194.02
194.03	07953	CENTER OF HOPE	0	0	0	0	194.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	99,493	101,622	50,391	534,891
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	994.930000	1,016.220000	503.910000	5,348.910000
204.00		Cost to be allocated (per Wkst. B, Part II)	0	743	1,097	4,420	48,296
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	7.430000	10.970000	44.200000	482.960000
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0	0
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000	0.000000

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024

Worksheet B-1

Date/Time Prepared:
4/14/2025 10:55 am

Cost Center Description		PARAMED ED PRGM- PHARMACY (ASSIGNED TIME)	
		23.02	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.04	00593	ADMINISTRATIVE & GENERAL	5.04
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM - EMERGENCY MEDICINE	23.00
23.01	02301	PARAMED ED PRGM- LAB	23.01
23.02	02302	PARAMED ED PRGM- PHARMACY	23.02
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	35.00
40.00	04000	SUBPROVIDER - IPF	40.00
41.00	04100	SUBPROVIDER - IRF	41.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
50.01	05001	OUTPATIENT SURGERY	50.01
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
56.00	05600	RADIOISOTOPE	56.00
60.00	06000	LABORATORY	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	63.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03630	ULTRA SOUND	76.00
76.01	03951	PAIN CLINIC	76.01
76.02	03952	CATH LAB	76.02
76.03	03953	ACTIVITY THERAPEUTIC	76.03
76.04	03954	WOUND CARE CENTER	76.04
76.05	03340	BARIATRIC CLINIC	76.05
76.06	03030	HEALTHY LIVING CENTER	76.06
76.07	03950	CV RESOURCE CENTER	76.07
76.08	03955	ANCILLARY OTHER	76.08
76.09	03956	LACTATION CLINIC	76.09
76.10	03957	ANCILLARY OTHER	76.10
76.11	03958	ANCILLARY OTHER	76.11
76.12	03959	ANTICOAGULATION CLINIC	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	78.00
OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	102.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024

Worksheet B-1

Date/Time Prepared:
4/14/2025 10:55 am

Cost Center Description		PARAMED ED PRGM- PHARMACY (ASSIGNED TIME)	
		23.02	
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	100	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	19201 WORKING WELL	0	192.01
192.02	19202 PHYSICIANS' PRIVATE OFFICES	0	192.02
192.03	19203 MISC	0	192.03
194.00	07950 RESIDENTIAL	0	194.00
194.01	07954 FITNESS CENTER	0	194.01
194.02	07952 INFUSION PHARMACY	0	194.02
194.03	07953 CENTER OF HOPE	0	194.03
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)	150,645	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	1,506.450000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	6,677	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	66.770000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)	0	206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet C
Part I
Date/Time Prepared:
4/14/2025 10:55 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	29,178,096		29,178,096	0	29,178,096	30.00
31.00	03100	INTENSIVE CARE UNIT	5,678,868		5,678,868	0	5,678,868	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	1,911,293		1,911,293	0	1,911,293	35.00
40.00	04000	SUBPROVIDER - IPF	11,071,545		11,071,545	0	11,071,545	40.00
41.00	04100	SUBPROVIDER - IRF	3,986,058		3,986,058	0	3,986,058	41.00
43.00	04300	NURSERY	813,186		813,186	0	813,186	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,909,563		6,909,563	0	6,909,563	50.00
50.01	05001	OUTPATIENT SURGERY	2,811,679		2,811,679	0	2,811,679	50.01
51.00	05100	RECOVERY ROOM	1,415,097		1,415,097	0	1,415,097	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,379,239		3,379,239	0	3,379,239	52.00
53.00	05300	ANESTHESIOLOGY	147,828		147,828	0	147,828	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,889,813		7,889,813	0	7,889,813	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	2,234,859		2,234,859	0	2,234,859	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
56.00	05600	RADIOISOTOPE	1,134,420		1,134,420	0	1,134,420	56.00
60.00	06000	LABORATORY	10,580,900		10,580,900	0	10,580,900	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	792,566		792,566	0	792,566	63.00
65.00	06500	RESPIRATORY THERAPY	3,912,567	0	3,912,567	0	3,912,567	65.00
66.00	06600	PHYSICAL THERAPY	7,090,044	0	7,090,044	0	7,090,044	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,082,271	0	1,082,271	0	1,082,271	67.00
68.00	06800	SPEECH PATHOLOGY	1,662,979	0	1,662,979	0	1,662,979	68.00
69.00	06900	ELECTROCARDIOLOGY	2,229,985		2,229,985	0	2,229,985	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	949,354		949,354	0	949,354	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,492,059		17,492,059	0	17,492,059	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,990,734		5,990,734	0	5,990,734	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,858,474		10,858,474	0	10,858,474	73.00
76.00	03630	ULTRA SOUND	1,222,313		1,222,313	0	1,222,313	76.00
76.01	03951	PAIN CLINIC	2,363,218		2,363,218	0	2,363,218	76.01
76.02	03952	CATH LAB	5,239,000		5,239,000	0	5,239,000	76.02
76.03	03953	ACTIVITY THERAPEUTIC	2,637,742		2,637,742	0	2,637,742	76.03
76.04	03954	WOUND CARE CENTER	1,526,258		1,526,258	0	1,526,258	76.04
76.05	03340	BARIATRIC CLINIC	0		0	0	0	76.05
76.06	03030	HEALTHY LIVING CENTER	0		0	0	0	76.06
76.07	03950	CV RESOURCE CENTER	0		0	0	0	76.07
76.08	03955	ANCILLARY OTHER	0		0	0	0	76.08
76.09	03956	LACTATION CLINIC	0		0	0	0	76.09
76.10	03957	ANCILLARY OTHER	0		0	0	0	76.10
76.11	03958	ANCILLARY OTHER	0		0	0	0	76.11
76.12	03959	ANTICOAGULATION CLINIC	921,343		921,343	0	921,343	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	9,426,687		9,426,687	0	9,426,687	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,215,572		3,215,572		3,215,572	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	14,503,375		14,503,375		14,503,375	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	182,258,985	0	182,258,985	0	182,258,985	200.00
201.00		Less Observation Beds	3,215,572		3,215,572		3,215,572	201.00
202.00		Total (see instructions)	179,043,413	0	179,043,413	0	179,043,413	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet C
Part I
Date/Time Prepared:
4/14/2025 10:55 am

			Title XVIII			Hospital	PPS
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00	9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	48,633,523		48,633,523		
31.00	03100	INTENSIVE CARE UNIT	10,730,712		10,730,712		
35.00	02060	NEONATAL INTENSIVE CARE UNIT	1,459,593		1,459,593		
40.00	04000	SUBPROVIDER - IPF	21,208,140		21,208,140		
41.00	04100	SUBPROVIDER - IRF	7,246,222		7,246,222		
43.00	04300	NURSERY	992,544		992,544		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	32,424,757	51,247,515	83,672,272	0.082579	0.000000
50.01	05001	OUTPATIENT SURGERY	2,032,350	2,163,484	4,195,834	0.670112	0.000000
51.00	05100	RECOVERY ROOM	3,707,372	14,030,383	17,737,755	0.079779	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,283,604	0	4,283,604	0.788878	0.000000
53.00	05300	ANESTHESIOLOGY	6,765,061	12,431,351	19,196,412	0.007701	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,221,273	67,880,362	97,101,635	0.081253	0.000000
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	3,851,283	7,918,447	11,769,730	0.189882	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000
56.00	05600	RADIOISOTOPE	1,523,252	9,868,452	11,391,704	0.099583	0.000000
60.00	06000	LABORATORY	39,729,122	40,097,996	79,827,118	0.132548	0.000000
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,025,146	234,620	2,259,766	0.350729	0.000000
65.00	06500	RESPIRATORY THERAPY	12,762,169	629,071	13,391,240	0.292174	0.000000
66.00	06600	PHYSICAL THERAPY	6,703,813	20,923,133	27,626,946	0.256635	0.000000
67.00	06700	OCCUPATIONAL THERAPY	6,120,879	6,175,589	12,296,468	0.088015	0.000000
68.00	06800	SPEECH PATHOLOGY	2,909,780	6,304,546	9,214,326	0.180478	0.000000
69.00	06900	ELECTROCARDIOLOGY	10,174,973	18,399,430	28,574,403	0.078041	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	466,891	4,858,338	5,325,229	0.178275	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	25,134,358	28,988,731	54,123,089	0.323190	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,240,017	12,558,224	19,798,241	0.302589	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	28,607,941	12,383,795	40,991,736	0.264894	0.000000
76.00	03630	ULTRA SOUND	4,129,207	10,644,594	14,773,801	0.082735	0.000000
76.01	03951	PAIN CLINIC	146,429	11,050,937	11,197,366	0.211051	0.000000
76.02	03952	CATH LAB	18,679,321	31,986,748	50,666,069	0.103403	0.000000
76.03	03953	ACTIVITY THERAPEUTIC	3,370,773	2,223,229	5,594,002	0.471530	0.000000
76.04	03954	WOUND CARE CENTER	188,679	3,010,781	3,199,460	0.477036	0.000000
76.05	03340	BARIATRIC CLINIC	0	0	0	0.000000	0.000000
76.06	03030	HEALTHY LIVING CENTER	0	0	0	0.000000	0.000000
76.07	03950	CV RESOURCE CENTER	0	0	0	0.000000	0.000000
76.08	03955	ANCILLARY OTHER	0	0	0	0.000000	0.000000
76.09	03956	LACTATION CLINIC	0	0	0	0.000000	0.000000
76.10	03957	ANCILLARY OTHER	0	0	0	0.000000	0.000000
76.11	03958	ANCILLARY OTHER	0	0	0	0.000000	0.000000
76.12	03959	ANTICOAGULATION CLINIC	6,897	1,556,036	1,562,933	0.589496	0.000000
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0.000000	0.000000
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	19,382,613	51,483,209	70,865,822	0.133022	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,037,841	5,181,991	8,219,832	0.391197	0.000000
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	10,768,824	10,768,824		
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0		
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
200.00		Subtotal (see instructions)	364,896,535	444,999,816	809,896,351		
201.00		Less Observation Beds					
202.00		Total (see instructions)	364,896,535	444,999,816	809,896,351		

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0090	Period: From 01/01/2024 To 12/31/2024	Worksheet C Part I Date/Time Prepared: 4/14/2025 10:55 am
			Title XVIII	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio		
			11.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT			35.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.082579		50.00
50.01	05001	OUTPATIENT SURGERY	0.670112		50.01
51.00	05100	RECOVERY ROOM	0.079779		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.788878		52.00
53.00	05300	ANESTHESIOLOGY	0.007701		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.081253		54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	0.189882		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600	RADIOISOTOPE	0.099583		56.00
60.00	06000	LABORATORY	0.132548		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.350729		63.00
65.00	06500	RESPIRATORY THERAPY	0.292174		65.00
66.00	06600	PHYSICAL THERAPY	0.256635		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.088015		67.00
68.00	06800	SPEECH PATHOLOGY	0.180478		68.00
69.00	06900	ELECTROCARDIOLOGY	0.078041		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.178275		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.323190		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.302589		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.264894		73.00
76.00	03630	ULTRA SOUND	0.082735		76.00
76.01	03951	PAIN CLINIC	0.211051		76.01
76.02	03952	CATH LAB	0.103403		76.02
76.03	03953	ACTIVITY THERAPEUTIC	0.471530		76.03
76.04	03954	WOUND CARE CENTER	0.477036		76.04
76.05	03340	BARIATRIC CLINIC	0.000000		76.05
76.06	03030	HEALTHY LIVING CENTER	0.000000		76.06
76.07	03950	CV RESOURCE CENTER	0.000000		76.07
76.08	03955	ANCILLARY OTHER	0.000000		76.08
76.09	03956	LACTATION CLINIC	0.000000		76.09
76.10	03957	ANCILLARY OTHER	0.000000		76.10
76.11	03958	ANCILLARY OTHER	0.000000		76.11
76.12	03959	ANTICOAGULATION CLINIC	0.589496		76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000		78.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.133022		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.391197		92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY			101.00
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet C
Part I
Date/Time Prepared:
4/14/2025 10:55 am

			Title XIX		Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
					Total Costs	RCE Disallowance	Total Costs
			1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	29,178,096		29,178,096	0	29,178,096
31.00	03100	INTENSIVE CARE UNIT	5,678,868		5,678,868	0	5,678,868
35.00	02060	NEONATAL INTENSIVE CARE UNIT	1,911,293		1,911,293	0	1,911,293
40.00	04000	SUBPROVIDER - IPF	11,071,545		11,071,545	0	11,071,545
41.00	04100	SUBPROVIDER - IRF	3,986,058		3,986,058	0	3,986,058
43.00	04300	NURSERY	813,186		813,186	0	813,186
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,909,563		6,909,563	0	6,909,563
50.01	05001	OUTPATIENT SURGERY	2,811,679		2,811,679	0	2,811,679
51.00	05100	RECOVERY ROOM	1,415,097		1,415,097	0	1,415,097
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,379,239		3,379,239	0	3,379,239
53.00	05300	ANESTHESIOLOGY	147,828		147,828	0	147,828
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,889,813		7,889,813	0	7,889,813
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	2,234,859		2,234,859	0	2,234,859
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0
56.00	05600	RADIOISOTOPE	1,134,420		1,134,420	0	1,134,420
60.00	06000	LABORATORY	10,580,900		10,580,900	0	10,580,900
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	792,566		792,566	0	792,566
65.00	06500	RESPIRATORY THERAPY	3,912,567	0	3,912,567	0	3,912,567
66.00	06600	PHYSICAL THERAPY	7,090,044	0	7,090,044	0	7,090,044
67.00	06700	OCCUPATIONAL THERAPY	1,082,271	0	1,082,271	0	1,082,271
68.00	06800	SPEECH PATHOLOGY	1,662,979	0	1,662,979	0	1,662,979
69.00	06900	ELECTROCARDIOLOGY	2,229,985		2,229,985	0	2,229,985
70.00	07000	ELECTROENCEPHALOGRAPHY	949,354		949,354	0	949,354
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,492,059		17,492,059	0	17,492,059
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,990,734		5,990,734	0	5,990,734
73.00	07300	DRUGS CHARGED TO PATIENTS	10,858,474		10,858,474	0	10,858,474
76.00	03630	ULTRA SOUND	1,222,313		1,222,313	0	1,222,313
76.01	03951	PAIN CLINIC	2,363,218		2,363,218	0	2,363,218
76.02	03952	CATH LAB	5,239,000		5,239,000	0	5,239,000
76.03	03953	ACTIVITY THERAPEUTIC	2,637,742		2,637,742	0	2,637,742
76.04	03954	WOUND CARE CENTER	1,526,258		1,526,258	0	1,526,258
76.05	03340	BARIATRIC CLINIC	0		0	0	0
76.06	03030	HEALTHY LIVING CENTER	0		0	0	0
76.07	03950	CV RESOURCE CENTER	0		0	0	0
76.08	03955	ANCILLARY OTHER	0		0	0	0
76.09	03956	LACTATION CLINIC	0		0	0	0
76.10	03957	ANCILLARY OTHER	0		0	0	0
76.11	03958	ANCILLARY OTHER	0		0	0	0
76.12	03959	ANTICOAGULATION CLINIC	921,343		921,343	0	921,343
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0		0	0	0
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	9,426,687		9,426,687	0	9,426,687
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,215,572		3,215,572	0	3,215,572
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	14,503,375		14,503,375		14,503,375
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
200.00		Subtotal (see instructions)	182,258,985	0	182,258,985	0	182,258,985
201.00		Less Observation Beds	3,215,572		3,215,572		3,215,572
202.00		Total (see instructions)	179,043,413	0	179,043,413	0	179,043,413

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet C
Part I
Date/Time Prepared:
4/14/2025 10:55 am

			Title XIX			Hospital	Cost		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	48,633,523		48,633,523			30.00	
31.00	03100	INTENSIVE CARE UNIT	10,730,712		10,730,712			31.00	
35.00	02060	NEONATAL INTENSIVE CARE UNIT	1,459,593		1,459,593			35.00	
40.00	04000	SUBPROVIDER - IPF	21,208,140		21,208,140			40.00	
41.00	04100	SUBPROVIDER - IRF	7,246,222		7,246,222			41.00	
43.00	04300	NURSERY	992,544		992,544			43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	32,424,757	51,247,515	83,672,272	0.082579	0.000000	50.00	
50.01	05001	OUTPATIENT SURGERY	2,032,350	2,163,484	4,195,834	0.670112	0.000000	50.01	
51.00	05100	RECOVERY ROOM	3,707,372	14,030,383	17,737,755	0.079779	0.000000	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,283,604	0	4,283,604	0.788878	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	6,765,061	12,431,351	19,196,412	0.007701	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,221,273	67,880,362	97,101,635	0.081253	0.000000	54.00	
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	3,851,283	7,918,447	11,769,730	0.189882	0.000000	54.01	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00	
56.00	05600	RADIOISOTOPE	1,523,252	9,868,452	11,391,704	0.099583	0.000000	56.00	
60.00	06000	LABORATORY	39,729,122	40,097,996	79,827,118	0.132548	0.000000	60.00	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,025,146	234,620	2,259,766	0.350729	0.000000	63.00	
65.00	06500	RESPIRATORY THERAPY	12,762,169	629,071	13,391,240	0.292174	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	6,703,813	20,923,133	27,626,946	0.256635	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	6,120,879	6,175,589	12,296,468	0.088015	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	2,909,780	6,304,546	9,214,326	0.180478	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	10,174,973	18,399,430	28,574,403	0.078041	0.000000	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	466,891	4,858,338	5,325,229	0.178275	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	25,134,358	28,988,731	54,123,089	0.323190	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,240,017	12,558,224	19,798,241	0.302589	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	28,607,941	12,383,795	40,991,736	0.264894	0.000000	73.00	
76.00	03630	ULTRA SOUND	4,129,207	10,644,594	14,773,801	0.082735	0.000000	76.00	
76.01	03951	PAIN CLINIC	146,429	11,050,937	11,197,366	0.211051	0.000000	76.01	
76.02	03952	CATH LAB	18,679,321	31,986,748	50,666,069	0.103403	0.000000	76.02	
76.03	03953	ACTIVITY THERAPEUTIC	3,370,773	2,223,229	5,594,002	0.471530	0.000000	76.03	
76.04	03954	WOUND CARE CENTER	188,679	3,010,781	3,199,460	0.477036	0.000000	76.04	
76.05	03340	BARIATRIC CLINIC	0	0	0	0.000000	0.000000	76.05	
76.06	03030	HEALTHY LIVING CENTER	0	0	0	0.000000	0.000000	76.06	
76.07	03950	CV RESOURCE CENTER	0	0	0	0.000000	0.000000	76.07	
76.08	03955	ANCILLARY OTHER	0	0	0	0.000000	0.000000	76.08	
76.09	03956	LACTATION CLINIC	0	0	0	0.000000	0.000000	76.09	
76.10	03957	ANCILLARY OTHER	0	0	0	0.000000	0.000000	76.10	
76.11	03958	ANCILLARY OTHER	0	0	0	0.000000	0.000000	76.11	
76.12	03959	ANTICOAGULATION CLINIC	6,897	1,556,036	1,562,933	0.589496	0.000000	76.12	
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0.000000	0.000000	77.00	
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00	
	OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	19,382,613	51,483,209	70,865,822	0.133022	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,037,841	5,181,991	8,219,832	0.391197	0.000000	92.00	
	OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	10,768,824	10,768,824			101.00	
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	364,896,535	444,999,816	809,896,351			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	364,896,535	444,999,816	809,896,351			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet C
Part I
Date/Time Prepared:
4/14/2025 10:55 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT				35.00
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
50.01	05001	OUTPATIENT SURGERY	0.000000			50.01
51.00	05100	RECOVERY ROOM	0.000000			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	0.000000			54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000			55.00
56.00	05600	RADIOISOTOPE	0.000000			56.00
60.00	06000	LABORATORY	0.000000			60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000			63.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03630	ULTRA SOUND	0.000000			76.00
76.01	03951	PAIN CLINIC	0.000000			76.01
76.02	03952	CATH LAB	0.000000			76.02
76.03	03953	ACTIVITY THERAPEUTIC	0.000000			76.03
76.04	03954	WOUND CARE CENTER	0.000000			76.04
76.05	03340	BARIATRIC CLINIC	0.000000			76.05
76.06	03030	HEALTHY LIVING CENTER	0.000000			76.06
76.07	03950	CV RESOURCE CENTER	0.000000			76.07
76.08	03955	ANCILLARY OTHER	0.000000			76.08
76.09	03956	LACTATION CLINIC	0.000000			76.09
76.10	03957	ANCILLARY OTHER	0.000000			76.10
76.11	03958	ANCILLARY OTHER	0.000000			76.11
76.12	03959	ANTICOAGULATION CLINIC	0.000000			76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000			77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000			78.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY				101.00
102.00	10200	OPIOID TREATMENT PROGRAM				102.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet D
Part I
Date/Time Prepared:
4/14/2025 10:55 am

			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)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,482,874	0	2,482,874	21,206	117.08	30.00
31.00	INTENSIVE CARE UNIT	405,641		405,641	2,388	169.87	31.00
35.00	NEONATAL INTENSIVE CARE UNIT	39,556		39,556	249	158.86	35.00
40.00	SUBPROVIDER - IPF	838,036	0	838,036	7,616	110.04	40.00
41.00	SUBPROVIDER - IRF	218,101	0	218,101	3,697	58.99	41.00
43.00	NURSERY	36,864		36,864	616	59.84	43.00
200.00	Total (lines 30 through 199)	4,021,072		4,021,072	35,772		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	6,560	768,045				30.00
31.00	INTENSIVE CARE UNIT	774	131,479				31.00
35.00	NEONATAL INTENSIVE CARE UNIT	0	0				35.00
40.00	SUBPROVIDER - IPF	523	57,551				40.00
41.00	SUBPROVIDER - IRF	2,297	135,500				41.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	10,154	1,092,575				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet D
Part II
Date/Time Prepared:
4/14/2025 10:55 am

			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								
50.00	05000	OPERATING ROOM	1,289,827	83,672,272	0.015415	7,809,665	120,386	50.00
50.01	05001	OUTPATIENT SURGERY	472,511	4,195,834	0.112614	772,070	86,946	50.01
51.00	05100	RECOVERY ROOM	198,780	17,737,755	0.011207	871,018	9,761	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	163,851	4,283,604	0.038251	40,092	1,534	52.00
53.00	05300	ANESTHESIOLOGY	5,066	19,196,412	0.000264	1,691,419	447	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,741,170	97,101,635	0.017931	10,590,506	189,898	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	146,694	11,769,730	0.012464	1,293,795	16,126	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00	05600	RADIOISOTOPE	227,774	11,391,704	0.019995	649,834	12,993	56.00
60.00	06000	LABORATORY	366,721	79,827,118	0.004594	12,483,629	57,350	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	77,492	2,259,766	0.034292	688,938	23,625	63.00
65.00	06500	RESPIRATORY THERAPY	194,030	13,391,240	0.014489	4,519,177	65,478	65.00
66.00	06600	PHYSICAL THERAPY	135,150	27,626,946	0.004892	1,612,358	7,888	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,130	12,296,468	0.001881	1,377,777	2,592	67.00
68.00	06800	SPEECH PATHOLOGY	145,249	9,214,326	0.015763	657,482	10,364	68.00
69.00	06900	ELECTROCARDIOLOGY	326,719	28,574,403	0.011434	3,763,801	43,035	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	172,419	5,325,229	0.032378	168,966	5,471	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	84,292	54,123,089	0.001557	7,663,124	11,931	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	29,069	19,798,241	0.001468	2,155,288	3,164	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	152,832	40,991,736	0.003728	8,630,501	32,175	73.00
76.00	03630	ULTRA SOUND	160,237	14,773,801	0.010846	1,407,017	15,261	76.00
76.01	03951	PAIN CLINIC	353,108	11,197,366	0.031535	35,595	1,122	76.01
76.02	03952	CATH LAB	475,207	50,666,069	0.009379	6,435,171	60,355	76.02
76.03	03953	ACTIVITY THERAPEUTIC	166,602	5,594,002	0.029782	0	0	76.03
76.04	03954	WOUND CARE CENTER	194,700	3,199,460	0.060854	61,133	3,720	76.04
76.05	03340	BARIATRIC CLINIC	0	0	0.000000	0	0	76.05
76.06	03030	HEALTHY LIVING CENTER	0	0	0.000000	0	0	76.06
76.07	03950	CV RESOURCE CENTER	0	0	0.000000	0	0	76.07
76.08	03955	ANCILLARY OTHER	0	0	0.000000	0	0	76.08
76.09	03956	LACTATION CLINIC	0	0	0.000000	0	0	76.09
76.10	03957	ANCILLARY OTHER	0	0	0.000000	0	0	76.10
76.11	03958	ANCILLARY OTHER	0	0	0.000000	0	0	76.11
76.12	03959	ANTICOAGULATION CLINIC	17,769	1,562,933	0.011369	2,113	24	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	579,108	70,865,822	0.008172	6,286,785	51,376	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	273,626	8,219,832	0.033289	1,221,984	40,679	92.00
200.00		Total (lines 50 through 199)	8,173,133	708,856,793		82,889,238	873,701	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 15-0090		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part III Date/Time Prepared: 4/14/2025 10:55 am	
					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			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00	
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	0	35.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	0	41.00	
43.00	04300	NURSERY	0	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days			
			4.00	5.00	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	21,206	0.00	6,560	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	2,388	0.00	774	31.00		
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	249	0.00	0	35.00		
40.00	04000	SUBPROVIDER - IPF	0	0	7,616	0.00	523	40.00		
41.00	04100	SUBPROVIDER - IRF	0	0	3,697	0.00	2,297	41.00		
43.00	04300	NURSERY	0	0	616	0.00	0	43.00		
200.00		Total (lines 30 through 199)	0	0	35,772		10,154	200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)							
			9.00							
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0						30.00	
31.00	03100	INTENSIVE CARE UNIT	0						31.00	
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0						35.00	
40.00	04000	SUBPROVIDER - IPF	0						40.00	
41.00	04100	SUBPROVIDER - IRF	0						41.00	
43.00	04300	NURSERY	0						43.00	
200.00		Total (lines 30 through 199)	0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 15-0090		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part IV Date/Time Prepared: 4/14/2025 10:55 am	
				Title XVIII		Hospital		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
50.01	05001	OUTPATIENT SURGERY		0	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES		0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
60.00	06000	LABORATORY		0	0	0	0	534,891	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	150,645	73.00
76.00	03630	ULTRA SOUND		0	0	0	0	0	76.00
76.01	03951	PAIN CLINIC		0	0	0	0	0	76.01
76.02	03952	CATH LAB		0	0	0	0	0	76.02
76.03	03953	ACTIVITY THERAPEUTIC		0	0	0	0	0	76.03
76.04	03954	WOUND CARE CENTER		0	0	0	0	0	76.04
76.05	03340	BARIATRIC CLINIC		0	0	0	0	0	76.05
76.06	03030	HEALTHY LIVING CENTER		0	0	0	0	0	76.06
76.07	03950	CV RESOURCE CENTER		0	0	0	0	0	76.07
76.08	03955	ANCILLARY OTHER		0	0	0	0	0	76.08
76.09	03956	LACTATION CLINIC		0	0	0	0	0	76.09
76.10	03957	ANCILLARY OTHER		0	0	0	0	0	76.10
76.11	03958	ANCILLARY OTHER		0	0	0	0	0	76.11
76.12	03959	ANTICOAGULATION CLINIC		0	0	0	0	0	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION		0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY		0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY		0	0	0	0	50,391	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	735,927	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 15-0090		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part IV Date/Time Prepared: 4/14/2025 10:55 am	
			Title XVIII		Hospital		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	83,672,272	0.000000	50.00
50.01	05001	OUTPATIENT SURGERY	0	0	0	4,195,834	0.000000	50.01
51.00	05100	RECOVERY ROOM	0	0	0	17,737,755	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	4,283,604	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	19,196,412	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	97,101,635	0.000000	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	0	0	0	11,769,730	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	11,391,704	0.000000	56.00
60.00	06000	LABORATORY	0	534,891	534,891	79,827,118	0.006701	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	2,259,766	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	13,391,240	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	27,626,946	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	12,296,468	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	9,214,326	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	28,574,403	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	5,325,229	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	54,123,089	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	19,798,241	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	150,645	150,645	40,991,736	0.003675	73.00
76.00	03630	ULTRA SOUND	0	0	0	14,773,801	0.000000	76.00
76.01	03951	PAIN CLINIC	0	0	0	11,197,366	0.000000	76.01
76.02	03952	CATH LAB	0	0	0	50,666,069	0.000000	76.02
76.03	03953	ACTIVITY THERAPEUTIC	0	0	0	5,594,002	0.000000	76.03
76.04	03954	WOUND CARE CENTER	0	0	0	3,199,460	0.000000	76.04
76.05	03340	BARIATRIC CLINIC	0	0	0	0	0.000000	76.05
76.06	03030	HEALTHY LIVING CENTER	0	0	0	0	0.000000	76.06
76.07	03950	CV RESOURCE CENTER	0	0	0	0	0.000000	76.07
76.08	03955	ANCILLARY OTHER	0	0	0	0	0.000000	76.08
76.09	03956	LACTATION CLINIC	0	0	0	0	0.000000	76.09
76.10	03957	ANCILLARY OTHER	0	0	0	0	0.000000	76.10
76.11	03958	ANCILLARY OTHER	0	0	0	0	0.000000	76.11
76.12	03959	ANTICOAGULATION CLINIC	0	0	0	1,562,933	0.000000	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	50,391	50,391	70,865,822	0.000711	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	8,219,832	0.000000	92.00
200.00		Total (lines 50 through 199)	0	735,927	735,927	708,856,793		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 15-0090		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part IV Date/Time Prepared: 4/14/2025 10:55 am	
				Title XVIII		Hospital		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	7,809,665	0	9,447,568	0	50.00
50.01	05001	OUTPATIENT SURGERY		0.000000	772,070	0	441,042	0	50.01
51.00	05100	RECOVERY ROOM		0.000000	871,018	0	2,958,714	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	40,092	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	1,691,419	0	2,095,992	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	10,590,506	0	15,759,722	0	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES		0.000000	1,293,795	0	1,948,030	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0.000000	649,834	0	3,315,528	0	56.00
60.00	06000	LABORATORY		0.006701	12,483,629	83,653	1,951,105	13,074	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0.000000	688,938	0	60,775	0	63.00
65.00	06500	RESPIRATORY THERAPY		0.000000	4,519,177	0	147,486	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	1,612,358	0	28,363	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	1,377,777	0	13,849	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	657,482	0	200,499	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	3,763,801	0	6,707,220	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	168,966	0	977,461	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	7,663,124	0	6,089,983	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	2,155,288	0	3,593,983	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.003675	8,630,501	31,717	2,841,314	10,442	73.00
76.00	03630	ULTRA SOUND		0.000000	1,407,017	0	2,388,881	0	76.00
76.01	03951	PAIN CLINIC		0.000000	35,595	0	2,078,887	0	76.01
76.02	03952	CATH LAB		0.000000	6,435,171	0	12,408,331	0	76.02
76.03	03953	ACTIVITY THERAPEUTIC		0.000000	0	0	43,806	0	76.03
76.04	03954	WOUND CARE CENTER		0.000000	61,133	0	1,333,155	0	76.04
76.05	03340	BARIATRIC CLINIC		0.000000	0	0	0	0	76.05
76.06	03030	HEALTHY LIVING CENTER		0.000000	0	0	0	0	76.06
76.07	03950	CV RESOURCE CENTER		0.000000	0	0	0	0	76.07
76.08	03955	ANCILLARY OTHER		0.000000	0	0	0	0	76.08
76.09	03956	LACTATION CLINIC		0.000000	0	0	0	0	76.09
76.10	03957	ANCILLARY OTHER		0.000000	0	0	0	0	76.10
76.11	03958	ANCILLARY OTHER		0.000000	0	0	0	0	76.11
76.12	03959	ANTICOAGULATION CLINIC		0.000000	2,113	0	875,342	0	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION		0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY		0.000000	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY		0.000711	6,286,785	4,470	7,459,283	5,304	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	1,221,984	0	761,581	0	92.00
200.00		Total (lines 50 through 199)			82,889,238	119,840	85,927,900	28,820	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 15-0090		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part V Date/Time Prepared: 4/14/2025 10:55 am	
				Title XVIII		Hospital		PPS	
Cost Center Description				Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
					PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
				1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.082579	9,447,568	0	0	780,171	50.00
50.01	05001	OUTPATIENT SURGERY		0.670112	441,042	0	0	295,548	50.01
51.00	05100	RECOVERY ROOM		0.079779	2,958,714	0	0	236,043	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.788878	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.007701	2,095,992	0	0	16,141	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.081253	15,759,722	0	0	1,280,525	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES		0.189882	1,948,030	0	0	369,896	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0.099583	3,315,528	0	0	330,170	56.00
60.00	06000	LABORATORY		0.132548	1,951,105	0	0	258,615	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0.350729	60,775	0	0	21,316	63.00
65.00	06500	RESPIRATORY THERAPY		0.292174	147,486	0	0	43,092	65.00
66.00	06600	PHYSICAL THERAPY		0.256635	28,363	0	0	7,279	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.088015	13,849	0	0	1,219	67.00
68.00	06800	SPEECH PATHOLOGY		0.180478	200,499	0	0	36,186	68.00
69.00	06900	ELECTROCARDIOLOGY		0.078041	6,707,220	0	0	523,438	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.178275	977,461	0	0	174,257	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.323190	6,089,983	0	0	1,968,222	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.302589	3,593,983	0	0	1,087,500	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.264894	2,841,314	0	3,452	752,647	73.00
76.00	03630	ULTRA SOUND		0.082735	2,388,881	0	0	197,644	76.00
76.01	03951	PAIN CLINIC		0.211051	2,078,887	0	0	438,751	76.01
76.02	03952	CATH LAB		0.103403	12,408,331	0	0	1,283,059	76.02
76.03	03953	ACTIVITY THERAPEUTIC		0.471530	43,806	0	0	20,656	76.03
76.04	03954	WOUND CARE CENTER		0.477036	1,333,155	0	0	635,963	76.04
76.05	03340	BARIATRIC CLINIC		0.000000	0	0	0	0	76.05
76.06	03030	HEALTHY LIVING CENTER		0.000000	0	0	0	0	76.06
76.07	03950	CV RESOURCE CENTER		0.000000	0	0	0	0	76.07
76.08	03955	ANCILLARY OTHER		0.000000	0	0	0	0	76.08
76.09	03956	LACTATION CLINIC		0.000000	0	0	0	0	76.09
76.10	03957	ANCILLARY OTHER		0.000000	0	0	0	0	76.10
76.11	03958	ANCILLARY OTHER		0.000000	0	0	0	0	76.11
76.12	03959	ANTICOAGULATION CLINIC		0.589496	875,342	0	0	516,011	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION		0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY		0.000000	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY		0.133022	7,459,283	0	0	992,249	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.391197	761,581	0	0	297,928	92.00
200.00		Subtotal (see instructions)			85,927,900	0	3,452	12,564,526	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0	0	201.00
202.00		Net Charges (line 200 - line 201)			85,927,900	0	3,452	12,564,526	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 15-0090		Period: From 01/01/2024 To 12/31/2024	Worksheet D Part V Date/Time Prepared: 4/14/2025 10:55 am
			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
50.01	05001	OUTPATIENT SURGERY	0	0		50.01
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	0	0		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	914		73.00
76.00	03630	ULTRA SOUND	0	0		76.00
76.01	03951	PAIN CLINIC	0	0		76.01
76.02	03952	CATH LAB	0	0		76.02
76.03	03953	ACTIVITY THERAPEUTIC	0	0		76.03
76.04	03954	WOUND CARE CENTER	0	0		76.04
76.05	03340	BARIATRIC CLINIC	0	0		76.05
76.06	03030	HEALTHY LIVING CENTER	0	0		76.06
76.07	03950	CV RESOURCE CENTER	0	0		76.07
76.08	03955	ANCILLARY OTHER	0	0		76.08
76.09	03956	LACTATION CLINIC	0	0		76.09
76.10	03957	ANCILLARY OTHER	0	0		76.10
76.11	03958	ANCILLARY OTHER	0	0		76.11
76.12	03959	ANTICOAGULATION CLINIC	0	0		76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	914		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	914		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 15-0090	Period: From 01/01/2024 To 12/31/2024	Worksheet D Part II Date/Time Prepared: 4/14/2025 10:55 am		
				Component CCN: 15-S090				
				Title XVIII		Subprovider - IPF	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							
50.00	05000	OPERATING ROOM	1,289,827	83,672,272	0.015415	0	0	50.00
50.01	05001	OUTPATIENT SURGERY	472,511	4,195,834	0.112614	0	0	50.01
51.00	05100	RECOVERY ROOM	198,780	17,737,755	0.011207	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	163,851	4,283,604	0.038251	0	0	52.00
53.00	05300	ANESTHESIOLOGY	5,066	19,196,412	0.000264	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,741,170	97,101,635	0.017931	57,129	1,024	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	146,694	11,769,730	0.012464	125	2	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00	05600	RADIOISOTOPE	227,774	11,391,704	0.019995	0	0	56.00
60.00	06000	LABORATORY	366,721	79,827,118	0.004594	170,189	782	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	77,492	2,259,766	0.034292	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	194,030	13,391,240	0.014489	5,040	73	65.00
66.00	06600	PHYSICAL THERAPY	135,150	27,626,946	0.004892	4,478	22	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,130	12,296,468	0.001881	3,048	6	67.00
68.00	06800	SPEECH PATHOLOGY	145,249	9,214,326	0.015763	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	326,719	28,574,403	0.011434	35,742	409	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	172,419	5,325,229	0.032378	2,862	93	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	84,292	54,123,089	0.001557	23,227	36	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	29,069	19,798,241	0.001468	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	152,832	40,991,736	0.003728	72,931	272	73.00
76.00	03630	ULTRA SOUND	160,237	14,773,801	0.010846	2,341	25	76.00
76.01	03951	PAIN CLINIC	353,108	11,197,366	0.031535	0	0	76.01
76.02	03952	CATH LAB	475,207	50,666,069	0.009379	2,925	27	76.02
76.03	03953	ACTIVITY THERAPEUTIC	166,602	5,594,002	0.029782	232,155	6,914	76.03
76.04	03954	WOUND CARE CENTER	194,700	3,199,460	0.060854	0	0	76.04
76.05	03340	BARIATRIC CLINIC	0	0	0.000000	0	0	76.05
76.06	03030	HEALTHY LIVING CENTER	0	0	0.000000	0	0	76.06
76.07	03950	CV RESOURCE CENTER	0	0	0.000000	0	0	76.07
76.08	03955	ANCILLARY OTHER	0	0	0.000000	0	0	76.08
76.09	03956	LACTATION CLINIC	0	0	0.000000	0	0	76.09
76.10	03957	ANCILLARY OTHER	0	0	0.000000	0	0	76.10
76.11	03958	ANCILLARY OTHER	0	0	0.000000	0	0	76.11
76.12	03959	ANTICOAGULATION CLINIC	17,769	1,562,933	0.011369	0	0	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	579,108	70,865,822	0.008172	150,310	1,228	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	8,219,832	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	7,899,507	708,856,793		762,502	10,913	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 15-0090 Component CCN: 15-S090		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part IV Date/Time Prepared: 4/14/2025 10:55 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
50.01	05001	OUTPATIENT SURGERY		0	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES		0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
60.00	06000	LABORATORY		0	0	0	0	534,891	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	150,645	73.00
76.00	03630	ULTRA SOUND		0	0	0	0	0	76.00
76.01	03951	PAIN CLINIC		0	0	0	0	0	76.01
76.02	03952	CATH LAB		0	0	0	0	0	76.02
76.03	03953	ACTIVITY THERAPEUTIC		0	0	0	0	0	76.03
76.04	03954	WOUND CARE CENTER		0	0	0	0	0	76.04
76.05	03340	BARIATRIC CLINIC		0	0	0	0	0	76.05
76.06	03030	HEALTHY LIVING CENTER		0	0	0	0	0	76.06
76.07	03950	CV RESOURCE CENTER		0	0	0	0	0	76.07
76.08	03955	ANCILLARY OTHER		0	0	0	0	0	76.08
76.09	03956	LACTATION CLINIC		0	0	0	0	0	76.09
76.10	03957	ANCILLARY OTHER		0	0	0	0	0	76.10
76.11	03958	ANCILLARY OTHER		0	0	0	0	0	76.11
76.12	03959	ANTICOAGULATION CLINIC		0	0	0	0	0	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION		0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY		0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY		0	0	0	0	50,391	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	735,927	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 15-0090 Component CCN: 15-S090		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part IV Date/Time Prepared: 4/14/2025 10:55 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	83,672,272	0.000000	50.00
50.01	05001	OUTPATIENT SURGERY	0	0	0	0	4,195,834	0.000000	50.01
51.00	05100	RECOVERY ROOM	0	0	0	0	17,737,755	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	4,283,604	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	19,196,412	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	97,101,635	0.000000	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	0	0	0	0	11,769,730	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	11,391,704	0.000000	56.00
60.00	06000	LABORATORY	0	534,891	534,891	0	79,827,118	0.006701	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	2,259,766	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	13,391,240	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	27,626,946	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	12,296,468	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	9,214,326	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	28,574,403	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	5,325,229	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	54,123,089	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	19,798,241	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	150,645	150,645	0	40,991,736	0.003675	73.00
76.00	03630	ULTRA SOUND	0	0	0	0	14,773,801	0.000000	76.00
76.01	03951	PAIN CLINIC	0	0	0	0	11,197,366	0.000000	76.01
76.02	03952	CATH LAB	0	0	0	0	50,666,069	0.000000	76.02
76.03	03953	ACTIVITY THERAPEUTIC	0	0	0	0	5,594,002	0.000000	76.03
76.04	03954	WOUND CARE CENTER	0	0	0	0	3,199,460	0.000000	76.04
76.05	03340	BARIATRIC CLINIC	0	0	0	0	0	0.000000	76.05
76.06	03030	HEALTHY LIVING CENTER	0	0	0	0	0	0.000000	76.06
76.07	03950	CV RESOURCE CENTER	0	0	0	0	0	0.000000	76.07
76.08	03955	ANCILLARY OTHER	0	0	0	0	0	0.000000	76.08
76.09	03956	LACTATION CLINIC	0	0	0	0	0	0.000000	76.09
76.10	03957	ANCILLARY OTHER	0	0	0	0	0	0.000000	76.10
76.11	03958	ANCILLARY OTHER	0	0	0	0	0	0.000000	76.11
76.12	03959	ANTICOAGULATION CLINIC	0	0	0	0	1,562,933	0.000000	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	0	50,391	50,391	0	70,865,822	0.000711	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	8,219,832	0.000000	92.00
200.00		Total (lines 50 through 199)	0	735,927	735,927	0	708,856,793		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 15-0090 Component CCN: 15-S090		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part IV Date/Time Prepared: 4/14/2025 10:55 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	0	0	0	0	50.00
50.01	05001	OUTPATIENT SURGERY		0.000000	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM		0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	57,129	0	11,242	0	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES		0.000000	125	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0.000000	0	0	0	0	56.00
60.00	06000	LABORATORY		0.006701	170,189	1,140	1,017	7	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY		0.000000	5,040	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	4,478	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	3,048	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	35,742	0	3,755	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	2,862	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	23,227	0	4,456	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.003675	72,931	268	946	3	73.00
76.00	03630	ULTRA SOUND		0.000000	2,341	0	0	0	76.00
76.01	03951	PAIN CLINIC		0.000000	0	0	0	0	76.01
76.02	03952	CATH LAB		0.000000	2,925	0	0	0	76.02
76.03	03953	ACTIVITY THERAPEUTIC		0.000000	232,155	0	3,076	0	76.03
76.04	03954	WOUND CARE CENTER		0.000000	0	0	0	0	76.04
76.05	03340	BARIATRIC CLINIC		0.000000	0	0	0	0	76.05
76.06	03030	HEALTHY LIVING CENTER		0.000000	0	0	0	0	76.06
76.07	03950	CV RESOURCE CENTER		0.000000	0	0	0	0	76.07
76.08	03955	ANCILLARY OTHER		0.000000	0	0	0	0	76.08
76.09	03956	LACTATION CLINIC		0.000000	0	0	0	0	76.09
76.10	03957	ANCILLARY OTHER		0.000000	0	0	0	0	76.10
76.11	03958	ANCILLARY OTHER		0.000000	0	0	0	0	76.11
76.12	03959	ANTICOAGULATION CLINIC		0.000000	0	0	0	0	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION		0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY		0.000000	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY		0.000711	150,310	107	8,375	6	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			762,502	1,515	32,867	16	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0090

Period:

Worksheet D

Component CCN: 15-S090

From 01/01/2024

Part V

To 12/31/2024

Date/Time Prepared:

4/14/2025 10:55 am

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
							1.00	2.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.082579	0	0	0	0	50.00
50.01	05001	OUTPATIENT SURGERY	0.670112	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0.079779	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.788878	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.007701	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.081253	11,242	0	0	913	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	0.189882	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.099583	0	0	0	0	56.00
60.00	06000	LABORATORY	0.132548	1,017	0	0	135	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.350729	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.292174	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.256635	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.088015	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.180478	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.078041	3,755	0	0	293	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.178275	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.323190	4,456	0	0	1,440	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.302589	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.264894	946	0	0	251	73.00
76.00	03630	ULTRA SOUND	0.082735	0	0	0	0	76.00
76.01	03951	PAIN CLINIC	0.211051	0	0	0	0	76.01
76.02	03952	CATH LAB	0.103403	0	0	0	0	76.02
76.03	03953	ACTIVITY THERAPEUTIC	0.471530	3,076	0	0	1,450	76.03
76.04	03954	WOUND CARE CENTER	0.477036	0	0	0	0	76.04
76.05	03340	BARIATRIC CLINIC	0.000000	0	0	0	0	76.05
76.06	03030	HEALTHY LIVING CENTER	0.000000	0	0	0	0	76.06
76.07	03950	CV RESOURCE CENTER	0.000000	0	0	0	0	76.07
76.08	03955	ANCILLARY OTHER	0.000000	0	0	0	0	76.08
76.09	03956	LACTATION CLINIC	0.000000	0	0	0	0	76.09
76.10	03957	ANCILLARY OTHER	0.000000	0	0	0	0	76.10
76.11	03958	ANCILLARY OTHER	0.000000	0	0	0	0	76.11
76.12	03959	ANTICOAGULATION CLINIC	0.589496	0	0	0	0	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.133022	8,375	0	0	1,114	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.391197	0	0	0	0	92.00
200.00		Subtotal (see instructions)		32,867	0	0	5,596	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		32,867	0	0	5,596	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 15-0090 Component CCN: 15-S090		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part V Date/Time Prepared: 4/14/2025 10:55 am		
			Title XVIII		Subprovider - IPF		PPS		
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0					50.00
50.01	05001	OUTPATIENT SURGERY	0	0					50.01
51.00	05100	RECOVERY ROOM	0	0					51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0					52.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	0	0					54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0					55.00
56.00	05600	RADIOISOTOPE	0	0					56.00
60.00	06000	LABORATORY	0	0					60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0					63.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0					67.00
68.00	06800	SPEECH PATHOLOGY	0	0					68.00
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0					70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0					73.00
76.00	03630	ULTRA SOUND	0	0					76.00
76.01	03951	PAIN CLINIC	0	0					76.01
76.02	03952	CATH LAB	0	0					76.02
76.03	03953	ACTIVITY THERAPEUTIC	0	0					76.03
76.04	03954	WOUND CARE CENTER	0	0					76.04
76.05	03340	BARIATRIC CLINIC	0	0					76.05
76.06	03030	HEALTHY LIVING CENTER	0	0					76.06
76.07	03950	CV RESOURCE CENTER	0	0					76.07
76.08	03955	ANCILLARY OTHER	0	0					76.08
76.09	03956	LACTATION CLINIC	0	0					76.09
76.10	03957	ANCILLARY OTHER	0	0					76.10
76.11	03958	ANCILLARY OTHER	0	0					76.11
76.12	03959	ANTICOAGULATION CLINIC	0	0					76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0					77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0					78.00
	OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0					92.00
200.00		Subtotal (see instructions)	0	0					200.00
201.00		Less PBP Clinic Lab. Services-Program	0						201.00
		Only Charges							
202.00		Net Charges (line 200 - line 201)	0	0					202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 15-0090		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part II Date/Time Prepared: 4/14/2025 10:55 am	
				Component CCN: 15-T090					
				Title XVIII		Subprovider - IRF		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								
50.00	05000	OPERATING ROOM	1,289,827	83,672,272	0.015415	202,887	3,128	50.00	
50.01	05001	OUTPATIENT SURGERY	472,511	4,195,834	0.112614	9,108	1,026	50.01	
51.00	05100	RECOVERY ROOM	198,780	17,737,755	0.011207	1,602	18	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	163,851	4,283,604	0.038251	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	5,066	19,196,412	0.000264	13,658	4	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,741,170	97,101,635	0.017931	198,439	3,558	54.00	
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	146,694	11,769,730	0.012464	49,211	613	54.01	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00	
56.00	05600	RADIOISOTOPE	227,774	11,391,704	0.019995	0	0	56.00	
60.00	06000	LABORATORY	366,721	79,827,118	0.004594	486,087	2,233	60.00	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	77,492	2,259,766	0.034292	9,761	335	63.00	
65.00	06500	RESPIRATORY THERAPY	194,030	13,391,240	0.014489	577,584	8,369	65.00	
66.00	06600	PHYSICAL THERAPY	135,150	27,626,946	0.004892	1,829,124	8,948	66.00	
67.00	06700	OCCUPATIONAL THERAPY	23,130	12,296,468	0.001881	1,777,932	3,344	67.00	
68.00	06800	SPEECH PATHOLOGY	145,249	9,214,326	0.015763	656,998	10,356	68.00	
69.00	06900	ELECTROCARDIOLOGY	326,719	28,574,403	0.011434	23,075	264	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	172,419	5,325,229	0.032378	1,431	46	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	84,292	54,123,089	0.001557	373,101	581	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	29,069	19,798,241	0.001468	4,300	6	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	152,832	40,991,736	0.003728	576,721	2,150	73.00	
76.00	03630	ULTRA SOUND	160,237	14,773,801	0.010846	56,644	614	76.00	
76.01	03951	PAIN CLINIC	353,108	11,197,366	0.031535	319	10	76.01	
76.02	03952	CATH LAB	475,207	50,666,069	0.009379	167,383	1,570	76.02	
76.03	03953	ACTIVITY THERAPEUTIC	166,602	5,594,002	0.029782	0	0	76.03	
76.04	03954	WOUND CARE CENTER	194,700	3,199,460	0.060854	1,288	78	76.04	
76.05	03340	BARIATRIC CLINIC	0	0	0.000000	0	0	76.05	
76.06	03030	HEALTHY LIVING CENTER	0	0	0.000000	0	0	76.06	
76.07	03950	CV RESOURCE CENTER	0	0	0.000000	0	0	76.07	
76.08	03955	ANCILLARY OTHER	0	0	0.000000	0	0	76.08	
76.09	03956	LACTATION CLINIC	0	0	0.000000	0	0	76.09	
76.10	03957	ANCILLARY OTHER	0	0	0.000000	0	0	76.10	
76.11	03958	ANCILLARY OTHER	0	0	0.000000	0	0	76.11	
76.12	03959	ANTICOAGULATION CLINIC	17,769	1,562,933	0.011369	1	0	76.12	
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000	0	0	77.00	
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00	
	OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	579,108	70,865,822	0.008172	16,907	138	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	8,219,832	0.000000	0	0	92.00	
200.00		Total (lines 50 through 199)	7,899,507	708,856,793		7,033,561	47,389	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 15-0090 Component CCN: 15-T090		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part IV Date/Time Prepared: 4/14/2025 10:55 am	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
50.01	05001	OUTPATIENT SURGERY		0	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES		0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
60.00	06000	LABORATORY		0	0	0	0	534,891	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	150,645	73.00
76.00	03630	ULTRA SOUND		0	0	0	0	0	76.00
76.01	03951	PAIN CLINIC		0	0	0	0	0	76.01
76.02	03952	CATH LAB		0	0	0	0	0	76.02
76.03	03953	ACTIVITY THERAPEUTIC		0	0	0	0	0	76.03
76.04	03954	WOUND CARE CENTER		0	0	0	0	0	76.04
76.05	03340	BARIATRIC CLINIC		0	0	0	0	0	76.05
76.06	03030	HEALTHY LIVING CENTER		0	0	0	0	0	76.06
76.07	03950	CV RESOURCE CENTER		0	0	0	0	0	76.07
76.08	03955	ANCILLARY OTHER		0	0	0	0	0	76.08
76.09	03956	LACTATION CLINIC		0	0	0	0	0	76.09
76.10	03957	ANCILLARY OTHER		0	0	0	0	0	76.10
76.11	03958	ANCILLARY OTHER		0	0	0	0	0	76.11
76.12	03959	ANTICOAGULATION CLINIC		0	0	0	0	0	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION		0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY		0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY		0	0	0	0	50,391	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	735,927	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 15-0090 Component CCN: 15-T090		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part IV Date/Time Prepared: 4/14/2025 10:55 am	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	83,672,272	0.000000	50.00
50.01	05001	OUTPATIENT SURGERY		0	0	0	4,195,834	0.000000	50.01
51.00	05100	RECOVERY ROOM		0	0	0	17,737,755	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	4,283,604	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	19,196,412	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	97,101,635	0.000000	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES		0	0	0	11,769,730	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE		0	0	0	11,391,704	0.000000	56.00
60.00	06000	LABORATORY		0	534,891	534,891	79,827,118	0.006701	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0	0	0	2,259,766	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	13,391,240	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	27,626,946	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	12,296,468	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	9,214,326	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	28,574,403	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	5,325,229	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	54,123,089	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	19,798,241	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	150,645	150,645	40,991,736	0.003675	73.00
76.00	03630	ULTRA SOUND		0	0	0	14,773,801	0.000000	76.00
76.01	03951	PAIN CLINIC		0	0	0	11,197,366	0.000000	76.01
76.02	03952	CATH LAB		0	0	0	50,666,069	0.000000	76.02
76.03	03953	ACTIVITY THERAPEUTIC		0	0	0	5,594,002	0.000000	76.03
76.04	03954	WOUND CARE CENTER		0	0	0	3,199,460	0.000000	76.04
76.05	03340	BARIATRIC CLINIC		0	0	0	0	0.000000	76.05
76.06	03030	HEALTHY LIVING CENTER		0	0	0	0	0.000000	76.06
76.07	03950	CV RESOURCE CENTER		0	0	0	0	0.000000	76.07
76.08	03955	ANCILLARY OTHER		0	0	0	0	0.000000	76.08
76.09	03956	LACTATION CLINIC		0	0	0	0	0.000000	76.09
76.10	03957	ANCILLARY OTHER		0	0	0	0	0.000000	76.10
76.11	03958	ANCILLARY OTHER		0	0	0	0	0.000000	76.11
76.12	03959	ANTICOAGULATION CLINIC		0	0	0	1,562,933	0.000000	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION		0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY		0	0	0	0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY		0	50,391	50,391	70,865,822	0.000711	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	8,219,832	0.000000	92.00
200.00		Total (lines 50 through 199)		0	735,927	735,927	708,856,793		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 15-0090 Component CCN: 15-T090		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part IV Date/Time Prepared: 4/14/2025 10:55 am	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	202,887	0	0	0	50.00
50.01	05001	OUTPATIENT SURGERY		0.000000	9,108	0	0	0	50.01
51.00	05100	RECOVERY ROOM		0.000000	1,602	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	13,658	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	198,439	0	0	0	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES		0.000000	49,211	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0.000000	0	0	0	0	56.00
60.00	06000	LABORATORY		0.006701	486,087	3,257	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0.000000	9,761	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY		0.000000	577,584	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	1,829,124	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	1,777,932	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	656,998	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	23,075	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	1,431	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	373,101	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	4,300	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.003675	576,721	2,119	29	0	73.00
76.00	03630	ULTRA SOUND		0.000000	56,644	0	0	0	76.00
76.01	03951	PAIN CLINIC		0.000000	319	0	0	0	76.01
76.02	03952	CATH LAB		0.000000	167,383	0	0	0	76.02
76.03	03953	ACTIVITY THERAPEUTIC		0.000000	0	0	0	0	76.03
76.04	03954	WOUND CARE CENTER		0.000000	1,288	0	0	0	76.04
76.05	03340	BARIATRIC CLINIC		0.000000	0	0	0	0	76.05
76.06	03030	HEALTHY LIVING CENTER		0.000000	0	0	0	0	76.06
76.07	03950	CV RESOURCE CENTER		0.000000	0	0	0	0	76.07
76.08	03955	ANCILLARY OTHER		0.000000	0	0	0	0	76.08
76.09	03956	LACTATION CLINIC		0.000000	0	0	0	0	76.09
76.10	03957	ANCILLARY OTHER		0.000000	0	0	0	0	76.10
76.11	03958	ANCILLARY OTHER		0.000000	0	0	0	0	76.11
76.12	03959	ANTICOAGULATION CLINIC		0.000000	1	0	0	0	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION		0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY		0.000000	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY		0.000711	16,907	12	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			7,033,561	5,388	29	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0090

Period:

Worksheet D

Component CCN: 15-T090

From 01/01/2024
To 12/31/2024Part V
Date/Time Prepared:
4/14/2025 10:55 am

Title XVIII

Subprovider -
IRF

PPS

Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.082579	0	0	0	50.00
50.01	05001	OUTPATIENT SURGERY	0.670112	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0.079779	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.788878	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.007701	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.081253	0	0	0	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	0.189882	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.099583	0	0	0	56.00
60.00	06000	LABORATORY	0.132548	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.350729	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.292174	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.256635	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.088015	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.180478	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.078041	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.178275	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.323190	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.302589	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.264894	29	0	75	8 73.00
76.00	03630	ULTRA SOUND	0.082735	0	0	0	76.00
76.01	03951	PAIN CLINIC	0.211051	0	0	0	76.01
76.02	03952	CATH LAB	0.103403	0	0	0	76.02
76.03	03953	ACTIVITY THERAPEUTIC	0.471530	0	0	0	76.03
76.04	03954	WOUND CARE CENTER	0.477036	0	0	0	76.04
76.05	03340	BARIATRIC CLINIC	0.000000	0	0	0	76.05
76.06	03030	HEALTHY LIVING CENTER	0.000000	0	0	0	76.06
76.07	03950	CV RESOURCE CENTER	0.000000	0	0	0	76.07
76.08	03955	ANCILLARY OTHER	0.000000	0	0	0	76.08
76.09	03956	LACTATION CLINIC	0.000000	0	0	0	76.09
76.10	03957	ANCILLARY OTHER	0.000000	0	0	0	76.10
76.11	03958	ANCILLARY OTHER	0.000000	0	0	0	76.11
76.12	03959	ANTICOAGULATION CLINIC	0.589496	0	0	0	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.133022	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.391197	0	0	0	92.00
200.00		Subtotal (see instructions)		29	0	75	8 200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0	201.00
		Only Charges					
202.00		Net Charges (line 200 - line 201)		29	0	75	8 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 15-0090 Component CCN: 15-T090		Period: From 01/01/2024 To 12/31/2024	Worksheet D Part V Date/Time Prepared: 4/14/2025 10:55 am
			Title XVIII		Subprovider - IRF	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
50.01	05001	OUTPATIENT SURGERY	0	0		50.01
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	0	0		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	20		73.00
76.00	03630	ULTRA SOUND	0	0		76.00
76.01	03951	PAIN CLINIC	0	0		76.01
76.02	03952	CATH LAB	0	0		76.02
76.03	03953	ACTIVITY THERAPEUTIC	0	0		76.03
76.04	03954	WOUND CARE CENTER	0	0		76.04
76.05	03340	BARIATRIC CLINIC	0	0		76.05
76.06	03030	HEALTHY LIVING CENTER	0	0		76.06
76.07	03950	CV RESOURCE CENTER	0	0		76.07
76.08	03955	ANCILLARY OTHER	0	0		76.08
76.09	03956	LACTATION CLINIC	0	0		76.09
76.10	03957	ANCILLARY OTHER	0	0		76.10
76.11	03958	ANCILLARY OTHER	0	0		76.11
76.12	03959	ANTICOAGULATION CLINIC	0	0		76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
	OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	20		200.00
201.00		Less PBP Clinic Lab. Services-Program	0			201.00
		Only Charges				
202.00		Net Charges (line 200 - line 201)	0	20		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 15-0090		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part V Date/Time Prepared: 4/14/2025 10:55 am	
				Title XIX		Hospital		Cost	
Cost Center Description				Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see inst.)	Charges		Costs	
						Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
				1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.082579	0	9,487,604	0	0	50.00
50.01	05001	OUTPATIENT SURGERY		0.670112	0	891,640	0	0	50.01
51.00	05100	RECOVERY ROOM		0.079779	0	2,621,079	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.788878	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.007701	0	2,832,075	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.081253	0	11,870,602	0	0	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES		0.189882	0	627,804	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0.099583	0	440,499	0	0	56.00
60.00	06000	LABORATORY		0.132548	0	7,972,096	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0.350729	0	26,650	0	0	63.00
65.00	06500	RESPIRATORY THERAPY		0.292174	0	197,880	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.256635	0	2,635,170	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.088015	0	1,751,752	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.180478	0	2,107,892	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.078041	0	1,406,641	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.178275	0	755,651	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.323190	0	4,856,530	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.302589	0	1,083,206	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.264894	0	1,729,118	0	0	73.00
76.00	03630	ULTRA SOUND		0.082735	0	1,658,081	0	0	76.00
76.01	03951	PAIN CLINIC		0.211051	0	1,496,858	0	0	76.01
76.02	03952	CATH LAB		0.103403	0	1,206,390	0	0	76.02
76.03	03953	ACTIVITY THERAPEUTIC		0.471530	0	59,185	0	0	76.03
76.04	03954	WOUND CARE CENTER		0.477036	0	152,857	0	0	76.04
76.05	03340	BARIATRIC CLINIC		0.000000	0	0	0	0	76.05
76.06	03030	HEALTHY LIVING CENTER		0.000000	0	0	0	0	76.06
76.07	03950	CV RESOURCE CENTER		0.000000	0	0	0	0	76.07
76.08	03955	ANCILLARY OTHER		0.000000	0	0	0	0	76.08
76.09	03956	LACTATION CLINIC		0.000000	0	0	0	0	76.09
76.10	03957	ANCILLARY OTHER		0.000000	0	0	0	0	76.10
76.11	03958	ANCILLARY OTHER		0.000000	0	0	0	0	76.11
76.12	03959	ANTICOAGULATION CLINIC		0.589496	0	97,629	0	0	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION		0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY		0.000000	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY		0.133022	0	17,451,615	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.391197	0	1,004,111	0	0	92.00
200.00		Subtotal (see instructions)			0	76,420,615	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0	0	201.00
202.00		Net Charges (line 200 - line 201)			0	76,420,615	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 15-0090		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part V Date/Time Prepared: 4/14/2025 10:55 am		
			Title XIX		Hospital		Cost		
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	783,477	0					50.00
50.01	05001	OUTPATIENT SURGERY	597,499	0					50.01
51.00	05100	RECOVERY ROOM	209,107	0					51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0					52.00
53.00	05300	ANESTHESIOLOGY	21,810	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	964,522	0					54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	119,209	0					54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0					55.00
56.00	05600	RADIOISOTOPE	43,866	0					56.00
60.00	06000	LABORATORY	1,056,685	0					60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	9,347	0					63.00
65.00	06500	RESPIRATORY THERAPY	57,815	0					65.00
66.00	06600	PHYSICAL THERAPY	676,277	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	154,180	0					67.00
68.00	06800	SPEECH PATHOLOGY	380,428	0					68.00
69.00	06900	ELECTROCARDIOLOGY	109,776	0					69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	134,714	0					70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,569,582	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	327,766	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	458,033	0					73.00
76.00	03630	ULTRA SOUND	137,181	0					76.00
76.01	03951	PAIN CLINIC	315,913	0					76.01
76.02	03952	CATH LAB	124,744	0					76.02
76.03	03953	ACTIVITY THERAPEUTIC	27,908	0					76.03
76.04	03954	WOUND CARE CENTER	72,918	0					76.04
76.05	03340	BARIATRIC CLINIC	0	0					76.05
76.06	03030	HEALTHY LIVING CENTER	0	0					76.06
76.07	03950	CV RESOURCE CENTER	0	0					76.07
76.08	03955	ANCILLARY OTHER	0	0					76.08
76.09	03956	LACTATION CLINIC	0	0					76.09
76.10	03957	ANCILLARY OTHER	0	0					76.10
76.11	03958	ANCILLARY OTHER	0	0					76.11
76.12	03959	ANTICOAGULATION CLINIC	57,552	0					76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0					77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0					78.00
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	2,321,449	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	392,805	0					92.00
200.00		Subtotal (see instructions)	11,124,563	0					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	11,124,563	0					202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 15-0090 Component CCN: 15-S090		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part IV Date/Time Prepared: 4/14/2025 10:55 am	
				Title XIX		Subprovider - IPF		Cost	
Cost Center Description				Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
50.01	05001	OUTPATIENT SURGERY		0	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES		0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
60.00	06000	LABORATORY		0	0	0	0	534,891	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	150,645	73.00
76.00	03630	ULTRA SOUND		0	0	0	0	0	76.00
76.01	03951	PAIN CLINIC		0	0	0	0	0	76.01
76.02	03952	CATH LAB		0	0	0	0	0	76.02
76.03	03953	ACTIVITY THERAPEUTIC		0	0	0	0	0	76.03
76.04	03954	WOUND CARE CENTER		0	0	0	0	0	76.04
76.05	03340	BARIATRIC CLINIC		0	0	0	0	0	76.05
76.06	03030	HEALTHY LIVING CENTER		0	0	0	0	0	76.06
76.07	03950	CV RESOURCE CENTER		0	0	0	0	0	76.07
76.08	03955	ANCILLARY OTHER		0	0	0	0	0	76.08
76.09	03956	LACTATION CLINIC		0	0	0	0	0	76.09
76.10	03957	ANCILLARY OTHER		0	0	0	0	0	76.10
76.11	03958	ANCILLARY OTHER		0	0	0	0	0	76.11
76.12	03959	ANTICOAGULATION CLINIC		0	0	0	0	0	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION		0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY		0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY		0	0	0	0	50,391	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	735,927	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 15-0090 Component CCN: 15-S090		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part IV Date/Time Prepared: 4/14/2025 10:55 am	
				Title XIX		Subprovider - IPF		Cost	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	83,672,272	0.000000	50.00
50.01	05001	OUTPATIENT SURGERY	0	0	0	0	4,195,834	0.000000	50.01
51.00	05100	RECOVERY ROOM	0	0	0	0	17,737,755	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	4,283,604	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	19,196,412	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	97,101,635	0.000000	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	0	0	0	0	11,769,730	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	11,391,704	0.000000	56.00
60.00	06000	LABORATORY	0	534,891	534,891	0	79,827,118	0.006701	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	2,259,766	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	13,391,240	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	27,626,946	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	12,296,468	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	9,214,326	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	28,574,403	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	5,325,229	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	54,123,089	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	19,798,241	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	150,645	150,645	0	40,991,736	0.003675	73.00
76.00	03630	ULTRA SOUND	0	0	0	0	14,773,801	0.000000	76.00
76.01	03951	PAIN CLINIC	0	0	0	0	11,197,366	0.000000	76.01
76.02	03952	CATH LAB	0	0	0	0	50,666,069	0.000000	76.02
76.03	03953	ACTIVITY THERAPEUTIC	0	0	0	0	5,594,002	0.000000	76.03
76.04	03954	WOUND CARE CENTER	0	0	0	0	3,199,460	0.000000	76.04
76.05	03340	BARIATRIC CLINIC	0	0	0	0	0	0.000000	76.05
76.06	03030	HEALTHY LIVING CENTER	0	0	0	0	0	0.000000	76.06
76.07	03950	CV RESOURCE CENTER	0	0	0	0	0	0.000000	76.07
76.08	03955	ANCILLARY OTHER	0	0	0	0	0	0.000000	76.08
76.09	03956	LACTATION CLINIC	0	0	0	0	0	0.000000	76.09
76.10	03957	ANCILLARY OTHER	0	0	0	0	0	0.000000	76.10
76.11	03958	ANCILLARY OTHER	0	0	0	0	0	0.000000	76.11
76.12	03959	ANTICOAGULATION CLINIC	0	0	0	0	1,562,933	0.000000	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	0	50,391	50,391	0	70,865,822	0.000711	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	8,219,832	0.000000	92.00
200.00		Total (lines 50 through 199)	0	735,927	735,927	0	708,856,793		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 15-0090 Component CCN: 15-S090		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part IV Date/Time Prepared: 4/14/2025 10:55 am	
				Title XIX		Subprovider - IPF		Cost	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	0	50.00
50.01	05001	OUTPATIENT SURGERY	0.000000	0	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	0	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	0.000000	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0.006701	5,644	38	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	522	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.003675	434	2	0	0	0	73.00
76.00	03630	ULTRA SOUND	0.000000	0	0	0	0	0	76.00
76.01	03951	PAIN CLINIC	0.000000	0	0	0	0	0	76.01
76.02	03952	CATH LAB	0.000000	0	0	0	0	0	76.02
76.03	03953	ACTIVITY THERAPEUTIC	0.000000	0	0	0	0	0	76.03
76.04	03954	WOUND CARE CENTER	0.000000	0	0	0	0	0	76.04
76.05	03340	BARIATRIC CLINIC	0.000000	0	0	0	0	0	76.05
76.06	03030	HEALTHY LIVING CENTER	0.000000	0	0	0	0	0	76.06
76.07	03950	CV RESOURCE CENTER	0.000000	0	0	0	0	0	76.07
76.08	03955	ANCILLARY OTHER	0.000000	0	0	0	0	0	76.08
76.09	03956	LACTATION CLINIC	0.000000	0	0	0	0	0	76.09
76.10	03957	ANCILLARY OTHER	0.000000	0	0	0	0	0	76.10
76.11	03958	ANCILLARY OTHER	0.000000	0	0	0	0	0	76.11
76.12	03959	ANTICOAGULATION CLINIC	0.000000	0	0	0	0	0	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	0.000711	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		6,600	40	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0090

Period:

Worksheet D

Component CCN: 15-S090

From 01/01/2024
To 12/31/2024Part V
Date/Time Prepared:
4/14/2025 10:55 am

Title XIX

Subprovider -
IPF

Cost

Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.082579	0	0	0	50.00
50.01	05001	OUTPATIENT SURGERY	0.670112	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0.079779	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.788878	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.007701	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.081253	0	0	0	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	0.189882	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.099583	0	0	0	56.00
60.00	06000	LABORATORY	0.132548	0	374	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.350729	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.292174	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.256635	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.088015	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.180478	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.078041	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.178275	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.323190	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.302589	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.264894	0	0	0	73.00
76.00	03630	ULTRA SOUND	0.082735	0	0	0	76.00
76.01	03951	PAIN CLINIC	0.211051	0	0	0	76.01
76.02	03952	CATH LAB	0.103403	0	0	0	76.02
76.03	03953	ACTIVITY THERAPEUTIC	0.471530	0	62,720	0	76.03
76.04	03954	WOUND CARE CENTER	0.477036	0	0	0	76.04
76.05	03340	BARIATRIC CLINIC	0.000000	0	0	0	76.05
76.06	03030	HEALTHY LIVING CENTER	0.000000	0	0	0	76.06
76.07	03950	CV RESOURCE CENTER	0.000000	0	0	0	76.07
76.08	03955	ANCILLARY OTHER	0.000000	0	0	0	76.08
76.09	03956	LACTATION CLINIC	0.000000	0	0	0	76.09
76.10	03957	ANCILLARY OTHER	0.000000	0	0	0	76.10
76.11	03958	ANCILLARY OTHER	0.000000	0	0	0	76.11
76.12	03959	ANTICOAGULATION CLINIC	0.589496	0	0	0	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.133022	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.391197	0	0	0	92.00
200.00		Subtotal (see instructions)		0	63,094	0	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0	201.00
		Only Charges					
202.00		Net Charges (line 200 - line 201)		0	63,094	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0090

Period:

Worksheet D

Component CCN: 15-S090

From 01/01/2024
To 12/31/2024Part V
Date/Time Prepared:
4/14/2025 10:55 am

Title XIX

Subprovider -
IPF

Cost

Cost Center Description			Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
50.01	05001	OUTPATIENT SURGERY	0	0	50.01
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
60.00	06000	LABORATORY	50	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03630	ULTRA SOUND	0	0	76.00
76.01	03951	PAIN CLINIC	0	0	76.01
76.02	03952	CATH LAB	0	0	76.02
76.03	03953	ACTIVITY THERAPEUTIC	29,574	0	76.03
76.04	03954	WOUND CARE CENTER	0	0	76.04
76.05	03340	BARIATRIC CLINIC	0	0	76.05
76.06	03030	HEALTHY LIVING CENTER	0	0	76.06
76.07	03950	CV RESOURCE CENTER	0	0	76.07
76.08	03955	ANCILLARY OTHER	0	0	76.08
76.09	03956	LACTATION CLINIC	0	0	76.09
76.10	03957	ANCILLARY OTHER	0	0	76.10
76.11	03958	ANCILLARY OTHER	0	0	76.11
76.12	03959	ANTICOAGULATION CLINIC	0	0	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	78.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	29,624	0	200.00
201.00		Less PBP Clinic Lab. Services-Program	0		201.00
		Only Charges			
202.00		Net Charges (line 200 - line 201)	29,624	0	202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 15-0090 Component CCN: 15-T090		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part IV Date/Time Prepared: 4/14/2025 10:55 am	
				Title XIX		Subprovider - IRF		Cost	
Cost Center Description				Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
50.01	05001	OUTPATIENT SURGERY		0	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES		0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
60.00	06000	LABORATORY		0	0	0	0	534,891	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	150,645	73.00
76.00	03630	ULTRA SOUND		0	0	0	0	0	76.00
76.01	03951	PAIN CLINIC		0	0	0	0	0	76.01
76.02	03952	CATH LAB		0	0	0	0	0	76.02
76.03	03953	ACTIVITY THERAPEUTIC		0	0	0	0	0	76.03
76.04	03954	WOUND CARE CENTER		0	0	0	0	0	76.04
76.05	03340	BARIATRIC CLINIC		0	0	0	0	0	76.05
76.06	03030	HEALTHY LIVING CENTER		0	0	0	0	0	76.06
76.07	03950	CV RESOURCE CENTER		0	0	0	0	0	76.07
76.08	03955	ANCILLARY OTHER		0	0	0	0	0	76.08
76.09	03956	LACTATION CLINIC		0	0	0	0	0	76.09
76.10	03957	ANCILLARY OTHER		0	0	0	0	0	76.10
76.11	03958	ANCILLARY OTHER		0	0	0	0	0	76.11
76.12	03959	ANTICOAGULATION CLINIC		0	0	0	0	0	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION		0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY		0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY		0	0	0	0	50,391	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	735,927	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 15-0090 Component CCN: 15-T090		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part IV Date/Time Prepared: 4/14/2025 10:55 am	
				Title XIX		Subprovider - IRF		Cost	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	83,672,272	0.000000	50.00
50.01	05001	OUTPATIENT SURGERY	0	0	0	0	4,195,834	0.000000	50.01
51.00	05100	RECOVERY ROOM	0	0	0	0	17,737,755	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	4,283,604	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	19,196,412	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	97,101,635	0.000000	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	0	0	0	0	11,769,730	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	11,391,704	0.000000	56.00
60.00	06000	LABORATORY	0	534,891	534,891	0	79,827,118	0.006701	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	2,259,766	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	13,391,240	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	27,626,946	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	12,296,468	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	9,214,326	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	28,574,403	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	5,325,229	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	54,123,089	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	19,798,241	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	150,645	150,645	0	40,991,736	0.003675	73.00
76.00	03630	ULTRA SOUND	0	0	0	0	14,773,801	0.000000	76.00
76.01	03951	PAIN CLINIC	0	0	0	0	11,197,366	0.000000	76.01
76.02	03952	CATH LAB	0	0	0	0	50,666,069	0.000000	76.02
76.03	03953	ACTIVITY THERAPEUTIC	0	0	0	0	5,594,002	0.000000	76.03
76.04	03954	WOUND CARE CENTER	0	0	0	0	3,199,460	0.000000	76.04
76.05	03340	BARIATRIC CLINIC	0	0	0	0	0	0.000000	76.05
76.06	03030	HEALTHY LIVING CENTER	0	0	0	0	0	0.000000	76.06
76.07	03950	CV RESOURCE CENTER	0	0	0	0	0	0.000000	76.07
76.08	03955	ANCILLARY OTHER	0	0	0	0	0	0.000000	76.08
76.09	03956	LACTATION CLINIC	0	0	0	0	0	0.000000	76.09
76.10	03957	ANCILLARY OTHER	0	0	0	0	0	0.000000	76.10
76.11	03958	ANCILLARY OTHER	0	0	0	0	0	0.000000	76.11
76.12	03959	ANTICOAGULATION CLINIC	0	0	0	0	1,562,933	0.000000	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	0	50,391	50,391	0	70,865,822	0.000711	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	8,219,832	0.000000	92.00
200.00		Total (lines 50 through 199)	0	735,927	735,927	0	708,856,793		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 15-0090 Component CCN: 15-T090		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part IV Date/Time Prepared: 4/14/2025 10:55 am	
				Title XIX		Subprovider - IRF		Cost	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	0	0	0	0	50.00
50.01	05001	OUTPATIENT SURGERY		0.000000	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM		0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	0	0	0	0	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES		0.000000	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0.000000	0	0	0	0	56.00
60.00	06000	LABORATORY		0.006701	136	1	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY		0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.003675	0	0	0	0	73.00
76.00	03630	ULTRA SOUND		0.000000	0	0	0	0	76.00
76.01	03951	PAIN CLINIC		0.000000	0	0	0	0	76.01
76.02	03952	CATH LAB		0.000000	0	0	0	0	76.02
76.03	03953	ACTIVITY THERAPEUTIC		0.000000	0	0	0	0	76.03
76.04	03954	WOUND CARE CENTER		0.000000	0	0	0	0	76.04
76.05	03340	BARIATRIC CLINIC		0.000000	0	0	0	0	76.05
76.06	03030	HEALTHY LIVING CENTER		0.000000	0	0	0	0	76.06
76.07	03950	CV RESOURCE CENTER		0.000000	0	0	0	0	76.07
76.08	03955	ANCILLARY OTHER		0.000000	0	0	0	0	76.08
76.09	03956	LACTATION CLINIC		0.000000	0	0	0	0	76.09
76.10	03957	ANCILLARY OTHER		0.000000	0	0	0	0	76.10
76.11	03958	ANCILLARY OTHER		0.000000	0	0	0	0	76.11
76.12	03959	ANTICOAGULATION CLINIC		0.000000	0	0	0	0	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION		0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY		0.000000	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY		0.000711	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			136	1	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0090

Period:

Worksheet D

Component CCN: 15-T090

From 01/01/2024
To 12/31/2024Part V
Date/Time Prepared:
4/14/2025 10:55 am

Title XIX

Subprovider -
IRF

Cost

Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.082579	0	0	0	50.00
50.01	05001	OUTPATIENT SURGERY	0.670112	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0.079779	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.788878	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.007701	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.081253	0	0	0	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	0.189882	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.099583	0	0	0	56.00
60.00	06000	LABORATORY	0.132548	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.350729	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.292174	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.256635	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.088015	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.180478	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.078041	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.178275	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.323190	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.302589	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.264894	0	0	0	73.00
76.00	03630	ULTRA SOUND	0.082735	0	0	0	76.00
76.01	03951	PAIN CLINIC	0.211051	0	0	0	76.01
76.02	03952	CATH LAB	0.103403	0	0	0	76.02
76.03	03953	ACTIVITY THERAPEUTIC	0.471530	0	0	0	76.03
76.04	03954	WOUND CARE CENTER	0.477036	0	0	0	76.04
76.05	03340	BARIATRIC CLINIC	0.000000	0	0	0	76.05
76.06	03030	HEALTHY LIVING CENTER	0.000000	0	0	0	76.06
76.07	03950	CV RESOURCE CENTER	0.000000	0	0	0	76.07
76.08	03955	ANCILLARY OTHER	0.000000	0	0	0	76.08
76.09	03956	LACTATION CLINIC	0.000000	0	0	0	76.09
76.10	03957	ANCILLARY OTHER	0.000000	0	0	0	76.10
76.11	03958	ANCILLARY OTHER	0.000000	0	0	0	76.11
76.12	03959	ANTICOAGULATION CLINIC	0.589496	0	0	0	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.133022	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.391197	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0	201.00
		Only Charges					
202.00		Net Charges (line 200 - line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 15-0090 Component CCN: 15-T090	Period: From 01/01/2024 To 12/31/2024	Worksheet D Part V Date/Time Prepared: 4/14/2025 10:55 am
			Title XIX	Subprovider - IRF	Cost
Cost Center Description			Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
50.01	05001	OUTPATIENT SURGERY	0	0	50.01
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
60.00	06000	LABORATORY	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03630	ULTRA SOUND	0	0	76.00
76.01	03951	PAIN CLINIC	0	0	76.01
76.02	03952	CATH LAB	0	0	76.02
76.03	03953	ACTIVITY THERAPEUTIC	0	0	76.03
76.04	03954	WOUND CARE CENTER	0	0	76.04
76.05	03340	BARIATRIC CLINIC	0	0	76.05
76.06	03030	HEALTHY LIVING CENTER	0	0	76.06
76.07	03950	CV RESOURCE CENTER	0	0	76.07
76.08	03955	ANCILLARY OTHER	0	0	76.08
76.09	03956	LACTATION CLINIC	0	0	76.09
76.10	03957	ANCILLARY OTHER	0	0	76.10
76.11	03958	ANCILLARY OTHER	0	0	76.11
76.12	03959	ANTICOAGULATION CLINIC	0	0	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	78.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program	0		201.00
		Only Charges			
202.00		Net Charges (line 200 - line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0090	Period: From 01/01/2024 To 12/31/2024	Worksheet D-1 Date/Time Prepared: 4/14/2025 10:55 am
		Title XVIII	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		21,206	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		21,206	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)		18,869	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)		6,560	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)		29,178,096	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)		29,178,096	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)		29,178,096	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,375.94	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		9,026,166	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)		9,026,166	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0090	Period: From 01/01/2024 To 12/31/2024	Worksheet D-1 Date/Time Prepared: 4/14/2025 10:55 am	
			Title XVIII		Hospital	PPS
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	5,678,868	2,388	2,378.09	774	1,840,642
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	NEONATAL INTENSIVE CARE UNIT	1,911,293	249	7,675.88	0	0
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					14,190,626
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					25,057,434
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					899,524
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					993,541
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,893,065
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					23,164,369
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
55.01	Permanent adjustment amount per discharge					0.00
55.02	Adjustment amount per discharge (contractor use only)					0.00
55.03	CAR T-cell amount paid as an interim payment					0
56.00	Target amount ((line 54 x sum of lines 55, 55.01, and 55.02) plus line 55.03)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					2,337
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,375.94

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0090	Period: From 01/01/2024 To 12/31/2024	Worksheet D-1 Date/Time Prepared: 4/14/2025 10:55 am	
				Title XVIII	Hospital	PPS	
Cost Center Description						1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,215,572	89.00
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,482,874	29,178,096	0.085094	3,215,572	273,626	90.00
91.00	Nursing Program cost	0	29,178,096	0.000000	3,215,572	0	91.00
92.00	Allied health cost	0	29,178,096	0.000000	3,215,572	0	92.00
93.00	All other Medical Education	0	29,178,096	0.000000	3,215,572	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0090 Component CCN: 15-S090	Period: From 01/01/2024 To 12/31/2024	Worksheet D-1 Date/Time Prepared: 4/14/2025 10:55 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,616	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,616	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)		7,616	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)		523	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)		11,071,545	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)		11,071,545	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)		11,071,545	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,453.72	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		760,296	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)		760,296	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0090	Period: From 01/01/2024 To 12/31/2024	Worksheet D-1	
				Component CCN: 15-S090		Date/Time Prepared: 4/14/2025 10:55 am	
				Title XVIII		Subprovider - IPF	PPS
Cost Center Description		Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					190,198	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)					950,494	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)					57,551	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					12,428	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					69,979	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					880,515	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						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
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0090 Component CCN: 15-S090	Period: From 01/01/2024 To 12/31/2024	Worksheet D-1 Date/Time Prepared: 4/14/2025 10:55 am	
				Title XVIII	Subprovider - IPF	PPS	
Cost Center Description						1.00	
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
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	838,036	11,071,545	0.075693	0	0	90.00
91.00	Nursing Program cost	0	11,071,545	0.000000	0	0	91.00
92.00	Allied health cost	0	11,071,545	0.000000	0	0	92.00
93.00	All other Medical Education	0	11,071,545	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0090 Component CCN: 15-T090	Period: From 01/01/2024 To 12/31/2024	Worksheet D-1 Date/Time Prepared: 4/14/2025 10:55 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,697	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,697	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		3,697	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		2,297	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)		3,986,058	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)		3,986,058	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)		3,986,058	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,078.19	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,476,602	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,476,602	41.00

Health Financial Systems		FRANCISCAN HEALTH - DYER			In Lieu of Form CMS-2552-10				
COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0090 Component CCN: 15-T090		Period: From 01/01/2024 To 12/31/2024		Worksheet D-1 Date/Time Prepared: 4/14/2025 10:55 am	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description		Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)			
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)					
		1.00	2.00	3.00	4.00	5.00			
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00		
Intensive Care Type Inpatient Hospital Units									
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00		
44.00	CORONARY CARE UNIT						44.00		
45.00	BURN INTENSIVE CARE UNIT						45.00		
46.00	SURGICAL INTENSIVE CARE UNIT						46.00		
47.00	NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	47.00		
Cost Center Description						1.00			
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					1,331,277	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)					3,807,879	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)					135,500	50.00		
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					52,777	51.00		
52.00	Total Program excludable cost (sum of lines 50 and 51)					188,277	52.00		
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					3,619,602	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						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		
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY									
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00		
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00		
72.00	Program routine service cost (line 9 x line 71)						72.00		
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00		
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00		
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00		
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00		
77.00	Program capital-related costs (line 9 x line 76)						77.00		
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00		
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00		
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00		
81.00	Inpatient routine service cost per diem limitation						81.00		
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00		
83.00	Reasonable inpatient routine service costs (see instructions)						83.00		
84.00	Program inpatient ancillary services (see instructions)						84.00		
85.00	Utilization review - physician compensation (see instructions)						85.00		
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00		
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST									
87.00	Total observation bed days (see instructions)					0	87.00		

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0090 Component CCN: 15-T090	Period: From 01/01/2024 To 12/31/2024	Worksheet D-1 Date/Time Prepared: 4/14/2025 10:55 am	
				Title XVIII	Subprovider - IRF	PPS	
Cost Center Description						1.00	
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
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	218,101	3,986,058	0.054716	0	0	90.00
91.00	Nursing Program cost	0	3,986,058	0.000000	0	0	91.00
92.00	Allied health cost	0	3,986,058	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,986,058	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0090 Component CCN: 15-S090	Period: From 01/01/2024 To 12/31/2024	Worksheet D-1 Date/Time Prepared: 4/14/2025 10:55 am
		Title XIX	Subprovider - IPF	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			7,616 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			7,616 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)			7,616 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			3,598 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)			616 15.00
16.00	Nursery days (title V or XIX only)			142 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)			11,071,545 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)			11,071,545 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)			11,071,545 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,453.72 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			5,230,485 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)			5,230,485 41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0090	Period: From 01/01/2024 To 12/31/2024	Worksheet D-1
			Component CCN: 15-S090		Date/Time Prepared: 4/14/2025 10:55 am
			Title XIX	Subprovider - IPF	Cost
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0
44.00 CORONARY CARE UNIT					
45.00 BURN INTENSIVE CARE UNIT					
46.00 SURGICAL INTENSIVE CARE UNIT					
47.00 NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0
Cost Center Description					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,032
48.01 Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0
49.00 Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					5,231,517
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
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00 Total Program excludable cost (sum of lines 50 and 51)					0
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
55.01 Permanent adjustment amount per discharge					0.00
55.02 Adjustment amount per discharge (contractor use only)					0.00
55.03 CAR T-cell amount paid as an interim payment					
56.00 Target amount ((line 54 x sum of lines 55, 55.01, and 55.02) plus line 55.03)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
59.00 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00
60.00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00
61.00 Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0
62.00 Relief payment (see instructions)					0
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					0
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					0

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0090 Component CCN: 15-S090	Period: From 01/01/2024 To 12/31/2024	Worksheet D-1 Date/Time Prepared: 4/14/2025 10:55 am	
				Title XIX	Subprovider - IPF	Cost	
Cost Center Description						1.00	
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
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	838,036	11,071,545	0.075693	0	0	90.00
91.00	Nursing Program cost	0	11,071,545	0.000000	0	0	91.00
92.00	Allied health cost	0	11,071,545	0.000000	0	0	92.00
93.00	All other Medical Education	0	11,071,545	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0090 Component CCN: 15-T090	Period: From 01/01/2024 To 12/31/2024	Worksheet D-1 Date/Time Prepared: 4/14/2025 10:55 am
		Title XIX	Subprovider - IRF	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,697 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,697 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			3,697 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)			616 15.00
16.00	Nursery days (title V or XIX only)			142 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)			3,986,058 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)			3,986,058 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)			3,986,058 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,078.19 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			0 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			0 41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0090	Period: From 01/01/2024 To 12/31/2024	Worksheet D-1
			Component CCN: 15-T090		Date/Time Prepared: 4/14/2025 10:55 am
			Title XIX	Subprovider - IRF	Cost
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0
44.00 CORONARY CARE UNIT					
45.00 BURN INTENSIVE CARE UNIT					
46.00 SURGICAL INTENSIVE CARE UNIT					
47.00 NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0
Cost Center Description					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					18
48.01 Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0
49.00 Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					18
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
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00 Total Program excludable cost (sum of lines 50 and 51)					0
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
55.01 Permanent adjustment amount per discharge					0.00
55.02 Adjustment amount per discharge (contractor use only)					0.00
55.03 CAR T-cell amount paid as an interim payment					
56.00 Target amount ((line 54 x sum of lines 55, 55.01, and 55.02) plus line 55.03)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
59.00 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00
60.00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00
61.00 Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0
62.00 Relief payment (see instructions)					0
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					0
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					0

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0090 Component CCN: 15-T090	Period: From 01/01/2024 To 12/31/2024	Worksheet D-1 Date/Time Prepared: 4/14/2025 10:55 am	
				Title XIX	Subprovider - IRF	Cost	
Cost Center Description						1.00	
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
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	218,101	3,986,058	0.054716	0	0	90.00
91.00	Nursing Program cost	0	3,986,058	0.000000	0	0	91.00
92.00	Allied health cost	0	3,986,058	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,986,058	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 15-0090	Period: From 01/01/2024 To 12/31/2024	Worksheet D-3 Date/Time Prepared: 4/14/2025 10:55 am
			Title XVIII	Hospital	PPS
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		16,669,998	30.00
31.00	03100	INTENSIVE CARE UNIT		3,534,653	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0	35.00
40.00	04000	SUBPROVIDER - IPF		2,612	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.082579	7,809,665	50.00
50.01	05001	OUTPATIENT SURGERY	0.670112	772,070	50.01
51.00	05100	RECOVERY ROOM	0.079779	871,018	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.788878	40,092	52.00
53.00	05300	ANESTHESIOLOGY	0.007701	1,691,419	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.081253	10,590,506	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	0.189882	1,293,795	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	55.00
56.00	05600	RADIOISOTOPE	0.099583	649,834	56.00
60.00	06000	LABORATORY	0.132548	12,483,629	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.350729	688,938	63.00
65.00	06500	RESPIRATORY THERAPY	0.292174	4,519,177	65.00
66.00	06600	PHYSICAL THERAPY	0.256635	1,612,358	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.088015	1,377,777	67.00
68.00	06800	SPEECH PATHOLOGY	0.180478	657,482	68.00
69.00	06900	ELECTROCARDIOLOGY	0.078041	3,763,801	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.178275	168,966	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.323190	7,663,124	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.302589	2,155,288	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.264894	8,630,501	73.00
76.00	03630	ULTRA SOUND	0.082735	1,407,017	76.00
76.01	03951	PAIN CLINIC	0.211051	35,595	76.01
76.02	03952	CATH LAB	0.103403	6,435,171	76.02
76.03	03953	ACTIVITY THERAPEUTIC	0.471530	0	76.03
76.04	03954	WOUND CARE CENTER	0.477036	61,133	76.04
76.05	03340	BARIATRIC CLINIC	0.000000	0	76.05
76.06	03030	HEALTHY LIVING CENTER	0.000000	0	76.06
76.07	03950	CV RESOURCE CENTER	0.000000	0	76.07
76.08	03955	ANCILLARY OTHER	0.000000	0	76.08
76.09	03956	LACTATION CLINIC	0.000000	0	76.09
76.10	03957	ANCILLARY OTHER	0.000000	0	76.10
76.11	03958	ANCILLARY OTHER	0.000000	0	76.11
76.12	03959	ANTICOAGULATION CLINIC	0.589496	2,113	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	78.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.133022	6,286,785	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.391197	1,221,984	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		82,889,238	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)		82,889,238	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0090 Component CCN: 15-S090	Period: From 01/01/2024 To 12/31/2024	Worksheet D-3 Date/Time Prepared: 4/14/2025 10:55 am	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT				35.00
40.00	04000 SUBPROVIDER - IPF		1,546,367		40.00
41.00	04100 SUBPROVIDER - IRF				41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.082579	0	0	50.00
50.01	05001 OUTPATIENT SURGERY	0.670112	0	0	50.01
51.00	05100 RECOVERY ROOM	0.079779	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.788878	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.007701	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.081253	57,129	4,642	54.00
54.01	05401 RADIOLOGY-SPECIAL PROCEDURES	0.189882	125	24	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
56.00	05600 RADIOISOTOPE	0.099583	0	0	56.00
60.00	06000 LABORATORY	0.132548	170,189	22,558	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.350729	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.292174	5,040	1,473	65.00
66.00	06600 PHYSICAL THERAPY	0.256635	4,478	1,149	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.088015	3,048	268	67.00
68.00	06800 SPEECH PATHOLOGY	0.180478	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.078041	35,742	2,789	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.178275	2,862	510	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.323190	23,227	7,507	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.302589	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.264894	72,931	19,319	73.00
76.00	03630 ULTRA SOUND	0.082735	2,341	194	76.00
76.01	03951 PAIN CLINIC	0.211051	0	0	76.01
76.02	03952 CATH LAB	0.103403	2,925	302	76.02
76.03	03953 ACTIVITY THERAPEUTIC	0.471530	232,155	109,468	76.03
76.04	03954 WOUND CARE CENTER	0.477036	0	0	76.04
76.05	03340 BARIATRIC CLINIC	0.000000	0	0	76.05
76.06	03030 HEALTHY LIVING CENTER	0.000000	0	0	76.06
76.07	03950 CV RESOURCE CENTER	0.000000	0	0	76.07
76.08	03955 ANCILLARY OTHER	0.000000	0	0	76.08
76.09	03956 LACTATION CLINIC	0.000000	0	0	76.09
76.10	03957 ANCILLARY OTHER	0.000000	0	0	76.10
76.11	03958 ANCILLARY OTHER	0.000000	0	0	76.11
76.12	03959 ANTICOAGULATION CLINIC	0.589496	0	0	76.12
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.133022	150,310	19,995	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.391197	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		762,502	190,198	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)		762,502		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0090 Component CCN: 15-T090	Period: From 01/01/2024 To 12/31/2024	Worksheet D-3 Date/Time Prepared: 4/14/2025 10:55 am	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT				35.00
40.00	04000 SUBPROVIDER - IPF				40.00
41.00	04100 SUBPROVIDER - IRF		4,509,786		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.082579	202,887	16,754	50.00
50.01	05001 OUTPATIENT SURGERY	0.670112	9,108	6,103	50.01
51.00	05100 RECOVERY ROOM	0.079779	1,602	128	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.788878	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.007701	13,658	105	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.081253	198,439	16,124	54.00
54.01	05401 RADIOLOGY-SPECIAL PROCEDURES	0.189882	49,211	9,344	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
56.00	05600 RADIOISOTOPE	0.099583	0	0	56.00
60.00	06000 LABORATORY	0.132548	486,087	64,430	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.350729	9,761	3,423	63.00
65.00	06500 RESPIRATORY THERAPY	0.292174	577,584	168,755	65.00
66.00	06600 PHYSICAL THERAPY	0.256635	1,829,124	469,417	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.088015	1,777,932	156,485	67.00
68.00	06800 SPEECH PATHOLOGY	0.180478	656,998	118,574	68.00
69.00	06900 ELECTROCARDIOLOGY	0.078041	23,075	1,801	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.178275	1,431	255	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.323190	373,101	120,583	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.302589	4,300	1,301	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.264894	576,721	152,770	73.00
76.00	03630 ULTRA SOUND	0.082735	56,644	4,686	76.00
76.01	03951 PAIN CLINIC	0.211051	319	67	76.01
76.02	03952 CATH LAB	0.103403	167,383	17,308	76.02
76.03	03953 ACTIVITY THERAPEUTIC	0.471530	0	0	76.03
76.04	03954 WOUND CARE CENTER	0.477036	1,288	614	76.04
76.05	03340 BARIATRIC CLINIC	0.000000	0	0	76.05
76.06	03030 HEALTHY LIVING CENTER	0.000000	0	0	76.06
76.07	03950 CV RESOURCE CENTER	0.000000	0	0	76.07
76.08	03955 ANCILLARY OTHER	0.000000	0	0	76.08
76.09	03956 LACTATION CLINIC	0.000000	0	0	76.09
76.10	03957 ANCILLARY OTHER	0.000000	0	0	76.10
76.11	03958 ANCILLARY OTHER	0.000000	0	0	76.11
76.12	03959 ANTICOAGULATION CLINIC	0.589496	1	1	76.12
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.133022	16,907	2,249	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.391197	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		7,033,561	1,331,277	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		7,033,561	0	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 15-0090	Period: From 01/01/2024 To 12/31/2024	Worksheet D-3 Date/Time Prepared: 4/14/2025 10:55 am
			Title XIX	Hospital	Cost
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		6,540,759	30.00
31.00	03100	INTENSIVE CARE UNIT		1,997,090	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		702,527	35.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		445,312	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.082579	5,351,217	50.00
50.01	05001	OUTPATIENT SURGERY	0.670112	231,536	50.01
51.00	05100	RECOVERY ROOM	0.079779	608,939	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.788878	1,416,887	52.00
53.00	05300	ANESTHESIOLOGY	0.007701	1,070,542	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.081253	4,141,037	54.00
54.01	05401	RADIOLOGY-SPECIAL PROCEDURES	0.189882	375,698	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	55.00
56.00	05600	RADIOISOTOPE	0.099583	138,063	56.00
60.00	06000	LABORATORY	0.132548	7,024,123	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.350729	414,577	63.00
65.00	06500	RESPIRATORY THERAPY	0.292174	1,344,669	65.00
66.00	06600	PHYSICAL THERAPY	0.256635	359,035	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.088015	348,144	67.00
68.00	06800	SPEECH PATHOLOGY	0.180478	274,472	68.00
69.00	06900	ELECTROCARDIOLOGY	0.078041	1,212,277	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.178275	86,846	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.323190	3,723,084	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.302589	835,191	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.264894	4,492,951	73.00
76.00	03630	ULTRA SOUND	0.082735	661,935	76.00
76.01	03951	PAIN CLINIC	0.211051	13,394	76.01
76.02	03952	CATH LAB	0.103403	1,609,637	76.02
76.03	03953	ACTIVITY THERAPEUTIC	0.471530	1,587,465	76.03
76.04	03954	WOUND CARE CENTER	0.477036	40,556	76.04
76.05	03340	BARIATRIC CLINIC	0.000000	0	76.05
76.06	03030	HEALTHY LIVING CENTER	0.000000	0	76.06
76.07	03950	CV RESOURCE CENTER	0.000000	0	76.07
76.08	03955	ANCILLARY OTHER	0.000000	0	76.08
76.09	03956	LACTATION CLINIC	0.000000	0	76.09
76.10	03957	ANCILLARY OTHER	0.000000	0	76.10
76.11	03958	ANCILLARY OTHER	0.000000	0	76.11
76.12	03959	ANTICOAGULATION CLINIC	0.589496	4,170	76.12
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	78.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.133022	3,654,379	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.391197	373,915	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		41,394,739	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)		41,394,739	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0090 Component CCN: 15-S090	Period: From 01/01/2024 To 12/31/2024	Worksheet D-3 Date/Time Prepared: 4/14/2025 10:55 am	
		Title XIX	Subprovider - IPF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT				35.00
40.00	04000 SUBPROVIDER - IPF		10,066,660		40.00
41.00	04100 SUBPROVIDER - IRF				41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.082579	0	0	50.00
50.01	05001 OUTPATIENT SURGERY	0.670112	0	0	50.01
51.00	05100 RECOVERY ROOM	0.079779	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.788878	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.007701	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.081253	0	0	54.00
54.01	05401 RADIOLOGY-SPECIAL PROCEDURES	0.189882	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
56.00	05600 RADIOISOTOPE	0.099583	0	0	56.00
60.00	06000 LABORATORY	0.132548	5,644	748	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.350729	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.292174	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.256635	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.088015	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.180478	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.078041	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.178275	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.323190	522	169	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.302589	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.264894	434	115	73.00
76.00	03630 ULTRA SOUND	0.082735	0	0	76.00
76.01	03951 PAIN CLINIC	0.211051	0	0	76.01
76.02	03952 CATH LAB	0.103403	0	0	76.02
76.03	03953 ACTIVITY THERAPEUTIC	0.471530	0	0	76.03
76.04	03954 WOUND CARE CENTER	0.477036	0	0	76.04
76.05	03340 BARIATRIC CLINIC	0.000000	0	0	76.05
76.06	03030 HEALTHY LIVING CENTER	0.000000	0	0	76.06
76.07	03950 CV RESOURCE CENTER	0.000000	0	0	76.07
76.08	03955 ANCILLARY OTHER	0.000000	0	0	76.08
76.09	03956 LACTATION CLINIC	0.000000	0	0	76.09
76.10	03957 ANCILLARY OTHER	0.000000	0	0	76.10
76.11	03958 ANCILLARY OTHER	0.000000	0	0	76.11
76.12	03959 ANTICOAGULATION CLINIC	0.589496	0	0	76.12
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.133022	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.391197	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		6,600	1,032	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		6,600		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0090 Component CCN: 15-T090	Period: From 01/01/2024 To 12/31/2024	Worksheet D-3 Date/Time Prepared: 4/14/2025 10:55 am	
		Title XIX	Subprovider - IRF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT				35.00
40.00	04000 SUBPROVIDER - IPF				40.00
41.00	04100 SUBPROVIDER - IRF		101,920		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.082579	0	0	50.00
50.01	05001 OUTPATIENT SURGERY	0.670112	0	0	50.01
51.00	05100 RECOVERY ROOM	0.079779	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.788878	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.007701	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.081253	0	0	54.00
54.01	05401 RADIOLOGY-SPECIAL PROCEDURES	0.189882	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
56.00	05600 RADIOISOTOPE	0.099583	0	0	56.00
60.00	06000 LABORATORY	0.132548	136	18	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.350729	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.292174	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.256635	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.088015	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.180478	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.078041	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.178275	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.323190	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.302589	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.264894	0	0	73.00
76.00	03630 ULTRA SOUND	0.082735	0	0	76.00
76.01	03951 PAIN CLINIC	0.211051	0	0	76.01
76.02	03952 CATH LAB	0.103403	0	0	76.02
76.03	03953 ACTIVITY THERAPEUTIC	0.471530	0	0	76.03
76.04	03954 WOUND CARE CENTER	0.477036	0	0	76.04
76.05	03340 BARIATRIC CLINIC	0.000000	0	0	76.05
76.06	03030 HEALTHY LIVING CENTER	0.000000	0	0	76.06
76.07	03950 CV RESOURCE CENTER	0.000000	0	0	76.07
76.08	03955 ANCILLARY OTHER	0.000000	0	0	76.08
76.09	03956 LACTATION CLINIC	0.000000	0	0	76.09
76.10	03957 ANCILLARY OTHER	0.000000	0	0	76.10
76.11	03958 ANCILLARY OTHER	0.000000	0	0	76.11
76.12	03959 ANTICOAGULATION CLINIC	0.589496	0	0	76.12
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.133022	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.391197	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		136	18	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)		136		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0090	Period: From 01/01/2024 To 12/31/2024	Worksheet E Part A Date/Time Prepared: 4/14/2025 10:55 am
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	13,097,080		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	4,308,415		1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0		1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0		1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount	0		2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0		2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	424,712		2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	36,027		2.04
3.00	Managed Care Simulated Payments	12,257,668		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	99.23		4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		7.80	5.00
5.01	FTE cap adjustment for qualifying hospitals under §131 of the CAA 2021 (see instructions)	0.00		5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00		6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)	0.00		6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.89		7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00		7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)	0.00		7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00		8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00		8.21
8.28	The amount of increase if the hospital was awarded FTE cap slots under §4122 of the CAA 2023 (see instructions)			8.28
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.28 (see instructions)	6.91		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	2.13		10.00
11.00	FTE count for residents in dental and podiatric programs.	4.83		11.00
12.00	Current year allowable FTE (see instructions)	6.96		12.00
13.00	Total allowable FTE count for the prior year.	5.74		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	4.12		14.00
15.00	Sum of lines 12 through 14 divided by 3.	5.61		15.00
16.00	Adjustment for residents in initial years of the program (see instructions)	0.00		16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00		17.00
18.00	Adjusted rolling average FTE count	5.61		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.056535		19.00
20.00	Prior year resident to bed ratio (see instructions)	0.036251		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.036251		21.00
22.00	IME payment adjustment (see instructions)	341,322		22.00
22.01	IME payment adjustment - Managed Care (see instructions)	240,373		22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	-4.78		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000		26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000		27.00
28.00	IME add-on adjustment amount (see instructions)	0		28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0		28.01
29.00	Total IME payment (sum of lines 22 and 28)	341,322		29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	240,373		29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	3.33		30.00
31.00	Percentage of Medicaid patient days (see instructions)	19.49		31.00
32.00	Sum of lines 30 and 31	22.82		32.00
33.00	Allowable disproportionate share percentage (see instructions)	8.04		33.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0090	Period: From 01/01/2024 To 12/31/2024	Worksheet E Part A Date/Time Prepared: 4/14/2025 10:55 am
		Title XVIII	Hospital	PPS
				1.00
34.00	Disproportionate share adjustment (see instructions)			349,850 34.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
		Uncompensated Care Payment Adjustment		
35.00	Total uncompensated care amount (see instructions)	5,938,006,757	5,705,743,275	35.00
35.01	Factor 3 (see instructions)	0.000225055	0.000197110	35.01
35.02	Hospital UCP, including supplemental UCP (see instructions)	1,336,380	1,124,661	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	1,000,460	283,476	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	1,283,936		36.00
		Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)		
40.00	Total Medicare discharges (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	19,841,342		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	29,338,476		48.00
				Amount
				1.00
49.00	Total payment for inpatient operating costs (see instructions)			27,204,566 49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			1,402,366 50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0 51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			166,430 52.00
53.00	Nursing and Allied Health Managed Care payment			58,693 53.00
54.00	Special add-on payments for new technologies			15,600 54.00
54.01	Islet isolation add-on payment			0 54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0 55.00
55.01	Cellular therapy acquisition cost (see instructions)			0 55.01
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0 56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0 57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			119,840 58.00
59.00	Total (sum of amounts on lines 49 through 58)			28,967,495 59.00
60.00	Primary payer payments			38,811 60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			28,928,684 61.00
62.00	Deductibles billed to program beneficiaries			1,687,040 62.00
63.00	Coinsurance billed to program beneficiaries			98,256 63.00
64.00	Allowable bad debts (see instructions)			314,283 64.00
65.00	Adjusted reimbursable bad debts (see instructions)			204,284 65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			202,856 66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			27,347,672 67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0 68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)			0 69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0 70.50
70.75	N95 respirator payment adjustment amount (see instructions)			0 70.75
70.76	Essential medicines payment adjustment amount (see instructions)			0 70.76
70.87	Demonstration payment adjustment amount before sequestration			0 70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0 70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			0 70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			-46,527 70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			-42,769 70.91
70.92	Bundled Model 1 discount amount (see instructions)			0 70.92
70.93	HVBP payment adjustment amount (see instructions)			-113,802 70.93
70.94	HRR adjustment amount (see instructions)			-104,376 70.94
70.95	Recovery of accelerated depreciation			0 70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0090	Period: From 01/01/2024 To 12/31/2024	Worksheet E Part A Date/Time Prepared: 4/14/2025 10:55 am
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3	0	0	70.98
70.99	HAC adjustment amount (see instructions)		283,150	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		26,757,048	71.00
71.01	Sequestration adjustment (see instructions)		535,141	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		26,615,506	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-393,599	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,454,366	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		5,332,408	1,790,443
HVPB Adjustment for HSP Bonus Payment				
101.00	HVPB adjustment factor (see instructions)	0.9934449361	0.9935364534	101.00
102.00	HVPB adjustment amount for HSP bonus payment (see instructions)	-34,954	-11,573	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.9948	0.9916	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	-27,729	-15,040	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet E
Part A Exhibit 4
Date/Time Prepared:
4/14/2025 10:55 am

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	13,097,080	0	13,097,080		13,097,080	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	4,308,415	0		4,308,415	4,308,415	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	424,712	0	424,712		424,712	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	36,027	0		36,027	36,027	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	12,257,668	0	8,793,478	3,464,190	12,257,668	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.036251	0.036251	0.036251	0.036251		5.00
6.00	IME payment adjustment (see instructions)	22.00	341,322	0	256,834	84,488	341,322	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	240,373	0	172,440	67,933	240,373	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	341,322	0	256,834	84,488	341,322	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	240,373	0	172,440	67,933	240,373	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0804	0.0804	0.0804	0.0804		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	349,850	0	263,251	86,599	349,850	11.00
11.01	Uncompensated care payments	36.00	1,283,936	0	1,000,460	283,476	1,283,936	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	19,841,342	0	15,042,337	4,799,005	19,841,342	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	29,338,476	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	27,204,566	0	22,337,628	4,866,938	27,204,566	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,402,366	0	1,058,676	343,690	1,402,366	16.00
17.00	Special add-on payments for new technologies	54.00	15,600	0	15,600	0	15,600	17.00
17.01	Net organ aquisition cost							17.01

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet E
Part A Exhibit 4
Date/Time Prepared:
4/14/2025 10:55 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	23,411,904	5,210,628	28,622,532
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	5.00
20.00	Capital DRG other than outlier	1.00	1,348,698	0	1,015,611	333,087	1,348,698
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	17,118	0	15,542	1,576	17,118
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.0271	0.0271	0.0271	0.0271	
23.00	Indirect medical education adjustment (see instructions)	6.00	36,550	0	27,523	9,027	36,550
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0
26.00	Total prospective capital payments (see instructions)	12.00	1,402,366	0	1,058,676	343,690	1,402,366
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.000000	0.000000	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet E
Part A Exhibit 5
Date/Time Prepared:
4/14/2025 10:55 am

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	13,097,080	13,097,080		13,097,080	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	4,308,415		4,308,415	4,308,415	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	424,712	424,712		424,712	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	36,027		36,027	36,027	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	12,257,668	8,793,478	3,464,190	12,257,668	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.036251	0.036251	0.036251		5.00
6.00	IME payment adjustment (see instructions)	22.00	341,322	256,834	84,488	341,322	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	240,373	172,440	67,933	240,373	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	341,322	256,834	84,488	341,322	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	240,373	172,440	67,933	240,373	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0804	0.0804	0.0804		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	349,850	263,251	86,599	349,850	11.00
11.01	Uncompensated care payments	36.00	1,283,936	1,000,460	283,476	1,283,936	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	19,841,342	15,042,337	4,799,005	19,841,342	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	29,338,476	22,341,540	6,996,936	29,338,476	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	27,204,566	20,689,180	6,515,386	27,204,566	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,402,366	1,058,676	343,690	1,402,366	16.00
17.00	Special add-on payments for new technologies	54.00	15,600	15,600	0	15,600	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			21,763,456	6,859,076	28,622,532	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet E
Part A Exhibit 5
Date/Time Prepared:
4/14/2025 10:55 am

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,348,698	1,015,611	333,087	1,348,698	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	17,118	15,542	1,576	17,118	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0271	0.0271	0.0271		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	36,550	27,523	9,027	36,550	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,402,366	1,058,676	343,690	1,402,366	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-113,802	-85,954	-27,848	-113,802	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	-46,527	-34,954	-11,573	-46,527	30.01
31.00	HRR adjustment (see instructions)	70.94	-104,376	-68,185	-36,191	-104,376	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	-42,769	-27,729	-15,040	-42,769	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		215,466	67,684	283,150	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0090	Period: From 01/01/2024 To 12/31/2024	Worksheet E Part B Date/Time Prepared: 4/14/2025 10:55 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		914	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		12,535,706	2.00
3.00	OPPS or REH payments		11,247,254	3.00
4.00	Outlier payment (see instructions)		32,875	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200		28,820	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		914	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		3,452	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		3,452	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		3,452	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		2,538	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		914	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		11,308,949	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,973,622	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		9,336,241	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		70,257	28.00
28.50	REH facility payment amount (see instructions)			28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)		9,406,498	30.00
31.00	Primary payer payments		428	31.00
32.00	Subtotal (line 30 minus line 31)		9,406,070	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		183,394	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		119,206	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		109,824	36.00
37.00	Subtotal (see instructions)		9,525,276	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.75	N95 respirator payment adjustment amount (see instructions)		0	39.75
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		9,525,276	40.00
40.01	Sequestration adjustment (see instructions)		190,506	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00	Interim payments		9,336,037	41.00
41.01	Interim payments-PARHM			41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)			42.01
43.00	Balance due provider/program (see instructions)		-1,267	43.00
43.01	Balance due provider/program-PARHM (see instructions)			43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

Health Financial Systems		FRANCISCAN HEALTH - DYER		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0090	Period: From 01/01/2024 To 12/31/2024	Worksheet E Part B Date/Time Prepared: 4/14/2025 10:55 am	
		Title XVIII	Hospital	PPS	
				1.00	
200.00	MEDICARE PART B ANCILLARY COSTS				
	Part B Combined Billed Days				0 200.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0090 Component CCN: 15-S090	Period: From 01/01/2024 To 12/31/2024	Worksheet E Part B Date/Time Prepared: 4/14/2025 10:55 am
		Title XVIII	Subprovider - IPF	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		5,580	2.00
3.00	OPPS or REH payments		7,699	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200		16	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		7,715	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,540	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		6,175	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
28.50	REH facility payment amount (see instructions)			28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)		6,175	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		6,175	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		6,175	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.75	N95 respirator payment adjustment amount (see instructions)		0	39.75
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		6,175	40.00
40.01	Sequestration adjustment (see instructions)		124	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00	Interim payments		6,036	41.00
41.01	Interim payments-PARHM			41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)			42.01
43.00	Balance due provider/program (see instructions)		15	43.00
43.01	Balance due provider/program-PARHM (see instructions)			43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00

Health Financial Systems			FRANCISCAN HEALTH - DYER			In Lieu of Form CMS-2552-10						
CALCULATION OF REIMBURSEMENT SETTLEMENT					Provider CCN: 15-0090		Period: From 01/01/2024		Worksheet E			
					Component CCN: 15-S090		To 12/31/2024		Part B			
					Title XVIII		Subprovider - IPF		Date/Time Prepared: 4/14/2025 10:55 am			
									PPS			
									1.00			
94.00	Total (sum of lines 91 and 93)										0	94.00
									1.00			
	MEDICARE PART B ANCILLARY COSTS											
200.00	Part B Combined Billed Days											200.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0090 Component CCN: 15-T090	Period: From 01/01/2024 To 12/31/2024	Worksheet E Part B Date/Time Prepared: 4/14/2025 10:55 am
		Title XVIII	Subprovider - IRF	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)	20	1.00	
2.00	Medical and other services reimbursed under OPPS (see instructions)	8	2.00	
3.00	OPPS or REH payments	44	3.00	
4.00	Outlier payment (see instructions)	0	4.00	
4.01	Outlier reconciliation amount (see instructions)	0	4.01	
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00	
6.00	Line 2 times line 5	0	6.00	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00	
8.00	Transitional corridor payment (see instructions)	0	8.00	
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00	
10.00	Organ acquisitions	0	10.00	
11.00	Total cost (sum of lines 1 and 10) (see instructions)	20	11.00	
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges	75	12.00	
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00	
14.00	Total reasonable charges (sum of lines 12 and 13)	75	14.00	
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00	
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00	
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00	
18.00	Total customary charges (see instructions)	75	18.00	
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	55	19.00	
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00	
21.00	Lesser of cost or charges (see instructions)	20	21.00	
22.00	Interns and residents (see instructions)	0	22.00	
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	44	24.00	
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00	
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	0	26.00	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	64	27.00	
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00	
28.50	REH facility payment amount (see instructions)		28.50	
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00	
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	64	30.00	
31.00	Primary payer payments	0	31.00	
32.00	Subtotal (line 30 minus line 31)	64	32.00	
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00	
34.00	Allowable bad debts (see instructions)	0	34.00	
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00	
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00	
37.00	Subtotal (see instructions)	64	37.00	
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00	
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00	
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50	
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75	
39.97	Demonstration payment adjustment amount before sequestration	0	39.97	
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98	
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99	
40.00	Subtotal (see instructions)	64	40.00	
40.01	Sequestration adjustment (see instructions)	1	40.01	
40.02	Demonstration payment adjustment amount after sequestration	0	40.02	
40.03	Sequestration adjustment-PARHM pass-throughs		40.03	
41.00	Interim payments	61	41.00	
41.01	Interim payments-PARHM		41.01	
42.00	Tentative settlement (for contractors use only)	0	42.00	
42.01	Tentative settlement-PARHM (for contractor use only)		42.01	
43.00	Balance due provider/program (see instructions)	2	43.00	
43.01	Balance due provider/program-PARHM (see instructions)		43.01	
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00	
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)	0	90.00	
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00	
92.00	The rate used to calculate the Time Value of Money	0.00	92.00	
93.00	Time Value of Money (see instructions)	0	93.00	

Health Financial Systems		FRANCISCAN HEALTH - DYER		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0090	Period: From 01/01/2024	Worksheet E	
		Component CCN: 15-T090	To 12/31/2024	Part B	
		Title XVIII	Subprovider -	Date/Time Prepared:	
			IRF	4/14/2025 10:55 am	
				PPS	
				1.00	
94.00	Total (sum of lines 91 and 93)			0	94.00
				1.00	
MEDICARE PART B ANCILLARY COSTS					
200.00	Part B Combined Billed Days				200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet E-1
Part I
Date/Time Prepared:
4/14/2025 10:55 am

		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		26,509,206		9,279,737	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	10/09/2024	106,300	10/09/2024	56,300	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)		106,300		56,300	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)		26,615,506		9,336,037	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		393,599		1,267	6.02
7.00	Total Medicare program liability (see instructions)		26,221,907		9,334,770	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 15-0090 Component CCN: 15-S090		Period: From 01/01/2024 To 12/31/2024		Worksheet E-1 Part I Date/Time Prepared: 4/14/2025 10:55 am	
		Title XVIII		Subprovider - IPF		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		396,963		6,036	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		396,963		6,036	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		1,510		15	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		398,473		6,051	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 15-0090 Component CCN: 15-T090		Period: From 01/01/2024 To 12/31/2024		Worksheet E-1 Part I Date/Time Prepared: 4/14/2025 10:55 am	
		Title XVIII		Subprovider - IRF		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						1.00
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		5,023,797		61		2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		5,023,797		61		4.00
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0		5.50
5.51			0		0		5.51
5.52			0		0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		2		6.01
6.02	SETTLEMENT TO PROGRAM		147,109		0		6.02
7.00	Total Medicare program liability (see instructions)		4,876,688		63		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0090	Period: From 01/01/2024 To 12/31/2024	Worksheet E-1 Part II Date/Time Prepared: 4/14/2025 10:55 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days (see instructions)			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days (see instructions)			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0090 Component CCN: 15-S090	Period: From 01/01/2024 To 12/31/2024	Worksheet E-3 Part II Date/Time Prepared: 4/14/2025 10:55 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
	PART II - MEDICARE PART A SERVICES - IPF PPS			
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			498,613 1.00
2.00	Net IPF PPS Outlier Payments			19,085 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			20.808743 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1)\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			517,698 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			517,698 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			517,698 18.00
19.00	Deductibles			63,648 19.00
20.00	Subtotal (line 18 minus line 19)			454,050 20.00
21.00	Coinsurance			48,960 21.00
22.00	Subtotal (line 20 minus line 21)			405,090 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			0 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 25.00
26.00	Subtotal (sum of lines 22 and 24)			405,090 26.00
27.00	Direct graduate medical education payments (see instructions)			0 27.00
28.00	Other pass through costs (see instructions)			1,515 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)			406,605 31.00
31.01	Sequestration adjustment (see instructions)			8,132 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			396,963 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)			1,510 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			19,085 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00
FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)				
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.			0.000000 99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)			0.000000 99.01

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0090 Component CCN: 15-T090	Period: From 01/01/2024 To 12/31/2024	Worksheet E-3 Part III Date/Time Prepared: 4/14/2025 10:55 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)		4,445,553	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)		0.0205	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)		56,014	3.00
4.00	Outlier Payments		512,065	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)		0.00	5.00
5.01	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	5.01
6.00	New Teaching program adjustment. (see instructions)		0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)		0.00	9.00
10.00	Average Daily Census (see instructions)		10.101093	10.00
11.00	Teaching Adjustment Factor (see instructions)		0.000000	11.00
12.00	Teaching Adjustment (see instructions)		0	12.00
13.00	Total PPS Payment (see instructions)		5,013,632	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)		0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		0	15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)		0	16.00
17.00	Subtotal (see instructions)		5,013,632	17.00
18.00	Primary payer payments		0	18.00
19.00	Subtotal (line 17 less line 18).		5,013,632	19.00
20.00	Deductibles		37,504	20.00
21.00	Subtotal (line 19 minus line 20)		4,976,128	21.00
22.00	Coinsurance		5,304	22.00
23.00	Subtotal (line 21 minus line 22)		4,970,824	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)		0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	26.00
27.00	Subtotal (sum of lines 23 and 25)		4,970,824	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	28.00
29.00	Other pass through costs (see instructions)		5,388	29.00
30.00	Outlier payments reconciliation		0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	31.50
31.98	Recovery of accelerated depreciation.		0	31.98
31.99	Demonstration payment adjustment amount before sequestration		0	31.99
32.00	Total amount payable to the provider (see instructions)		4,976,212	32.00
32.01	Sequestration adjustment (see instructions)		99,524	32.01
32.02	Demonstration payment adjustment amount after sequestration		0	32.02
33.00	Interim payments		5,023,797	33.00
34.00	Tentative settlement (for contractor use only)		0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)		-147,109	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4		512,065	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00
FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)				
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.		0.000000	99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)		0.000000	99.01

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0090	Period: From 01/01/2024 To 12/31/2024	Worksheet E-3 Part VII Date/Time Prepared: 4/14/2025 10:55 am
		Title XIX	Hospital	Cost
			Inpatient	Outpatient
			1.00	2.00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		11,124,563	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	11,124,563	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	11,124,563	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	41,394,739	76,420,615	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	41,394,739	76,420,615	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	41,394,739	76,420,615	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	41,394,739	65,296,052	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	11,124,563	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments		0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	11,124,563	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	11,124,563	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	11,124,563	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	11,124,563	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	11,124,563	40.00
41.00	Interim payments	0	11,124,563	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0090 Component CCN: 15-S090	Period: From 01/01/2024 To 12/31/2024	Worksheet E-3 Part VII Date/Time Prepared: 4/14/2025 10:55 am
		Title XIX	Subprovider - IPF	Cost
		Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	5,231,517		1.00
2.00	Medical and other services		29,624	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	5,231,517	29,624	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	5,231,517	29,624	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	6,600	63,094	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	6,600	63,094	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	6,600	63,094	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	33,470	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	5,224,917	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	6,600	29,624	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	6,600	29,624	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	5,224,917	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	6,600	29,624	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	6,600	29,624	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	6,600	29,624	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	6,600	29,624	40.00
41.00	Interim payments	6,600	29,624	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0090 Component CCN: 15-T090	Period: From 01/01/2024 To 12/31/2024	Worksheet E-3 Part VII Date/Time Prepared: 4/14/2025 10:55 am	
		Title XIX	Subprovider - IRF	Cost	
			Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		18		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant programs only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		18	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		18	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		136	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		136	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		136	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		118	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		18	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0		28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		18	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		18	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinsurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		18	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		37.00
38.00	Subtotal (line 36 ± line 37)		18	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		18	0	40.00
41.00	Interim payments		18	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0		42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0		43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0090	Period: From 01/01/2024 To 12/31/2024	Worksheet E-4 Date/Time Prepared: 4/14/2025 10:55 am	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			7.76	1.00
1.01	FTE cap adjustment under §131 of the CAA 2021 (see instructions)			0.00	1.01
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
2.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)			0.00	2.26
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.86	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
3.02	Adjustment (increase or decrease) to the hospital's rural track FTE limitation(s) for rural track programs with a rural track Medicare GME affiliation agreement in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)			0.00	3.02
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
4.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)			0.00	4.21
4.28	The amount of increase if the hospital was awarded FTE cap slots under §4122 of the CAA 2023 (see instructions)				4.28
5.00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lines 2.26 through 2.49, minus lines 3 and 3.01, plus or minus line 3.02, plus or minus line 4, plus lines 4.01 through 4.28)			6.90	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			2.13	6.00
7.00	Enter the lesser of line 5 or line 6			2.13	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	2.13	2.13	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6. For cost reporting periods beginning on or after October 1, 2022, or if Worksheet S-2, Part I, line 68, is "Y", see instructions.	0.00	2.13	2.13	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		4.83		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		4.83		10.01
11.00	Total weighted FTE count	0.00	6.96		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	2.09		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	3.79		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	4.28		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.00	4.28		17.00
18.00	Per resident amount	109,474.97	105,803.92		18.00
18.01	Per resident amount under §131 of the CAA 2021	0.00	0.00		18.01
19.00	Approved amount for resident costs	0	452,841	452,841	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			452,841	25.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0090	Period: From 01/01/2024 To 12/31/2024	Worksheet E-4 Date/Time Prepared: 4/14/2025 10:55 am
		Title XVIII	Hospital	PPS
		Inpatient Part A	Managed Care	Total
		1.00	2.00	3.00
COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	10,154	7,287	26.00
27.00	Total Inpatient Days (see instructions)	32,987	32,987	27.00
28.00	Ratio of inpatient days to total inpatient days	0.307818	0.220905	28.00
29.00	Program direct GME amount	139,393	100,035	239,428
29.01	Percent reduction for MA DGME		2.74	29.01
30.00	Reduction for direct GME payments for Medicare Advantage		2,741	2,741
31.00	Net Program direct GME amount		236,687	31.00
				1.00
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			0
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			0
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			0.000000
35.00	Medicare outpatient ESRD charges (see instructions)			0
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			0
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)			29,815,807
38.00	Organ acquisition and HSCT acquisition costs (see instructions)			0
39.00	Cost of physicians' services in a teaching hospital (see instructions)			0
40.00	Primary payer payments (see instructions)			38,811
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			29,776,996
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)			12,571,064
43.00	Primary payer payments (see instructions)			985
44.00	Total Part B reasonable cost (line 42 minus line 43)			12,570,079
45.00	Total reasonable cost (sum of lines 41 and 44)			42,347,075
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.703165
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.296835
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)			236,687
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			166,430
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			70,257

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT		Provider CCN: 15-0090	Period: From 01/01/2024 To 12/31/2024	Worksheet E-5 Date/Time Prepared: 4/14/2025 10:55 am
		Title XVIII		PPS
				1.00
TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)			0 1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2			0 2.00
3.00	Operating outlier reconciliation adjustment amount (see instructions)			0 3.00
4.00	Capital outlier reconciliation adjustment amount (see instructions)			0 4.00
5.00	The rate used to calculate the time value of money (see instructions)			0.00 5.00
6.00	Time value of money for operating expenses (see instructions)			0 6.00
7.00	Time value of money for capital related expenses (see instructions)			0 7.00

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

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024

Worksheet G

Date/Time Prepared:
4/14/2025 10:55 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	-82,363,863	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	126,074,785	0	0	0	4.00
5.00	Other receivable	181,359	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-95,780,879	0	0	0	6.00
7.00	Inventory	3,699,174	0	0	0	7.00
8.00	Prepaid expenses	3,384,167	0	0	0	8.00
9.00	Other current assets	421,110	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)	-44,384,147	0	0	0	11.00
FIXED ASSETS						
12.00	Land	694,364	0	0	0	12.00
13.00	Land improvements	10,393,616	0	0	0	13.00
14.00	Accumulated depreciation	-18,121	0	0	0	14.00
15.00	Buildings	87,716,415	0	0	0	15.00
16.00	Accumulated depreciation	-3,041,874	0	0	0	16.00
17.00	Leasehold improvements	2,224,290	0	0	0	17.00
18.00	Accumulated depreciation	-17,610	0	0	0	18.00
19.00	Fixed equipment	123,207,924	0	0	0	19.00
20.00	Accumulated depreciation	-10,626,421	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	56,578,036	0	0	0	23.00
24.00	Accumulated depreciation	-172,201,469	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)	94,909,150	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	127,411	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	46,249,275	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	46,376,686	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	96,901,689	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	7,134,106	0	0	0	37.00
38.00	Salaries, wages, and fees payable	7,041,695	0	0	0	38.00
39.00	Payroll taxes payable	313,876	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	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,182,325	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	16,672,002	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	740,962	0	0	0	48.00
49.00	Other long term liabilities	14,969,728	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	15,710,690	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	32,382,692	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	64,518,997				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)	64,518,997	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	96,901,689	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024

Worksheet G-1

Date/Time Prepared:
4/14/2025 10:55 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		50,313,699		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		14,205,298				2.00
3.00	Total (sum of line 1 and line 2)		64,518,997		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		64,518,997		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		64,518,997		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024Worksheet G-2
Parts I & II
Date/Time Prepared:
4/14/2025 10:55 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	49,626,067		49,626,067	1.00
2.00	SUBPROVIDER - IPF	21,208,140		21,208,140	2.00
3.00	SUBPROVIDER - IRF	7,246,222		7,246,222	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				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)	78,080,429		78,080,429	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	10,730,712		10,730,712	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	NEONATAL INTENSIVE CARE UNIT	1,459,593		1,459,593	15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	12,190,305		12,190,305	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	90,270,734		90,270,734	17.00
18.00	Ancillary services	252,205,346	377,565,792	629,771,138	18.00
19.00	Outpatient services	22,420,454	56,665,200	79,085,654	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		10,768,824	10,768,824	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES & NRCC	0	2,590,194	2,590,194	27.00
27.01	NON REIMBURSEABLE COST CENTERS	0	1,237,569	1,237,569	27.01
27.02	TITLE IV	8,488,270	2,339	8,490,609	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	373,384,804	448,829,918	822,214,722	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		206,639,921		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)		206,639,921		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0090

Period:
From 01/01/2024
To 12/31/2024

Worksheet G-3

Date/Time Prepared:
4/14/2025 10:55 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	822,214,722	1.00
2.00	Less contractual allowances and discounts on patients' accounts	614,647,284	2.00
3.00	Net patient revenues (line 1 minus line 2)	207,567,438	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	206,639,921	4.00
5.00	Net income from service to patients (line 3 minus line 4)	927,517	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	34,255	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	779,577	10.00
11.00	Rebates and refunds of expenses	954,620	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	414,248	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	7	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	44,782	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	25,323	21.00
22.00	Rental of hospital space	440,150	22.00
23.00	Governmental appropriations	75,000	23.00
24.00	OTHER OPERATING REVENUE	2,268,449	24.00
24.01	PROVIDER TAX	8,241,370	24.01
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	13,277,781	25.00
26.00	Total (line 5 plus line 25)	14,205,298	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)	14,205,298	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-0090

Period:

Worksheet H

HHA CCN: 15-7145

From 01/01/2024

Date/Time Prepared:

To 12/31/2024

4/14/2025 10:55 am

Home Health
Agency I

PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		111,769	111,769	1.00
2.00	Capital Related - Movable Equipment			0		485	485	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	31,736	31,736	3.00
4.00	Transportation	0	0	96,002	0	0	96,002	4.00
5.00	Administrative and General	1,744,850	4	0	55,348	182,413	1,982,615	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	3,292,671	7	0	104,445	0	3,397,123	6.00
7.00	Physical Therapy	2,192,237	5	0	257,141	0	2,449,383	7.00
8.00	Occupational Therapy	252,343	1	0	107,159	0	359,503	8.00
9.00	Speech Pathology	16,584	0	0	28,528	0	45,112	9.00
10.00	Medical Social Services	241,198	1	0	7,651	0	248,850	10.00
11.00	Home Health Aide	47,671	0	0	80,924	0	128,595	11.00
12.00	Supplies (see instructions)	0	0	0	0	302,879	302,879	12.00
13.00	Drugs	0	0	0	0	5,538	5,538	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	7,787,554	18	96,002	641,196	634,820	9,159,590	24.00
		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	-111,769	0	0	0			1.00
2.00	Capital Related - Movable Equipment	-485	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	31,736	0	31,736			3.00
4.00	Transportation	0	96,002	0	96,002			4.00
5.00	Administrative and General	0	1,982,615	-50	1,982,565			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	3,397,123	0	3,397,123			6.00
7.00	Physical Therapy	0	2,449,383	0	2,449,383			7.00
8.00	Occupational Therapy	0	359,503	0	359,503			8.00
9.00	Speech Pathology	0	45,112	0	45,112			9.00
10.00	Medical Social Services	0	248,850	0	248,850			10.00
11.00	Home Health Aide	0	128,595	0	128,595			11.00
12.00	Supplies (see instructions)	-302,879	0	0	0			12.00
13.00	Drugs	-5,538	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	-420,671	8,738,919	-50	8,738,869			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 15-0090

Period:

Worksheet H-1

HHA CCN: 15-7145

From 01/01/2024
To 12/31/2024Part I
Date/Time Prepared:
4/14/2025 10:55 amHome Health
Agency I

PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
			Bldgs & Fixtures	Movable Equipment				
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	31,736	0	0	31,736		0	3.00
4.00	Transportation	96,002	0	0	0	96,002		4.00
5.00	Administrative and General	1,982,565	0	0	31,736	96,002	2,110,303	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	3,397,123	0	0	0	0	3,397,123	6.00
7.00	Physical Therapy	2,449,383	0	0	0	0	2,449,383	7.00
8.00	Occupational Therapy	359,503	0	0	0	0	359,503	8.00
9.00	Speech Pathology	45,112	0	0	0	0	45,112	9.00
10.00	Medical Social Services	248,850	0	0	0	0	248,850	10.00
11.00	Home Health Aide	128,595	0	0	0	0	128,595	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	8,738,869	0	0	31,736	96,002	8,738,869	24.00
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable Equipment							2.00
3.00	Plant Operation & Maintenance							3.00
4.00	Transportation							4.00
5.00	Administrative and General	2,110,303						5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	1,081,525	4,478,648					6.00
7.00	Physical Therapy	779,798	3,229,181					7.00
8.00	Occupational Therapy	114,453	473,956					8.00
9.00	Speech Pathology	14,362	59,474					9.00
10.00	Medical Social Services	79,225	328,075					10.00
11.00	Home Health Aide	40,940	169,535					11.00
12.00	Supplies (see instructions)	0	0					12.00
13.00	Drugs	0	0					13.00
14.00	DME	0	0					14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00	Private Duty Nursing	0	0					17.00
18.00	Clinic	0	0					18.00
19.00	Health Promotion Activities	0	0					19.00
20.00	Day Care Program	0	0					20.00
21.00	Home Delivered Meals Program	0	0					21.00
22.00	Homemaker Service	0	0					22.00
23.00	All Others (specify)	0	0					23.00
23.50	Telemedicine	0	0					23.50
24.00	Total (sum of lines 1-23)		8,738,869					24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 15-0090

Period:

Worksheet H-1

HHA CCN: 15-7145

From 01/01/2024
To 12/31/2024Part II
Date/Time Prepared:
4/14/2025 10:55 amHome Health
Agency I

PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00	3.00	4.00	5A.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	100	0		3.00
4.00	Transportation (see instructions)	0	0	0	100		4.00
5.00	Administrative and General	0	0	100	100	-2,110,303	6,628,566
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	3,397,123	6.00
7.00	Physical Therapy	0	0	0	0	2,449,383	7.00
8.00	Occupational Therapy	0	0	0	0	359,503	8.00
9.00	Speech Pathology	0	0	0	0	45,112	9.00
10.00	Medical Social Services	0	0	0	0	248,850	10.00
11.00	Home Health Aide	0	0	0	0	128,595	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	100	100	-2,110,303	6,628,566
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	31,736	96,002		2,110,303
26.00	Unit Cost Multiplier	0.000000	0.000000	317.360000	960.020000		0.318365

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0090

Period:

Worksheet H-2

HHA CCN: 15-7145

From 01/01/2024
To 12/31/2024Part I
Date/Time Prepared:
4/14/2025 10:55 amHome Health
Agency I

PPS

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			BLDG & FIXT	MVBLE EQUIP				
		0	1.00	2.00	4.00	4A	5.04	
1.00	Administrative and General	0	6,033	130	461,898	468,061	122,319	1.00
2.00	Skilled Nursing Care	4,478,648	11,356	242	871,640	5,361,886	1,401,227	2.00
3.00	Physical Therapy	3,229,181	7,556	163	580,331	3,817,231	997,561	3.00
4.00	Occupational Therapy	473,956	870	19	66,800	541,645	141,549	4.00
5.00	Speech Pathology	59,474	59	1	4,390	63,924	16,705	5.00
6.00	Medical Social Services	328,075	831	18	63,850	392,774	102,644	6.00
7.00	Home Health Aide	169,535	158	4	12,620	182,317	47,645	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	8,738,869	26,863	577	2,061,529	10,827,838	2,829,650	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00
Cost Center Description		MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	10,702	2,563	0	3,963	0	45,819	1.00
2.00	Skilled Nursing Care	20,142	4,822	0	7,459	0	86,465	2.00
3.00	Physical Therapy	13,404	3,210	0	4,964	0	57,566	3.00
4.00	Occupational Therapy	1,544	370	0	572	0	6,641	4.00
5.00	Speech Pathology	105	25	0	39	0	434	5.00
6.00	Medical Social Services	1,474	353	0	546	0	6,341	6.00
7.00	Home Health Aide	281	67	0	104	0	1,268	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	47,652	11,410	0	17,647	0	204,534	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0090

Period:

Worksheet H-2

HHA CCN: 15-7145

From 01/01/2024
To 12/31/2024Part I
Date/Time Prepared:
4/14/2025 10:55 amHome Health
Agency I

PPS

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES	
		13.00	14.00	15.00	16.00	17.00	21.00	
1.00	Administrative and General	87,964	32,640	0	5,909	0	0	1.00
2.00	Skilled Nursing Care	165,995	61,593	0	11,151	0	0	2.00
3.00	Physical Therapy	110,513	41,010	0	7,424	0	0	3.00
4.00	Occupational Therapy	12,719	4,722	0	855	0	0	4.00
5.00	Speech Pathology	835	311	0	56	0	0	5.00
6.00	Medical Social Services	12,156	4,513	0	817	0	0	6.00
7.00	Home Health Aide	2,411	889	0	161	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	392,593	145,678	0	26,373	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM - EMERGENCY MEDICINE	PARAMED ED PRGM- LAB	PARAMED ED PRGM- PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		22.00	23.00	23.01	23.02	24.00	25.00	
1.00	Administrative and General	0	0	0	0	779,940	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	7,120,740	0	2.00
3.00	Physical Therapy	0	0	0	0	5,052,883	0	3.00
4.00	Occupational Therapy	0	0	0	0	710,617	0	4.00
5.00	Speech Pathology	0	0	0	0	82,434	0	5.00
6.00	Medical Social Services	0	0	0	0	521,618	0	6.00
7.00	Home Health Aide	0	0	0	0	235,143	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	14,503,375	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0090

Period:

Worksheet H-2

HHA CCN: 15-7145

From 01/01/2024
To 12/31/2024Part I
Date/Time Prepared:
4/14/2025 10:55 amHome Health
Agency I

PPS

Cost Center Description		Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs		
		26.00	27.00	28.00		
1.00	Administrative and General	779,940				1.00
2.00	Skilled Nursing Care	7,120,740	404,690	7,525,430		2.00
3.00	Physical Therapy	5,052,883	287,170	5,340,053		3.00
4.00	Occupational Therapy	710,617	40,386	751,003		4.00
5.00	Speech Pathology	82,434	4,685	87,119		5.00
6.00	Medical Social Services	521,618	29,645	551,263		6.00
7.00	Home Health Aide	235,143	13,364	248,507		7.00
8.00	Supplies (see instructions)	0	0	0		8.00
9.00	Drugs	0	0	0		9.00
10.00	DME	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0		13.00
14.00	Clinic	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0		15.00
16.00	Day Care Program	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0		17.00
18.00	Homemaker Service	0	0	0		18.00
19.00	All Others (specify)	0	0	0		19.00
19.50	Telemedicine	0	0	0		19.50
20.00	Total (sum of lines 1-19) (2)	14,503,375	779,940	14,503,375		20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		0.056833			21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0090

Period:

Worksheet H-2

HHA CCN: 15-7145

From 01/01/2024
To 12/31/2024Part II
Date/Time Prepared:
4/14/2025 10:55 amHome Health
Agency I

PPS

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
		1.00	2.00				4.00	
1.00	Administrative and General	305	109	1,744,850	0	468,061	305	1.00
2.00	Skilled Nursing Care	574	204	3,292,671	0	5,361,886	574	2.00
3.00	Physical Therapy	382	137	2,192,237	0	3,817,231	382	3.00
4.00	Occupational Therapy	44	16	252,343	0	541,645	44	4.00
5.00	Speech Pathology	3	1	16,584	0	63,924	3	5.00
6.00	Medical Social Services	42	15	241,198	0	392,774	42	6.00
7.00	Home Health Aide	8	3	47,671	0	182,317	8	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,358	485	7,787,554		10,827,838	1,358	20.00
21.00	Total cost to be allocated	26,863	577	2,061,529		2,829,650	47,652	21.00
22.00	Unit cost multiplier	19.781296	1.189691	0.264721		0.261331	35.089838	22.00
Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUND)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT MEALS)	CAFETERIA (HOURS WORKED)	NURSING ADMINISTRATION (DIRECT NRSING)	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	305	0	305	0	1,373	9,378	1.00
2.00	Skilled Nursing Care	574	0	574	0	2,591	17,697	2.00
3.00	Physical Therapy	382	0	382	0	1,725	11,782	3.00
4.00	Occupational Therapy	44	0	44	0	199	1,356	4.00
5.00	Speech Pathology	3	0	3	0	13	89	5.00
6.00	Medical Social Services	42	0	42	0	190	1,296	6.00
7.00	Home Health Aide	8	0	8	0	38	257	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,358	0	1,358	0	6,129	41,855	20.00
21.00	Total cost to be allocated	11,410	0	17,647	0	204,534	392,593	21.00
22.00	Unit cost multiplier	8.402062	0.000000	12.994845	0.000000	33.371512	9.379835	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0090

Period:

Worksheet H-2

HHA CCN: 15-7145

From 01/01/2024
To 12/31/2024Part II
Date/Time Prepared:
4/14/2025 10:55 amHome Health
Agency I

PPS

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQ UISI)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	SOCIAL SERVICE (GROSS CHAR GES)	INTERNS & RESIDENTS	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	
						SERVICES-SALAR Y & FRINGES (ASSIGNED TIME)		
		14.00	15.00	16.00	17.00	21.00	22.00	
1.00	Administrative and General	10,611	0	2,412,822	2,412,822	0	0	1.00
2.00	Skilled Nursing Care	20,024	0	4,553,188	4,553,188	0	0	2.00
3.00	Physical Therapy	13,332	0	3,031,480	3,031,480	0	0	3.00
4.00	Occupational Therapy	1,535	0	348,946	348,946	0	0	4.00
5.00	Speech Pathology	101	0	22,932	22,932	0	0	5.00
6.00	Medical Social Services	1,467	0	333,534	333,534	0	0	6.00
7.00	Home Health Aide	289	0	65,922	65,922	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	47,359	0	10,768,824	10,768,824	0	0	20.00
21.00	Total cost to be allocated	145,678	0	26,373	0	0	0	21.00
22.00	Unit cost multiplier	3.076036	0.000000	0.002449	0.000000	0.000000	0.000000	22.00
Cost Center Description		PARAMED ED PRGM - EMERGENCY MEDICINE (ASSIGNED TIME)	PARAMED ED PRGM- LAB (ASSIGNED TIME)	PARAMED ED PRGM- PHARMACY (ASSIGNED TIME)				
		23.00	23.01	23.02				
1.00	Administrative and General	0	0	0				1.00
2.00	Skilled Nursing Care	0	0	0				2.00
3.00	Physical Therapy	0	0	0				3.00
4.00	Occupational Therapy	0	0	0				4.00
5.00	Speech Pathology	0	0	0				5.00
6.00	Medical Social Services	0	0	0				6.00
7.00	Home Health Aide	0	0	0				7.00
8.00	Supplies (see instructions)	0	0	0				8.00
9.00	Drugs	0	0	0				9.00
10.00	DME	0	0	0				10.00
11.00	Home Dialysis Aide Services	0	0	0				11.00
12.00	Respiratory Therapy	0	0	0				12.00
13.00	Private Duty Nursing	0	0	0				13.00
14.00	Clinic	0	0	0				14.00
15.00	Health Promotion Activities	0	0	0				15.00
16.00	Day Care Program	0	0	0				16.00
17.00	Home Delivered Meals Program	0	0	0				17.00
18.00	Homemaker Service	0	0	0				18.00
19.00	All Others (specify)	0	0	0				19.00
19.50	Telemedicine	0	0	0				19.50
20.00	Total (sum of lines 1-19)	0	0	0				20.00
21.00	Total cost to be allocated	0	0	0				21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000				22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0090

Period:

Worksheet H-3

HHA CCN: 15-7145

From 01/01/2024
To 12/31/2024Part I
Date/Time Prepared:
4/14/2025 10:55 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
	0	1.00	2.00	3.00	4.00	5.00	

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION

Cost Per Visit Computation

1.00	Skilled Nursing Care	2.00	7,525,430		7,525,430	26,075	288.61	1.00
2.00	Physical Therapy	3.00	5,340,053	0	5,340,053	25,554	208.97	2.00
3.00	Occupational Therapy	4.00	751,003	0	751,003	3,667	204.80	3.00
4.00	Speech Pathology	5.00	87,119	0	87,119	312	279.23	4.00
5.00	Medical Social Services	6.00	551,263		551,263	24	22,969.29	5.00
6.00	Home Health Aide	7.00	248,507		248,507	1,578	157.48	6.00
7.00	Total (sum of lines 1-6)		14,503,375	0	14,503,375	57,210		7.00

Program Visits

Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Part B			
				Not Subject to Deductibles & Coinsurance	Subject to Deductibles		
	0	1.00	2.00	3.00	4.00	5.00	

Limitation Cost Computation

8.00	Skilled Nursing Care		16984	0	11			8.00
8.01	Skilled Nursing Care		23844	0	7,133			8.01
8.02	Skilled Nursing Care		33140	0	2,742			8.02
8.03	Skilled Nursing Care		43780	0	10			8.03
8.04	Skilled Nursing Care		99915	0	0			8.04
9.00	Physical Therapy		16984	0	28			9.00
9.01	Physical Therapy		23844	0	7,006			9.01
9.02	Physical Therapy		33140	0	3,399			9.02
9.03	Physical Therapy		43780	0	53			9.03
9.04	Physical Therapy		99915	0	9			9.04
10.00	Occupational Therapy		16984	0	1			10.00
10.01	Occupational Therapy		23844	0	841			10.01
10.02	Occupational Therapy		33140	0	588			10.02
10.03	Occupational Therapy		43780	0	5			10.03
10.04	Occupational Therapy		99915	0	0			10.04
11.00	Speech Pathology		16984	0	0			11.00
11.01	Speech Pathology		23844	0	126			11.01
11.02	Speech Pathology		33140	0	0			11.02
11.03	Speech Pathology		43780	0	0			11.03
11.04	Speech Pathology		99915	0	0			11.04
12.00	Medical Social Services		16984	0	0			12.00
12.01	Medical Social Services		23844	0	6			12.01
12.02	Medical Social Services		33140	0	0			12.02
12.03	Medical Social Services		43780	0	0			12.03
12.04	Medical Social Services		99915	0	0			12.04
13.00	Home Health Aide		16984	0	0			13.00
13.01	Home Health Aide		23844	0	565			13.01
13.02	Home Health Aide		33140	0	369			13.02
13.03	Home Health Aide		43780	0	0			13.03
13.04	Home Health Aide		99915	0	0			13.04
14.00	Total (sum of lines 8-13)			0	22,892			14.00

Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
	0	1.00	2.00	3.00	4.00	5.00	

Supplies and Drugs Cost Computations

15.00	Cost of Medical Supplies	8.00	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0.000000	16.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0090

Period:

Worksheet H-3

HHA CCN: 15-7145

From 01/01/2024
To 12/31/2024Part I
Date/Time Prepared:
4/14/2025 10:55 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description	Program Visits			Cost of Services	Agency 1			
	Part A	Part B		Part A	Part B			
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
		6.00	7.00		8.00	9.00		10.00
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	0	9,896	0	2,856,085		1.00	
2.00	Physical Therapy	0	10,495	0	2,193,140		2.00	
3.00	Occupational Therapy	0	1,435	0	293,888		3.00	
4.00	Speech Pathology	0	126	0	35,183		4.00	
5.00	Medical Social Services	0	6	0	137,816		5.00	
6.00	Home Health Aide	0	934	0	147,086		6.00	
7.00	Total (sum of lines 1-6)	0	22,892	0	5,663,198		7.00	
Cost Center Description								
6.007.008.009.0010.0011.00								
Limitation Cost Computation								
8.00	Skilled Nursing Care						8.00	
8.01	Skilled Nursing Care						8.01	
8.02	Skilled Nursing Care						8.02	
8.03	Skilled Nursing Care						8.03	
8.04	Skilled Nursing Care						8.04	
9.00	Physical Therapy						9.00	
9.01	Physical Therapy						9.01	
9.02	Physical Therapy						9.02	
9.03	Physical Therapy						9.03	
9.04	Physical Therapy						9.04	
10.00	Occupational Therapy						10.00	
10.01	Occupational Therapy						10.01	
10.02	Occupational Therapy						10.02	
10.03	Occupational Therapy						10.03	
10.04	Occupational Therapy						10.04	
11.00	Speech Pathology						11.00	
11.01	Speech Pathology						11.01	
11.02	Speech Pathology						11.02	
11.03	Speech Pathology						11.03	
11.04	Speech Pathology						11.04	
12.00	Medical Social Services						12.00	
12.01	Medical Social Services						12.01	
12.02	Medical Social Services						12.02	
12.03	Medical Social Services						12.03	
12.04	Medical Social Services						12.04	
13.00	Home Health Aide						13.00	
13.01	Home Health Aide						13.01	
13.02	Home Health Aide						13.02	
13.03	Home Health Aide						13.03	
13.04	Home Health Aide						13.04	
14.00	Total (sum of lines 8-13)						14.00	
Cost Center Description		Program Covered Charges			Cost of Services			
		Part A	Part B		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
			6.00	7.00		8.00	9.00	
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	0	225,872	0	0	0	15.00	
16.00	Cost of Drugs		0	0		0	16.00	

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0090

Period:

Worksheet H-3

HHA CCN: 15-7145

From 01/01/2024
To 12/31/2024Part I
Date/Time Prepared:
4/14/2025 10:55 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description		Total Program Cost (sum of cols. 9-10)		
		12.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION				
Cost Per Visit Computation				
1.00	Skilled Nursing Care	2,856,085		1.00
2.00	Physical Therapy	2,193,140		2.00
3.00	Occupational Therapy	293,888		3.00
4.00	Speech Pathology	35,183		4.00
5.00	Medical Social Services	137,816		5.00
6.00	Home Health Aide	147,086		6.00
7.00	Total (sum of lines 1-6)	5,663,198		7.00
Cost Center Description				
		12.00		
Limitation Cost Computation				
8.00	Skilled Nursing Care			8.00
8.01	Skilled Nursing Care			8.01
8.02	Skilled Nursing Care			8.02
8.03	Skilled Nursing Care			8.03
8.04	Skilled Nursing Care			8.04
9.00	Physical Therapy			9.00
9.01	Physical Therapy			9.01
9.02	Physical Therapy			9.02
9.03	Physical Therapy			9.03
9.04	Physical Therapy			9.04
10.00	Occupational Therapy			10.00
10.01	Occupational Therapy			10.01
10.02	Occupational Therapy			10.02
10.03	Occupational Therapy			10.03
10.04	Occupational Therapy			10.04
11.00	Speech Pathology			11.00
11.01	Speech Pathology			11.01
11.02	Speech Pathology			11.02
11.03	Speech Pathology			11.03
11.04	Speech Pathology			11.04
12.00	Medical Social Services			12.00
12.01	Medical Social Services			12.01
12.02	Medical Social Services			12.02
12.03	Medical Social Services			12.03
12.04	Medical Social Services			12.04
13.00	Home Health Aide			13.00
13.01	Home Health Aide			13.01
13.02	Home Health Aide			13.02
13.03	Home Health Aide			13.03
13.04	Home Health Aide			13.04
14.00	Total (sum of lines 8-13)			14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0090

Period:

Worksheet H-3

HHA CCN: 15-7145

From 01/01/2024
To 12/31/2024Part II
Date/Time Prepared:
4/14/2025 10:55 amHome Health
Agency I

PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.256635	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.088015	0	0	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.180478	0	0	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.323190	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.264894	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0090 HHA CCN: 15-7145	Period: From 01/01/2024 To 12/31/2024	Worksheet H-4 Part I-II Date/Time Prepared: 4/14/2025 10:55 am
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	557	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	-557
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	5,093,062
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	550,164
13.00	Total PPS Reimbursement - LUPA Episodes		0	50,533
14.00	Total PPS Reimbursement - PEP Episodes		0	6,732
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	119,718
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	773
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	5,820,425
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	5,820,425
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	5,820,425
27.00	Allowable bad debts (from your records)		0	0
27.01	Adjusted reimbursable bad debts (see instructions)		0	0
28.00	Allowable bad debts for dual eligible (see instructions)		0	0
29.00	Total costs - current cost reporting period (see instructions)		0	5,820,425
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
30.99	Demonstration payment adjustment amount before sequestration		0	0
31.00	Subtotal (see instructions)		0	5,820,425
31.01	Sequestration adjustment (see instructions)		0	116,409
31.02	Demonstration payment adjustment amount after sequestration		0	0
31.75	Sequestration adjustment for non-claims based amounts (see instructions)		0	0
32.00	Interim payments (see instructions)		0	5,704,015
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 31.75, 32, and 33)		0	1
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 15-0090 HHA CCN: 15-7145		Period: From 01/01/2024 To 12/31/2024		Worksheet H-5 Date/Time Prepared: 4/14/2025 10:55 am	
				Home Health Agency I		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		0				1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		5,704,015		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			0		0		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50			0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		5,704,015		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			0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
Provider to Program							
5.50			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		1		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		0		5,704,016		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0090	Period: From 01/01/2024 To 12/31/2024	Worksheet L Parts I-III Date/Time Prepared: 4/14/2025 10:55 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,348,698	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		17,118	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		59.22	3.00
4.00	Number of interns & residents (see instructions)		5.61	4.00
5.00	Indirect medical education percentage (see instructions)		2.71	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		36,550	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30)(see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		1,402,366	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00