

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0042	Period: From 01/01/2024 To 12/31/2024	Worksheet S Parts I-III Date/Time Prepared: 4/10/2025 8:15 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 4/10/2025	Time: 8:15 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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 GOOD SAMARITAN HOSPITAL (15-0042) 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	Matt Schuckman	☒	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	Matt Schuckman		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	-1,224,461	-34,772	0	-225,101	1.00
2.00	SUBPROVIDER - IPF	0	16,137	-1		44,957	2.00
3.00	SUBPROVIDER - IRF	0	-50,186	1		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	0		0	9.00
10.00	FAMILY PRACTICE 120 I	0		30,075		0	10.00
10.01	GOOD SAMARITAN FP 110 HB II	0		6,687		0	10.01
10.02	GOOD SAMARITAN IM 100 HB III	0		16,462		0	10.02
10.03	GOOD SAMARITAN IM 110 HB IV	0		11,351		0	10.03
10.04	GOOD SAMARITANKIDS HB V	0		0		0	10.04
10.05	GOOD SAMARITAN FP 100 HB VI	0		36,143		0	10.05
200.00	TOTAL	0	-1,258,510	65,946	0	-180,144	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: 15-0042	Period: From 01/01/2024 To 12/31/2024	Worksheet S-2 Part I Date/Time Prepared: 4/10/2025 8:15 am	
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	1.00		2.00		3.00		4.00		7/10/2025 3:10 AM				
	Hospital and Hospital Health Care Complex Address:												
1.00	Street:520 SOUTH 7TH STREET			PO Box:						1.00			
2.00	City: VINCENNES			State: IN		Zip Code: 47591		County: KNOX			2.00		
			Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
									V	XVIII	XIX		
			1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00		
Hospital and Hospital-Based Component Identification:													
3.00	Hospital		GOOD SAMARITAN HOSPITAL		150042	99915	1	07/01/1966	N	P	O	3.00	
4.00	Subprovider - IPF		GOOD SAMARITAN HOSPITAL		15S042	99915	4	01/01/1984	N	P	O	4.00	
5.00	Subprovider - IRF		GOOD SAMARITAN - REHAB		15T042	99915	5	01/01/2001	N	P	O	5.00	
6.00	Subprovider - (Other)											6.00	
7.00	Swing Beds - SNF											7.00	
8.00	Swing Beds - NF											8.00	
9.00	Hospital-Based SNF											9.00	
10.00	Hospital-Based NF											10.00	
11.00	Hospital-Based OLTG											11.00	
12.00	Hospital-Based HHA		GOOD SAMARITAN HOME CENTER		157432	99915		06/27/1995	N	P	N	12.00	
13.00	Separately Certified ASC											13.00	
14.00	Hospital-Based Hospice		GOOD SAMARITAN LINCOLN TRAIL HOSPICE		151526	99915		01/01/1984				14.00	
15.00	Hospital-Based Health Clinic - RHC		GOOD SAMARITAN FAMILY PRACTICE 120		158577	99915		12/27/2023	N	O	O	15.00	
15.01	Hospital-Based Health Clinic - RHC II		GOOD SAMARITAN FP 110 HB		158583	99915		01/31/2024	N	O	O	15.01	
15.02	Hospital-Based Health Clinic - RHC III		GOOD SAMARITAN IM 100 HB		158585	99915		02/27/2024	N	O	O	15.02	
15.03	Hospital-Based Health Clinic - RHC IV		GOOD SAMARITAN IM 110 HB		158584	99915		02/09/2024	N	O	O	15.03	
15.04	Hospital-Based Health Clinic - RHC V		GOOD SAMARITANKIDS HB		158582	99915		03/14/2024	N	O	O	15.04	
15.05	Hospital-Based Health Clinic - RHC VI		GOOD SAMARITAN FP 100 HB		158580	99915		03/06/2024	N	O	O	15.05	
16.00	Hospital-Based Health Clinic - FQHC											16.00	
17.00	Hospital-Based (CMHC) I											17.00	
18.00	Renal Dialysis											18.00	
19.00	Other											19.00	
								From:		To:			
								1.00		2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)							01/01/2024		12/31/2024		20.00	
21.00	Type of Control (see instructions)							9				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.												
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)												
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.												
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.												

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0042		Period: From 01/01/2024 To 12/31/2024		Worksheet S-2 Part I Date/Time Prepared: 4/10/2025 8:15 am	
		1.00	2.00	3.00			
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.	2	N				23.00
		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.	397	95	82	68	2,357	27
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	16	143	
		Urban/Rural S					Date of Geogr
		1.00					2.00
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					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 OPPI 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
		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
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	N

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			V 1.00	XVIII 2.00	XIX 3.00	
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	Y	Y		56.00	
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.	Y			57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00	
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)		23.01	1	60.01	
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 15-0042

Period:
From 01/01/2024
To 12/31/2024Worksheet S-2
Part I
Date/Time Prepared:
4/10/2025 8:15 am

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)				N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000 65.00

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		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)	0.50	18.34	0.026539		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)	INTERNAL MEDICINE	1400	0.15	18.52	0.008034 67.00	
						1.00	
Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)							
68.00	For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?	68.00					
						1.00	2.00 3.00
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y		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		Y 5		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		N		75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	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		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		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		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.	N		N		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		N		87.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0042	Period: From 01/01/2024 To 12/31/2024	Worksheet S-2 Part I Date/Time Prepared: 4/10/2025 8:15 am	
			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
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0042		Period: From 01/01/2024 To 12/31/2024		Worksheet S-2 Part I Date/Time Prepared: 4/10/2025 8:15 am	
		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	N		109.00
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N					110.00
						1.00	
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.	1					118.00
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	1,536,454		0			0118.01
						1.00	
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				5.00	122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	Y				N	123.00
124.00	Did the hospital incur cost, either directly or through a contract with an outside supplier, to establish and maintain access to no less than a 6-month buffer stock of one or more essential medicines according to 42 CFR 412.113(g)? Enter "Y" for yes or "N" for no.						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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 15-0042

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Part I
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		1.00	2.00		
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)	N			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:	Contractor's Name:		Contractor's Number:	
142.00	Street:	PO Box:			
143.00	City:	State:		Zip Code:	
				1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y			144.00
		1.00	2.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N			146.00
				1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N			147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N			148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N			149.00
		Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N
				1.00	
Multicampus					
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N			165.00
		Name	County	State	Zip Code
		0	1.00	2.00	3.00
					4.00
					5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)				0.00
					166.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0042	Period: From 01/01/2024 To 12/31/2024	Worksheet S-2 Part I Date/Time Prepared: 4/10/2025 8:15 am
			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.			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)			9.99169.00
			Beginning	Ending
			1.00	2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)			0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0042		Period: From 01/01/2024 To 12/31/2024		Worksheet S-2 Part II Date/Time Prepared: 4/10/2025 8:15 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	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			N			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			Y	A		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.			Y			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.			Y			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.			Y			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.				Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.				N		13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.				N		14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.				N		15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, in columns 2 and 4, from the PS&R used to prepare this cost report, enter the "Paid Claims Verified Current As Of" date, if present, or the paid-through date.(see instructions)			Y	02/19/2025	Y	02/19/2025
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, in columns 2 and 4, enter the "Paid Claims Verified Current As Of" date, if present, or the paid-through date. (see instructions)			N		N	
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	
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	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 15-0042

Period:
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Date/Time Prepared:
4/10/2025 8:15 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		Y		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		Y		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.		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.		Y		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KYLE	SMITH		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO, LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957	KCSMITH@BLUEANDCO.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

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		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR	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: 15-0042

Period:
From 01/01/2024
To 12/31/2024Worksheet S-3
Part I
Date/Time Prepared:
4/10/2025 8:15 am

Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
PART I - STATISTICAL DATA						
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	69	25,254	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)		69	25,254	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	30	10,980	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 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		99	36,234	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	20	7,320		0	16.00
17.00 SUBPROVIDER - IRF	41.00	25	9,150		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	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 FAMILY PRACTICE 120	88.00				0	26.00
26.01 GOOD SAMARITAN FP 110 HB	88.01				0	26.01
26.02 GOOD SAMARITAN IM 100 HB	88.02				0	26.02
26.03 GOOD SAMARITAN IM 110 HB	88.03				0	26.03
26.04 GOOD SAMARITANKIDS HB	88.04				0	26.04
26.05 GOOD SAMARITAN FP 100 HB	88.05				0	26.05
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		144				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: 15-0042

Period:
From 01/01/2024
To 12/31/2024Worksheet S-3
Part I
Date/Time Prepared:
4/10/2025 8:15 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)	4,820	397	10,378			1.00
2.00	HMO and other (see instructions)	3,973	2,602				2.00
3.00	HMO IPF Subprovider	663	1,464				3.00
4.00	HMO IRF Subprovider	297	159				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)	4,820	397	10,378			7.00
8.00	INTENSIVE CARE UNIT	1,655	0	4,263			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	790			13.00
14.00	Total (see instructions)	6,475	397	15,431	32.68	1,273.30	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	650	279	5,021	4.83	30.55	16.00
17.00	SUBPROVIDER - IRF	4,753	0	5,926	0.00	28.60	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	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	FAMILY PRACTICE 120	3,424	0	15,644	0.00	16.72	26.00
26.01	GOOD SAMARITAN FP 110 HB	192	0	5,157	0.00	6.18	26.01
26.02	GOOD SAMARITAN IM 100 HB	734	0	6,619	0.00	6.82	26.02
26.03	GOOD SAMARITAN IM 110 HB	523	0	3,060	0.00	5.80	26.03
26.04	GOOD SAMARITANKIDS HB	0	0	4,522	0.00	5.60	26.04
26.05	GOOD SAMARITAN FP 100 HB	2,397	0	8,128	0.00	11.54	26.05
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				37.51	1,385.11	27.00
28.00	Observation Bed Days		490	3,052			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	27	772			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: 15-0042

Period:
From 01/01/2024
To 12/31/2024Worksheet S-3
Part I
Date/Time Prepared:
4/10/2025 8:15 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	1,662	81	4,127	1.00
2.00 HMO and other (see instructions)			828	653		2.00
3.00 HMO IPF Subprovider				417		3.00
4.00 HMO IRF Subprovider				13		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,662	81	4,127	14.00
15.00 CAH visits						15.00
15.10 REH hours and visits						15.10
16.00 SUBPROVIDER - IPF	0.00	0	73	42	841	16.00
17.00 SUBPROVIDER - IRF	0.00	0	324	0	399	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	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 FAMILY PRACTICE 120	0.00					26.00
26.01 GOOD SAMARITAN FP 110 HB	0.00					26.01
26.02 GOOD SAMARITAN IM 100 HB	0.00					26.02
26.03 GOOD SAMARITAN IM 110 HB	0.00					26.03
26.04 GOOD SAMARITANKIDS HB	0.00					26.04
26.05 GOOD SAMARITAN FP 100 HB	0.00					26.05
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: 15-0042

Period:
From 01/01/2024
To 12/31/2024Worksheet S-3
Part II
Date/Time Prepared:
4/10/2025 8:15 am

		Wkst. A Line Number	Amount Reported	Reclassificat ion 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	113,252,203	0	113,252,203	2,772,681.00	40.85	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		13,458,232	0	13,458,232	52,152.00	258.06	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		2,365,569	0	2,365,569	82,302.00	28.74	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		4,131,789	0	4,131,789	78,021.00	52.96	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		18,718,163	519,362	19,237,525	420,166.00	45.79	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		6,143,317	0	6,143,317	103,844.00	59.16	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		604,600	0	604,600	3,102.00	194.91	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
15.01	Home office Physicians Part A - Administrative		0	0	0	0.00	0.00	15.01
15.02	Home office contract Physicians Part A - Administrative		0	0	0	0.00	0.00	15.02
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		23,332,364	0	23,332,364			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		4,607,668	0	4,607,668			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		1,199,261	0	1,199,261			23.00
24.00	Wage-related costs (RHC/FQHC)		802,574	0	802,574			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0042

Period:
From 01/01/2024
To 12/31/2024Worksheet S-3
Part II
Date/Time Prepared:
4/10/2025 8:15 am

		Wkst. A Line Number	Amount Reported	Reclassificat ion 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	
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	6,395,818	0	6,395,818	269,915.00	23.70	26.00
27.00	Administrative & General	5.00	8,801,904	0	8,801,904	224,918.00	39.13	27.00
28.00	Administrative & General under contract (see inst.)		474,612	0	474,612	2,831.00	167.65	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,624,007	0	2,624,007	90,608.00	28.96	30.00
31.00	Laundry & Linen Service	8.00	253,110	0	253,110	14,219.00	17.80	31.00
32.00	Housekeeping	9.00	2,461,198	0	2,461,198	126,571.00	19.45	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,902,392	-1,388,175	514,217	22,871.00	22.48	34.00
35.00	Dietary under contract (see instructions)		14,122	0	14,122	112.00	126.09	35.00
36.00	Cafeteria	11.00	0	1,388,175	1,388,175	64,859.00	21.40	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,335,214	0	2,335,214	45,846.00	50.94	38.00
39.00	Central Services and Supply	14.00	401,377	0	401,377	17,588.00	22.82	39.00
40.00	Pharmacy	15.00	3,372,977	0	3,372,977	65,111.00	51.80	40.00
41.00	Medical Records & Medical Records Library	16.00	4,297,247	0	4,297,247	127,854.00	33.61	41.00
42.00	Social Service	17.00	705,253	0	705,253	4,294.00	164.24	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0042

Period:
From 01/01/2024
To 12/31/2024Worksheet S-3
Part III
Date/Time Prepared:
4/10/2025 8:15 am

	Worksheet A Line Number	Amount Reported	Reclassificat ion 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)	93,785,347	0	93,785,347	2,563,149.00	36.59	1.00
2.00	Excluded area salaries (see instructions)	18,718,163	519,362	19,237,525	420,166.00	45.79	2.00
3.00	Subtotal salaries (line 1 minus line 2)	75,067,184	-519,362	74,547,822	2,142,983.00	34.79	3.00
4.00	Subtotal other wages & related costs (see inst.)	6,747,917	0	6,747,917	106,946.00	63.10	4.00
5.00	Subtotal wage-related costs (see inst.)	23,332,364	0	23,332,364	0.00	31.30	5.00
6.00	Total (sum of lines 3 thru 5)	105,147,465	-519,362	104,628,103	2,249,929.00	46.50	6.00
7.00	Total overhead cost (see instructions)	34,039,231	0	34,039,231	1,077,597.00	31.59	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 15-0042

Period:
From 01/01/2024
To 12/31/2024Worksheet S-3
Part IV
Date/Time Prepared:
4/10/2025 8:15 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	4,405,592	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	16,783,575	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	269,706	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	103,363	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)	214,374	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	507,013	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	7,578,897	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	12,543	22.00
23.00	Tuition Reimbursement	66,804	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	29,941,867	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: 15-0042

Period:
From 01/01/2024
To 12/31/2024Worksheet S-3
Part V
Date/Time Prepared:
4/10/2025 8:15 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	6,143,317	29,941,867	1.00
2.00	Hospital	6,143,317	29,941,867	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	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	0	14.02
14.03	Hospital-Based Health Clinic RHC 3	0	0	14.03
14.04	Hospital-Based Health Clinic RHC 4	0	0	14.04
14.05	Hospital-Based Health Clinic RHC 5	0	0	14.05
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I			17.00
18.00	Other	0	0	18.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 15-0042 Component CCN: 15-8577		Period: From 01/01/2024 To 12/31/2024		Worksheet S-8 Date/Time Prepared: 4/10/2025 8:15 am	
			RHC I		Cost			
			1.00					
1.00	Clinic Address and Identification							
	Street				406 N. 1ST, SUITE C			
					City		State	
					1.00		2.00	
2.00	City, State, ZIP Code, County				VINCENNES		IN 47591	
							1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban						0	
					Grant Award		Date	
					1.00		2.00	
	Source of Federal Funds							
4.00	Community Health Center (Section 330(d), PHS Act)							
5.00	Migrant Health Center (Section 329(d), PHS Act)							
6.00	Health Services for the Homeless (Section 340(d), PHS Act)							
7.00	Appalachian Regional Commission							
8.00	Look-Alikes							
9.00	OTHER (SPECIFY)							
					1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N		0	
					Sunday		Monday	
					from to		from to	
					1.00 2.00		3.00 4.00	
							Tuesday	
							from	
							5.00	
11.00	Facility hours of operations (1)							
	CLINIC				08:30		16:30	
					08:30			
					1.00		2.00	
							3.00	
12.00	Have you received an approval for an exception to the productivity standard?				N			
13.00	Is this worksheet prepared for a consolidated group as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If column 1 is Y, enter in column 2 the number of providers included in the group. List the provider name and provider number of each member in the consolidated group on line 14. If column 1 is Y, in column 3 enter G or N to identify the grouping as grandfathered or non-grandfathered, respectively.				N		0	
					Provider name		CCN	
					1.00		2.00	
14.00	RHC/FQHC name, CCN							
					Y/N		V	
					1.00		2.00	
					XVIII		XIX	
					3.00		4.00	
							Total Visits	
							5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)							
					County			
					4.00			
2.00	City, State, ZIP Code, County				KNOX			
							2.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 15-0042 Component CCN: 15-8577		Period: From 01/01/2024 To 12/31/2024	Worksheet S-8 Date/Time Prepared: 4/10/2025 8:15 am
					RHC I	Cost
		Tuesday	Wednesday		Thursday	
		to	from	to	from	to
		6.00	7.00	8.00	9.00	10.00
Facility hours of operations (1)						
11.00	CLINIC	16:30	08:30	16:30	08:30	16:30
		Friday		Saturday		
		from	to	from	to	
		11.00	12.00	13.00	14.00	
Facility hours of operations (1)						
11.00	CLINIC	08:30	16:30			11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 15-0042 Component CCN: 15-8583		Period: From 01/01/2024 To 12/31/2024		Worksheet S-8 Date/Time Prepared: 4/10/2025 8:15 am		
			RHC II		Cost				
			1.00						
Clinic Address and Identification									
1.00	Street				406 N 1ST STREET STE A		1.00		
				City	State	ZIP Code			
				1.00	2.00	3.00			
2.00	City, State, ZIP Code, County				VINCENNES IN 47591		2.00		
						1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban						0 3.00		
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)						4.00		
5.00	Migrant Health Center (Section 329(d), PHS Act)						5.00		
6.00	Health Services for the Homeless (Section 340(d), PHS Act)						6.00		
7.00	Appalachian Regional Commission						7.00		
8.00	Look-Alikes						8.00		
9.00	OTHER (SPECIFY)						9.00		
						1.00			
						2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N		0 10.00		
				Sunday		Monday		Tuesday	
				from	to	from	to	from	
				1.00	2.00	3.00	4.00	5.00	
Facility hours of operations (1)									
11.00	CLINIC				08:30		16:30		08:30
				1.00		2.00		3.00	
12.00	Have you received an approval for an exception to the productivity standard?								12.00
13.00	Is this worksheet prepared for a consolidated group as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If column 1 is Y, enter in column 2 the number of providers included in the group. List the provider name and provider number of each member in the consolidated group on line 14. If column 1 is Y, in column 3 enter G or N to identify the grouping as grandfathered or non-grandfathered, respectively.				N		0		13.00
				Provider name		CCN			
				1.00		2.00			
14.00	RHC/FQHC name, CCN								14.00
				Y/N	V	XVIII	XIX	Total Visits	
				1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)								15.00
				County					
				4.00					
2.00	City, State, ZIP Code, County				KNOX				2.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 15-0042 Component CCN: 15-8583		Period: From 01/01/2024 To 12/31/2024	Worksheet S-8 Date/Time Prepared: 4/10/2025 8:15 am
					RHC II	Cost
		Tuesday	Wednesday		Thursday	
		to	from	to	from	to
		6.00	7.00	8.00	9.00	10.00
Facility hours of operations (1)						
11.00	CLINIC	16:30	08:30	16:30	08:30	16:30
		Friday		Saturday		
		from	to	from	to	
		11.00	12.00	13.00	14.00	
Facility hours of operations (1)						
11.00	CLINIC	08:30	16:30			11.00

Health Financial Systems		GOOD SAMARITAN HOSPITAL		In Lieu of Form CMS-2552-10		
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 15-0042 Component CCN: 15-8585		Period: From 01/01/2024 To 12/31/2024 Worksheet S-8 Date/Time Prepared: 4/10/2025 8:15 am		
		RHC III		Cost		
		1.00				
1.00	Clinic Address and Identification					
	Street	700 WILLOW STREET, SUITE 202				1.00
		City	State	ZIP Code		
		1.00	2.00	3.00		
2.00	City, State, ZIP Code, County	VINCENNES		IN	47591	2.00
		1.00				
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0
		Grant Award				Date
		1.00				2.00
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
		1.00				2.00
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N				0
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
11.00	Facility hours of operations (1)					
	CLINIC			08:30	16:30	08:30
		1.00				2.00
		3.00				
12.00	Have you received an approval for an exception to the productivity standard?					12.00
13.00	Is this worksheet prepared for a consolidated group as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If column 1 is Y, enter in column 2 the number of providers included in the group. List the provider name and provider number of each member in the consolidated group on line 14. If column 1 is Y, in column 3 enter G or N to identify the grouping as grandfathered or non-grandfathered, respectively.	N				0
		Provider name				CCN
		1.00				2.00
14.00	RHC/FQHC name, CCN					14.00
		Y/N	V	XVIII	XIX	Total Visits
		1.00	2.00	3.00	4.00	5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00
		County				
		4.00				
2.00	City, State, ZIP Code, County	KNOX				2.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 15-0042 Component CCN: 15-8585		Period: From 01/01/2024 To 12/31/2024		Worksheet S-8 Date/Time Prepared: 4/10/2025 8:15 am						
						RHC III		Cost						
				Tuesday		Wednesday		Thursday						
				to		from		to		from		to		
				6.00		7.00		8.00		9.00		10.00		
Facility hours of operations (1)														
11.00	CLINIC			16:30	08:30	16:30	08:30	16:30	11.00					
				Friday		Saturday								
				from		to					from		to	
				11.00		12.00					13.00		14.00	
Facility hours of operations (1)														
11.00	CLINIC			08:30	16:30				11.00					

Health Financial Systems		GOOD SAMARITAN HOSPITAL		In Lieu of Form CMS-2552-10		
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 15-0042 Component CCN: 15-8584		Period: From 01/01/2024 To 12/31/2024 Worksheet S-8 Date/Time Prepared: 4/10/2025 8:15 am		
		RHC IV		Cost		
		1.00				
1.00	Clinic Address and Identification					1.00
	Street	406 N 1ST STREET STE J				1.00
		City	State	ZIP Code		
		1.00	2.00	3.00		
2.00	City, State, ZIP Code, County	VINCENNES		IN	47591	2.00
						1.00
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0
		Grant Award		Date		
		1.00		2.00		
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
		1.00		2.00		
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0		10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
11.00	Facility hours of operations (1)					
	CLINIC			08:30	16:30	08:30
		1.00		2.00		3.00
12.00	Have you received an approval for an exception to the productivity standard?					12.00
13.00	Is this worksheet prepared for a consolidated group as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If column 1 is Y, enter in column 2 the number of providers included in the group. List the provider name and provider number of each member in the consolidated group on line 14. If column 1 is Y, in column 3 enter G or N to identify the grouping as grandfathered or non-grandfathered, respectively.	N		0		13.00
		Provider name		CCN		
		1.00		2.00		
14.00	RHC/FQHC name, CCN					14.00
		Y/N	V	XVIII	XIX	Total Visits
		1.00	2.00	3.00	4.00	5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00
		County				
		4.00				
2.00	City, State, ZIP Code, County	KNOX				2.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 15-0042 Component CCN: 15-8584		Period: From 01/01/2024 To 12/31/2024	Worksheet S-8 Date/Time Prepared: 4/10/2025 8:15 am
					RHC IV	Cost
		Tuesday	Wednesday		Thursday	
		to	from	to	from	to
		6.00	7.00	8.00	9.00	10.00
Facility hours of operations (1)						
11.00	CLINIC	16:30	08:30	16:30	08:30	16:30
		Friday		Saturday		
		from	to	from	to	
		11.00	12.00	13.00	14.00	
Facility hours of operations (1)						
11.00	CLINIC	08:30	16:30			11.00

Health Financial Systems		GOOD SAMARITAN HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 15-0042 Component CCN: 15-8582		Period: From 01/01/2024 To 12/31/2024 Worksheet S-8 Date/Time Prepared: 4/10/2025 8:15 am	
		RHC V		Cost	
		1.00			
1.00	Clinic Address and Identification			514 S 9TH STREET	
	Street	City	State	ZIP Code	1.00
2.00	City, State, ZIP Code, County			VINCENNES IN 47591	2.00
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00
	Grant Award			Date	
	1.00			2.00	
4.00	Source of Federal Funds				4.00
5.00	Community Health Center (Section 330(d), PHS Act)				5.00
6.00	Migrant Health Center (Section 329(d), PHS Act)				6.00
7.00	Health Services for the Homeless (Section 340(d), PHS Act)				7.00
8.00	Appalachian Regional Commission				8.00
9.00	Look-Alikes				9.00
9.00	OTHER (SPECIFY)				9.00
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0
	Sunday			Monday	Tuesday
	from	to	from	to	from
	1.00	2.00	3.00	4.00	5.00
11.00	Facility hours of operations (1)				
	CLINIC		08:30	16:30	08:30
			1.00	2.00	3.00
12.00	Have you received an approval for an exception to the productivity standard?			N	0
13.00	Is this worksheet prepared for a consolidated group as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If column 1 is Y, enter in column 2 the number of providers included in the group. List the provider name and provider number of each member in the consolidated group on line 14. If column 1 is Y, in column 3 enter G or N to identify the grouping as grandfathered or non-grandfathered, respectively.				
	Provider name			CCN	
	1.00			2.00	
14.00	RHC/FQHC name, CCN				14.00
	Y/N	V	XVIII	XIX	Total Visits
	1.00	2.00	3.00	4.00	5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				15.00
2.00	City, State, ZIP Code, County			KNOX	2.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 15-0042 Component CCN: 15-8582		Period: From 01/01/2024 To 12/31/2024	Worksheet S-8 Date/Time Prepared: 4/10/2025 8:15 am
					RHC V	Cost
		Tuesday	Wednesday		Thursday	
		to	from	to	from	to
		6.00	7.00	8.00	9.00	10.00
Facility hours of operations (1)						
11.00	CLINIC	16:30	08:30	16:30	08:30	16:30
		Friday		Saturday		
		from	to	from	to	
		11.00	12.00	13.00	14.00	
Facility hours of operations (1)						
11.00	CLINIC	08:30	16:30			11.00

Health Financial Systems		GOOD SAMARITAN HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 15-0042 Component CCN: 15-8580		Period: From 01/01/2024 To 12/31/2024 Worksheet S-8 Date/Time Prepared: 4/10/2025 8:15 am	
		RHC VI		Cost	
		1.00			
1.00	Clinic Address and Identification			406 N 1ST STREET STE D	
	Street			1.00	
	City			State	
	1.00			2.00	
2.00	City, State, ZIP Code, County			VINCENNES IN 47591	
				1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	
	Grant Award			Date	
	1.00			2.00	
4.00	Source of Federal Funds				
5.00	Community Health Center (Section 330(d), PHS Act)			4.00	
6.00	Migrant Health Center (Section 329(d), PHS Act)			5.00	
7.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00	
8.00	Appalachian Regional Commission			7.00	
9.00	Look-Alikes			8.00	
	OTHER (SPECIFY)			9.00	
				1.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N 0	
	Sunday			Monday	
	from to			from to	
	1.00 2.00			3.00 4.00	
	Tuesday			from	
				5.00	
11.00	Facility hours of operations (1)				
	CLINIC			08:30 16:30 08:30	
				1.00 2.00 3.00	
12.00	Have you received an approval for an exception to the productivity standard?			N 0	
13.00	Is this worksheet prepared for a consolidated group as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If column 1 is Y, enter in column 2 the number of providers included in the group. List the provider name and provider number of each member in the consolidated group on line 14. If column 1 is Y, in column 3 enter G or N to identify the grouping as grandfathered or non-grandfathered, respectively.			13.00	
	Provider name			CCN	
	1.00			2.00	
14.00	RHC/FQHC name, CCN			14.00	
	Y/N V			XVIII XIX Total Visits	
	1.00 2.00			3.00 4.00 5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			15.00	
	County				
	4.00				
2.00	City, State, ZIP Code, County			KNOX	
				2.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 15-0042 Component CCN: 15-8580		Period: From 01/01/2024 To 12/31/2024	Worksheet S-8 Date/Time Prepared: 4/10/2025 8:15 am
					RHC VI	Cost
		Tuesday	Wednesday		Thursday	
		to	from	to	from	to
		6.00	7.00	8.00	9.00	10.00
Facility hours of operations (1)						
11.00	CLINIC	16:30	08:30	16:30	08:30	16:30
		Friday		Saturday		
		from	to	from	to	
		11.00	12.00	13.00	14.00	
Facility hours of operations (1)						
11.00	CLINIC	08:30	16:30			11.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 15-0042

Period:

Worksheet S-9

Hospice CCN: 15-1526

From 01/01/2024
To 12/31/2024PARTS I THROUGH IV
Date/Time Prepared:
4/10/2025 8:15 am

		Hospice I					
		Unduplicated Days					
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)
		1.00	2.00	3.00	4.00	5.00	6.00
PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
1.00	Hospice Continuous Home Care						1.00
2.00	Hospice Routine Home Care						2.00
3.00	Hospice Inpatient Respite Care						3.00
4.00	Hospice General Inpatient Care						4.00
5.00	Total Hospice Days						5.00
Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
6.00	Number of patients receiving hospice care						6.00
7.00	Total number of unduplicated Continuous Care hours billable to Medicare						7.00
8.00	Average Length of Stay (line 5 / line 6)						8.00
9.00	Unduplicated census count						9.00

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	3,383	90	207	3,680	11.00
12.00	Hospice Inpatient Respite Care	3	0	0	3	12.00
13.00	Hospice General Inpatient Care	217	0	0	217	13.00
14.00	Total Hospice Days	3,603	90	207	3,900	14.00
PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 15-0042	Period: From 01/01/2024 To 12/31/2024	Worksheet S-10 Parts I & II Date/Time Prepared: 4/10/2025 8:15 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)		0.267220	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		15,466,688	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	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		106,188,965	6.00
7.00	Medicaid cost (line 1 times line 6)		28,375,815	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)		12,909,127	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)		12,909,127	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)	5,628,620	489,556	6,118,176
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,504,080	489,556	1,993,636
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)	1,504,080	489,556	1,993,636
				1.00
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
25.01	Charges for insured patients' liability (see instructions)		0	25.01
26.00	Bad debt amount (see instructions)		8,064,271	26.00
27.00	Medicare reimbursable bad debts (see instructions)		317,444	27.00
27.01	Medicare allowable bad debts (see instructions)		488,377	27.01
28.00	Non-Medicare bad debt amount (see instructions)		7,575,894	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)		2,195,363	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)		4,188,999	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		17,098,126	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 15-0042	Period: From 01/01/2024 To 12/31/2024	Worksheet S-10 Parts I & II Date/Time Prepared: 4/10/2025 8:15 am
				1.00
PART II - HOSPITAL DATA				
Uncompensated and Indigent Care Cost-to-Charge Ratio				
1.00	Cost to charge ratio (see instructions)		0.245610	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)	5,628,620	485,888	6,114,508
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,382,445	485,888	1,868,333
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)	1,382,445	485,888	1,868,333
				1.00
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
25.01	Charges for insured patients' liability (see instructions)		0	25.01
26.00	Bad debt amount (see instructions)		7,970,890	26.00
27.00	Medicare reimbursable bad debts (see instructions)		303,170	27.00
27.01	Medicare allowable bad debts (see instructions)		466,416	27.01
28.00	Non-Medicare bad debt amount (see instructions)		7,504,474	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)		2,006,420	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)		3,874,753	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		3,874,753	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0042

Period:

From 01/01/2024
To 12/31/2024

Worksheet A

Date/Time Prepared:
4/10/2025 8:15 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (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		15,934,205	15,934,205	5,657,090	21,591,295	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	729,416	1,998,201	2,727,617	27,965,821	30,693,438	4.00
4.01	00401	COMMUNICATIONS	349,881	129,084	478,965	-127,638	351,327	4.01
4.02	00402	PURCHASING & RECEIVING	835,503	970,233	1,805,736	-390,542	1,415,194	4.02
4.03	00403	REGISTRATION	2,109,969	800,098	2,910,067	-780,592	2,129,475	4.03
4.04	00404	PATIENT ACCOUNTS	2,371,049	3,077,158	5,448,207	-735,904	4,712,303	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	8,801,904	30,247,870	39,049,774	-2,940,730	36,109,044	5.00
7.00	00700	OPERATION OF PLANT	2,624,007	5,667,201	8,291,208	-856,652	7,434,556	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	253,110	240,736	493,846	-113,094	380,752	8.00
9.00	00900	HOUSEKEEPING	2,461,198	1,062,536	3,523,734	-816,698	2,707,036	9.00
10.00	01000	DIETARY	1,902,392	2,199,603	4,101,995	-3,607,169	494,826	10.00
11.00	01100	CAFETERIA	0	0	0	2,993,225	2,993,225	11.00
13.00	01300	NURSING ADMINISTRATION	2,335,214	1,705,928	4,041,142	-405,374	3,635,768	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	401,377	397,785	799,162	-127,396	671,766	14.00
15.00	01500	PHARMACY	3,372,977	27,012,710	30,385,687	-26,489,549	3,896,138	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,297,247	1,722,598	6,019,845	-1,334,110	4,685,735	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	705,253	316,283	1,021,536	-124,196	897,340	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	4,131,789	4,131,789	0	4,131,789	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	2,527,337	1,305,743	3,833,080	-587,516	3,245,564	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	223,921	81,152	305,073	-60,556	244,517	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,422,290	6,907,330	15,329,620	-2,543,944	12,785,676	30.00
31.00	03100	INTENSIVE CARE UNIT	3,412,561	1,214,891	4,627,452	-720,466	3,906,986	31.00
40.00	04000	SUBPROVIDER - IPF	2,427,729	1,223,127	3,650,856	-590,494	3,060,362	40.00
41.00	04100	SUBPROVIDER - IRF	2,172,333	602,332	2,774,665	-487,302	2,287,363	41.00
43.00	04300	NURSERY	0	0	0	175,763	175,763	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,217,683	8,271,615	11,489,298	-3,794,471	7,694,827	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	908,422	1,297,777	2,206,199	-426,518	1,779,681	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	434,501	434,501	52.00
53.00	05300	ANESTHESIOLOGY	3,495,884	2,071,643	5,567,527	-517,775	5,049,752	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,212,253	8,401,901	13,614,154	-3,185,784	10,428,370	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,029,221	3,490,278	6,519,499	-747,774	5,771,725	55.00
60.00	06000	LABORATORY	2,622,871	5,662,239	8,285,110	-610,222	7,674,888	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	3,070,948	2,487,761	5,558,709	-1,165,976	4,392,733	65.00
66.00	06600	PHYSICAL THERAPY	5,869,920	2,043,264	7,913,184	-1,496,966	6,416,218	66.00
69.00	06900	ELECTROCARDIOLOGY	6,181,329	4,139,731	10,321,060	-2,877,987	7,443,073	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	741,959	1,244,959	1,986,918	-210,613	1,776,305	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,332,193	3,332,193	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,128,037	6,128,037	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	25,583,026	25,583,026	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,141,923	2,555,781	3,697,704	-1,115,799	2,581,905	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	177,087	351,177	528,264	-44,455	483,809	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	FAMILY PRACTICE 120	1,913,291	671,259	2,584,550	-442,852	2,141,698	88.00
88.01	08801	GOOD SAMARITAN FP 110 HB	625,561	286,530	912,091	-253,383	658,708	88.01
88.02	08802	GOOD SAMARITAN IM 100 HB	771,368	273,673	1,045,041	-353,089	691,952	88.02
88.03	08803	GOOD SAMARITAN IM 110 HB	485,308	216,103	701,411	-234,317	467,094	88.03
88.04	08804	GOOD SAMARITANKIDS HB	442,314	377,536	819,850	-262,759	557,091	88.04
88.05	08805	GOOD SAMARITAN FP 100 HB	1,163,162	330,158	1,493,320	-446,023	1,047,297	88.05
90.00	09000	CLINIC	0	4,143	4,143	0	4,143	90.00
90.01	04950	WOUND CLINIC	397,796	1,724,513	2,122,309	-1,135,181	987,128	90.01
91.00	09100	EMERGENCY	5,061,253	3,402,926	8,464,179	-1,210,971	7,253,208	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	91,802	72,573	164,375	-21,316	143,059	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		5,089,082	5,089,082	-5,089,082	0	113.00
116.00	11600	HOSPICE	646,658	509,779	1,156,437	-184,429	972,008	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100,004,681	163,924,994	263,929,675	2,601,992	266,531,667	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,002,819	7,109,683	17,112,502	-1,725,966	15,386,536	192.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0042

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

Worksheet A

Date/Time Prepared:
4/10/2025 8:15 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
192.01	19201	FP PETERSBURG	0	0	0	3	3	192.01
192.02	19202	PEDIATRICS	916,692	592,319	1,509,011	-295,072	1,213,939	192.02
192.03	19203	WASHINGTON PRIMARY CARE	1,506,216	603,206	2,109,422	-379,809	1,729,613	192.03
192.04	19204	FQHC	241,233	184,108	425,341	-49,319	376,022	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	63,127	31,980	95,107	-4,987	90,120	194.00
194.01	07960	CCBHC GRANTS	237,479	604,582	842,061	-72,193	769,868	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	270,633	546,536	817,169	-74,590	742,579	194.02
194.03	07953	MH RESIDENTIAL	0	0	0	0	0	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	0	194.04
194.05	07955	MOB	0	45,641	45,641	0	45,641	194.05
194.06	07956	FOUNDATION	0	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	9,323	79,276	88,599	-59	88,540	194.09
194.10	07951	BEIRHAUS BUILDING	0	91,600	91,600	0	91,600	194.10
194.11	07961	SPECIALTY PHARMACY	0	3,156,446	3,156,446	0	3,156,446	194.11
200.00		TOTAL (SUM OF LINES 118 through 199)	113,252,203	176,970,371	290,222,574	0	290,222,574	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0042

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

Worksheet A

Date/Time Prepared:
4/10/2025 8:15 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	-1,723,866	19,867,429	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,747	30,691,691	4.00
4.01	00401	COMMUNICATIONS	-89,368	261,959	4.01
4.02	00402	PURCHASING & RECEIVING	-223,203	1,191,991	4.02
4.03	00403	REGISTRATION	0	2,129,475	4.03
4.04	00404	PATIENT ACCOUNTS	-160,299	4,552,004	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	-15,800,077	20,308,967	5.00
7.00	00700	OPERATION OF PLANT	-45,840	7,388,716	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	380,752	8.00
9.00	00900	HOUSEKEEPING	-37,217	2,669,819	9.00
10.00	01000	DIETARY	0	494,826	10.00
11.00	01100	CAFETERIA	-1,513,443	1,479,782	11.00
13.00	01300	NURSING ADMINISTRATION	-138,350	3,497,418	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-6	671,760	14.00
15.00	01500	PHARMACY	-367,862	3,528,276	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-247,456	4,438,279	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
17.01	01701	MENTAL HEALTH OH	-869,170	28,170	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	4,131,789	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	-20,000	3,225,564	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	-12,689	231,828	23.01
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,342,476	11,443,200	30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,906,986	31.00
40.00	04000	SUBPROVIDER - IPF	-88,733	2,971,629	40.00
41.00	04100	SUBPROVIDER - IRF	0	2,287,363	41.00
43.00	04300	NURSERY	0	175,763	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-1,014,489	6,680,338	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
51.01	05101	ENDOSCOPY	-4,809	1,774,872	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	434,501	52.00
53.00	05300	ANESTHESIOLOGY	-3,816,431	1,233,321	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,284,144	9,144,226	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-2,628,243	3,143,482	55.00
60.00	06000	LABORATORY	-126,259	7,548,629	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	-1,761,591	2,631,142	65.00
66.00	06600	PHYSICAL THERAPY	-1,905,064	4,511,154	66.00
69.00	06900	ELECTROCARDIOLOGY	-4,071,688	3,371,385	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	-450,859	1,325,446	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,332,193	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,128,037	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-423,415	25,159,611	73.00
75.00	07500	ASC (NON-DISTINCT PART)	-86,779	2,495,126	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	-17,416	466,393	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	FAMILY PRACTICE 120	0	2,141,698	88.00
88.01	08801	GOOD SAMARITAN FP 110 HB	0	658,708	88.01
88.02	08802	GOOD SAMARITAN IM 100 HB	0	691,952	88.02
88.03	08803	GOOD SAMARITAN IM 110 HB	0	467,094	88.03
88.04	08804	GOOD SAMARITANKIDS HB	0	557,091	88.04
88.05	08805	GOOD SAMARITAN FP 100 HB	0	1,047,297	88.05
90.00	09000	CLINIC	0	4,143	90.00
90.01	04950	WOUND CLINIC	-3,606	983,522	90.01
91.00	09100	EMERGENCY	-1,416,337	5,836,871	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	143,059	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	0	972,008	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-41,692,932	224,838,735	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	15,386,536	192.00
192.01	19201	FP PETERSBURG	0	3	192.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0042

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

Worksheet A

Date/Time Prepared:
4/10/2025 8:15 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
192.02	19202	PEDIATRICS	0	1,213,939	192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	1,729,613	192.03
192.04	19204	FQHC	0	376,022	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	0	90,120	194.00
194.01	07960	CCBHC GRANTS	0	769,868	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	742,579	194.02
194.03	07953	MH RESIDENTIAL	0	0	194.03
194.04	07954	UNUSED SPACE	0	0	194.04
194.05	07955	MOB	0	45,641	194.05
194.06	07956	FOUNDATION	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	88,540	194.09
194.10	07951	BEIRHAUS BUILDING	0	91,600	194.10
194.11	07961	SPECIALTY PHARMACY	0	3,156,446	194.11
200.00		TOTAL (SUM OF LINES 118 through 199)	-41,692,932	248,529,642	200.00

RECLASSIFICATIONS

Provider CCN: 15-0042

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

Worksheet A-6

Date/Time Prepared:
4/10/2025 8:15 am

	Increases					4/10/2025 8:15 am
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - DRUGS CHARGED TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	25,583,026	1.00	
	0		0	25,583,026		
	B - MEDICAL SUPPLIES CHARGED TO PATIENTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,332,193	1.00	
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	6,128,037	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	
	0		0	9,460,230		
	C - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	28,045,335	1.00	
2.00	FP PETERSBURG	192.01	0	3	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	
35.00		0.00	0	0	35.00	
36.00		0.00	0	0	36.00	
37.00		0.00	0	0	37.00	
38.00		0.00	0	0	38.00	
39.00		0.00	0	0	39.00	
40.00		0.00	0	0	40.00	

Provider CCN: 15-0042

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

Worksheet A-6

Date/Time Prepared:
4/10/2025 8:15 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
41.00		0.00	0	0		41.00
42.00		0.00	0	0		42.00
43.00		0.00	0	0		43.00
44.00		0.00	0	0		44.00
45.00		0.00	0	0		45.00
46.00		0.00	0	0		46.00
47.00		0.00	0	0		47.00
48.00		0.00	0	0		48.00
49.00		0.00	0	0		49.00
50.00		0.00	0	0		50.00
0			0	28,045,338		
D - INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,089,082		1.00
0			0	5,089,082		
E - INSURANCE EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	568,008		1.00
0			0	568,008		
F - DIETARY RECLASS						
1.00	CAFETERIA	11.00	1,388,175	1,605,050		1.00
0			1,388,175	1,605,050		
G - OB RECLASS						
1.00	NURSERY	43.00	156,597	19,166		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	387,122	47,379		2.00
0			543,719	66,545		
I - RHC RECLASS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	519,362	89,790		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
0			519,362	89,790		
500.00	Grand Total: Increases		2,451,256	70,507,069		500.00

RECLASSIFICATIONS

Provider CCN: 15-0042

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

Worksheet A-6

Date/Time Prepared:
4/10/2025 8:15 am

	Decreases						4/10/2025 8:15 am
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DRUGS CHARGED TO PATIENTS						
1.00	PHARMACY	15.00	0	25,583,026	0		1.00
	0		0	25,583,026			
	B - MEDICAL SUPPLIES CHARGED TO PATIENTS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		79,514	0		1.00
2.00	PURCHASING & RECEIVING	4.02		94	0		2.00
3.00	REGISTRATION	4.03		1,284	0		3.00
4.00	ADMINISTRATIVE & GENERAL	5.00		4,127	0		4.00
5.00	OPERATION OF PLANT	7.00		4,933	0		5.00
6.00	HOUSEKEEPING	9.00		41	0		6.00
7.00	NURSING ADMINISTRATION	13.00		2,025	0		7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00		761	0		8.00
9.00	PHARMACY	15.00		58,398	0		9.00
10.00	ADULTS & PEDIATRICS	30.00		149,441	0		10.00
11.00	INTENSIVE CARE UNIT	31.00		44,659	0		11.00
12.00	SUBPROVIDER - IPF	40.00		189	0		12.00
13.00	SUBPROVIDER - IRF	41.00		3,420	0		13.00
14.00	OPERATING ROOM	50.00		2,974,046	0		14.00
15.00	ENDOSCOPY	51.01		191,656	0		15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00		1,919,712	0		16.00
17.00	RADIOLOGY-THERAPEUTIC	55.00		39,937	0		17.00
18.00	LABORATORY	60.00		37,330	0		18.00
19.00	RESPIRATORY THERAPY	65.00		216,079	0		19.00
20.00	PHYSICAL THERAPY	66.00		91,015	0		20.00
21.00	ELECTROCARDIOLOGY	69.00		1,770,167	0		21.00
22.00	NEURODIAGNOSTICS	70.01		4,291	0		22.00
23.00	ASC (NON-DISTINCT PART)	75.00		782,139	0		23.00
24.00	INPATIENT DIALYSIS	76.01		2,978	0		24.00
25.00	WOUND CLINIC	90.01		1,027,835	0		25.00
26.00	EMERGENCY	91.00		54,159	0		26.00
	0		0	9,460,230			
	C - EMPLOYEE BENEFITS						
1.00	COMMUNICATIONS	4.01		127,638	0		1.00
2.00	PURCHASING & RECEIVING	4.02		390,448	0		2.00
3.00	REGISTRATION	4.03		779,308	0		3.00
4.00	PATIENT ACCOUNTS	4.04		735,904	0		4.00
5.00	ADMINISTRATIVE & GENERAL	5.00		2,368,595	0		5.00
6.00	OPERATION OF PLANT	7.00		851,719	0		6.00
7.00	LAUNDRY & LINEN SERVICE	8.00		113,094	0		7.00
8.00	HOUSEKEEPING	9.00		816,657	0		8.00
9.00	DIETARY	10.00		613,944	0		9.00
10.00	NURSING ADMINISTRATION	13.00		403,349	0		10.00
11.00	CENTRAL SERVICES & SUPPLY	14.00		126,635	0		11.00
12.00	PHARMACY	15.00		848,125	0		12.00
13.00	MEDICAL RECORDS & LIBRARY	16.00		1,334,110	0		13.00
14.00	MENTAL HEALTH OH	17.01		124,196	0		14.00
15.00	I&R SERVICES-OTHER PRGM	22.00		587,516	0		15.00
	COSTS APPRVD						
16.00	PARAMED ED PRGM-LAB	23.01		60,556	0		16.00
17.00	ADULTS & PEDIATRICS	30.00		1,784,239	0		17.00
18.00	INTENSIVE CARE UNIT	31.00		675,807	0		18.00
19.00	SUBPROVIDER - IPF	40.00		590,305	0		19.00
20.00	SUBPROVIDER - IRF	41.00		483,882	0		20.00
21.00	OPERATING ROOM	50.00		820,425	0		21.00
22.00	ENDOSCOPY	51.01		234,862	0		22.00
23.00	ANESTHESIOLOGY	53.00		517,775	0		23.00
24.00	RADIOLOGY-DIAGNOSTIC	54.00		1,266,072	0		24.00
25.00	RADIOLOGY-THERAPEUTIC	55.00		707,837	0		25.00
26.00	LABORATORY	60.00		572,892	0		26.00
27.00	RESPIRATORY THERAPY	65.00		949,897	0		27.00
28.00	PHYSICAL THERAPY	66.00		1,405,951	0		28.00
29.00	ELECTROCARDIOLOGY	69.00		1,107,820	0		29.00
30.00	NEURODIAGNOSTICS	70.01		206,322	0		30.00
31.00	ASC (NON-DISTINCT PART)	75.00		333,660	0		31.00
32.00	INPATIENT DIALYSIS	76.01		41,477	0		32.00
33.00	FAMILY PRACTICE 120	88.00		442,852	0		33.00
34.00	GOOD SAMARITAN FP 110 HB	88.01		194,388	0		34.00
35.00	GOOD SAMARITAN IM 100 HB	88.02		224,998	0		35.00
36.00	GOOD SAMARITAN IM 110 HB	88.03		178,466	0		36.00
37.00	GOOD SAMARITANKIDS HB	88.04		123,486	0		37.00
38.00	GOOD SAMARITAN FP 100 HB	88.05		219,081	0		38.00
39.00	WOUND CLINIC	90.01		107,346	0		39.00
40.00	EMERGENCY	91.00		1,156,812	0		40.00
41.00	DURABLE MEDICAL EQUIP-RENTED	96.00		21,316	0		41.00

RECLASSIFICATIONS

Provider CCN: 15-0042

Period:
From 01/01/2024
To 12/31/2024Worksheet A-6
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Decreases						wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00	10.00		
42.00	HOSPICE	116.00		184,429	0		42.00
43.00	PHYSICIANS' PRIVATE OFFICES	192.00		2,335,118	0		43.00
44.00	PEDIATRICS	192.02		295,072	0		44.00
45.00	WASHINGTON PRIMARY CARE	192.03		379,809	0		45.00
46.00	FQHC	192.04		49,319	0		46.00
47.00	COMMUNITY HEALTH SERVICES	194.00		4,987	0		47.00
48.00	CCBHC GRANTS	194.01		72,193	0		48.00
49.00	MARKETING AND PUBLIC RELATIONS	194.02		74,590	0		49.00
50.00	COMMUNITY MENTAL HEALTH CENTER	194.09	0	59	0		50.00
	0		0	28,045,338			
D - INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	5,089,082	11		1.00
	0		0	5,089,082			
E - INSURANCE EXPENSE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	568,008	12		1.00
	0		0	568,008			
F - DIETARY RECLASS							
1.00	DIETARY	10.00	1,388,175	1,605,050	0		1.00
	0		1,388,175	1,605,050			
G - OB RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	543,719	66,545	0		1.00
2.00	0	0.00	0	0	0		2.00
	0		543,719	66,545			
I - RHC RECLASS							
1.00	GOOD SAMARITAN FP 110 HB	88.01	51,421	7,574	0		1.00
2.00	GOOD SAMARITAN IM 100 HB	88.02	120,488	7,603	0		2.00
3.00	GOOD SAMARITAN IM 110 HB	88.03	51,831	4,020	0		3.00
4.00	GOOD SAMARITANKIDS HB	88.04	88,463	50,810	0		4.00
5.00	GOOD SAMARITAN FP 100 HB	88.05	207,159	19,783	0		5.00
	0		519,362	89,790			
500.00	Grand Total: Decreases		2,451,256	70,507,069			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0042

Period:
From 01/01/2024
To 12/31/2024Worksheet A-7
Part I
Date/Time Prepared:
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		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	6,581,448	0	0	0	0	1.00	
2.00	Land Improvements	10,854,720	74,519	0	74,519	0	2.00	
3.00	Buildings and Fixtures	177,946,557	7,571,518	0	7,571,518	0	3.00	
4.00	Building Improvements	479,187	0	0	0	1,977	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	229,789,855	0	0	0	3,414,126	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	425,651,767	7,646,037	0	7,646,037	3,416,103	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	425,651,767	7,646,037	0	7,646,037	3,416,103	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	6,581,448	0				1.00	
2.00	Land Improvements	10,929,239	0				2.00	
3.00	Buildings and Fixtures	185,518,075	0				3.00	
4.00	Building Improvements	477,210	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	226,375,729	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	429,881,701	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	429,881,701	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS	Provider CCN: 15-0042	Period: From 01/01/2024 To 12/31/2024	Worksheet A-7 Part II Date/Time Prepared: 4/10/2025 8:15 am
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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	15,934,205	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)	15,934,205	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Relat ed Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	15,934,205				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	15,934,205				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0042

Period:
From 01/01/2024
To 12/31/2024Worksheet A-7
Part III
Date/Time Prepared:
4/10/2025 8:15 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	203,505,972	0	203,505,972	0.473400	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	226,375,729	0	226,375,729	0.526600	0	2.00
3.00	Total (sum of lines 1-2)	429,881,701	0	429,881,701	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Relat ed 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	15,934,205	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	15,934,205	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Relat ed 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	3,365,216	568,008	0	0	19,867,429	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,365,216	568,008	0	0	19,867,429	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0042

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

Worksheet A-8

Date/Time Prepared:
4/10/2025 8:15 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 #		
				3.00	4.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-1,723,866	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-130,578	PURCHASING & RECEIVING	4.02	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	B	-37,658	OPERATION OF PLANT	7.00	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	-20,733,512			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	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-979,711	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	B	-423,415	DRUGS CHARGED TO PATIENTS	73.00	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
19.01	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
19.02	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.02
19.03	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.03
20.00	Vending machines	B	-76,316	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

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0042

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

Worksheet A-8

Date/Time Prepared:
4/10/2025 8:15 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 #		
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	*** Cost Center Deleted ***	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	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME	B	-1,747	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	MISC INCOME	B	-92,625	PURCHASING & RECEIVING	4.02	0	33.01
33.02	MISC INCOME	B	-305	PATIENT ACCOUNTS	4.04	0	33.02
33.03	MISC INCOME	B	-1,136,317	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	MISC INCOME	B	-8,182	OPERATION OF PLANT	7.00	0	33.04
33.05	MISC INCOME	B	-37,217	HOUSEKEEPING	9.00	0	33.05
33.06	MISC INCOME	B	-6	CENTRAL SERVICES & SUPPLY	14.00	0	33.06
33.07	MISC INCOME	B	-185,747	PHARMACY	15.00	0	33.07
33.09	MISC INCOME	B	-49,914	MEDICAL RECORDS & LIBRARY	16.00	0	33.09
33.10	MISC INCOME	B	-12,689	PARAMED ED PRGM-LAB	23.01	0	33.10
33.11	MISC INCOME	B	-50,084	ADULTS & PEDIATRICS	30.00	0	33.11
33.12	MISC INCOME	B	-27,733	SUBPROVIDER - IPF	40.00	0	33.12
33.13	MISC INCOME	B	-60,556	OPERATING ROOM	50.00	0	33.13
33.14	MISC INCOME	B	-4,809	ENDOSCOPY	51.01	0	33.14
33.15	MISC INCOME	B	-109,291	RADIOLOGY-DIAGNOSTIC	54.00	0	33.15
33.16	MISC INCOME	B	-16	LABORATORY	60.00	0	33.16
33.17	MISC INCOME	B	-3,977	RESPIRATORY THERAPY	65.00	0	33.17
33.18	MISC INCOME	B	20,000	PHYSICAL THERAPY	66.00	0	33.18
33.19	MISC INCOME	B	-60,387	ELECTROCARDIOLOGY	69.00	0	33.19
33.20	MISC INCOME	B	-1	ASC (NON-DISTINCT PART)	75.00	0	33.20
33.21	MISC INCOME	B	-3,606	WOUND CLINIC	90.01	0	33.21
33.22	MISC INCOME	B	-700	EMERGENCY	91.00	0	33.22
33.23	ADVERTISING	A	-22,191	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24	ADVERTISING	A	-150	MENTAL HEALTH OH	17.01	0	33.24
33.25	ADVERTISING	A	-8	RADIOLOGY-DIAGNOSTIC	54.00	0	33.25
33.26	ADVERTISING	A	-675	PHYSICAL THERAPY	66.00	0	33.26
33.27	ADVERTISING	A	-4,466	ELECTROCARDIOLOGY	69.00	0	33.27
33.28	PHYSICIAN BILLING COSTS	A	-159,994	PATIENT ACCOUNTS	4.04	0	33.28
33.29	2012 BOND ISSUE COSTS	A	45,855	ADMINISTRATIVE & GENERAL	5.00	0	33.29
33.30	AHA LOBBYING OFFSET	A	-10,776	ADMINISTRATIVE & GENERAL	5.00	0	33.30
33.31	IHA LOBBYING OFFSET	A	-8,753	ADMINISTRATIVE & GENERAL	5.00	0	33.31
33.32	INDIANA CHAMBER LOBBYING OFFSET	A	-196	ADMINISTRATIVE & GENERAL	5.00	0	33.32
33.33	IHRA LOBBYING OFFSET	A	-1,000	ADMINISTRATIVE & GENERAL	5.00	0	33.33
33.34	PROVIDER ASSESSMENT FEE	A	-14,201,238	ADMINISTRATIVE & GENERAL	5.00	0	33.34
33.35	RENTAL	A	-131,853	ADMINISTRATIVE & GENERAL	5.00	0	33.35
33.36	RENTAL	A	-61,000	SUBPROVIDER - IPF	40.00	0	33.36
33.37	RENTAL	A	-300	ELECTROCARDIOLOGY	69.00	0	33.37
33.38	RENTAL	A	-17,416	INPATIENT DIALYSIS	76.01	0	33.38
33.39	PHYSICIAN LOAN EXPENSE	A	-95,703	ADMINISTRATIVE & GENERAL	5.00	0	33.39
33.40	PHYSICIAN LOAN EXPENSE	A	-20,000	MENTAL HEALTH OH	17.01	0	33.40
33.41	PHYSICIAN LOAN EXPENSE	A	-20,000	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	0	33.41
33.42	PHYSICIAN LOAN EXPENSE	A	-50,000	OPERATING ROOM	50.00	0	33.42
33.43	PHYSICIAN LOAN EXPENSE	A	-20,000	RADIOLOGY-DIAGNOSTIC	54.00	0	33.43
33.44	PHYSICIAN LOAN EXPENSE	A	-25,000	RADIOLOGY-THERAPEUTIC	55.00	0	33.44
33.45	PHYSICIAN LOAN EXPENSE	B	-115,000	ANESTHESIOLOGY	53.00	0	33.45
33.46	PHYSICIAN LOAN EXPENSE	B	-7,200	RESPIRATORY THERAPY	65.00	0	33.46
33.47	OTHER MISC FEES	B	-457,416	CAFETERIA	11.00	0	33.47
33.48	DONATIONS EXPENSE	B	-115,171	ADMINISTRATIVE & GENERAL	5.00	0	33.48
33.49	TELEPHONE OFFSET	A	-89,368	COMMUNICATIONS	4.01	0	33.49
33.50	340B	B	-172,948	PHARMACY	15.00	0	33.50

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0042

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

Worksheet A-8

Date/Time Prepared:
4/10/2025 8:15 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 #		
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-41,692,932				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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0042

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

Worksheet A-8-2

Date/Time Prepared:
4/10/2025 8:15 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	5.00	ADMINISTRATIVE & GENERAL	189,539	60,039	129,500	211,500	657	1.00
2.00	13.00	NURSING ADMINISTRATION	138,350	138,350	0	211,500	0	2.00
3.00	15.00	PHARMACY	9,167	9,167	0	211,500	0	3.00
4.00	16.00	MEDICAL RECORDS & LIBRARY	197,542	197,542	0	211,500	0	4.00
5.00	17.01	MENTAL HEALTH OH	886,337	831,337	55,000	211,500	367	5.00
6.00	30.00	ADULTS & PEDIATRICS	1,292,392	1,292,392	0	211,500	0	6.00
7.00	50.00	OPERATING ROOM	903,933	903,933	0	246,400	0	7.00
8.00	53.00	ANESTHESIOLOGY	3,702,260	3,701,260	1,000	246,400	7	8.00
9.00	54.00	RADIOLOGY-DIAGNOSTIC	1,237,069	1,142,709	94,360	271,900	629	9.00
10.00	55.00	RADIOLOGY-THERAPEUTIC	2,613,831	2,597,631	16,200	271,900	81	10.00
11.00	60.00	LABORATORY	132,000	0	132,000	260,300	46	11.00
12.00	65.00	RESPIRATORY THERAPY	1,765,666	1,746,166	19,500	211,500	150	12.00
13.00	66.00	PHYSICAL THERAPY	1,924,389	1,924,389	0	211,500	0	13.00
14.00	69.00	ELECTROCARDIOLOGY	4,006,535	4,006,535	0	211,500	0	14.00
15.00	70.01	NEURODIAGNOSTICS	459,197	441,197	18,000	211,500	82	15.00
16.00	75.00	ASC (NON-DISTINCT PART)	100,200	77,100	23,100	211,500	132	16.00
17.00	76.01	INPATIENT DIALYSIS	43,940	0	43,940	211,500	566	17.00
18.00	91.00	EMERGENCY	1,454,887	1,382,887	72,000	211,500	386	18.00
200.00			21,057,234	20,452,634	604,600		3,103	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	66,805	3,340	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	2.00
3.00	15.00	PHARMACY	0	0	0	0	0	3.00
4.00	16.00	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	4.00
5.00	17.01	MENTAL HEALTH OH	37,317	1,866	0	0	0	5.00
6.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	6.00
7.00	50.00	OPERATING ROOM	0	0	0	0	0	7.00
8.00	53.00	ANESTHESIOLOGY	829	41	0	0	0	8.00
9.00	54.00	RADIOLOGY-DIAGNOSTIC	82,224	4,111	0	0	0	9.00
10.00	55.00	RADIOLOGY-THERAPEUTIC	10,588	529	0	0	0	10.00
11.00	60.00	LABORATORY	5,757	288	0	0	0	11.00
12.00	65.00	RESPIRATORY THERAPY	15,252	763	0	0	0	12.00
13.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	13.00
14.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	14.00
15.00	70.01	NEURODIAGNOSTICS	8,338	417	0	0	0	15.00
16.00	75.00	ASC (NON-DISTINCT PART)	13,422	671	0	0	0	16.00
17.00	76.01	INPATIENT DIALYSIS	57,552	2,878	0	0	0	17.00
18.00	91.00	EMERGENCY	39,250	1,963	0	0	0	18.00
200.00			337,334	16,867	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	5.00	ADMINISTRATIVE & GENERAL	0	66,805	62,695	122,734		1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	138,350		2.00
3.00	15.00	PHARMACY	0	0	0	9,167		3.00
4.00	16.00	MEDICAL RECORDS & LIBRARY	0	0	0	197,542		4.00
5.00	17.01	MENTAL HEALTH OH	0	37,317	17,683	849,020		5.00
6.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,292,392		6.00
7.00	50.00	OPERATING ROOM	0	0	0	903,933		7.00
8.00	53.00	ANESTHESIOLOGY	0	829	171	3,701,431		8.00
9.00	54.00	RADIOLOGY-DIAGNOSTIC	0	82,224	12,136	1,154,845		9.00
10.00	55.00	RADIOLOGY-THERAPEUTIC	0	10,588	5,612	2,603,243		10.00
11.00	60.00	LABORATORY	0	5,757	126,243	126,243		11.00
12.00	65.00	RESPIRATORY THERAPY	0	15,252	4,248	1,750,414		12.00
13.00	66.00	PHYSICAL THERAPY	0	0	0	1,924,389		13.00
14.00	69.00	ELECTROCARDIOLOGY	0	0	0	4,006,535		14.00
15.00	70.01	NEURODIAGNOSTICS	0	8,338	9,662	450,859		15.00
16.00	75.00	ASC (NON-DISTINCT PART)	0	13,422	9,678	86,778		16.00
17.00	76.01	INPATIENT DIALYSIS	0	57,552	0	0		17.00
18.00	91.00	EMERGENCY	0	39,250	32,750	1,415,637		18.00
200.00			0	337,334	280,878	20,733,512		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0042

Period:
From 01/01/2024
To 12/31/2024Worksheet B
Part I
Date/Time Prepared:
4/10/2025 8:15 am

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATION S	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	4.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	19,867,429	19,867,429			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	30,691,691	109,210	0	30,800,901	4.00
4.01	00401	COMMUNICATIONS	261,959	0	0	95,773	4.01
4.02	00402	PURCHASING & RECEIVING	1,191,991	259,996	0	228,702	4.02
4.03	00403	REGISTRATION	2,129,475	253,909	0	577,562	4.03
4.04	00404	PATIENT ACCOUNTS	4,552,004	0	0	649,027	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	20,308,967	1,077,406	0	2,409,345	5.00
7.00	00700	OPERATION OF PLANT	7,388,716	5,389,275	0	718,269	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	380,752	118,284	0	69,284	8.00
9.00	00900	HOUSEKEEPING	2,669,819	164,556	0	673,704	9.00
10.00	01000	DIETARY	494,826	76,011	0	140,757	10.00
11.00	01100	CAFETERIA	1,479,782	205,189	0	379,985	11.00
13.00	01300	NURSING ADMINISTRATION	3,497,418	219,295	0	639,218	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	671,760	89,106	0	109,869	14.00
15.00	01500	PHARMACY	3,528,276	134,299	0	923,285	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,438,279	102,875	0	1,176,285	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	28,170	58,513	0	193,049	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	4,131,789	227,853	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	3,225,564	0	0	691,808	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	231,828	0	0	61,294	23.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	11,443,200	1,032,774	0	2,156,601	30.00
31.00	03100	INTENSIVE CARE UNIT	3,906,986	470,666	0	934,120	31.00
40.00	04000	SUBPROVIDER - IPF	2,971,629	292,768	0	664,542	40.00
41.00	04100	SUBPROVIDER - IRF	2,287,363	386,187	0	594,633	41.00
43.00	04300	NURSERY	175,763	229,605	0	42,865	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,680,338	539,669	0	880,776	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	1,774,872	274,866	0	248,662	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	434,501	131,739	0	105,967	52.00
53.00	05300	ANESTHESIOLOGY	1,233,321	0	0	956,928	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,144,226	486,659	0	1,426,750	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,143,482	403,977	0	829,189	55.00
60.00	06000	LABORATORY	7,548,629	163,927	0	717,958	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	2,631,142	127,561	0	840,611	65.00
66.00	06600	PHYSICAL THERAPY	4,511,154	636,704	0	1,606,773	66.00
69.00	06900	ELECTROCARDIOLOGY	3,371,385	408,379	0	1,692,015	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	1,325,446	173,136	0	203,096	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,332,193	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,128,037	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,159,611	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	2,495,126	0	0	312,579	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	466,393	192,768	0	48,474	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	FAMILY PRACTICE 120	2,141,698	85,400	0	523,725	88.00
88.01	08801	GOOD SAMARITAN FP 110 HB	658,708	58,041	0	157,159	88.01
88.02	08802	GOOD SAMARITAN IM 100 HB	691,952	51,707	0	178,165	88.02
88.03	08803	GOOD SAMARITAN IM 110 HB	467,094	75,876	0	118,656	88.03
88.04	08804	GOOD SAMARITANKIDS HB	557,091	73,405	0	96,860	88.04
88.05	08805	GOOD SAMARITAN FP 100 HB	1,047,297	95,238	0	261,687	88.05
90.00	09000	CLINIC	4,143	50,629	0	0	90.00
90.01	04950	WOUND CLINIC	983,522	66,847	0	108,889	90.01
91.00	09100	EMERGENCY	5,836,871	531,650	0	1,385,417	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	143,059	8,850	0	25,129	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
116.00	11600	HOSPICE	972,008	109,187	0	177,010	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	224,838,735	15,643,992	0	27,032,452	118.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0042

Period:
From 01/01/2024
To 12/31/2024Worksheet B
Part I
Date/Time Prepared:
4/10/2025 8:15 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATION S	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4.01
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15,386,536	2,122,781	0	2,880,276	33,882 192.00
192.01	19201	FP PETERSBURG	3	83,221	0	0	0 192.01
192.02	19202	PEDIATRICS	1,213,939	0	0	250,926	3,576 192.02
192.03	19203	WASHINGTON PRIMARY CARE	1,729,613	152,741	0	412,297	0 192.03
192.04	19204	FQHC	376,022	0	0	66,033	0 192.04
194.00	07950	COMMUNITY HEALTH SERVICES	90,120	9,322	0	17,280	681 194.00
194.01	07960	CCBHC GRANTS	769,868	0	0	65,005	511 194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	742,579	37,961	0	74,080	1,022 194.02
194.03	07953	MH RESIDENTIAL	0	455,077	0	0	0 194.03
194.04	07954	UNUSED SPACE	0	457,548	0	0	0 194.04
194.05	07955	MOB	45,641	0	0	0	0 194.05
194.06	07956	FOUNDATION	0	10,467	0	0	511 194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	105,840	0	0	0 194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0 194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	88,540	788,479	0	2,552	0 194.09
194.10	07951	BEIRHAUS BUILDING	91,600	0	0	0	0 194.10
194.11	07961	SPECIALTY PHARMACY	3,156,446	0	0	0	0 194.11
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	248,529,642	19,867,429	0	30,800,901	357,732 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0042

Period:
From 01/01/2024
To 12/31/2024Worksheet B
Part I
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Cost Center Description			PURCHASING & RECEIVING	REGISTRATION	PATIENT ACCOUNTS	Subtotal	ADMINISTRATIVE & GENERAL	
			4.02	4.03	4.04	4A.04	5.00	
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
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING	1,684,094					4.02
4.03	00403	REGISTRATION	498	2,967,914				4.03
4.04	00404	PATIENT ACCOUNTS	752	0	5,209,445			4.04
5.00	00500	ADMINISTRATIVE & GENERAL	8,546	0	0	23,836,785	23,836,785	5.00
7.00	00700	OPERATION OF PLANT	19,019	0	0	13,536,562	1,436,040	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,158	0	0	574,478	60,944	8.00
9.00	00900	HOUSEKEEPING	14,888	0	0	3,529,267	374,406	9.00
10.00	01000	DIETARY	26,621	0	0	739,407	78,441	10.00
11.00	01100	CAFETERIA	71,866	0	0	2,139,887	227,012	11.00
13.00	01300	NURSING ADMINISTRATION	331	0	0	4,359,667	462,500	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,855	0	0	882,441	93,615	14.00
15.00	01500	PHARMACY	2,521	0	0	4,593,489	487,305	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	386	0	0	5,725,828	607,430	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	2	0	0	294,207	31,211	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	4,359,642	462,497	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	999	0	0	3,924,330	416,316	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	105	0	0	293,227	31,107	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	28,653	142,780	250,599	15,084,574	1,600,262	30.00
31.00	03100	INTENSIVE CARE UNIT	23,929	44,289	77,733	5,474,069	580,722	31.00
40.00	04000	SUBPROVIDER - IPF	2,047	42,357	74,342	4,047,685	429,403	40.00
41.00	04100	SUBPROVIDER - IRF	4,798	30,960	54,339	3,370,880	357,603	41.00
43.00	04300	NURSERY	0	4,931	8,654	461,818	48,992	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	138,244	206,827	363,012	8,834,406	937,207	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	46,610	57,461	100,852	2,507,750	266,037	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,011	12,189	21,394	722,144	76,609	52.00
53.00	05300	ANESTHESIOLOGY	0	36,345	63,790	2,290,384	242,978	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	49,817	521,081	914,904	12,559,102	1,332,345	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	8,037	126,875	222,683	4,740,373	502,887	55.00
60.00	06000	LABORATORY	214,670	329,455	578,241	9,558,669	1,014,041	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	4,598	52,556	92,243	3,755,522	398,408	65.00
66.00	06600	PHYSICAL THERAPY	2,795	108,250	189,994	7,065,886	749,592	66.00
69.00	06900	ELECTROCARDIOLOGY	40,267	258,738	454,121	6,238,867	661,856	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	5,259	25,692	45,093	1,781,127	188,953	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	237,856	22,004	38,620	3,630,673	385,164	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	434,989	60,498	106,183	6,729,707	713,928	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	473,822	831,626	26,465,059	2,807,595	73.00
75.00	07500	ASC (NON-DISTINCT PART)	40,202	94,464	165,797	3,108,168	329,733	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	239	4,408	7,737	720,360	76,420	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	FAMILY PRACTICE 120	12,932	15,237	26,744	2,811,355	298,245	88.00
88.01	08801	GOOD SAMARITAN FP 110 HB	5,171	4,347	7,629	892,758	94,709	88.01
88.02	08802	GOOD SAMARITAN IM 100 HB	1,426	4,669	8,195	937,646	99,471	88.02
88.03	08803	GOOD SAMARITAN IM 110 HB	1,245	2,641	4,636	672,872	71,382	88.03
88.04	08804	GOOD SAMARITANKIDS HB	16,692	5,033	8,834	759,788	80,603	88.04
88.05	08805	GOOD SAMARITAN FP 100 HB	5,691	6,920	12,146	1,431,533	151,866	88.05
90.00	09000	CLINIC	0	112	197	55,251	5,861	90.00
90.01	04950	WOUND CLINIC	7,858	20,195	35,445	1,224,459	129,898	90.01
91.00	09100	EMERGENCY	32,530	244,400	428,956	8,476,340	899,221	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	3,330	1,751	3,074	185,193	19,646	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	2,356	6,627	11,632	1,282,736	136,080	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,543,799	2,967,914	5,209,445	216,666,371	20,456,541	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	109,086	0	0	20,532,561	2,178,217	192.00
192.01	19201	FP PETERSBURG	0	0	0	83,224	8,829	192.01
192.02	19202	PEDIATRICS	18,478	0	0	1,486,919	157,741	192.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0042

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

 Worksheet B
 Part I
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Cost Center Description			PURCHASING & RECEIVING	REGISTRATION	PATIENT ACCOUNTS	Subtotal	ADMINISTRATIVE & GENERAL	
			4.02	4.03	4.04	4A.04	5.00	
192.03	19203	WASHINGTON PRIMARY CARE	8,822	0	0	2,303,473	244,366	192.03
192.04	19204	FQHC	0	0	0	442,055	46,896	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	193	0	0	117,596	12,475	194.00
194.01	07960	CCBHC GRANTS	119	0	0	835,503	88,635	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	696	0	0	856,338	90,845	194.02
194.03	07953	MH RESIDENTIAL	0	0	0	455,077	48,277	194.03
194.04	07954	UNUSED SPACE	0	0	0	457,548	48,539	194.04
194.05	07955	MOB	0	0	0	45,641	4,842	194.05
194.06	07956	FOUNDATION	0	0	0	10,978	1,165	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	105,840	11,228	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	472	0	0	880,043	93,360	194.09
194.10	07951	BEIRHAUS BUILDING	113	0	0	91,713	9,729	194.10
194.11	07961	SPECIALTY PHARMACY	2,316	0	0	3,158,762	335,100	194.11
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,684,094	2,967,914	5,209,445	248,529,642	23,836,785	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0042

Period:
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To 12/31/2024Worksheet B
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Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
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
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	14,972,602					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	138,603	774,025				8.00
9.00	00900	HOUSEKEEPING	192,823	44,120	4,140,616			9.00
10.00	01000	DIETARY	89,068	2,258	100,557	1,009,731		10.00
11.00	01100	CAFETERIA	240,437	6,096	24,376	0	2,637,808	11.00
13.00	01300	NURSING ADMINISTRATION	256,966	0	0	0	65,770	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	104,413	14,550	43,266	0	24,929	14.00
15.00	01500	PHARMACY	157,370	0	34,217	0	93,658	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	120,547	0	37,836	0	181,325	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	68,565	0	107,344	0	6,086	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	266,994	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	88,737	0	56,924	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	0	0	0	8,163	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,210,186	225,218	665,783	493,357	205,674	30.00
31.00	03100	INTENSIVE CARE UNIT	551,518	40,858	221,984	144,727	118,634	31.00
40.00	04000	SUBPROVIDER - IPF	343,060	15,965	0	170,461	90,064	40.00
41.00	04100	SUBPROVIDER - IRF	452,527	41,330	174,533	201,186	84,305	41.00
43.00	04300	NURSERY	269,047	28,725	84,891	0	26,233	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	632,374	34,907	164,693	0	99,081	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	322,083	21,679	58,875	0	36,070	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	154,369	70,999	209,881	0	64,840	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	19,379	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	570,258	43,374	120,522	0	156,809	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	473,373	9,608	66,284	0	81,228	55.00
60.00	06000	LABORATORY	192,086	0	56,613	0	135,811	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	149,474	323	41,173	0	89,664	65.00
66.00	06600	PHYSICAL THERAPY	746,078	6,677	171,197	0	177,527	66.00
69.00	06900	ELECTROCARDIOLOGY	478,531	14,768	187,372	0	127,643	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	202,878	7,329	57,405	0	28,112	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
75.00	07500	ASC (NON-DISTINCT PART)	0	21,011	166,842	0	49,324	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	225,882	0	0	0	4,910	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	FAMILY PRACTICE 120	100,070	361	0	0	0	88.00
88.01	08801	GOOD SAMARITAN FP 110 HB	68,012	1,018	0	0	0	88.01
88.02	08802	GOOD SAMARITAN IM 100 HB	60,590	1,189	0	0	0	88.02
88.03	08803	GOOD SAMARITAN IM 110 HB	88,910	635	0	0	0	88.03
88.04	08804	GOOD SAMARITANKIDS HB	86,015	1,351	0	0	0	88.04
88.05	08805	GOOD SAMARITAN FP 100 HB	111,599	1,809	0	0	0	88.05
90.00	09000	CLINIC	59,326	24	63,683	0	1,433	90.00
90.01	04950	WOUND CLINIC	78,330	7,738	19,964	0	15,224	90.01
91.00	09100	EMERGENCY	622,978	91,497	258,520	0	185,051	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	10,370	0	0	0	4,248	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	127,944	0	70,978	0	28,783	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,023,654	755,417	3,297,526	1,009,731	2,266,902	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,487,437	18,608	761,932	0	271,846	192.00
192.01	19201	FP PETERSBURG	97,517	0	0	0	0	192.01
192.02	19202	PEDIATRICS	0	0	0	0	26,454	192.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0042

Period:
From 01/01/2024
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Part I
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Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
192.03	19203	WASHINGTON PRIMARY CARE	178,979	0	0	0	43,670	192.03
192.04	19204	FQHC	0	0	0	0	2,401	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	10,923	0	16,175	0	1,113	194.00
194.01	07960	CCBHC GRANTS	0	0	0	0	14,470	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	44,481	0	3,280	0	10,952	194.02
194.03	07953	MH RESIDENTIAL	533,252	0	0	0	0	194.03
194.04	07954	UNUSED SPACE	536,147	0	0	0	0	194.04
194.05	07955	MOB	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	12,265	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	124,022	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	923,925	0	0	0	0	194.09
194.10	07951	BEIRHAUS BUILDING	0	0	61,703	0	0	194.10
194.11	07961	SPECIALTY PHARMACY	0	0	0	0	0	194.11
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)	14,972,602	774,025	4,140,616	1,009,731	2,637,808	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0042

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Cost Center Description			NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	5,144,903					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,163,214				14.00
15.00	01500	PHARMACY	0	1,924	5,367,963			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	531,814	295	0	7,205,075		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	0	2	0	0	0	17.01
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 APPRVD	245,463	762	3,252	0	0	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	80	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	862,292	21,862	197	1,025,965	0	30.00
31.00	03100	INTENSIVE CARE UNIT	511,565	18,257	25	209,857	0	31.00
40.00	04000	SUBPROVIDER - IPF	388,366	1,562	0	1,095,918	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	3,661	0	641,228	0	41.00
43.00	04300	NURSERY	109,979	0	25	46,635	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	362,048	105,478	2,042	256,491	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	155,537	35,563	2,243	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	271,842	6,112	62	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	68,393	38,009	99,892	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	235,225	6,132	1,704	0	0	55.00
60.00	06000	LABORATORY	0	163,790	50	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	3,508	566	0	0	65.00
66.00	06600	PHYSICAL THERAPY	195,406	2,133	15,018	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	30,723	231	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	14,314	4,012	7	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	181,480	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	331,891	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	4,563,732	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	212,690	30,673	2,713	2,215,153	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	21,172	182	531	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	FAMILY PRACTICE 120	0	9,867	27,088	0	0	88.00
88.01	08801	GOOD SAMARITAN FP 110 HB	0	3,946	9,270	0	0	88.01
88.02	08802	GOOD SAMARITAN IM 100 HB	0	1,088	2,305	0	0	88.02
88.03	08803	GOOD SAMARITAN IM 110 HB	0	950	2,187	0	0	88.03
88.04	08804	GOOD SAMARITANKIDS HB	0	12,736	31,694	0	0	88.04
88.05	08805	GOOD SAMARITAN FP 100 HB	0	4,342	8,651	0	0	88.05
90.00	09000	CLINIC	0	0	0	291,467	0	90.00
90.01	04950	WOUND CLINIC	14,461	5,995	4,150	1,422,361	0	90.01
91.00	09100	EMERGENCY	797,966	24,820	3,028	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	2,540	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	124,116	1,797	168	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,122,649	1,056,172	4,780,831	7,205,075	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	22,254	83,231	141,104	0	0	192.00
192.01	19201	FP PETERSBURG	0	0	0	0	0	192.01

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
192.02	19202	PEDIATRICS	0	14,098	39,233	0	0	192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	6,731	16,242	0	0	192.03
192.04	19204	FQHC	0	0	0	0	0	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	0	147	172	0	0	194.00
194.01	07960	CCBHC GRANTS	0	91	0	0	0	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	531	0	0	0	194.02
194.03	07953	MH RESIDENTIAL	0	0	0	0	0	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	0	194.04
194.05	07955	MOB	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	360	0	0	0	194.09
194.10	07951	BEIRHAUS BUILDING	0	86	0	0	0	194.10
194.11	07961	SPECIALTY PHARMACY	0	1,767	390,381	0	0	194.11
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)	5,144,903	1,163,214	5,367,963	7,205,075	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0042

Period:
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Cost Center Description			INTERNS & RESIDENTS			PARAMED ED PRGM-RADIOLOG Y	PARAMED ED PRGM-LAB		
			MENTAL HEALTH OH	SERVICES-SALA RY & FRINGES	SERVICES-OTHE R PRGM COSTS				
			17.01	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	
4.01	00401	COMMUNICATIONS						4.01	
4.02	00402	PURCHASING & RECEIVING						4.02	
4.03	00403	REGISTRATION						4.03	
4.04	00404	PATIENT ACCOUNTS						4.04	
5.00	00500	ADMINISTRATIVE & GENERAL						5.00	
7.00	00700	OPERATION OF PLANT						7.00	
8.00	00800	LAUNDRY & LINEN SERVICE						8.00	
9.00	00900	HOUSEKEEPING						9.00	
10.00	01000	DIETARY						10.00	
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	
17.01	01701	MENTAL HEALTH OH	507,415					17.01	
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	5,089,133				21.00	
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0		4,735,784			22.00	
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0			0		23.00	
23.01	02301	PARAMED ED PRGM-LAB	0				332,577	23.01	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	760,518	707,714	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	38,026	35,386	0	0	31.00	
40.00	04000	SUBPROVIDER - IPF	506,363	466,451	434,064	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00	
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00	
51.01	05101	ENDOSCOPY	0	144,498	134,466	0	0	51.01	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0	5,070	4,718	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	17,745	16,513	0	0	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	45,631	42,463	0	0	55.00	
60.00	06000	LABORATORY	0	0	0	0	332,577	60.00	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00	
65.00	06500	RESPIRATORY THERAPY	0	58,306	54,258	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00	
69.00	06900	ELECTROCARDIOLOGY	0	86,192	80,208	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00	
70.01	07001	NEURODIAGNOSTICS	0	0	0	0	0	70.01	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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	
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00	
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00	
76.01	03951	INPATIENT DIALYSIS	0	20,280	18,872	0	0	76.01	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	FAMILY PRACTICE 120	0	0	0	0	0	88.00	
88.01	08801	GOOD SAMARITAN FP 110 HB	0	0	0	0	0	88.01	
88.02	08802	GOOD SAMARITAN IM 100 HB	0	0	0	0	0	88.02	
88.03	08803	GOOD SAMARITAN IM 110 HB	0	0	0	0	0	88.03	
88.04	08804	GOOD SAMARITANKIDS HB	0	0	0	0	0	88.04	
88.05	08805	GOOD SAMARITAN FP 100 HB	0	0	0	0	0	88.05	
90.00	09000	CLINIC	0	0	0	0	0	90.00	
90.01	04950	WOUND CLINIC	0	0	0	0	0	90.01	
91.00	09100	EMERGENCY	0	1,318,233	1,226,703	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00	
	OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00	
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00	
116.00	11600	HOSPICE	0	0	0	0	0	116.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	506,363	2,960,950	2,755,365	0	332,577	118.00	
	NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00	

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			MENTAL HEALTH OH	INTERNS & RESIDENTS		PARAMED ED PRGM-RADIOLOG Y	PARAMED ED PRGM-LAB	
				SERVICES-SALA RY & FRINGES	SERVICES-OTHE R PRGM COSTS			
				17.01	21.00			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	955,718	889,360	0	0	192.00
192.01	19201	FP PETERSBURG	0	0	0	0	0	192.01
192.02	19202	PEDIATRICS	0	0	0	0	0	192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	0	0	0	0	192.03
192.04	19204	FQHC	0	0	0	0	0	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	0	0	0	0	0	194.00
194.01	07960	CCBHC GRANTS	0	0	0	0	0	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	MH RESIDENTIAL	0	0	0	0	0	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	0	194.04
194.05	07955	MOB	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	1,052	1,172,465	1,091,059	0	0	194.09
194.10	07951	BEIRHAUS BUILDING	0	0	0	0	0	194.10
194.11	07961	SPECIALTY PHARMACY	0	0	0	0	0	194.11
200.00		Cross Foot Adjustments		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)	507,415	5,089,133	4,735,784	0	332,577	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
4.01	00401	COMMUNICATIONS				4.01
4.02	00402	PURCHASING & RECEIVING				4.02
4.03	00403	REGISTRATION				4.03
4.04	00404	PATIENT ACCOUNTS				4.04
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
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
17.01	01701	MENTAL HEALTH OH				17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD				22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY				23.00
23.01	02301	PARAMED ED PRGM-LAB				23.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,863,602	-1,468,232	21,395,370	30.00
31.00	03100	INTENSIVE CARE UNIT	7,945,628	-73,412	7,872,216	31.00
40.00	04000	SUBPROVIDER - IPF	7,989,362	-900,515	7,088,847	40.00
41.00	04100	SUBPROVIDER - IRF	5,327,253	0	5,327,253	41.00
43.00	04300	NURSERY	1,076,345	0	1,076,345	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,428,727	0	11,428,727	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
51.01	05101	ENDOSCOPY	3,684,801	-278,964	3,405,837	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,576,858	0	1,576,858	52.00
53.00	05300	ANESTHESIOLOGY	2,562,529	-9,788	2,552,741	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,022,962	-34,258	14,988,704	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,204,908	-88,094	6,116,814	55.00
60.00	06000	LABORATORY	11,453,637	0	11,453,637	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	4,551,202	-112,564	4,438,638	65.00
66.00	06600	PHYSICAL THERAPY	9,129,514	0	9,129,514	66.00
69.00	06900	ELECTROCARDIOLOGY	7,906,391	-166,400	7,739,991	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	2,284,137	0	2,284,137	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,197,317	0	4,197,317	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,775,526	0	7,775,526	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33,836,386	0	33,836,386	73.00
75.00	07500	ASC (NON-DISTINCT PART)	6,136,307	0	6,136,307	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	1,088,609	-39,152	1,049,457	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY PRACTICE 120	3,246,986	0	3,246,986	88.00
88.01	08801	GOOD SAMARITAN FP 110 HB	1,069,713	0	1,069,713	88.01
88.02	08802	GOOD SAMARITAN IM 100 HB	1,102,289	0	1,102,289	88.02
88.03	08803	GOOD SAMARITAN IM 110 HB	836,936	0	836,936	88.03
88.04	08804	GOOD SAMARITANKIDS HB	972,187	0	972,187	88.04
88.05	08805	GOOD SAMARITAN FP 100 HB	1,709,800	0	1,709,800	88.05
90.00	09000	CLINIC	477,045	0	477,045	90.00
90.01	04950	WOUND CLINIC	2,922,580	0	2,922,580	90.01
91.00	09100	EMERGENCY	13,904,357	-2,544,936	11,359,421	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	221,997	0	221,997	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	1,772,602	0	1,772,602	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	202,278,493	-5,716,315	196,562,178	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEN	0	0	0	190.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	28,342,268	-1,845,078	26,497,190	192.00
192.01	19201	FP PETERSBURG	189,570	0	189,570	192.01
192.02	19202	PEDIATRICS	1,724,445	0	1,724,445	192.02
192.03	19203	WASHINGTON PRIMARY CARE	2,793,461	0	2,793,461	192.03
192.04	19204	FQHC	491,352	0	491,352	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	158,601	0	158,601	194.00
194.01	07960	CCBHC GRANTS	938,699	0	938,699	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	1,006,427	0	1,006,427	194.02
194.03	07953	MH RESIDENTIAL	1,036,606	0	1,036,606	194.03
194.04	07954	UNUSED SPACE	1,042,234	0	1,042,234	194.04
194.05	07955	MOB	50,483	0	50,483	194.05
194.06	07956	FOUNDATION	24,408	0	24,408	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	241,090	0	241,090	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	4,162,264	-2,263,524	1,898,740	194.09
194.10	07951	BEIRHAUS BUILDING	163,231	0	163,231	194.10
194.11	07961	SPECIALTY PHARMACY	3,886,010	0	3,886,010	194.11
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	248,529,642	-9,824,917	238,704,725	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0042

Period:
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	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	109,210	0	109,210	4.00
4.01	00401	COMMUNICATIONS	0	0	0	340	4.01
4.02	00402	PURCHASING & RECEIVING	0	259,996	0	811	4.02
4.03	00403	REGISTRATION	0	253,909	0	2,049	4.03
4.04	00404	PATIENT ACCOUNTS	0	0	0	2,302	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	0	1,077,406	0	8,547	5.00
7.00	00700	OPERATION OF PLANT	0	5,389,275	0	2,548	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	118,284	0	246	8.00
9.00	00900	HOUSEKEEPING	0	164,556	0	2,390	9.00
10.00	01000	DIETARY	0	76,011	0	499	10.00
11.00	01100	CAFETERIA	0	205,189	0	1,348	11.00
13.00	01300	NURSING ADMINISTRATION	0	219,295	0	2,267	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	89,106	0	390	14.00
15.00	01500	PHARMACY	0	134,299	0	3,275	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	102,875	0	4,173	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	0	58,513	0	685	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	227,853	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	2,454	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	0	0	217	23.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	1,032,774	0	7,650	30.00
31.00	03100	INTENSIVE CARE UNIT	0	470,666	0	3,314	31.00
40.00	04000	SUBPROVIDER - IPF	0	292,768	0	2,357	40.00
41.00	04100	SUBPROVIDER - IRF	0	386,187	0	2,109	41.00
43.00	04300	NURSERY	0	229,605	0	152	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	539,669	0	3,124	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0	274,866	0	882	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	131,739	0	376	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,395	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	486,659	0	5,061	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	403,977	0	2,941	55.00
60.00	06000	LABORATORY	0	163,927	0	2,547	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	127,561	0	2,982	65.00
66.00	06600	PHYSICAL THERAPY	0	636,704	0	5,700	66.00
69.00	06900	ELECTROCARDIOLOGY	0	408,379	0	6,002	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	173,136	0	720	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	1,109	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	192,768	0	172	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	FAMILY PRACTICE 120	0	85,400	0	1,858	88.00
88.01	08801	GOOD SAMARITAN FP 110 HB	0	58,041	0	557	88.01
88.02	08802	GOOD SAMARITAN IM 100 HB	0	51,707	0	632	88.02
88.03	08803	GOOD SAMARITAN IM 110 HB	0	75,876	0	421	88.03
88.04	08804	GOOD SAMARITANKIDS HB	0	73,405	0	344	88.04
88.05	08805	GOOD SAMARITAN FP 100 HB	0	95,238	0	928	88.05
90.00	09000	CLINIC	0	50,629	0	0	90.00
90.01	04950	WOUND CLINIC	0	66,847	0	386	90.01
91.00	09100	EMERGENCY	0	531,650	0	4,914	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	8,850	0	89	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	109,187	0	628	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	15,643,992	0	95,891	118.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0042

Period:
From 01/01/2024
To 12/31/2024Worksheet B
Part II
Date/Time Prepared:
4/10/2025 8:15 am

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,122,781	0	2,122,781	10,168 192.00
192.01	19201	FP PETERSBURG	0	83,221	0	83,221	0 192.01
192.02	19202	PEDIATRICS	0	0	0	0	890 192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	152,741	0	152,741	1,463 192.03
192.04	19204	FQHC	0	0	0	0	234 192.04
194.00	07950	COMMUNITY HEALTH SERVICES	0	9,322	0	9,322	61 194.00
194.01	07960	CCBHC GRANTS	0	0	0	0	231 194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	37,961	0	37,961	263 194.02
194.03	07953	MH RESIDENTIAL	0	455,077	0	455,077	0 194.03
194.04	07954	UNUSED SPACE	0	457,548	0	457,548	0 194.04
194.05	07955	MOB	0	0	0	0	0 194.05
194.06	07956	FOUNDATION	0	10,467	0	10,467	0 194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	105,840	0	105,840	0 194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0 194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	788,479	0	788,479	9 194.09
194.10	07951	BEIRHAUS BUILDING	0	0	0	0	0 194.10
194.11	07961	SPECIALTY PHARMACY	0	0	0	0	0 194.11
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	0	19,867,429	0	19,867,429	109,210 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0042

Period:
From 01/01/2024
To 12/31/2024Worksheet B
Part II
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Cost Center Description			COMMUNICATION S	PURCHASING & RECEIVING	REGISTRATION	PATIENT ACCOUNTS	ADMINISTRATIVE & GENERAL	
			4.01	4.02	4.03	4.04	5.00	
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
4.01	00401	COMMUNICATIONS	340					4.01
4.02	00402	PURCHASING & RECEIVING	3	260,810				4.02
4.03	00403	REGISTRATION	6	77	256,041			4.03
4.04	00404	PATIENT ACCOUNTS	7	116	0	2,425		4.04
5.00	00500	ADMINISTRATIVE & GENERAL	31	1,324	0	0	1,087,308	5.00
7.00	00700	OPERATION OF PLANT	20	2,946	0	0	65,503	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	954	0	0	2,780	8.00
9.00	00900	HOUSEKEEPING	6	2,306	0	0	17,078	9.00
10.00	01000	DIETARY	1	4,123	0	0	3,578	10.00
11.00	01100	CAFETERIA	3	11,130	0	0	10,355	11.00
13.00	01300	NURSING ADMINISTRATION	3	51	0	0	21,096	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1	1,681	0	0	4,270	14.00
15.00	01500	PHARMACY	5	390	0	0	22,228	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8	60	0	0	27,707	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	14	0	0	0	1,424	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21,096	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	6	155	0	0	18,990	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	16	0	0	1,419	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	28	4,437	12,314	106	72,994	30.00
31.00	03100	INTENSIVE CARE UNIT	16	3,706	3,820	33	26,489	31.00
40.00	04000	SUBPROVIDER - IPF	0	317	3,653	31	19,587	40.00
41.00	04100	SUBPROVIDER - IRF	12	743	2,670	23	16,312	41.00
43.00	04300	NURSERY	0	0	425	4	2,235	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	24	21,410	17,838	154	42,750	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	4	7,218	4,956	43	12,135	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	8	1,241	1,051	9	3,494	52.00
53.00	05300	ANESTHESIOLOGY	0	0	3,135	27	11,083	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15	7,715	45,011	609	60,773	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6	1,245	10,942	94	22,939	55.00
60.00	06000	LABORATORY	6	33,246	28,414	245	46,254	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	6	712	4,533	39	18,173	65.00
66.00	06600	PHYSICAL THERAPY	10	433	9,336	80	34,192	66.00
69.00	06900	ELECTROCARDIOLOGY	13	6,236	22,315	192	30,190	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	3	814	2,216	19	8,619	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	36,837	1,898	16	17,569	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	67,360	5,218	45	32,565	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	40,865	352	128,085	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	6,226	8,147	70	15,040	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	37	380	3	3,486	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	FAMILY PRACTICE 120	5	2,003	1,314	11	13,604	88.00
88.01	08801	GOOD SAMARITAN FP 110 HB	2	801	375	3	4,320	88.01
88.02	08802	GOOD SAMARITAN IM 100 HB	1	221	403	3	4,537	88.02
88.03	08803	GOOD SAMARITAN IM 110 HB	3	193	228	2	3,256	88.03
88.04	08804	GOOD SAMARITANKIDS HB	2	2,585	434	4	3,677	88.04
88.05	08805	GOOD SAMARITAN FP 100 HB	2	881	597	5	6,927	88.05
90.00	09000	CLINIC	0	0	10	0	267	90.00
90.01	04950	WOUND CLINIC	2	1,217	1,742	15	5,925	90.01
91.00	09100	EMERGENCY	16	5,038	21,078	182	41,017	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	516	151	1	896	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	4	365	572	5	6,207	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	302	239,082	256,041	2,425	933,121	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	33	16,894	0	0	99,357	192.00
192.01	19201	FP PETERSBURG	0	0	0	0	403	192.01
192.02	19202	PEDIATRICS	3	2,862	0	0	7,195	192.02

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0042

Period:
From 01/01/2024
To 12/31/2024Worksheet B
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Cost Center Description			COMMUNICATION S	PURCHASING & RECEIVING	REGISTRATION	PATIENT ACCOUNTS	ADMINISTRATIV E & GENERAL	
			4.01	4.02	4.03	4.04	5.00	
192.03	19203	WASHINGTON PRIMARY CARE	0	1,366	0	0	11,147	192.03
192.04	19204	FQHC	0	0	0	0	2,139	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	1	30	0	0	569	194.00
194.01	07960	CCBHC GRANTS	0	18	0	0	4,043	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	1	108	0	0	4,144	194.02
194.03	07953	MH RESIDENTIAL	0	0	0	0	2,202	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	2,214	194.04
194.05	07955	MOB	0	0	0	0	221	194.05
194.06	07956	FOUNDATION	0	0	0	0	53	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	512	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	73	0	0	4,259	194.09
194.10	07951	BEIRHAUS BUILDING	0	18	0	0	444	194.10
194.11	07961	SPECIALTY PHARMACY	0	359	0	0	15,285	194.11
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)	340	260,810	256,041	2,425	1,087,308	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0042

Period:
From 01/01/2024
To 12/31/2024Worksheet B
Part II
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Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
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
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	5,460,292					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	50,547	172,811				8.00
9.00	00900	HOUSEKEEPING	70,320	9,850	266,506			9.00
10.00	01000	DIETARY	32,482	504	6,472	123,670		10.00
11.00	01100	CAFETERIA	87,684	1,361	1,569	0	318,639	11.00
13.00	01300	NURSING ADMINISTRATION	93,712	0	0	0	7,945	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	38,078	3,248	2,785	0	3,011	14.00
15.00	01500	PHARMACY	57,390	0	2,202	0	11,314	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	43,962	0	2,435	0	21,903	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	25,005	0	6,909	0	735	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	97,369	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	5,711	0	6,876	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	0	0	0	986	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	441,337	50,285	42,852	60,425	24,845	30.00
31.00	03100	INTENSIVE CARE UNIT	201,131	9,122	14,288	17,726	14,331	31.00
40.00	04000	SUBPROVIDER - IPF	125,109	3,564	0	20,878	10,879	40.00
41.00	04100	SUBPROVIDER - IRF	165,030	9,227	11,234	24,641	10,184	41.00
43.00	04300	NURSERY	98,118	6,413	5,464	0	3,169	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	230,618	7,793	10,600	0	11,969	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	117,459	4,840	3,789	0	4,357	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	56,296	15,851	13,509	0	7,832	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	2,341	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	207,965	9,684	7,757	0	18,942	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	172,632	2,145	4,266	0	9,812	55.00
60.00	06000	LABORATORY	70,051	0	3,644	0	16,406	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	54,511	72	2,650	0	10,831	65.00
66.00	06600	PHYSICAL THERAPY	272,084	1,491	11,019	0	21,445	66.00
69.00	06900	ELECTROCARDIOLOGY	174,513	3,297	12,060	0	15,419	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	73,987	1,636	3,695	0	3,396	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
75.00	07500	ASC (NON-DISTINCT PART)	0	4,691	10,739	0	5,958	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	82,376	0	0	0	593	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	FAMILY PRACTICE 120	36,494	81	0	0	0	88.00
88.01	08801	GOOD SAMARITAN FP 110 HB	24,803	227	0	0	0	88.01
88.02	08802	GOOD SAMARITAN IM 100 HB	22,096	265	0	0	0	88.02
88.03	08803	GOOD SAMARITAN IM 110 HB	32,424	142	0	0	0	88.03
88.04	08804	GOOD SAMARITANKIDS HB	31,368	302	0	0	0	88.04
88.05	08805	GOOD SAMARITAN FP 100 HB	40,698	404	0	0	0	88.05
90.00	09000	CLINIC	21,635	5	4,099	0	173	90.00
90.01	04950	WOUND CLINIC	28,566	1,728	1,285	0	1,839	90.01
91.00	09100	EMERGENCY	227,191	20,428	16,639	0	22,354	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	3,782	0	0	0	513	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	46,659	0	4,568	0	3,477	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,655,482	168,656	212,240	123,670	273,835	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	907,133	4,155	49,043	0	32,838	192.00
192.01	19201	FP PETERSBURG	35,563	0	0	0	0	192.01
192.02	19202	PEDIATRICS	0	0	0	0	3,196	192.02

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0042

Period:
From 01/01/2024
To 12/31/2024Worksheet B
Part II
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Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
192.03	19203	WASHINGTON PRIMARY CARE	65,271	0	0	0	5,275	192.03
192.04	19204	FQHC	0	0	0	0	290	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	3,983	0	1,041	0	134	194.00
194.01	07960	CCBHC GRANTS	0	0	0	0	1,748	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	16,222	0	211	0	1,323	194.02
194.03	07953	MH RESIDENTIAL	194,469	0	0	0	0	194.03
194.04	07954	UNUSED SPACE	195,525	0	0	0	0	194.04
194.05	07955	MOB	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	4,473	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	45,229	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	336,942	0	0	0	0	194.09
194.10	07951	BEIRHAUS BUILDING	0	0	3,971	0	0	194.10
194.11	07961	SPECIALTY PHARMACY	0	0	0	0	0	194.11
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)	5,460,292	172,811	266,506	123,670	318,639	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0042

Period:
From 01/01/2024
To 12/31/2024Worksheet B
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Cost Center Description			NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	344,369					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	142,570				14.00
15.00	01500	PHARMACY	0	236	231,339			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	35,596	36	0	238,755		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	0	0	0	0	0	17.01
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 APPRVD	16,430	93	140	0	0	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	10	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	57,717	2,680	8	33,997	0	30.00
31.00	03100	INTENSIVE CARE UNIT	34,241	2,238	1	6,954	0	31.00
40.00	04000	SUBPROVIDER - IPF	25,995	191	0	36,315	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	449	0	21,248	0	41.00
43.00	04300	NURSERY	7,361	0	1	1,545	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	24,233	12,928	88	8,499	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	10,411	4,359	97	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,195	749	3	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,578	4,659	4,305	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	15,745	752	73	0	0	55.00
60.00	06000	LABORATORY	0	20,075	2	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	430	24	0	0	65.00
66.00	06600	PHYSICAL THERAPY	13,079	261	647	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	3,766	10	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	958	492	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	22,243	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	40,678	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	196,682	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	14,236	3,760	117	73,406	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	1,417	22	23	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	FAMILY PRACTICE 120	0	1,209	1,167	0	0	88.00
88.01	08801	GOOD SAMARITAN FP 110 HB	0	484	400	0	0	88.01
88.02	08802	GOOD SAMARITAN IM 100 HB	0	133	99	0	0	88.02
88.03	08803	GOOD SAMARITAN IM 110 HB	0	116	94	0	0	88.03
88.04	08804	GOOD SAMARITANKIDS HB	0	1,561	1,366	0	0	88.04
88.05	08805	GOOD SAMARITAN FP 100 HB	0	532	373	0	0	88.05
90.00	09000	CLINIC	0	0	0	9,658	0	90.00
90.01	04950	WOUND CLINIC	968	735	179	47,133	0	90.01
91.00	09100	EMERGENCY	53,411	3,042	131	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	311	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	8,308	220	7	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	342,879	129,450	206,037	238,755	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,490	10,201	6,081	0	0	192.00
192.01	19201	FP PETERSBURG	0	0	0	0	0	192.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0042

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Cost Center Description			NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
192.02	19202	PEDIATRICS	0	1,728	1,691	0	0	192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	825	700	0	0	192.03
192.04	19204	FQHC	0	0	0	0	0	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	0	18	7	0	0	194.00
194.01	07960	CCBHC GRANTS	0	11	0	0	0	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	65	0	0	0	194.02
194.03	07953	MH RESIDENTIAL	0	0	0	0	0	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	0	194.04
194.05	07955	MOB	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	44	0	0	0	194.09
194.10	07951	BEIRHAUS BUILDING	0	11	0	0	0	194.10
194.11	07961	SPECIALTY PHARMACY	0	217	16,823	0	0	194.11
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)	344,369	142,570	231,339	238,755	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0042

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Cost Center Description			INTERNS & RESIDENTS			PARAMED ED PRGM-RADIOLOG Y	PARAMED ED PRGM-LAB		
			MENTAL HEALTH OH	SERVICES-SALA RY & FRINGES	SERVICES-OTHE R PRGM COSTS				
			17.01	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	
4.01	00401	COMMUNICATIONS						4.01	
4.02	00402	PURCHASING & RECEIVING						4.02	
4.03	00403	REGISTRATION						4.03	
4.04	00404	PATIENT ACCOUNTS						4.04	
5.00	00500	ADMINISTRATIVE & GENERAL						5.00	
7.00	00700	OPERATION OF PLANT						7.00	
8.00	00800	LAUNDRY & LINEN SERVICE						8.00	
9.00	00900	HOUSEKEEPING						9.00	
10.00	01000	DIETARY						10.00	
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	
17.01	01701	MENTAL HEALTH OH	93,285					17.01	
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	346,318				21.00	
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0		50,855			22.00	
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0			0		23.00	
23.01	02301	PARAMED ED PRGM-LAB	0				2,648	23.01	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0					30.00	
31.00	03100	INTENSIVE CARE UNIT	0					31.00	
40.00	04000	SUBPROVIDER - IPF	93,092					40.00	
41.00	04100	SUBPROVIDER - IRF	0					41.00	
43.00	04300	NURSERY	0					43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0					50.00	
51.00	05100	RECOVERY ROOM	0					51.00	
51.01	05101	ENDOSCOPY	0					51.01	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0					52.00	
53.00	05300	ANESTHESIOLOGY	0					53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0					54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0					55.00	
60.00	06000	LABORATORY	0					60.00	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0					63.00	
65.00	06500	RESPIRATORY THERAPY	0					65.00	
66.00	06600	PHYSICAL THERAPY	0					66.00	
69.00	06900	ELECTROCARDIOLOGY	0					69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0					70.00	
70.01	07001	NEURODIAGNOSTICS	0					70.01	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0					71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0					72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0					73.00	
75.00	07500	ASC (NON-DISTINCT PART)	0					75.00	
76.00	03950	MH ANCILLARY OUTPATIENT	0					76.00	
76.01	03951	INPATIENT DIALYSIS	0					76.01	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	FAMILY PRACTICE 120	0					88.00	
88.01	08801	GOOD SAMARITAN FP 110 HB	0					88.01	
88.02	08802	GOOD SAMARITAN IM 100 HB	0					88.02	
88.03	08803	GOOD SAMARITAN IM 110 HB	0					88.03	
88.04	08804	GOOD SAMARITANKIDS HB	0					88.04	
88.05	08805	GOOD SAMARITAN FP 100 HB	0					88.05	
90.00	09000	CLINIC	0					90.00	
90.01	04950	WOUND CLINIC	0					90.01	
91.00	09100	EMERGENCY	0					91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00	
	OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0					96.00	
101.00	10100	HOME HEALTH AGENCY	0					101.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
116.00	11600	HOSPICE	0					116.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	93,092	0	0	0	0	118.00	
	NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0					190.00	

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			MENTAL HEALTH OH	INTERNS & RESIDENTS		PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LAB	
				SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS			
			17.01	21.00	22.00	23.00	23.01	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0					192.00
192.01	19201	FP PETERSBURG	0					192.01
192.02	19202	PEDIATRICS	0					192.02
192.03	19203	WASHINGTON PRIMARY CARE	0					192.03
192.04	19204	FQHC	0					192.04
194.00	07950	COMMUNITY HEALTH SERVICES	0					194.00
194.01	07960	CCBHC GRANTS	0					194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	0					194.02
194.03	07953	MH RESIDENTIAL	0					194.03
194.04	07954	UNUSED SPACE	0					194.04
194.05	07955	MOB	0					194.05
194.06	07956	FOUNDATION	0					194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0					194.07
194.08	07958	INDUSTRIAL HEALTH	0					194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	193					194.09
194.10	07951	BEIRHAUS BUILDING	0					194.10
194.11	07961	SPECIALTY PHARMACY	0					194.11
200.00		Cross Foot Adjustments		346,318	50,855	0	2,648	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	93,285	346,318	50,855	0	2,648	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0042

Period:
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
4.01	00401	COMMUNICATIONS				4.01
4.02	00402	PURCHASING & RECEIVING				4.02
4.03	00403	REGISTRATION				4.03
4.04	00404	PATIENT ACCOUNTS				4.04
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
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
17.01	01701	MENTAL HEALTH OH				17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD				22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY				23.00
23.01	02301	PARAMED ED PRGM-LAB				23.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,844,449	0	1,844,449	30.00
31.00	03100	INTENSIVE CARE UNIT	808,076	0	808,076	31.00
40.00	04000	SUBPROVIDER - IPF	634,736	0	634,736	40.00
41.00	04100	SUBPROVIDER - IRF	650,069	0	650,069	41.00
43.00	04300	NURSEY	354,492	0	354,492	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	931,697	0	931,697	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
51.01	05101	ENDOSCOPY	445,416	0	445,416	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	250,353	0	250,353	52.00
53.00	05300	ANESTHESIOLOGY	19,981	0	19,981	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	863,733	0	863,733	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	647,569	0	647,569	55.00
60.00	06000	LABORATORY	384,817	0	384,817	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	222,524	0	222,524	65.00
66.00	06600	PHYSICAL THERAPY	1,006,481	0	1,006,481	66.00
69.00	06900	ELECTROCARDIOLOGY	682,392	0	682,392	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	269,691	0	269,691	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	78,563	0	78,563	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	145,866	0	145,866	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	365,984	0	365,984	73.00
75.00	07500	ASC (NON-DISTINCT PART)	143,499	0	143,499	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	281,277	0	281,277	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY PRACTICE 120	143,146	0	143,146	88.00
88.01	08801	GOOD SAMARITAN FP 110 HB	90,013	0	90,013	88.01
88.02	08802	GOOD SAMARITAN IM 100 HB	80,097	0	80,097	88.02
88.03	08803	GOOD SAMARITAN IM 110 HB	112,755	0	112,755	88.03
88.04	08804	GOOD SAMARITANKIDS HB	115,048	0	115,048	88.04
88.05	08805	GOOD SAMARITAN FP 100 HB	146,585	0	146,585	88.05
90.00	09000	CLINIC	86,476	0	86,476	90.00
90.01	04950	WOUND CLINIC	158,567	0	158,567	90.01
91.00	09100	EMERGENCY	947,091	0	947,091	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	15,109	0	15,109	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	180,207	0	180,207	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,106,759	0	13,106,759	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEN	0	0	0	190.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0042

Period:
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To 12/31/2024Worksheet B
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,260,174	0	3,260,174		192.00
192.01	19201	FP PETERSBURG	119,187	0	119,187		192.01
192.02	19202	PEDIATRICS	17,565	0	17,565		192.02
192.03	19203	WASHINGTON PRIMARY CARE	238,788	0	238,788		192.03
192.04	19204	FQHC	2,663	0	2,663		192.04
194.00	07950	COMMUNITY HEALTH SERVICES	15,166	0	15,166		194.00
194.01	07960	CCBHC GRANTS	6,051	0	6,051		194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	60,298	0	60,298		194.02
194.03	07953	MH RESIDENTIAL	651,748	0	651,748		194.03
194.04	07954	UNUSED SPACE	655,287	0	655,287		194.04
194.05	07955	MOB	221	0	221		194.05
194.06	07956	FOUNDATION	14,993	0	14,993		194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	151,581	0	151,581		194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0		194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	1,129,999	0	1,129,999		194.09
194.10	07951	BEIRHAUS BUILDING	4,444	0	4,444		194.10
194.11	07961	SPECIALTY PHARMACY	32,684	0	32,684		194.11
200.00		Cross Foot Adjustments	399,821	0	399,821		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	19,867,429	0	19,867,429		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0042

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

Worksheet B-1

Date/Time Prepared:
4/10/2025 8:15 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NUMBER OF PHONES)	PURCHASING & RECEIVING (SUPPLIES COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	4.01	4.02	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	884,496					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		884,496				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,862	4,862	112,522,787			4.00
4.01	00401	COMMUNICATIONS	0	0	349,881	2,101		4.01
4.02	00402	PURCHASING & RECEIVING	11,575	11,575	835,503	20	23,725,534	4.02
4.03	00403	REGISTRATION	11,304	11,304	2,109,969	38	7,022	4.03
4.04	00404	PATIENT ACCOUNTS	0	0	2,371,049	45	10,595	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	47,966	47,966	8,801,904	191	120,398	5.00
7.00	00700	OPERATION OF PLANT	239,930	239,930	2,624,007	125	267,946	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,266	5,266	253,110	0	86,759	8.00
9.00	00900	HOUSEKEEPING	7,326	7,326	2,461,198	37	209,742	9.00
10.00	01000	DIETARY	3,384	3,384	514,217	7	375,042	10.00
11.00	01100	CAFETERIA	9,135	9,135	1,388,175	18	1,012,460	11.00
13.00	01300	NURSING ADMINISTRATION	9,763	9,763	2,335,214	20	4,657	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,967	3,967	401,377	5	152,922	14.00
15.00	01500	PHARMACY	5,979	5,979	3,372,977	30	35,520	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,580	4,580	4,297,247	47	5,440	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	2,605	2,605	705,253	85	30	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	10,144	10,144	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	2,527,337	35	14,078	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	0	223,921	0	1,476	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	45,979	45,979	7,878,571	176	403,663	30.00
31.00	03100	INTENSIVE CARE UNIT	20,954	20,954	3,412,561	96	337,110	31.00
40.00	04000	SUBPROVIDER - IPF	13,034	13,034	2,427,729	0	28,845	40.00
41.00	04100	SUBPROVIDER - IRF	17,193	17,193	2,172,333	74	67,592	41.00
43.00	04300	NURSERY	10,222	10,222	156,597	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	24,026	24,026	3,217,683	150	1,947,589	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	12,237	12,237	908,422	26	656,645	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,865	5,865	387,122	49	112,860	52.00
53.00	05300	ANESTHESIOLOGY	0	0	3,495,884	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,666	21,666	5,212,253	92	701,822	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	17,985	17,985	3,029,221	36	113,227	55.00
60.00	06000	LABORATORY	7,298	7,298	2,622,871	34	3,024,293	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	5,679	5,679	3,070,948	40	64,782	65.00
66.00	06600	PHYSICAL THERAPY	28,346	28,346	5,869,920	60	39,377	66.00
69.00	06900	ELECTROCARDIOLOGY	18,181	18,181	6,181,329	82	567,287	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	7,708	7,708	741,959	20	74,086	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	3,350,934	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	6,128,037	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	1,141,923	0	566,367	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	8,582	8,582	177,087	2	3,364	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	FAMILY PRACTICE 120	3,802	3,802	1,913,291	33	182,181	88.00
88.01	08801	GOOD SAMARITAN FP 110 HB	2,584	2,584	574,140	10	72,856	88.01
88.02	08802	GOOD SAMARITAN IM 100 HB	2,302	2,302	650,880	9	20,083	88.02
88.03	08803	GOOD SAMARITAN IM 110 HB	3,378	3,378	433,477	16	17,541	88.03
88.04	08804	GOOD SAMARITANKIDS HB	3,268	3,268	353,851	11	235,157	88.04
88.05	08805	GOOD SAMARITAN FP 100 HB	4,240	4,240	956,003	15	80,179	88.05
90.00	09000	CLINIC	2,254	2,254	0	1	0	90.00
90.01	04950	WOUND CLINIC	2,976	2,976	397,796	10	110,703	90.01
91.00	09100	EMERGENCY	23,669	23,669	5,061,253	97	458,292	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	394	394	91,802	0	46,908	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	4,861	4,861	646,658	23	33,186	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	696,469	696,469	98,755,903	1,865	21,749,053	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0042

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

Worksheet B-1

Date/Time Prepared:
4/10/2025 8:15 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATION S (NUMBER OF PHONES)	PURCHASING & RECEIVING (SUPPLIES COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	4.01	4.02	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	94,506	94,506	10,522,181	199	1,536,809	192.00
192.01	19201	FP PETERSBURG	3,705	3,705	0	0	0	192.01
192.02	19202	PEDIATRICS	0	0	916,692	21	260,321	192.02
192.03	19203	WASHINGTON PRIMARY CARE	6,800	6,800	1,506,216	0	124,289	192.03
192.04	19204	FQHC	0	0	241,233	0	0	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	415	415	63,127	4	2,720	194.00
194.01	07960	CCBHC GRANTS	0	0	237,479	3	1,675	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	1,690	1,690	270,633	6	9,800	194.02
194.03	07953	MH RESIDENTIAL	20,260	20,260	0	0	0	194.03
194.04	07954	UNUSED SPACE	20,370	20,370	0	0	0	194.04
194.05	07955	MOB	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	466	466	0	3	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	4,712	4,712	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	35,103	35,103	9,323	0	6,648	194.09
194.10	07951	BEIRHAUS BUILDING	0	0	0	0	1,593	194.10
194.11	07961	SPECIALTY PHARMACY	0	0	0	0	32,626	194.11
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)	19,867,429	0	30,800,901	357,732	1,684,094	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	22.461864	0.000000	0.273730	170.267492	0.070982	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			109,210	340	260,810	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000971	0.161828	0.010993	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: 15-0042

Period:

From 01/01/2024

To 12/31/2024

Worksheet B-1

Date/Time Prepared:
4/10/2025 8:15 am

Cost Center Description			REGISTRATION (GROSS CHARGES)	PATIENT ACCOUNTS (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			4.03	4.04	5A	5.00	7.00	
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
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION	735,581,519					4.03
4.04	00404	PATIENT ACCOUNTS	0	735,581,519				4.04
5.00	00500	ADMINISTRATIVE & GENERAL	0	0	-23,836,785	224,692,857		5.00
7.00	00700	OPERATION OF PLANT	0	0	0	13,536,562	568,859	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	574,478	5,266	8.00
9.00	00900	HOUSEKEEPING	0	0	0	3,529,267	7,326	9.00
10.00	01000	DIETARY	0	0	0	739,407	3,384	10.00
11.00	01100	CAFETERIA	0	0	0	2,139,887	9,135	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	4,359,667	9,763	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	882,441	3,967	14.00
15.00	01500	PHARMACY	0	0	0	4,593,489	5,979	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	5,725,828	4,580	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	0	0	0	294,207	2,605	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	4,359,642	10,144	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	3,924,330	0	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	0	0	293,227	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	35,385,349	35,385,349	0	15,084,574	45,979	30.00
31.00	03100	INTENSIVE CARE UNIT	10,976,118	10,976,118	0	5,474,069	20,954	31.00
40.00	04000	SUBPROVIDER - IPF	10,497,284	10,497,284	0	4,047,685	13,034	40.00
41.00	04100	SUBPROVIDER - IRF	7,672,819	7,672,819	0	3,370,880	17,193	41.00
43.00	04300	NURSERY	1,222,010	1,222,010	0	461,818	10,222	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	51,258,349	51,258,349	0	8,834,406	24,026	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	14,240,609	14,240,609	0	2,507,750	12,237	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,020,926	3,020,926	0	722,144	5,865	52.00
53.00	05300	ANESTHESIOLOGY	9,007,341	9,007,341	0	2,290,384	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	129,179,204	129,179,204	0	12,559,102	21,666	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	31,443,566	31,443,566	0	4,740,373	17,985	55.00
60.00	06000	LABORATORY	81,649,357	81,649,357	0	9,558,669	7,298	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	13,025,045	13,025,045	0	3,755,522	5,679	65.00
66.00	06600	PHYSICAL THERAPY	26,827,734	26,827,734	0	7,065,886	28,346	66.00
69.00	06900	ELECTROCARDIOLOGY	64,123,321	64,123,321	0	6,238,867	18,181	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	6,367,215	6,367,215	0	1,781,127	7,708	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,453,227	5,453,227	0	3,630,673	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,993,370	14,993,370	0	6,729,707	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	117,428,064	117,428,064	0	26,465,059	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	23,411,062	23,411,062	0	3,108,168	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	1,092,450	1,092,450	0	720,360	8,582	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	FAMILY PRACTICE 120	3,776,296	3,776,296	0	2,811,355	3,802	88.00
88.01	08801	GOOD SAMARITAN FP 110 HB	1,077,259	1,077,259	0	892,758	2,584	88.01
88.02	08802	GOOD SAMARITAN IM 100 HB	1,157,193	1,157,193	0	937,646	2,302	88.02
88.03	08803	GOOD SAMARITAN IM 110 HB	654,615	654,615	0	672,872	3,378	88.03
88.04	08804	GOOD SAMARITANKIDS HB	1,247,338	1,247,338	0	759,788	3,268	88.04
88.05	08805	GOOD SAMARITAN FP 100 HB	1,715,078	1,715,078	0	1,431,533	4,240	88.05
90.00	09000	CLINIC	27,874	27,874	0	55,251	2,254	90.00
90.01	04950	WOUND CLINIC	5,005,006	5,005,006	0	1,224,459	2,976	90.01
91.00	09100	EMERGENCY	60,569,937	60,569,937	0	8,476,340	23,669	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	434,066	434,066	0	185,193	394	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,642,437	1,642,437	0	1,282,736	4,861	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	735,581,519	735,581,519	-23,836,785	192,829,586	380,832	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	20,532,561	94,506	192.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0042

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

Worksheet B-1

Date/Time Prepared:
4/10/2025 8:15 am

Cost Center Description			REGISTRATION (GROSS CHARGES)	PATIENT ACCOUNTS (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			4.03	4.04	5A	5.00	7.00	
192.01	19201	FP PETERSBURG	0	0	0	83,224	3,705	192.01
192.02	19202	PEDIATRICS	0	0	0	1,486,919	0	192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	0	0	2,303,473	6,800	192.03
192.04	19204	FQHC	0	0	0	442,055	0	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	0	0	0	117,596	415	194.00
194.01	07960	CCBHC GRANTS	0	0	0	835,503	0	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	0	0	856,338	1,690	194.02
194.03	07953	MH RESIDENTIAL	0	0	0	455,077	20,260	194.03
194.04	07954	UNUSED SPACE	0	0	0	457,548	20,370	194.04
194.05	07955	MOB	0	0	0	45,641	0	194.05
194.06	07956	FOUNDATION	0	0	0	10,978	466	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	105,840	4,712	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	0	0	880,043	35,103	194.09
194.10	07951	BEIRHAUS BUILDING	0	0	0	91,713	0	194.10
194.11	07961	SPECIALTY PHARMACY	0	0	0	3,158,762	0	194.11
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)	2,967,914	5,209,445		23,836,785	14,972,602	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.004035	0.007082		0.106086	26.320410	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	256,041	2,425		1,087,308	5,460,292	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000348	0.000003		0.004839	9.598674	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: 15-0042

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

Worksheet B-1

Date/Time Prepared:
4/10/2025 8:15 am

Cost Center Description			LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATIO N (DIRECT NURSING)	
			8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	873,514					8.00
9.00	00900	HOUSEKEEPING	49,791	73,212				9.00
10.00	01000	DIETARY	2,548	1,778	29,742			10.00
11.00	01100	CAFETERIA	6,880	431	0	1,861,033		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	46,402	841,776	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	16,420	765	0	17,588	0	14.00
15.00	01500	PHARMACY	0	605	0	66,078	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	669	0	127,929	87,012	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	0	1,898	0	4,294	0	17.01
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 APPRVD	0	1,569	0	40,161	40,161	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	0	0	5,759	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	254,165	11,772	14,532	145,108	141,083	30.00
31.00	03100	INTENSIVE CARE UNIT	46,110	3,925	4,263	83,699	83,699	31.00
40.00	04000	SUBPROVIDER - IPF	18,017	0	5,021	63,542	63,542	40.00
41.00	04100	SUBPROVIDER - IRF	46,642	3,086	5,926	59,479	0	41.00
43.00	04300	NURSERY	32,417	1,501	0	18,508	17,994	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	39,394	2,912	0	69,904	59,236	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	24,466	1,041	0	25,448	25,448	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	80,125	3,711	0	45,746	44,477	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	13,672	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	48,949	2,131	0	110,632	11,190	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	10,843	1,172	0	57,308	38,486	55.00
60.00	06000	LABORATORY	0	1,001	0	95,818	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	364	728	0	63,260	0	65.00
66.00	06600	PHYSICAL THERAPY	7,535	3,027	0	125,249	31,971	66.00
69.00	06900	ELECTROCARDIOLOGY	16,666	3,313	0	90,055	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	8,271	1,015	0	19,834	2,342	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
75.00	07500	ASC (NON-DISTINCT PART)	23,712	2,950	0	34,799	34,799	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	3,464	3,464	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	FAMILY PRACTICE 120	407	0	0	0	0	88.00
88.01	08801	GOOD SAMARITAN FP 110 HB	1,149	0	0	0	0	88.01
88.02	08802	GOOD SAMARITAN IM 100 HB	1,342	0	0	0	0	88.02
88.03	08803	GOOD SAMARITAN IM 110 HB	717	0	0	0	0	88.03
88.04	08804	GOOD SAMARITANKIDS HB	1,525	0	0	0	0	88.04
88.05	08805	GOOD SAMARITAN FP 100 HB	2,042	0	0	0	0	88.05
90.00	09000	CLINIC	27	1,126	0	1,011	0	90.00
90.01	04950	WOUND CLINIC	8,733	353	0	10,741	2,366	90.01
91.00	09100	EMERGENCY	103,257	4,571	0	130,558	130,558	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	2,997	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	1,255	0	20,307	20,307	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	852,514	58,305	29,742	1,599,350	838,135	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0042

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

Worksheet B-1

Date/Time Prepared:
4/10/2025 8:15 am

Cost Center Description			LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATIO N (DIRECT NURSING)	
			8.00	9.00	10.00	11.00	13.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	21,000	13,472	0	191,794	3,641	192.00
192.01	19201	FP PETERSBURG	0	0	0	0	0	192.01
192.02	19202	PEDIATRICS	0	0	0	18,664	0	192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	0	0	30,810	0	192.03
192.04	19204	FQHC	0	0	0	1,694	0	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	0	286	0	785	0	194.00
194.01	07960	CCBHC GRANTS	0	0	0	10,209	0	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	58	0	7,727	0	194.02
194.03	07953	MH RESIDENTIAL	0	0	0	0	0	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	0	194.04
194.05	07955	MOB	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	0	0	0	0	194.09
194.10	07951	BEIRHAUS BUILDING	0	1,091	0	0	0	194.10
194.11	07961	SPECIALTY PHARMACY	0	0	0	0	0	194.11
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)	774,025	4,140,616	1,009,731	2,637,808	5,144,903	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.886105	56.556521	33.949667	1.417389	6.111962	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	172,811	266,506	123,670	318,639	344,369	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.197834	3.640196	4.158093	0.171216	0.409098	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: 15-0042

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

Worksheet B-1

Date/Time Prepared:
4/10/2025 8:15 am

Cost Center Description			CENTRAL SERVICES & SUPPLY (SUPPLIES COST)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (NET CHARGES)	MENTAL HEALTH OH (NET CHARGES)	
			14.00	15.00	16.00	17.00	17.01	
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
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	21,477,991					14.00
15.00	01500	PHARMACY	35,520	30,097,512				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,440	0	618			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0		17.00
17.01	01701	MENTAL HEALTH OH	30	0	0	0	10,551,028	17.01
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 APPRVD	14,078	18,235	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	1,476	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	403,663	1,104	88	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	337,110	139	18	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	28,845	0	94	0	10,529,146	40.00
41.00	04100	SUBPROVIDER - IRF	67,592	0	55	0	0	41.00
43.00	04300	NURSERY	0	141	4	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,947,589	11,452	22	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	656,645	12,578	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	112,860	348	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	701,822	560,083	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	113,227	9,556	0	0	0	55.00
60.00	06000	LABORATORY	3,024,293	279	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	64,782	3,175	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	39,377	84,202	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	567,287	1,295	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	74,086	38	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,350,934	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,128,037	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	25,588,270	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	566,367	15,213	190	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	3,364	2,978	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	FAMILY PRACTICE 120	182,181	151,877	0	0	0	88.00
88.01	08801	GOOD SAMARITAN FP 110 HB	72,856	51,978	0	0	0	88.01
88.02	08802	GOOD SAMARITAN IM 100 HB	20,083	12,925	0	0	0	88.02
88.03	08803	GOOD SAMARITAN IM 110 HB	17,541	12,263	0	0	0	88.03
88.04	08804	GOOD SAMARITANKIDS HB	235,157	177,705	0	0	0	88.04
88.05	08805	GOOD SAMARITAN FP 100 HB	80,179	48,506	0	0	0	88.05
90.00	09000	CLINIC	0	0	25	0	0	90.00
90.01	04950	WOUND CLINIC	110,703	23,268	122	0	0	90.01
91.00	09100	EMERGENCY	458,292	16,979	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	46,908	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	33,186	940	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,501,510	26,805,527	618	0	10,529,146	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0042

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

Worksheet B-1

Date/Time Prepared:
4/10/2025 8:15 am

Cost Center Description			CENTRAL SERVICES & SUPPLY (SUPPLIES COST)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (NET CHARGES)	MENTAL HEALTH OH (NET CHARGES)	
			14.00	15.00	16.00	17.00	17.01	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,536,809	791,155	0	0	0	192.00
192.01	19201	FP PETERSBURG	0	0	0	0	0	192.01
192.02	19202	PEDIATRICS	260,321	219,977	0	0	0	192.02
192.03	19203	WASHINGTON PRIMARY CARE	124,289	91,069	0	0	0	192.03
192.04	19204	FQHC	0	0	0	0	0	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	2,720	962	0	0	0	194.00
194.01	07960	CCBHC GRANTS	1,675	0	0	0	0	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	9,800	0	0	0	0	194.02
194.03	07953	MH RESIDENTIAL	0	0	0	0	0	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	0	194.04
194.05	07955	MOB	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	6,648	0	0	0	21,882	194.09
194.10	07951	BEIRHAUS BUILDING	1,593	0	0	0	0	194.10
194.11	07961	SPECIALTY PHARMACY	32,626	2,188,822	0	0	0	194.11
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,163,214	5,367,963	7,205,075	0	507,415	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.054158	0.178352	11,658.697411	0.000000	0.048092	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	142,570	231,339	238,755	0	93,285	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.006638	0.007686	386.334951	0.000000	0.008841	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: 15-0042

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

Worksheet B-1

Date/Time Prepared:
4/10/2025 8:15 am

Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM-RADIOLOG Y (ASSIGNED TIME)	PARAMED ED PRGM-LAB (ASSIGNED TIME)		
			SERVICES-SALA RY & FRINGES (ASSIGNED TIME)	SERVICES-OTHE R PRGM COSTS (ASSIGNED TIME)				
			21.00	22.00				
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
4.01	00401	COMMUNICATIONS					4.01	
4.02	00402	PURCHASING & RECEIVING					4.02	
4.03	00403	REGISTRATION					4.03	
4.04	00404	PATIENT ACCOUNTS					4.04	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
7.00	00700	OPERATION OF PLANT					7.00	
8.00	00800	LAUNDRY & LINEN SERVICE					8.00	
9.00	00900	HOUSEKEEPING					9.00	
10.00	01000	DIETARY					10.00	
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	
17.01	01701	MENTAL HEALTH OH					17.01	
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	4,015				21.00	
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		4,015			22.00	
23.00	02300	PARAMED ED PRGM-RADIOLOGY			0		23.00	
23.01	02301	PARAMED ED PRGM-LAB				100	23.01	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	600	600	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	30	30	0	0	31.00	
40.00	04000	SUBPROVIDER - IPF	368	368	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00	
43.00	04300	NURSERY	0	0	0	0	43.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	50.00	
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00	
51.01	05101	ENDOSCOPY	114	114	0	0	51.01	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	4	4	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	14	14	0	0	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	36	36	0	0	55.00	
60.00	06000	LABORATORY	0	0	0	100	60.00	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00	
65.00	06500	RESPIRATORY THERAPY	46	46	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00	
69.00	06900	ELECTROCARDIOLOGY	68	68	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00	
70.01	07001	NEURODIAGNOSTICS	0	0	0	0	70.01	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00	
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00	
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	76.00	
76.01	03951	INPATIENT DIALYSIS	16	16	0	0	76.01	
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	FAMILY PRACTICE 120	0	0	0	0	88.00	
88.01	08801	GOOD SAMARITAN FP 110 HB	0	0	0	0	88.01	
88.02	08802	GOOD SAMARITAN IM 100 HB	0	0	0	0	88.02	
88.03	08803	GOOD SAMARITAN IM 110 HB	0	0	0	0	88.03	
88.04	08804	GOOD SAMARITANKIDS HB	0	0	0	0	88.04	
88.05	08805	GOOD SAMARITAN FP 100 HB	0	0	0	0	88.05	
90.00	09000	CLINIC	0	0	0	0	90.00	
90.01	04950	WOUND CLINIC	0	0	0	0	90.01	
91.00	09100	EMERGENCY	1,040	1,040	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00	
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00	
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00	
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE					113.00	
116.00	11600	HOSPICE			0	0	116.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,336	2,336	0	100	118.00	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0042

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

Worksheet B-1

Date/Time Prepared:
4/10/2025 8:15 am

Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM-RADIOLOG Y (ASSIGNED TIME)	PARAMED ED PRGM-LAB (ASSIGNED TIME)		
			SERVICES-SALA RY & FRINGES (ASSIGNED TIME)	SERVICES-OTHE R PRGM COSTS (ASSIGNED TIME)				
			21.00	22.00				
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	754	754	0	0		192.00
192.01	19201	FP PETERSBURG	0	0	0	0		192.01
192.02	19202	PEDIATRICS	0	0	0	0		192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	0	0	0		192.03
192.04	19204	FQHC	0	0	0	0		192.04
194.00	07950	COMMUNITY HEALTH SERVICES	0	0	0	0		194.00
194.01	07960	CCBHC GRANTS	0	0	0	0		194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	0	0	0		194.02
194.03	07953	MH RESIDENTIAL	0	0	0	0		194.03
194.04	07954	UNUSED SPACE	0	0	0	0		194.04
194.05	07955	MOB	0	0	0	0		194.05
194.06	07956	FOUNDATION	0	0	0	0		194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0		194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0		194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	925	925	0	0		194.09
194.10	07951	BEIRHAUS BUILDING	0	0	0	0		194.10
194.11	07961	SPECIALTY PHARMACY	0	0	0	0		194.11
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,089,133	4,735,784	0	332,577		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1,267.530012	1,179.522790	0.000000	3,325.770000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	346,318	50,855	0	2,648		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	86.256040	12.666252	0.000000	26.480000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			0	0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			0.000000	0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0042

Period:
From 01/01/2024
To 12/31/2024Worksheet C
Part I
Date/Time Prepared:
4/10/2025 8:15 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	21,395,370		21,395,370	0	21,395,370	30.00
31.00	03100	INTENSIVE CARE UNIT	7,872,216		7,872,216	0	7,872,216	31.00
40.00	04000	SUBPROVIDER - IPF	7,088,847		7,088,847	0	7,088,847	40.00
41.00	04100	SUBPROVIDER - IRF	5,327,253		5,327,253	0	5,327,253	41.00
43.00	04300	NURSERY	1,076,345		1,076,345	0	1,076,345	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,428,727		11,428,727	0	11,428,727	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
51.01	05101	ENDOSCOPY	3,405,837		3,405,837	0	3,405,837	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,576,858		1,576,858	0	1,576,858	52.00
53.00	05300	ANESTHESIOLOGY	2,552,741		2,552,741	171	2,552,912	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,988,704		14,988,704	12,136	15,000,840	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,116,814		6,116,814	5,612	6,122,426	55.00
60.00	06000	LABORATORY	11,453,637		11,453,637	126,243	11,579,880	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	4,438,638	0	4,438,638	4,248	4,442,886	65.00
66.00	06600	PHYSICAL THERAPY	9,129,514	0	9,129,514	0	9,129,514	66.00
69.00	06900	ELECTROCARDIOLOGY	7,739,991		7,739,991	0	7,739,991	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	2,284,137		2,284,137	9,662	2,293,799	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,197,317		4,197,317	0	4,197,317	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,775,526		7,775,526	0	7,775,526	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33,836,386		33,836,386	0	33,836,386	73.00
75.00	07500	ASC (NON-DISTINCT PART)	6,136,307		6,136,307	9,678	6,145,985	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0		0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	1,049,457		1,049,457	0	1,049,457	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	FAMILY PRACTICE 120	3,246,986		3,246,986	0	3,246,986	88.00
88.01	08801	GOOD SAMARITAN FP 110 HB	1,069,713		1,069,713	0	1,069,713	88.01
88.02	08802	GOOD SAMARITAN IM 100 HB	1,102,289		1,102,289	0	1,102,289	88.02
88.03	08803	GOOD SAMARITAN IM 110 HB	836,936		836,936	0	836,936	88.03
88.04	08804	GOOD SAMARITANKIDS HB	972,187		972,187	0	972,187	88.04
88.05	08805	GOOD SAMARITAN FP 100 HB	1,709,800		1,709,800	0	1,709,800	88.05
90.00	09000	CLINIC	477,045		477,045	0	477,045	90.00
90.01	04950	WOUND CLINIC	2,922,580		2,922,580	0	2,922,580	90.01
91.00	09100	EMERGENCY	11,359,421		11,359,421	32,750	11,392,171	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,862,141		4,862,141	0	4,862,141	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	221,997		221,997	0	221,997	96.00
101.00	10100	HOME HEALTH AGENCY	0		0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,772,602		1,772,602		1,772,602	116.00
200.00		Subtotal (see instructions)	201,424,319	0	201,424,319	200,500	201,624,819	200.00
201.00		Less Observation Beds	4,862,141		4,862,141		4,862,141	201.00
202.00		Total (see instructions)	196,562,178	0	196,562,178	200,500	196,762,678	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0042

Period:
From 01/01/2024
To 12/31/2024Worksheet C
Part I
Date/Time Prepared:
4/10/2025 8:15 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		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	18,441,657		18,441,657		30.00
31.00	03100	INTENSIVE CARE UNIT	10,976,118		10,976,118		31.00
40.00	04000	SUBPROVIDER - IPF	10,497,284		10,497,284		40.00
41.00	04100	SUBPROVIDER - IRF	7,672,819		7,672,819		41.00
43.00	04300	NURSERY	1,222,010		1,222,010		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	14,584,739	36,673,610	51,258,349	0.222963	0.000000
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000
51.01	05101	ENDOSCOPY	1,118,373	13,122,236	14,240,609	0.239164	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,000,754	20,172	3,020,926	0.521978	0.000000
53.00	05300	ANESTHESIOLOGY	2,246,568	6,760,773	9,007,341	0.283407	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,216,091	110,963,113	129,179,204	0.116030	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	162,353	31,281,213	31,443,566	0.194533	0.000000
60.00	06000	LABORATORY	21,715,247	59,934,110	81,649,357	0.140278	0.000000
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000
65.00	06500	RESPIRATORY THERAPY	8,856,095	4,168,950	13,025,045	0.340777	0.000000
66.00	06600	PHYSICAL THERAPY	13,858,226	12,969,508	26,827,734	0.340301	0.000000
69.00	06900	ELECTROCARDIOLOGY	23,298,539	40,824,782	64,123,321	0.120705	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000
70.01	07001	NEURODIAGNOSTICS	239,518	6,127,697	6,367,215	0.358734	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,434,740	3,018,487	5,453,227	0.769694	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,003,644	11,989,726	14,993,370	0.518598	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	16,321,700	101,106,364	117,428,064	0.288146	0.000000
75.00	07500	ASC (NON-DISTINCT PART)	102,380	23,308,682	23,411,062	0.262111	0.000000
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0.000000	0.000000
76.01	03951	INPATIENT DIALYSIS	1,037,065	55,385	1,092,450	0.960645	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	FAMILY PRACTICE 120	101,431	3,674,865	3,776,296		88.00
88.01	08801	GOOD SAMARITAN FP 110 HB	14,956	1,062,303	1,077,259		88.01
88.02	08802	GOOD SAMARITAN IM 100 HB	0	1,157,193	1,157,193		88.02
88.03	08803	GOOD SAMARITAN IM 110 HB	0	654,615	654,615		88.03
88.04	08804	GOOD SAMARITANKIDS HB	3,192	1,244,146	1,247,338		88.04
88.05	08805	GOOD SAMARITAN FP 100 HB	0	1,715,078	1,715,078		88.05
90.00	09000	CLINIC	154	27,720	27,874	17.114336	0.000000
90.01	04950	WOUND CLINIC	66,442	4,938,564	5,005,006	0.583931	0.000000
91.00	09100	EMERGENCY	12,356,868	48,213,069	60,569,937	0.187542	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,660,602	11,283,090	16,943,692	0.286959	0.000000
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	434,066	434,066	0.511436	0.000000
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	1,642,437	1,642,437		116.00
200.00		Subtotal (see instructions)	197,209,565	538,371,954	735,581,519		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	197,209,565	538,371,954	735,581,519		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0042

Period:
From 01/01/2024
To 12/31/2024Worksheet C
Part I
Date/Time Prepared:
4/10/2025 8:15 am

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
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	0.222963			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
51.01	05101	ENDOSCOPY	0.239164			51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.521978			52.00
53.00	05300	ANESTHESIOLOGY	0.283426			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.116124			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.194712			55.00
60.00	06000	LABORATORY	0.141825			60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000			63.00
65.00	06500	RESPIRATORY THERAPY	0.341103			65.00
66.00	06600	PHYSICAL THERAPY	0.340301			66.00
69.00	06900	ELECTROCARDIOLOGY	0.120705			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
70.01	07001	NEURODIAGNOSTICS	0.360252			70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.769694			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.518598			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.288146			73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.262525			75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000			76.00
76.01	03951	INPATIENT DIALYSIS	0.960645			76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY PRACTICE 120				88.00
88.01	08801	GOOD SAMARITAN FP 110 HB				88.01
88.02	08802	GOOD SAMARITAN IM 100 HB				88.02
88.03	08803	GOOD SAMARITAN IM 110 HB				88.03
88.04	08804	GOOD SAMARITANKIDS HB				88.04
88.05	08805	GOOD SAMARITAN FP 100 HB				88.05
90.00	09000	CLINIC	17.114336			90.00
90.01	04950	WOUND CLINIC	0.583931			90.01
91.00	09100	EMERGENCY	0.188083			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.286959			92.00
OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.511436			96.00
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE				116.00
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: 15-0042

Period:
From 01/01/2024
To 12/31/2024Worksheet C
Part I
Date/Time Prepared:
4/10/2025 8:15 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	21,395,370		21,395,370	0	21,395,370	30.00
31.00	03100	INTENSIVE CARE UNIT	7,872,216		7,872,216	0	7,872,216	31.00
40.00	04000	SUBPROVIDER - IPF	7,088,847		7,088,847	0	7,088,847	40.00
41.00	04100	SUBPROVIDER - IRF	5,327,253		5,327,253	0	5,327,253	41.00
43.00	04300	NURSERY	1,076,345		1,076,345	0	1,076,345	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,428,727		11,428,727	0	11,428,727	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
51.01	05101	ENDOSCOPY	3,405,837		3,405,837	0	3,405,837	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,576,858		1,576,858	0	1,576,858	52.00
53.00	05300	ANESTHESIOLOGY	2,552,741		2,552,741	171	2,552,912	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,988,704		14,988,704	12,136	15,000,840	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,116,814		6,116,814	5,612	6,122,426	55.00
60.00	06000	LABORATORY	11,453,637		11,453,637	126,243	11,579,880	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	4,438,638	0	4,438,638	4,248	4,442,886	65.00
66.00	06600	PHYSICAL THERAPY	9,129,514	0	9,129,514	0	9,129,514	66.00
69.00	06900	ELECTROCARDIOLOGY	7,739,991		7,739,991	0	7,739,991	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	2,284,137		2,284,137	9,662	2,293,799	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,197,317		4,197,317	0	4,197,317	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,775,526		7,775,526	0	7,775,526	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33,836,386		33,836,386	0	33,836,386	73.00
75.00	07500	ASC (NON-DISTINCT PART)	6,136,307		6,136,307	9,678	6,145,985	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0		0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	1,049,457		1,049,457	0	1,049,457	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	FAMILY PRACTICE 120	3,246,986		3,246,986	0	3,246,986	88.00
88.01	08801	GOOD SAMARITAN FP 110 HB	1,069,713		1,069,713	0	1,069,713	88.01
88.02	08802	GOOD SAMARITAN IM 100 HB	1,102,289		1,102,289	0	1,102,289	88.02
88.03	08803	GOOD SAMARITAN IM 110 HB	836,936		836,936	0	836,936	88.03
88.04	08804	GOOD SAMARITANKIDS HB	972,187		972,187	0	972,187	88.04
88.05	08805	GOOD SAMARITAN FP 100 HB	1,709,800		1,709,800	0	1,709,800	88.05
90.00	09000	CLINIC	477,045		477,045	0	477,045	90.00
90.01	04950	WOUND CLINIC	2,922,580		2,922,580	0	2,922,580	90.01
91.00	09100	EMERGENCY	11,359,421		11,359,421	32,750	11,392,171	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,862,141		4,862,141		4,862,141	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	221,997		221,997	0	221,997	96.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,772,602		1,772,602		1,772,602	116.00
200.00		Subtotal (see instructions)	201,424,319	0	201,424,319	200,500	201,624,819	200.00
201.00		Less Observation Beds	4,862,141		4,862,141		4,862,141	201.00
202.00		Total (see instructions)	196,562,178	0	196,562,178	200,500	196,762,678	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0042

Period:
From 01/01/2024
To 12/31/2024Worksheet C
Part I
Date/Time Prepared:
4/10/2025 8:15 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		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	18,441,657		18,441,657		30.00
31.00	03100	INTENSIVE CARE UNIT	10,976,118		10,976,118		31.00
40.00	04000	SUBPROVIDER - IPF	10,497,284		10,497,284		40.00
41.00	04100	SUBPROVIDER - IRF	7,672,819		7,672,819		41.00
43.00	04300	NURSERY	1,222,010		1,222,010		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	14,584,739	36,673,610	51,258,349	0.222963	0.000000
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000
51.01	05101	ENDOSCOPY	1,118,373	13,122,236	14,240,609	0.239164	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,000,754	20,172	3,020,926	0.521978	0.000000
53.00	05300	ANESTHESIOLOGY	2,246,568	6,760,773	9,007,341	0.283407	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,216,091	110,963,113	129,179,204	0.116030	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	162,353	31,281,213	31,443,566	0.194533	0.000000
60.00	06000	LABORATORY	21,715,247	59,934,110	81,649,357	0.140278	0.000000
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000
65.00	06500	RESPIRATORY THERAPY	8,856,095	4,168,950	13,025,045	0.340777	0.000000
66.00	06600	PHYSICAL THERAPY	13,858,226	12,969,508	26,827,734	0.340301	0.000000
69.00	06900	ELECTROCARDIOLOGY	23,298,539	40,824,782	64,123,321	0.120705	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000
70.01	07001	NEURODIAGNOSTICS	239,518	6,127,697	6,367,215	0.358734	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,434,740	3,018,487	5,453,227	0.769694	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,003,644	11,989,726	14,993,370	0.518598	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	16,321,700	101,106,364	117,428,064	0.288146	0.000000
75.00	07500	ASC (NON-DISTINCT PART)	102,380	23,308,682	23,411,062	0.262111	0.000000
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0.000000	0.000000
76.01	03951	INPATIENT DIALYSIS	1,037,065	55,385	1,092,450	0.960645	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	FAMILY PRACTICE 120	101,431	3,674,865	3,776,296	0.859834	0.000000
88.01	08801	GOOD SAMARITAN FP 110 HB	14,956	1,062,303	1,077,259	0.992995	0.000000
88.02	08802	GOOD SAMARITAN IM 100 HB	0	1,157,193	1,157,193	0.952554	0.000000
88.03	08803	GOOD SAMARITAN IM 110 HB	0	654,615	654,615	1.278516	0.000000
88.04	08804	GOOD SAMARITANKIDS HB	3,192	1,244,146	1,247,338	0.779409	0.000000
88.05	08805	GOOD SAMARITAN FP 100 HB	0	1,715,078	1,715,078	0.996923	0.000000
90.00	09000	CLINIC	154	27,720	27,874	17.114336	0.000000
90.01	04950	WOUND CLINIC	66,442	4,938,564	5,005,006	0.583931	0.000000
91.00	09100	EMERGENCY	12,356,868	48,213,069	60,569,937	0.187542	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,660,602	11,283,090	16,943,692	0.286959	0.000000
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	434,066	434,066	0.511436	0.000000
101.00	10100	HOME HEALTH AGENCY	0	0	0		
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	1,642,437	1,642,437		116.00
200.00		Subtotal (see instructions)	197,209,565	538,371,954	735,581,519		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	197,209,565	538,371,954	735,581,519		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0042

Period:
From 01/01/2024
To 12/31/2024Worksheet C
Part I
Date/Time Prepared:
4/10/2025 8:15 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
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
51.00	05100	RECOVERY ROOM	0.000000			51.00
51.01	05101	ENDOSCOPY	0.000000			51.01
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
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000			55.00
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
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
70.01	07001	NEURODIAGNOSTICS	0.000000			70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
75.00	07500	ASC (NON-DISTINCT PART)	0.000000			75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000			76.00
76.01	03951	INPATIENT DIALYSIS	0.000000			76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY PRACTICE 120	0.000000			88.00
88.01	08801	GOOD SAMARITAN FP 110 HB	0.000000			88.01
88.02	08802	GOOD SAMARITAN IM 100 HB	0.000000			88.02
88.03	08803	GOOD SAMARITAN IM 110 HB	0.000000			88.03
88.04	08804	GOOD SAMARITANKIDS HB	0.000000			88.04
88.05	08805	GOOD SAMARITAN FP 100 HB	0.000000			88.05
90.00	09000	CLINIC	0.000000			90.00
90.01	04950	WOUND CLINIC	0.000000			90.01
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000			96.00
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE				116.00
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: 15-0042

Period:
From 01/01/2024
To 12/31/2024Worksheet D
Part I
Date/Time Prepared:
4/10/2025 8:15 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	1,844,449	0	1,844,449	13,430	137.34	30.00	
31.00	INTENSIVE CARE UNIT	808,076		808,076	4,263	189.56	31.00	
40.00	SUBPROVIDER - IPF	634,736	0	634,736	5,021	126.42	40.00	
41.00	SUBPROVIDER - IRF	650,069	0	650,069	5,926	109.70	41.00	
43.00	NURSERY	354,492		354,492	790	448.72	43.00	
200.00	Total (lines 30 through 199)	4,291,822		4,291,822	29,430		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	4,820	661,979					30.00
31.00	INTENSIVE CARE UNIT	1,655	313,722					31.00
40.00	SUBPROVIDER - IPF	650	82,173					40.00
41.00	SUBPROVIDER - IRF	4,753	521,404					41.00
43.00	NURSERY	0	0					43.00
200.00	Total (lines 30 through 199)	11,878	1,579,278					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0042

Period:
From 01/01/2024
To 12/31/2024Worksheet D
Part II
Date/Time Prepared:
4/10/2025 8:15 am

Cost Center Description			Title XVIII		Hospital	PPS	
			Capital Related Cost (from Wkst. C, 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	931,697	51,258,349	0.018176	5,439,160	98,862
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0
51.01	05101	ENDOSCOPY	445,416	14,240,609	0.031278	422,180	13,205
52.00	05200	DELIVERY ROOM & LABOR ROOM	250,353	3,020,926	0.082873	0	0
53.00	05300	ANESTHESIOLOGY	19,981	9,007,341	0.002218	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	863,733	129,179,204	0.006686	7,462,109	49,892
55.00	05500	RADIOLOGY-THERAPEUTIC	647,569	31,443,566	0.020595	82,051	1,690
60.00	06000	LABORATORY	384,817	81,649,357	0.004713	8,468,409	39,912
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0
65.00	06500	RESPIRATORY THERAPY	222,524	13,025,045	0.017084	2,692,995	46,007
66.00	06600	PHYSICAL THERAPY	1,006,481	26,827,734	0.037516	2,714,315	101,830
69.00	06900	ELECTROCARDIOLOGY	682,392	64,123,321	0.010642	9,182,393	97,719
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0
70.01	07001	NEURODIAGNOSTICS	269,691	6,367,215	0.042356	50,460	2,137
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	78,563	5,453,227	0.014407	929,127	13,386
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	145,866	14,993,370	0.009729	1,339,780	13,035
73.00	07300	DRUGS CHARGED TO PATIENTS	365,984	117,428,064	0.003117	5,565,314	17,347
75.00	07500	ASC (NON-DISTINCT PART)	143,499	23,411,062	0.006130	0	0
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0.000000	0	0
76.01	03951	INPATIENT DIALYSIS	281,277	1,092,450	0.257474	393,756	101,382
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	FAMILY PRACTICE 120	143,146	3,776,296	0.037906	0	0
88.01	08801	GOOD SAMARITAN FP 110 HB	90,013	1,077,259	0.083557	0	0
88.02	08802	GOOD SAMARITAN IM 100 HB	80,097	1,157,193	0.069217	0	0
88.03	08803	GOOD SAMARITAN IM 110 HB	112,755	654,615	0.172246	0	0
88.04	08804	GOOD SAMARITANKIDS HB	115,048	1,247,338	0.092235	0	0
88.05	08805	GOOD SAMARITAN FP 100 HB	146,585	1,715,078	0.085468	0	0
90.00	09000	CLINIC	86,476	27,874	3.102389	0	0
90.01	04950	WOUND CLINIC	158,567	5,005,006	0.031682	8,863	281
91.00	09100	EMERGENCY	947,091	60,569,937	0.015636	4,480,282	70,054
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	419,155	16,943,692	0.024738	2,226,824	55,087
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	15,109	434,066	0.034808	0	0
200.00		Total (lines 50 through 199)	9,053,885	685,129,194		51,458,018	721,826

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042

Period:
From 01/01/2024
To 12/31/2024Worksheet D
Part III
Date/Time Prepared:
4/10/2025 8:15 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	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
			4.00	5.00	6.00	7.00	8.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	13,430	0.00	4,820	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	4,263	0.00	1,655	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	5,021	0.00	650	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	5,926	0.00	4,753	41.00	
43.00	04300	NURSERY		0	790	0.00	0	43.00	
200.00		Total (lines 30 through 199)		0	29,430		11,878	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
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: 15-0042

Period:
From 01/01/2024
To 12/31/2024Worksheet D
Part IV
Date/Time Prepared:
4/10/2025 8:15 am

Cost Center Description			Title XVIII		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0	0	0	0	0	51.01
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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	332,577	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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	FAMILY PRACTICE 120	0	0	0	0	0	88.00
88.01	08801	GOOD SAMARITAN FP 110 HB	0	0	0	0	0	88.01
88.02	08802	GOOD SAMARITAN IM 100 HB	0	0	0	0	0	88.02
88.03	08803	GOOD SAMARITAN IM 110 HB	0	0	0	0	0	88.03
88.04	08804	GOOD SAMARITANKIDS HB	0	0	0	0	0	88.04
88.05	08805	GOOD SAMARITAN FP 100 HB	0	0	0	0	0	88.05
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	WOUND CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)	0	0	0	0	332,577	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 15-0042		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part IV Date/Time Prepared: 4/10/2025 8:15 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	51,258,349	0.000000		50.00		
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000		51.00		
51.01	05101	ENDOSCOPY	0	0	0	14,240,609	0.000000		51.01		
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,020,926	0.000000		52.00		
53.00	05300	ANESTHESIOLOGY	0	0	0	9,007,341	0.000000		53.00		
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	129,179,204	0.000000		54.00		
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	31,443,566	0.000000		55.00		
60.00	06000	LABORATORY	0	332,577	332,577	81,649,357	0.004073		60.00		
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000		63.00		
65.00	06500	RESPIRATORY THERAPY	0	0	0	13,025,045	0.000000		65.00		
66.00	06600	PHYSICAL THERAPY	0	0	0	26,827,734	0.000000		66.00		
69.00	06900	ELECTROCARDIOLOGY	0	0	0	64,123,321	0.000000		69.00		
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000		70.00		
70.01	07001	NEURODIAGNOSTICS	0	0	0	6,367,215	0.000000		70.01		
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	5,453,227	0.000000		71.00		
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14,993,370	0.000000		72.00		
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	117,428,064	0.000000		73.00		
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	23,411,062	0.000000		75.00		
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0.000000		76.00		
76.01	03951	INPATIENT DIALYSIS	0	0	0	1,092,450	0.000000		76.01		
	OUTPATIENT SERVICE COST CENTERS										
88.00	08800	FAMILY PRACTICE 120	0	0	0	3,776,296	0.000000		88.00		
88.01	08801	GOOD SAMARITAN FP 110 HB	0	0	0	1,077,259	0.000000		88.01		
88.02	08802	GOOD SAMARITAN IM 100 HB	0	0	0	1,157,193	0.000000		88.02		
88.03	08803	GOOD SAMARITAN IM 110 HB	0	0	0	654,615	0.000000		88.03		
88.04	08804	GOOD SAMARITANKIDS HB	0	0	0	1,247,338	0.000000		88.04		
88.05	08805	GOOD SAMARITAN FP 100 HB	0	0	0	1,715,078	0.000000		88.05		
90.00	09000	CLINIC	0	0	0	27,874	0.000000		90.00		
90.01	04950	WOUND CLINIC	0	0	0	5,005,006	0.000000		90.01		
91.00	09100	EMERGENCY	0	0	0	60,569,937	0.000000		91.00		
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	16,943,692	0.000000		92.00		
	OTHER REIMBURSABLE COST CENTERS										
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	434,066	0.000000		96.00		
200.00		Total (lines 50 through 199)	0	332,577	332,577	685,129,194			200.00		

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042

Period:
From 01/01/2024
To 12/31/2024Worksheet D
Part IV
Date/Time Prepared:
4/10/2025 8:15 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	5,439,160	0	10,784,168	0
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0
51.01	05101	ENDOSCOPY	0.000000	422,180	0	4,304,555	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	7,462,109	0	33,971,361	0
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	82,051	0	14,203,434	0
60.00	06000	LABORATORY	0.004073	8,468,409	34,492	7,171,823	29,211
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0.000000	2,692,995	0	1,194,721	0
66.00	06600	PHYSICAL THERAPY	0.000000	2,714,315	0	1,011,321	0
69.00	06900	ELECTROCARDIOLOGY	0.000000	9,182,393	0	16,667,707	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0
70.01	07001	NEURODIAGNOSTICS	0.000000	50,460	0	1,801,859	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	929,127	0	1,185,368	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,339,780	0	4,445,393	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	5,565,314	0	47,707,119	0
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	6,862,118	0
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0
76.01	03951	INPATIENT DIALYSIS	0.000000	393,756	0	24,166	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	FAMILY PRACTICE 120	0.000000	0	0	0	0
88.01	08801	GOOD SAMARITAN FP 110 HB	0.000000	0	0	0	0
88.02	08802	GOOD SAMARITAN IM 100 HB	0.000000	0	0	0	0
88.03	08803	GOOD SAMARITAN IM 110 HB	0.000000	0	0	0	0
88.04	08804	GOOD SAMARITANKIDS HB	0.000000	0	0	0	0
88.05	08805	GOOD SAMARITAN FP 100 HB	0.000000	0	0	0	0
90.00	09000	CLINIC	0.000000	0	0	8,634	0
90.01	04950	WOUND CLINIC	0.000000	8,863	0	2,071,782	0
91.00	09100	EMERGENCY	0.000000	4,480,282	0	8,946,500	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	2,226,824	0	1,889,571	0
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0
200.00		Total (lines 50 through 199)		51,458,018	34,492	164,251,600	29,211

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 15-0042		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part V Date/Time Prepared: 4/10/2025 8:15 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		0.222963	10,784,168	0	0	2,404,470	50.00
51.00	05100	RECOVERY ROOM		0.000000	0	0	0	0	51.00
51.01	05101	ENDOSCOPY		0.239164	4,304,555	0	0	1,029,495	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.521978	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.283407	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.116030	33,971,361	0	0	3,941,697	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0.194533	14,203,434	0	0	2,763,037	55.00
60.00	06000	LABORATORY		0.140278	7,171,823	5,938	0	1,006,049	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY		0.340777	1,194,721	0	0	407,133	65.00
66.00	06600	PHYSICAL THERAPY		0.340301	1,011,321	0	0	344,154	66.00
69.00	06900	ELECTROCARDIOLOGY		0.120705	16,667,707	0	0	2,011,876	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS		0.358734	1,801,859	0	0	646,388	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.769694	1,185,368	0	0	912,371	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.518598	4,445,393	0	0	2,305,372	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.288146	47,707,119	0	9,016	13,746,616	73.00
75.00	07500	ASC (NON-DISTINCT PART)		0.262111	6,862,118	0	0	1,798,637	75.00
76.00	03950	MH ANCILLARY OUTPATIENT		0.000000	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS		0.960645	24,166	0	0	23,215	76.01
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	FAMILY PRACTICE 120							88.00
88.01	08801	GOOD SAMARITAN FP 110 HB							88.01
88.02	08802	GOOD SAMARITAN IM 100 HB							88.02
88.03	08803	GOOD SAMARITAN IM 110 HB							88.03
88.04	08804	GOOD SAMARITANKIDS HB							88.04
88.05	08805	GOOD SAMARITAN FP 100 HB							88.05
90.00	09000	CLINIC		17.114336	8,634	0	0	147,765	90.00
90.01	04950	WOUND CLINIC		0.583931	2,071,782	0	0	1,209,778	90.01
91.00	09100	EMERGENCY		0.187542	8,946,500	0	0	1,677,845	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0.286959	1,889,571	0	0	542,229	92.00
OTHER REIMBURSABLE COST CENTERS									
96.00	09600	DURABLE MEDICAL EQUIP-RENTED		0.511436	0	0	0	0	96.00
200.00		Subtotal (see instructions)			164,251,600	5,938	9,016	36,918,127	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0		201.00
202.00		Net Charges (line 200 - line 201)			164,251,600	5,938	9,016	36,918,127	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN:15-0042		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part V Date/Time Prepared: 4/10/2025 8:15 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					
51.00	05100	RECOVERY ROOM	0	0					
51.01	05101	ENDOSCOPY	0	0					
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0					
53.00	05300	ANESTHESIOLOGY	0	0					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0					
60.00	06000	LABORATORY	833	0					
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0					
65.00	06500	RESPIRATORY THERAPY	0	0					
66.00	06600	PHYSICAL THERAPY	0	0					
69.00	06900	ELECTROCARDIOLOGY	0	0					
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0					
70.01	07001	NEURODIAGNOSTICS	0	0					
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0					
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,598					
75.00	07500	ASC (NON-DISTINCT PART)	0	0					
76.00	03950	MH ANCILLARY OUTPATIENT	0	0					
76.01	03951	INPATIENT DIALYSIS	0	0					
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	FAMILY PRACTICE 120							
88.01	08801	GOOD SAMARITAN FP 110 HB							
88.02	08802	GOOD SAMARITAN IM 100 HB							
88.03	08803	GOOD SAMARITAN IM 110 HB							
88.04	08804	GOOD SAMARITANKIDS HB							
88.05	08805	GOOD SAMARITAN FP 100 HB							
90.00	09000	CLINIC	0	0					
90.01	04950	WOUND CLINIC	0	0					
91.00	09100	EMERGENCY	0	0					
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0					
OTHER REIMBURSABLE COST CENTERS									
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0					
200.00		Subtotal (see instructions)	833	2,598					
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						
202.00		Net Charges (line 200 - line 201)	833	2,598					

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0042

Period:

Worksheet D

Component CCN: 15-S042

From 01/01/2024
To 12/31/2024Part II
Date/Time Prepared:
4/10/2025 8:15 am

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	931,697	51,258,349	0.018176	15,080	274	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0	0	51.00
51.01	05101 ENDOSCOPY	445,416	14,240,609	0.031278	0	0	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	250,353	3,020,926	0.082873	0	0	52.00
53.00	05300 ANESTHESIOLOGY	19,981	9,007,341	0.002218	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	863,733	129,179,204	0.006686	36,726	246	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	647,569	31,443,566	0.020595	0	0	55.00
60.00	06000 LABORATORY	384,817	81,649,357	0.004713	139,898	659	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	222,524	13,025,045	0.017084	26,382	451	65.00
66.00	06600 PHYSICAL THERAPY	1,006,481	26,827,734	0.037516	31,309	1,175	66.00
69.00	06900 ELECTROCARDIOLOGY	682,392	64,123,321	0.010642	42,995	458	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
70.01	07001 NEURODIAGNOSTICS	269,691	6,367,215	0.042356	5,306	225	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	78,563	5,453,227	0.014407	1,075	15	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	145,866	14,993,370	0.009729	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	365,984	117,428,064	0.003117	107,383	335	73.00
75.00	07500 ASC (NON-DISTINCT PART)	143,499	23,411,062	0.006130	0	0	75.00
76.00	03950 MH ANCILLARY OUTPATIENT	0	0	0.000000	0	0	76.00
76.01	03951 INPATIENT DIALYSIS	281,277	1,092,450	0.257474	2,843	732	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 FAMILY PRACTICE 120	143,146	3,776,296	0.037906	0	0	88.00
88.01	08801 GOOD SAMARITAN FP 110 HB	90,013	1,077,259	0.083557	0	0	88.01
88.02	08802 GOOD SAMARITAN IM 100 HB	80,097	1,157,193	0.069217	0	0	88.02
88.03	08803 GOOD SAMARITAN IM 110 HB	112,755	654,615	0.172246	0	0	88.03
88.04	08804 GOOD SAMARITANKIDS HB	115,048	1,247,338	0.092235	0	0	88.04
88.05	08805 GOOD SAMARITAN FP 100 HB	146,585	1,715,078	0.085468	0	0	88.05
90.00	09000 CLINIC	86,476	27,874	3.102389	0	0	90.00
90.01	04950 WOUND CLINIC	158,567	5,005,006	0.031682	0	0	90.01
91.00	09100 EMERGENCY	947,091	60,569,937	0.015636	150,755	2,357	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	16,943,692	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	15,109	434,066	0.034808	0	0	96.00
200.00	Total (lines 50 through 199)	8,634,730	685,129,194		559,752	6,927	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 15-0042 Component CCN: 15-S042		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part IV Date/Time Prepared: 4/10/2025 8:15 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	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0	0	0	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	0	332,577	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	FAMILY PRACTICE 120	0	0	0	0	0	0	88.00
88.01	08801	GOOD SAMARITAN FP 110 HB	0	0	0	0	0	0	88.01
88.02	08802	GOOD SAMARITAN IM 100 HB	0	0	0	0	0	0	88.02
88.03	08803	GOOD SAMARITAN IM 110 HB	0	0	0	0	0	0	88.03
88.04	08804	GOOD SAMARITANKIDS HB	0	0	0	0	0	0	88.04
88.05	08805	GOOD SAMARITAN FP 100 HB	0	0	0	0	0	0	88.05
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
90.01	04950	WOUND CLINIC	0	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	332,577	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 15-0042 Component CCN: 15-S042		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part IV Date/Time Prepared: 4/10/2025 8:15 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	51,258,349	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0.000000	51.00
51.01	05101	ENDOSCOPY	0	0	0	0	14,240,609	0.000000	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	3,020,926	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	9,007,341	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	129,179,204	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	31,443,566	0.000000	55.00
60.00	06000	LABORATORY	0	332,577	332,577	81,649,357	0.004073	60.00	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	13,025,045	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	26,827,734	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	64,123,321	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0.000000	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	0	6,367,215	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	5,453,227	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	14,993,370	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	117,428,064	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	23,411,062	0.000000	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	0.000000	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	0	1,092,450	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	FAMILY PRACTICE 120	0	0	0	0	3,776,296	0.000000	88.00
88.01	08801	GOOD SAMARITAN FP 110 HB	0	0	0	0	1,077,259	0.000000	88.01
88.02	08802	GOOD SAMARITAN IM 100 HB	0	0	0	0	1,157,193	0.000000	88.02
88.03	08803	GOOD SAMARITAN IM 110 HB	0	0	0	0	654,615	0.000000	88.03
88.04	08804	GOOD SAMARITANKIDS HB	0	0	0	0	1,247,338	0.000000	88.04
88.05	08805	GOOD SAMARITAN FP 100 HB	0	0	0	0	1,715,078	0.000000	88.05
90.00	09000	CLINIC	0	0	0	0	27,874	0.000000	90.00
90.01	04950	WOUND CLINIC	0	0	0	0	5,005,006	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	0	60,569,937	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	16,943,692	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS									
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	434,066	0.000000	96.00
200.00		Total (lines 50 through 199)	0	332,577	332,577	685,129,194			200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN:15-0042 Component CCN:15-S042		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part IV Date/Time Prepared: 4/10/2025 8:15 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		15,080	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000		0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0.000000		0	0	0	0	51.01
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		36,726	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		0	0	0	0	55.00
60.00	06000	LABORATORY	0.004073		139,898	570	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		26,382	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000		31,309	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		42,995	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.000000		5,306	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		1,075	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	0.000000		107,383	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		0	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000		0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.000000		2,843	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	FAMILY PRACTICE 120	0.000000		0	0	0	0	88.00
88.01	08801	GOOD SAMARITAN FP 110 HB	0.000000		0	0	0	0	88.01
88.02	08802	GOOD SAMARITAN IM 100 HB	0.000000		0	0	0	0	88.02
88.03	08803	GOOD SAMARITAN IM 110 HB	0.000000		0	0	0	0	88.03
88.04	08804	GOOD SAMARITANKIDS HB	0.000000		0	0	0	0	88.04
88.05	08805	GOOD SAMARITAN FP 100 HB	0.000000		0	0	0	0	88.05
90.00	09000	CLINIC	0.000000		0	0	0	0	90.00
90.01	04950	WOUND CLINIC	0.000000		0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000		150,755	0	82	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000		0	0	0	0	96.00
200.00		Total (lines 50 through 199)			559,752	570	82	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0042

Period:

Worksheet D

Component CCN: 15-S042

From 01/01/2024
To 12/31/2024Part V
Date/Time Prepared:
4/10/2025 8:15 am

Title XVIII

Subprovider -

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	0.222963	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0.239164	0	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.521978	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.283407	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.116030	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.194533	0	0	0	0	55.00
60.00	06000	LABORATORY	0.140278	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.340777	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.340301	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.120705	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.358734	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.769694	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.518598	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.288146	0	0	27	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.262111	0	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.960645	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	FAMILY PRACTICE 120						88.00
88.01	08801	GOOD SAMARITAN FP 110 HB						88.01
88.02	08802	GOOD SAMARITAN IM 100 HB						88.02
88.03	08803	GOOD SAMARITAN IM 110 HB						88.03
88.04	08804	GOOD SAMARITANKIDS HB						88.04
88.05	08805	GOOD SAMARITAN FP 100 HB						88.05
90.00	09000	CLINIC	17.114336	0	0	0	0	90.00
90.01	04950	WOUND CLINIC	0.583931	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.187542	82	0	0	15	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.286959	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.511436	0	0	0	0	96.00
200.00		Subtotal (see instructions)		82	0	27	15	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		82	0	27	15	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0042

Period:

Worksheet D

Component CCN: 15-S042

From 01/01/2024
To 12/31/2024Part V
Date/Time Prepared:
4/10/2025 8:15 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
51.00	05100	RECOVERY ROOM	0	0	51.00
51.01	05101	ENDOSCOPY	0	0	51.01
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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
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
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	FAMILY PRACTICE 120			88.00
88.01	08801	GOOD SAMARITAN FP 110 HB			88.01
88.02	08802	GOOD SAMARITAN IM 100 HB			88.02
88.03	08803	GOOD SAMARITAN IM 110 HB			88.03
88.04	08804	GOOD SAMARITANKIDS HB			88.04
88.05	08805	GOOD SAMARITAN FP 100 HB			88.05
90.00	09000	CLINIC	0	0	90.00
90.01	04950	WOUND CLINIC	0	0	90.01
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00		Subtotal (see instructions)	0	8	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	8	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 15-0042	Period: From 01/01/2024 To 12/31/2024	Worksheet D Part II Date/Time Prepared: 4/10/2025 8:15 am		
				Component CCN: 15-T042				
				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	931,697	51,258,349	0.018176	46,795	851	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	445,416	14,240,609	0.031278	11,382	356	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	250,353	3,020,926	0.082873	0	0	52.00
53.00	05300	ANESTHESIOLOGY	19,981	9,007,341	0.002218	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	863,733	129,179,204	0.006686	435,724	2,913	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	647,569	31,443,566	0.020595	251	5	55.00
60.00	06000	LABORATORY	384,817	81,649,357	0.004713	855,315	4,031	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	222,524	13,025,045	0.017084	827,726	14,141	65.00
66.00	06600	PHYSICAL THERAPY	1,006,481	26,827,734	0.037516	6,815,916	255,706	66.00
69.00	06900	ELECTROCARDIOLOGY	682,392	64,123,321	0.010642	99,068	1,054	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	269,691	6,367,215	0.042356	5,102	216	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	78,563	5,453,227	0.014407	70,637	1,018	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	145,866	14,993,370	0.009729	700	7	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	365,984	117,428,064	0.003117	1,024,271	3,193	73.00
75.00	07500	ASC (NON-DISTINCT PART)	143,499	23,411,062	0.006130	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	281,277	1,092,450	0.257474	100,927	25,986	76.01
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	FAMILY PRACTICE 120	143,146	3,776,296	0.037906	0	0	88.00
88.01	08801	GOOD SAMARITAN FP 110 HB	90,013	1,077,259	0.083557	0	0	88.01
88.02	08802	GOOD SAMARITAN IM 100 HB	80,097	1,157,193	0.069217	0	0	88.02
88.03	08803	GOOD SAMARITAN IM 110 HB	112,755	654,615	0.172246	0	0	88.03
88.04	08804	GOOD SAMARITANKIDS HB	115,048	1,247,338	0.092235	0	0	88.04
88.05	08805	GOOD SAMARITAN FP 100 HB	146,585	1,715,078	0.085468	0	0	88.05
90.00	09000	CLINIC	86,476	27,874	3.102389	0	0	90.00
90.01	04950	WOUND CLINIC	158,567	5,005,006	0.031682	0	0	90.01
91.00	09100	EMERGENCY	947,091	60,569,937	0.015636	182,640	2,856	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	16,943,692	0.000000	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	15,109	434,066	0.034808	0	0	96.00
200.00		Total (lines 50 through 199)	8,634,730	685,129,194		10,476,454	312,333	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 15-0042 Component CCN: 15-T042		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part IV Date/Time Prepared: 4/10/2025 8:15 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	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0	0	0	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	0	332,577	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	FAMILY PRACTICE 120	0	0	0	0	0	0	88.00
88.01	08801	GOOD SAMARITAN FP 110 HB	0	0	0	0	0	0	88.01
88.02	08802	GOOD SAMARITAN IM 100 HB	0	0	0	0	0	0	88.02
88.03	08803	GOOD SAMARITAN IM 110 HB	0	0	0	0	0	0	88.03
88.04	08804	GOOD SAMARITANKIDS HB	0	0	0	0	0	0	88.04
88.05	08805	GOOD SAMARITAN FP 100 HB	0	0	0	0	0	0	88.05
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
90.01	04950	WOUND CLINIC	0	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	332,577	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 15-0042 Component CCN: 15-T042		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part IV Date/Time Prepared: 4/10/2025 8:15 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	0	51,258,349	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0.000000	51.00
51.01	05101	ENDOSCOPY	0	0	0	0	14,240,609	0.000000	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	3,020,926	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	9,007,341	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	129,179,204	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	31,443,566	0.000000	55.00
60.00	06000	LABORATORY	0	332,577	332,577	81,649,357	0.004073	60.00	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	13,025,045	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	26,827,734	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	64,123,321	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0.000000	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	0	6,367,215	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	5,453,227	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	14,993,370	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	117,428,064	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	23,411,062	0.000000	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	0.000000	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	0	1,092,450	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	FAMILY PRACTICE 120	0	0	0	0	3,776,296	0.000000	88.00
88.01	08801	GOOD SAMARITAN FP 110 HB	0	0	0	0	1,077,259	0.000000	88.01
88.02	08802	GOOD SAMARITAN IM 100 HB	0	0	0	0	1,157,193	0.000000	88.02
88.03	08803	GOOD SAMARITAN IM 110 HB	0	0	0	0	654,615	0.000000	88.03
88.04	08804	GOOD SAMARITANKIDS HB	0	0	0	0	1,247,338	0.000000	88.04
88.05	08805	GOOD SAMARITAN FP 100 HB	0	0	0	0	1,715,078	0.000000	88.05
90.00	09000	CLINIC	0	0	0	0	27,874	0.000000	90.00
90.01	04950	WOUND CLINIC	0	0	0	0	5,005,006	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	0	60,569,937	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	16,943,692	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS									
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	434,066	0.000000	96.00
200.00		Total (lines 50 through 199)	0	332,577	332,577	685,129,194			200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 15-0042 Component CCN: 15-T042		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part IV Date/Time Prepared: 4/10/2025 8:15 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	46,795	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	0	0	0	0	51.00
51.01	05101	ENDOSCOPY		0.000000	11,382	0	0	0	51.01
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	435,724	0	5,777	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	251	0	0	0	55.00
60.00	06000	LABORATORY		0.004073	855,315	3,484	562	2	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY		0.000000	827,726	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	6,815,916	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	99,068	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS		0.000000	5,102	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.000000	70,637	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	700	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	1,024,271	0	90	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)		0.000000	0	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT		0.000000	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS		0.000000	100,927	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	FAMILY PRACTICE 120		0.000000	0	0	0	0	88.00
88.01	08801	GOOD SAMARITAN FP 110 HB		0.000000	0	0	0	0	88.01
88.02	08802	GOOD SAMARITAN IM 100 HB		0.000000	0	0	0	0	88.02
88.03	08803	GOOD SAMARITAN IM 110 HB		0.000000	0	0	0	0	88.03
88.04	08804	GOOD SAMARITANKIDS HB		0.000000	0	0	0	0	88.04
88.05	08805	GOOD SAMARITAN FP 100 HB		0.000000	0	0	0	0	88.05
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
90.01	04950	WOUND CLINIC		0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY		0.000000	182,640	0	5,241	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0.000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
96.00	09600	DURABLE MEDICAL EQUIP-RENTED		0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)			10,476,454	3,484	11,670	2	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 15-0042		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part V Date/Time Prepared: 4/10/2025 8:15 am	
				Component CCN: 15-T042					
				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	0.222963	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0.239164	0	0	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.521978	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.283407	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.116030	5,777	0	0	0	670	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.194533	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0.140278	562	0	0	0	79	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.340777	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.340301	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.120705	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.358734	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.769694	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.518598	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.288146	90	0	0	503	26	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.262111	0	0	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.960645	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	FAMILY PRACTICE 120							88.00
88.01	08801	GOOD SAMARITAN FP 110 HB							88.01
88.02	08802	GOOD SAMARITAN IM 100 HB							88.02
88.03	08803	GOOD SAMARITAN IM 110 HB							88.03
88.04	08804	GOOD SAMARITANKIDS HB							88.04
88.05	08805	GOOD SAMARITAN FP 100 HB							88.05
90.00	09000	CLINIC	17.114336	0	0	0	0	0	90.00
90.01	04950	WOUND CLINIC	0.583931	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.187542	5,241	0	0	0	983	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.286959	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.511436	0	0	0	0	0	96.00
200.00		Subtotal (see instructions)		11,670	0	0	503	1,758	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)		11,670	0	0	503	1,758	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 15-0042 Component CCN: 15-T042		Period: From 01/01/2024 To 12/31/2024	Worksheet D Part V Date/Time Prepared: 4/10/2025 8:15 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
51.00	05100	RECOVERY ROOM	0	0		51.00
51.01	05101	ENDOSCOPY	0	0		51.01
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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
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
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01	07001	NEURODIAGNOSTICS	0	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	145		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0		76.00
76.01	03951	INPATIENT DIALYSIS	0	0		76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY PRACTICE 120				88.00
88.01	08801	GOOD SAMARITAN FP 110 HB				88.01
88.02	08802	GOOD SAMARITAN IM 100 HB				88.02
88.03	08803	GOOD SAMARITAN IM 110 HB				88.03
88.04	08804	GOOD SAMARITANKIDS HB				88.04
88.05	08805	GOOD SAMARITAN FP 100 HB				88.05
90.00	09000	CLINIC	0	0		90.00
90.01	04950	WOUND CLINIC	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Subtotal (see instructions)	0	145		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	145		202.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0042

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

Worksheet D-1

Date/Time Prepared:
4/10/2025 8:15 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)	13,430	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	13,430	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	10,378	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)	4,820	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	21,395,370	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	21,395,370	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	21,395,370	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)	1,593.10	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	7,678,742	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)	7,678,742	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0042

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

Worksheet D-1

Date/Time Prepared:
4/10/2025 8:15 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	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	7,872,216	4,263	1,846.64	1,655	3,056,189	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					11,244,731	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)					21,979,662	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)					975,701	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					756,318	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,732,019	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					20,247,643	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
55.01	Permanent adjustment amount per discharge					0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)					0.00	55.02
55.03	CAR T-cell amount paid as an interim payment					0	55.03
56.00	Target amount ((line 54 x sum of lines 55, 55.01, and 55.02) plus line 55.03)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
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)						87.00
						3,052	

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN:15-0042		Period: From 01/01/2024 To 12/31/2024		Worksheet D-1 Date/Time Prepared: 4/10/2025 8:15 am		
				Title XVIII		Hospital		PPS		
Cost Center Description										
						1.00				
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,593.10		88.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)						4,862,141		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			1,844,449	21,395,370	0.086208	4,862,141	419,155	90.00	
91.00	Nursing Program cost			0	21,395,370	0.000000	4,862,141	0	91.00	
92.00	Allied health cost			0	21,395,370	0.000000	4,862,141	0	92.00	
93.00	All other Medical Education			0	21,395,370	0.000000	4,862,141	0	93.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2024 To 12/31/2024	Worksheet D-1 Date/Time Prepared: 4/10/2025 8:15 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)		5,021	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,021	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		5,021	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)		650	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		7,088,847	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		7,088,847	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		7,088,847	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)		1,411.84	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		917,696	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)		917,696	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0042	Period: From 01/01/2024 To 12/31/2024	Worksheet D-1		
				Component CCN: 15-S042		Date/Time Prepared: 4/10/2025 8:15 am		
				Title XVIII		Subprovider - IPF	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	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	OTHER SPECIAL CARE (SPECIFY)						47.00	
	Cost Center Description							
						1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						117,076	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)						0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)						1,034,772	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)						82,173	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						7,497	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						89,670	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						945,102	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

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN:15-0042 Component CCN:15-S042	Period: From 01/01/2024 To 12/31/2024	Worksheet D-1 Date/Time Prepared: 4/10/2025 8:15 am	
				Title XVIII	Subprovider - IPF	PPS	
Cost Center Description						1.00	
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00
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	634,736	7,088,847	0.089540	0	0	90.00
91.00	Nursing Program cost	0	7,088,847	0.000000	0	0	91.00
92.00	Allied health cost	0	7,088,847	0.000000	0	0	92.00
93.00	All other Medical Education	0	7,088,847	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2024 To 12/31/2024	Worksheet D-1 Date/Time Prepared: 4/10/2025 8:15 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)		5,926	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,926	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		5,926	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)		4,753	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)		5,327,253	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)		5,327,253	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)		5,327,253	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)		898.96	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,272,757	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)		4,272,757	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0042	Period: From 01/01/2024 To 12/31/2024	Worksheet D-1	
				Component CCN: 15-T042		Date/Time Prepared: 4/10/2025 8:15 am	
				Title XVIII		Subprovider - IRF	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	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	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					3,281,885	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)					7,554,642	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)					521,404	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					315,817	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					837,221	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					6,717,421	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

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN:15-0042 Component CCN:15-T042	Period: From 01/01/2024 To 12/31/2024	Worksheet D-1 Date/Time Prepared: 4/10/2025 8:15 am	
				Title XVIII	Subprovider - IRF	PPS	
Cost Center Description						1.00	
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00
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	650,069	5,327,253	0.122027	0	0	90.00
91.00	Nursing Program cost	0	5,327,253	0.000000	0	0	91.00
92.00	Allied health cost	0	5,327,253	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,327,253	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0042

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

Worksheet D-1

Date/Time Prepared:
4/10/2025 8:15 am

Title XIX		Hospital	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)	13,430	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	13,430	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	10,378	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)	397	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)	790	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	21,395,370	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	21,395,370	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	21,395,370	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)	1,593.10	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	632,461	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)	632,461	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0042

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

Worksheet D-1

Date/Time Prepared:
4/10/2025 8:15 am

		Title XIX		Hospital		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)	1,076,345	790	1,362.46	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	7,872,216	4,263	1,846.64	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	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					431,713	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					1,064,174	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
55.01	Permanent adjustment amount per discharge					0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)					0.00	55.02
55.03	CAR T-cell amount paid as an interim payment					0	55.03
56.00	Target amount ((line 54 x sum of lines 55, 55.01, and 55.02) plus line 55.03)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
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)						3,052
						87.00	

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN:15-0042		Period: From 01/01/2024 To 12/31/2024		Worksheet D-1 Date/Time Prepared: 4/10/2025 8:15 am	
				Title XIX		Hospital		Cost	
Cost Center Description								1.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,593.10	88.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)						4,862,141	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	1,844,449	21,395,370	0.086208	4,862,141	419,155	90.00		
91.00	Nursing Program cost	0	21,395,370	0.000000	4,862,141	0	91.00		
92.00	Allied health cost	0	21,395,370	0.000000	4,862,141	0	92.00		
93.00	All other Medical Education	0	21,395,370	0.000000	4,862,141	0	93.00		

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2024 To 12/31/2024	Worksheet D-1 Date/Time Prepared: 4/10/2025 8:15 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)		5,021	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,021	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		5,021	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)		279	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)		790	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		7,088,847	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		7,088,847	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		7,088,847	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)		1,411.84	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		393,903	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)		393,903	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0042	Period: From 01/01/2024 To 12/31/2024	Worksheet D-1		
				Component CCN: 15-S042		Date/Time Prepared: 4/10/2025 8:15 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		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	OTHER SPECIAL CARE (SPECIFY)						47.00	
	Cost Center Description							
						1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						29,636	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)						423,539	49.00
	PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						0	54.00
55.00	Target amount per discharge						0.00	55.00
55.01	Permanent adjustment amount per discharge						0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)						0.00	55.02
55.03	CAR T-cell amount paid as an interim payment							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

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN:15-0042 Component CCN:15-S042		Period: From 01/01/2024 To 12/31/2024		Worksheet D-1 Date/Time Prepared: 4/10/2025 8:15 am	
				Title XIX		Subprovider - IPF		Cost	
Cost Center Description								1.00	
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST									
87.00	Total observation bed days (see instructions)							0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)							0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)							0	89.00
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	634,736	7,088,847	0.089540	0	0			
91.00	Nursing Program cost	0	7,088,847	0.000000	0	0			
92.00	Allied health cost	0	7,088,847	0.000000	0	0			
93.00	All other Medical Education	0	7,088,847	0.000000	0	0			

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 15-0042	Period: From 01/01/2024 To 12/31/2024	Worksheet D-3 Date/Time Prepared: 4/10/2025 8:15 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		9,021,011	30.00
31.00	03100	INTENSIVE CARE UNIT		4,348,107	31.00
40.00	04000	SUBPROVIDER - IPF		0	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	0.222963	5,439,160	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
51.01	05101	ENDOSCOPY	0.239164	422,180	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.521978	0	52.00
53.00	05300	ANESTHESIOLOGY	0.283426	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.116124	7,462,109	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.194712	82,051	55.00
60.00	06000	LABORATORY	0.141825	8,468,409	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.341103	2,692,995	65.00
66.00	06600	PHYSICAL THERAPY	0.340301	2,714,315	66.00
69.00	06900	ELECTROCARDIOLOGY	0.120705	9,182,393	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.360252	50,460	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.769694	929,127	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.518598	1,339,780	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.288146	5,565,314	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.262525	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.960645	393,756	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	FAMILY PRACTICE 120	0.000000		88.00
88.01	08801	GOOD SAMARITAN FP 110 HB	0.000000		88.01
88.02	08802	GOOD SAMARITAN IM 100 HB	0.000000		88.02
88.03	08803	GOOD SAMARITAN IM 110 HB	0.000000		88.03
88.04	08804	GOOD SAMARITANKIDS HB	0.000000		88.04
88.05	08805	GOOD SAMARITAN FP 100 HB	0.000000		88.05
90.00	09000	CLINIC	17.114336	0	90.00
90.01	04950	WOUND CLINIC	0.583931	8,863	90.01
91.00	09100	EMERGENCY	0.188083	4,480,282	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.286959	2,226,824	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.511436	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		51,458,018	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)		51,458,018	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2024 To 12/31/2024	Worksheet D-3 Date/Time Prepared: 4/10/2025 8:15 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
40.00	04000 SUBPROVIDER - IPF		1,157,560		40.00
41.00	04100 SUBPROVIDER - IRF				41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.222963	15,080	3,362	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
51.01	05101 ENDOSCOPY	0.239164	0	0	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.521978	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.283426	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.116124	36,726	4,265	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.194712	0	0	55.00
60.00	06000 LABORATORY	0.141825	139,898	19,841	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.341103	26,382	8,999	65.00
66.00	06600 PHYSICAL THERAPY	0.340301	31,309	10,654	66.00
69.00	06900 ELECTROCARDIOLOGY	0.120705	42,995	5,190	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	07001 NEURODIAGNOSTICS	0.360252	5,306	1,911	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.769694	1,075	827	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.518598	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.288146	107,383	30,942	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.262525	0	0	75.00
76.00	03950 MH ANCILLARY OUTPATIENT	0.000000	0	0	76.00
76.01	03951 INPATIENT DIALYSIS	0.960645	2,843	2,731	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 FAMILY PRACTICE 120	0.000000		0	88.00
88.01	08801 GOOD SAMARITAN FP 110 HB	0.000000		0	88.01
88.02	08802 GOOD SAMARITAN IM 100 HB	0.000000		0	88.02
88.03	08803 GOOD SAMARITAN IM 110 HB	0.000000		0	88.03
88.04	08804 GOOD SAMARITANKIDS HB	0.000000		0	88.04
88.05	08805 GOOD SAMARITAN FP 100 HB	0.000000		0	88.05
90.00	09000 CLINIC	17.114336	0	0	90.00
90.01	04950 WOUND CLINIC	0.583931	0	0	90.01
91.00	09100 EMERGENCY	0.188083	150,755	28,354	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.286959	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.511436	0	0	96.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		559,752	117,076	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)		559,752		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0042	Period: From 01/01/2024 To 12/31/2024	Worksheet D-3 Date/Time Prepared: 4/10/2025 8:15 am	
		Component CCN: 15-T042			
		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
40.00	04000 SUBPROVIDER - IPF				40.00
41.00	04100 SUBPROVIDER - IRF		6,166,711		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.222963	46,795	10,434	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
51.01	05101 ENDOSCOPY	0.239164	11,382	2,722	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.521978	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.283426	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.116124	435,724	50,598	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.194712	251	49	55.00
60.00	06000 LABORATORY	0.141825	855,315	121,305	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.341103	827,726	282,340	65.00
66.00	06600 PHYSICAL THERAPY	0.340301	6,815,916	2,319,463	66.00
69.00	06900 ELECTROCARDIOLOGY	0.120705	99,068	11,958	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	07001 NEURODIAGNOSTICS	0.360252	5,102	1,838	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.769694	70,637	54,369	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.518598	700	363	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.288146	1,024,271	295,140	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.262525	0	0	75.00
76.00	03950 MH ANCILLARY OUTPATIENT	0.000000	0	0	76.00
76.01	03951 INPATIENT DIALYSIS	0.960645	100,927	96,955	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 FAMILY PRACTICE 120	0.000000		0	88.00
88.01	08801 GOOD SAMARITAN FP 110 HB	0.000000		0	88.01
88.02	08802 GOOD SAMARITAN IM 100 HB	0.000000		0	88.02
88.03	08803 GOOD SAMARITAN IM 110 HB	0.000000		0	88.03
88.04	08804 GOOD SAMARITANKIDS HB	0.000000		0	88.04
88.05	08805 GOOD SAMARITAN FP 100 HB	0.000000		0	88.05
90.00	09000 CLINIC	17.114336	0	0	90.00
90.01	04950 WOUND CLINIC	0.583931	0	0	90.01
91.00	09100 EMERGENCY	0.188083	182,640	34,351	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.286959	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.511436	0	0	96.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		10,476,454	3,281,885	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)		10,476,454		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 15-0042	Period: From 01/01/2024 To 12/31/2024	Worksheet D-3 Date/Time Prepared: 4/10/2025 8:15 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		454,416	30.00
31.00	03100	INTENSIVE CARE UNIT		173,670	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.222963	219,548	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
51.01	05101	ENDOSCOPY	0.239164	16,982	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.521978	0	52.00
53.00	05300	ANESTHESIOLOGY	0.283407	32,829	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.116030	283,829	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.194533	2,497	55.00
60.00	06000	LABORATORY	0.140278	317,320	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.340777	148,756	65.00
66.00	06600	PHYSICAL THERAPY	0.340301	212,507	66.00
69.00	06900	ELECTROCARDIOLOGY	0.120705	419,311	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.358734	4,680	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.769694	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.518598	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.288146	222,718	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.262111	1,570	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.960645	15,154	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	FAMILY PRACTICE 120	0.859834	0	88.00
88.01	08801	GOOD SAMARITAN FP 110 HB	0.992995	0	88.01
88.02	08802	GOOD SAMARITAN IM 100 HB	0.952554	0	88.02
88.03	08803	GOOD SAMARITAN IM 110 HB	1.278516	0	88.03
88.04	08804	GOOD SAMARITANKIDS HB	0.779409	0	88.04
88.05	08805	GOOD SAMARITAN FP 100 HB	0.996923	0	88.05
90.00	09000	CLINIC	17.114336	2	90.00
90.01	04950	WOUND CLINIC	0.583931	1,168	90.01
91.00	09100	EMERGENCY	0.187542	181,181	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.286959	8,099	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.511436	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,088,151	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		2,088,151	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0042	Period: From 01/01/2024 To 12/31/2024	Worksheet D-3 Date/Time Prepared: 4/10/2025 8:15 am	
		Component CCN: 15-S042			
		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
40.00	04000 SUBPROVIDER - IPF		581,904		40.00
41.00	04100 SUBPROVIDER - IRF				41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.222963	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
51.01	05101 ENDOSCOPY	0.239164	0	0	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.521978	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.283407	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.116030	17,078	1,982	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.194533	0	0	55.00
60.00	06000 LABORATORY	0.140278	38,454	5,394	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.340777	10,759	3,666	65.00
66.00	06600 PHYSICAL THERAPY	0.340301	9,418	3,205	66.00
69.00	06900 ELECTROCARDIOLOGY	0.120705	2,840	343	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	07001 NEURODIAGNOSTICS	0.358734	831	298	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.769694	1,971	1,517	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.518598	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.288146	43,375	12,498	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.262111	0	0	75.00
76.00	03950 MH ANCILLARY OUTPATIENT	0.000000	0	0	76.00
76.01	03951 INPATIENT DIALYSIS	0.960645	763	733	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 FAMILY PRACTICE 120	0.859834	0	0	88.00
88.01	08801 GOOD SAMARITAN FP 110 HB	0.992995	0	0	88.01
88.02	08802 GOOD SAMARITAN IM 100 HB	0.952554	0	0	88.02
88.03	08803 GOOD SAMARITAN IM 110 HB	1.278516	0	0	88.03
88.04	08804 GOOD SAMARITANKIDS HB	0.779409	0	0	88.04
88.05	08805 GOOD SAMARITAN FP 100 HB	0.996923	0	0	88.05
90.00	09000 CLINIC	17.114336	0	0	90.00
90.01	04950 WOUND CLINIC	0.583931	0	0	90.01
91.00	09100 EMERGENCY	0.187542	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.286959	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.511436	0	0	96.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		125,489	29,636	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)		125,489		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2024 To 12/31/2024	Worksheet D-3 Date/Time Prepared: 4/10/2025 8:15 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
40.00	04000 SUBPROVIDER - IPF				40.00
41.00	04100 SUBPROVIDER - IRF		56,385		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.222963	175	39	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
51.01	05101 ENDOSCOPY	0.239164	452	108	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.521978	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.283407	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.116030	4,407	511	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.194533	0	0	55.00
60.00	06000 LABORATORY	0.140278	6,505	913	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.340777	1,999	681	65.00
66.00	06600 PHYSICAL THERAPY	0.340301	46,290	15,753	66.00
69.00	06900 ELECTROCARDIOLOGY	0.120705	840	101	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	07001 NEURODIAGNOSTICS	0.358734	106	38	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.769694	1,676	1,290	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.518598	65	34	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.288146	6,695	1,929	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.262111	0	0	75.00
76.00	03950 MH ANCILLARY OUTPATIENT	0.000000	0	0	76.00
76.01	03951 INPATIENT DIALYSIS	0.960645	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 FAMILY PRACTICE 120	0.859834	0	0	88.00
88.01	08801 GOOD SAMARITAN FP 110 HB	0.992995	0	0	88.01
88.02	08802 GOOD SAMARITAN IM 100 HB	0.952554	0	0	88.02
88.03	08803 GOOD SAMARITAN IM 110 HB	1.278516	0	0	88.03
88.04	08804 GOOD SAMARITANKIDS HB	0.779409	0	0	88.04
88.05	08805 GOOD SAMARITAN FP 100 HB	0.996923	0	0	88.05
90.00	09000 CLINIC	17.114336	0	0	90.00
90.01	04950 WOUND CLINIC	0.583931	721	421	90.01
91.00	09100 EMERGENCY	0.187542	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.286959	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.511436	0	0	96.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		69,931	21,818	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)		69,931		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0042	Period: From 01/01/2024 To 12/31/2024	Worksheet E Part A Date/Time Prepared: 4/10/2025 8:15 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)		11,236,311	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		4,351,848	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)		72,918	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		0	2.04
3.00	Managed Care Simulated Payments		8,371,917	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		90.66	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
5.01	FTE cap adjustment for qualifying hospitals under §131 of the CAA 2021 (see instructions)		0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)		0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)		0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)		0.00	8.21
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)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	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.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)		32.68	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		32.68	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.360468	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.359516	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.359516	21.00
22.00	IME payment adjustment (see instructions)		2,787,365	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		1,497,008	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		2,787,365	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		1,497,008	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.59	30.00
31.00	Percentage of Medicaid patient days (see instructions)		18.68	31.00
32.00	Sum of lines 30 and 31		23.27	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0042	Period: From 01/01/2024 To 12/31/2024	Worksheet E Part A Date/Time Prepared: 4/10/2025 8:15 am
		Title XVIII	Hospital	PPS
				1.00
33.00	Allowable disproportionate share percentage (see instructions)			8.41 33.00
34.00	Disproportionate share adjustment (see instructions)			327,742 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)	0	5,705,743,275	35.00
35.01	Factor 3 (see instructions)	0.000224628	0.000170133	35.01
35.02	Hospital UCP, including supplemental UCP (see instructions)	1,333,842	970,735	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	998,559	244,679	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	1,243,238		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)	20,019,422		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	18,758,403		48.00
				Amount
				1.00
49.00	Total payment for inpatient operating costs (see instructions)		21,516,430	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,509,557	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).		1,369,715	52.00
53.00	Nursing and Allied Health Managed Care payment		14,257	53.00
54.00	Special add-on payments for new technologies		0	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)		34,492	58.00
59.00	Total (sum of amounts on lines 49 through 58)		24,444,451	59.00
60.00	Primary payer payments		8,471	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		24,435,980	61.00
62.00	Deductibles billed to program beneficiaries		1,909,120	62.00
63.00	Coinurance billed to program beneficiaries		31,008	63.00
64.00	Allowable bad debts (see instructions)		106,419	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		69,172	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		25,314	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		22,565,024	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)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		-108,264	70.93
70.94	HRR adjustment amount (see instructions)		-79,974	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0042	Period: From 01/01/2024 To 12/31/2024	Worksheet E Part A Date/Time Prepared: 4/10/2025 8:15 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)		165,763	70.99	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		22,211,023	71.00	
71.01	Sequestration adjustment (see instructions)		444,220	71.01	
71.02	Demonstration payment adjustment amount after sequestration		0	71.02	
71.03	Sequestration adjustment-PARHM pass-throughs			71.03	
72.00	Interim payments		22,991,264	72.00	
72.01	Interim payments-PARHM			72.01	
73.00	Tentative settlement (for contractor use only)		0	73.00	
73.01	Tentative settlement-PARHM (for contractor use only)			73.01	
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-1,224,461	74.00	
74.01	Balance due provider/program-PARHM (see instructions)			74.01	
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,237,474	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)		0	100.00	
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.9899650703	1.0010318450	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.9954	0.9935	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. 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: 15-0042

Period:
From 01/01/2024
To 12/31/2024Worksheet E
Part A Exhibit 4
Date/Time Prepared:
4/10/2025 8:15 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	11,236,311	0	11,236,311		11,236,311	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	4,351,848	0		4,351,848	4,351,848	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	72,918	0	72,918		72,918	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	8,371,917	0	6,133,699	2,238,218	8,371,917	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.359516	0.359516	0.359516	0.359516		5.00
6.00	IME payment adjustment (see instructions)	22.00	2,787,365	0	2,009,198	778,167	2,787,365	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	1,497,008	0	1,096,786	400,222	1,497,008	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	2,787,365	0	2,009,198	778,167	2,787,365	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	1,497,008	0	1,096,786	400,222	1,497,008	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0841	0.0841	0.0841	0.0841		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	327,742	0	236,244	91,498	327,742	11.00
11.01	Uncompensated care payments	36.00	1,243,238	0	1,243,238	0	1,243,238	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	20,019,422	0	14,797,909	5,221,513	20,019,422	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	21,516,430	0	15,894,695	5,621,735	21,516,430	15.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0042

Period:
From 01/01/2024
To 12/31/2024Worksheet E
Part A Exhibit 4
Date/Time Prepared:
4/10/2025 8:15 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
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,509,557	0	1,090,752	418,805	1,509,557
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0
17.01	Net organ acquisition cost						
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	16,985,447	6,040,540	23,025,987
		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	1,202,095	0	865,651	336,444	1,202,095
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	13,189	0	13,189	0	13,189
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	0.2448	0.2448	0.2448	0.2448	
23.00	Indirect medical education adjustment (see instructions)	6.00	294,273	0	211,912	82,361	294,273
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	1,509,557	0	1,090,752	418,805	1,509,557
		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: 15-0042

Period:
From 01/01/2024
To 12/31/2024Worksheet E
Part A Exhibit 5
Date/Time Prepared:
4/10/2025 8:15 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	11,236,311	11,236,311		11,236,311	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	4,351,848		4,351,848	4,351,848	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	72,918	72,918		72,918	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	8,371,917	6,133,700	2,238,217	8,371,917	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.359516	0.359516	0.359516		5.00
6.00	IME payment adjustment (see instructions)	22.00	2,787,365	2,009,198	778,167	2,787,365	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	1,497,008	1,096,786	400,222	1,497,008	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	2,787,365	2,009,198	778,167	2,787,365	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	1,497,008	1,096,786	400,222	1,497,008	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0841	0.0841	0.0841		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	327,742	236,244	91,498	327,742	11.00
11.01	Uncompensated care payments	36.00	1,243,238	998,559	244,679	1,243,238	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	20,019,422	14,553,230	5,466,192	20,019,422	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	21,516,430	15,650,016	5,866,414	21,516,430	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,509,557	1,090,752	418,805	1,509,557	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	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			16,740,768	6,285,219	23,025,987	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 15-0042

Period:
From 01/01/2024
To 12/31/2024Worksheet E
Part A Exhibit 5
Date/Time Prepared:
4/10/2025 8:15 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	1,202,095	865,651	336,444	1,202,095	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	13,189	13,189	0	13,189	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	0.2448	0.2448	0.2448		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	294,273	211,912	82,361	294,273	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	1,509,557	1,090,752	418,805	1,509,557	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	-108,264	-112,755	4,491	-108,264	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-79,974	-51,687	-28,287	-79,974	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		165,763	0	165,763	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0042	Period: From 01/01/2024 To 12/31/2024	Worksheet E Part B Date/Time Prepared: 4/10/2025 8:15 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		3,431	1.00
2.00	Medical and other services reimbursed under OPPI (see instructions)		36,888,916	2.00
3.00	OPPI or REH payments		33,925,467	3.00
4.00	Outlier payment (see instructions)		27,750	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		29,211	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		3,431	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		14,954	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)		14,954	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)		14,954	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		11,523	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)		3,431	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)		33,982,428	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)		6,038,671	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)		27,947,188	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		1,699,730	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)		29,646,918	30.00
31.00	Primary payer payments		10,284	31.00
32.00	Subtotal (line 30 minus line 31)		29,636,634	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)		359,997	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		233,998	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		216,494	36.00
37.00	Subtotal (see instructions)		29,870,632	37.00
38.00	MSP-LCC reconciliation amount from PS&R		37	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)		29,870,595	40.00
40.01	Sequestration adjustment (see instructions)		597,412	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		29,307,955	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)		-34,772	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		GOOD SAMARITAN HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0042	Period: From 01/01/2024 To 12/31/2024	Worksheet E Part B Date/Time Prepared: 4/10/2025 8:15 am	
		Title XVIII	Hospital	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				0 200.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:15-0042 Component CCN:15-S042	Period: From 01/01/2024 To 12/31/2024	Worksheet E Part B Date/Time Prepared: 4/10/2025 8:15 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		8	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		15	2.00
3.00	OPPS or REH payments		43	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)		8	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		27	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)		27	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)		27	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		19	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)		8	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)		43	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)		51	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)		51	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		51	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)		51	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)		51	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		51	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	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

Health Financial Systems		GOOD SAMARITAN HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0042	Period: From 01/01/2024	Worksheet E	
		Component CCN: 15-S042	To 12/31/2024	Part B	
		Title XVIII	Subprovider -	Date/Time Prepared:	
			IPF	4/10/2025 8:15 am	
				PPS	
				1.00	
93.00	Time Value of Money (see instructions)			0	93.00
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:15-0042 Component CCN:15-T042	Period: From 01/01/2024 To 12/31/2024	Worksheet E Part B Date/Time Prepared: 4/10/2025 8:15 am
		Title XVIII	Subprovider - IRF	PPS
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		145	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		1,756	2.00
3.00	OPPS or REH payments		1,664	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		2	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		145	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		503	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)		503	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)		503	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		358	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)		145	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)		1,666	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)		290	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)		1,521	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)		1,521	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		1,521	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)		1,521	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)		1,521	40.00
40.01	Sequestration adjustment (see instructions)		30	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		1,490	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	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

Health Financial Systems		GOOD SAMARITAN HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0042	Period: From 01/01/2024	Worksheet E	
		Component CCN: 15-T042	To 12/31/2024	Part B	
		Title XVIII	Subprovider -	Date/Time Prepared:	
			IRF	4/10/2025 8:15 am	
				PPS	
				1.00	
93.00	Time Value of Money (see instructions)			0	93.00
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: 15-0042		Period: From 01/01/2024 To 12/31/2024		Worksheet E-1 Part I Date/Time Prepared: 4/10/2025 8:15 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		21,158,120		27,349,430	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	12/31/2024	1,780,544	12/31/2024	1,867,225	3.01	
3.02		07/31/2024	52,600	07/31/2024	91,300	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)		1,833,144		1,958,525	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)		22,991,264		29,307,955	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		1,224,461		34,772	6.02	
7.00	Total Medicare program liability (see instructions)		21,766,803		29,273,183	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: 15-0042 Component CCN: 15-S042		Period: From 01/01/2024 To 12/31/2024		Worksheet E-1 Part I Date/Time Prepared: 4/10/2025 8:15 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		653,067		51	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)		653,067		51	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		16,137		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		1	6.02	
7.00	Total Medicare program liability (see instructions)		669,204		50	7.00	
		0		Contractor Number	NPR Date (Mo/Day/Yr)		
				1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 15-0042 Component CCN: 15-T042		Period: From 01/01/2024 To 12/31/2024		Worksheet E-1 Part I Date/Time Prepared: 4/10/2025 8:15 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		8,376,197		1,490		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)		8,376,197		1,490		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		1		6.01
6.02	SETTLEMENT TO PROGRAM		50,186		0		6.02
7.00	Total Medicare program liability (see instructions)		8,326,011		1,491		7.00
		0		Contractor Number	NPR Date (Mo/Day/Yr)		
				1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 15-0042

Period:
From 01/01/2024
To 12/31/2024Worksheet E-1
Part II
Date/Time Prepared:
4/10/2025 8:15 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: 15-0042 Component CCN: 15-S042	Period: From 01/01/2024 To 12/31/2024	Worksheet E-3 Part II Date/Time Prepared: 4/10/2025 8:15 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)			665,745 1.00
2.00	Net IPF PPS Outlier Payments			0 2.00
3.00	Net IPF PPS ECT Payments			3,019 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)			4.83 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			4.83 8.00
9.00	Average Daily Census (see instructions)			13.718579 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1)\}$.			0.168062 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			111,886 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			780,650 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)			780,650 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			780,650 18.00
19.00	Deductibles			73,440 19.00
20.00	Subtotal (line 18 minus line 19)			707,210 20.00
21.00	Coinsurance			31,416 21.00
22.00	Subtotal (line 20 minus line 21)			675,794 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			9,996 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			6,497 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			1,996 25.00
26.00	Subtotal (sum of lines 22 and 24)			682,291 26.00
27.00	Direct graduate medical education payments (see instructions)			0 27.00
28.00	Other pass through costs (see instructions)			570 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)			682,861 31.00
31.01	Sequestration adjustment (see instructions)			13,657 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			653,067 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)			16,137 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00
FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)				
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.			0.000000 99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)			0.000000 99.01

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2024 To 12/31/2024	Worksheet E-3 Part III Date/Time Prepared: 4/10/2025 8:15 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			8,344,067 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0090 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			93,454 3.00
4.00	Outlier Payments			139,765 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)			16.191257 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)			8,577,286 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)			8,577,286 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			8,577,286 19.00
20.00	Deductibles			55,488 20.00
21.00	Subtotal (line 19 minus line 20)			8,521,798 21.00
22.00	Coinurance			35,496 22.00
23.00	Subtotal (line 21 minus line 22)			8,486,302 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			9,452 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			6,144 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			4,896 26.00
27.00	Subtotal (sum of lines 23 and 25)			8,492,446 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)			3,484 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)			8,495,930 32.00
32.01	Sequestration adjustment (see instructions)			169,919 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			8,376,197 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)			-50,186 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			139,765 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: 15-0042	Period: From 01/01/2024 To 12/31/2024	Worksheet E-3 Part VII Date/Time Prepared: 4/10/2025 8:15 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		1,064,174		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)		1,064,174	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)		1,064,174	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		807,145		8.00
9.00	Ancillary service charges		2,088,151	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)		2,895,296	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)		2,895,296	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		1,831,122	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)		1,064,174	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)		1,064,174	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)		1,064,174	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		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)		1,064,174	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		37.00
38.00	Subtotal (line 36 ± line 37)		1,064,174	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)		1,064,174	0	40.00
41.00	Interim payments		1,289,275	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		-225,101		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: 15-0042 Component CCN: 15-S042	Period: From 01/01/2024 To 12/31/2024	Worksheet E-3 Part VII Date/Time Prepared: 4/10/2025 8:15 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	423,539		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)	423,539	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)	423,539	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	581,904		8.00
9.00	Ancillary service charges	125,489	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)	707,393	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)	707,393	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	283,854	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)	423,539	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	423,539	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)	423,539	0	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	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	423,539	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	423,539	0	38.00
39.00	Direct graduate medical education payments (from wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	423,539	0	40.00
41.00	Interim payments	378,582	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	44,957	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: 15-0042 Component CCN: 15-T042	Period: From 01/01/2024 To 12/31/2024	Worksheet E-3 Part VII Date/Time Prepared: 4/10/2025 8:15 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	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	69,931	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)	69,931	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)	69,931	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	69,931	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0042	Period: From 01/01/2024 To 12/31/2024	Worksheet E-4 Date/Time Prepared: 4/10/2025 8:15 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.			0.00	1.00
1.01	FTE cap adjustment under §131 of the CAA 2021 (see instructions)			0.00	1.01
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
2.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)			0.00	2.26
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
3.02	Adjustment (increase or decrease) to the hospital's rural track FTE limitation(s) for rural track programs with a rural track Medicare GME affiliation agreement in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)			0.00	3.02
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
4.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)			0.00	4.21
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			0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.00	6.00
7.00	Enter the lesser of line 5 or line 6			0.00	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	0.00	0.00	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6. For cost reporting periods beginning on or after October 1, 2022, or if Worksheet S-2, Part I, line 68, is "Y", see instructions.	0.00	0.00	0.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	18.67	18.59		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	18.67	18.84		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	18.67	18.59		17.00
18.00	Per resident amount	130,219.03	130,219.03		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	2,431,189	2,420,772	4,851,961	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)			4,851,961	25.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0042	Period: From 01/01/2024 To 12/31/2024	Worksheet E-4 Date/Time Prepared: 4/10/2025 8:15 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)	11,878	4,933		26.00
27.00	Total Inpatient Days (see instructions)	26,360	26,360		27.00
28.00	Ratio of inpatient days to total inpatient days	0.450607	0.187140		28.00
29.00	Program direct GME amount	2,186,328	907,996	3,094,324	29.00
29.01	Percent reduction for MA DGME		2.74		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		24,879	24,879	30.00
31.00	Net Program direct GME amount			3,069,445	31.00
				1.00	
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS)					
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			0	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY					
Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)			30,569,076	37.00
38.00	Organ acquisition and HSCT acquisition costs (see instructions)			0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)			0	39.00
40.00	Primary payer payments (see instructions)			8,471	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			30,560,605	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			37,934,014	42.00
43.00	Primary payer payments (see instructions)			10,284	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			37,923,730	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			68,484,335	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.446242	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.553758	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			3,069,445	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			1,369,715	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			1,699,730	50.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT		Provider CCN: 15-0042	Period: From 01/01/2024 To 12/31/2024	Worksheet E-5 Date/Time Prepared: 4/10/2025 8:15 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: 15-0042

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

Worksheet G

Date/Time Prepared:
4/10/2025 8:15 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	13,730,015	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	92,143,721	0	0	0	4.00
5.00	Other receivable	128,871,369	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-55,719,003	0	0	0	6.00
7.00	Inventory	4,329,385	0	0	0	7.00
8.00	Prepaid expenses	6,237,060	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	150	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	189,592,697	0	0	0	11.00
FIXED ASSETS						
12.00	Land	6,581,447	0	0	0	12.00
13.00	Land improvements	10,929,239	0	0	0	13.00
14.00	Accumulated depreciation	-8,320,431	0	0	0	14.00
15.00	Buildings	185,518,075	0	0	0	15.00
16.00	Accumulated depreciation	-103,025,421	0	0	0	16.00
17.00	Leasehold improvements	477,210	0	0	0	17.00
18.00	Accumulated depreciation	-400,515	0	0	0	18.00
19.00	Fixed equipment	111,348,444	0	0	0	19.00
20.00	Accumulated depreciation	-78,467,258	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	115,027,285	0	0	0	23.00
24.00	Accumulated depreciation	-98,846,567	0	0	0	24.00
25.00	Minor equipment depreciable	338,098	0	0	0	25.00
26.00	Accumulated depreciation	-338,098	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)	140,821,508	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	85,057,347	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	21,432,350	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	106,489,697	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	436,903,902	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	128,465,354	0	0	0	37.00
38.00	Salaries, wages, and fees payable	14,670,364	0	0	0	38.00
39.00	Payroll taxes payable	304	0	0	0	39.00
40.00	Notes and loans payable (short term)	7,770,173	0	0	0	40.00
41.00	Deferred income	-309,743	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	35,430	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	150,631,882	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	107,641,983	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	107,641,983	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	258,273,865	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	178,630,037				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)	178,630,037	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	436,903,902	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0042

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

Worksheet G-1

Date/Time Prepared:
4/10/2025 8:15 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		178,693,454		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-2,424,173				2.00
3.00	Total (sum of line 1 and line 2)		176,269,281		0		3.00
4.00	ADDITIONS	2,360,756		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)		2,360,756		0		10.00
11.00	Subtotal (line 3 plus line 10)		178,630,037		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)		178,630,037		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		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: 15-0042

Period:
From 01/01/2024
To 12/31/2024Worksheet G-2
Parts I & II
Date/Time Prepared:
4/10/2025 8:15 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	31,097,169		31,097,169	1.00
2.00	SUBPROVIDER - IPF	9,695,199		9,695,199	2.00
3.00	SUBPROVIDER - IRF	7,739,143		7,739,143	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)	48,531,511		48,531,511	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	11,884,803		11,884,803	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	11,884,803		11,884,803	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	60,416,314		60,416,314	17.00
18.00	Ancillary services	124,569,297	462,283,283	586,852,580	18.00
19.00	Outpatient services	13,033,178	58,334,946	71,368,124	19.00
20.00	FAMILY PRACTICE 120	101,431	3,674,865	3,776,296	20.00
20.01	GOOD SAMARITAN FP 110 HB	16,296	1,157,445	1,173,741	20.01
20.02	GOOD SAMARITAN IM 100 HB	0	1,371,407	1,371,407	20.02
20.03	GOOD SAMARITAN IM 110 HB	0	732,887	732,887	20.03
20.04	GOOD SAMARITANKIDS HB	3,192	1,555,182	1,558,374	20.04
20.05	GOOD SAMARITAN FP 100 HB	0	2,086,723	2,086,723	20.05
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	25.00
26.00	HOSPICE	0	1,642,437	1,642,437	26.00
27.00	DME	0	434,066	434,066	27.00
27.01	PHYSICIAN OFFICE	1,518,924	35,355,726	36,874,650	27.01
27.02	PROFESSIONAL FEES	5,278,367	19,924,386	25,202,753	27.02
27.03	DIETARY REVENUE	0	457,416	457,416	27.03
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	204,936,999	589,010,769	793,947,768	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		290,222,574		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)		290,222,574		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0042

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

Worksheet G-3

Date/Time Prepared:
4/10/2025 8:15 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	793,947,768	1.00
2.00	Less contractual allowances and discounts on patients' accounts	526,970,471	2.00
3.00	Net patient revenues (line 1 minus line 2)	266,977,297	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	290,222,574	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-23,245,277	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	3,121,135	23.00
24.00	OTHER OPERATING INCOME	6,322,455	24.00
24.01	INTEREST INCOME & DISTRIBUTIONS	6,565,644	24.01
24.02	OTHER INCOME	0	24.02
24.03	OTHER NONOPERATING INCOME	524,972	24.03
24.04	UNREALIZED GAIN/LOSS ON INVESTMENTS	0	24.04
24.05	OTHER INCOME AND EXPENSE	0	24.05
24.06	OTHER INCOME AND EXPENSE	0	24.06
24.07	340B INCOME	2,923,963	24.07
24.08	LESSOR REVENUE	1,210,449	24.08
24.09	LESSOR INTEREST INCOME	146,559	24.09
24.10	GAIN ON TERMINATION	5,927	24.10
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	20,821,104	25.00
26.00	Total (line 5 plus line 25)	-2,424,173	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-2,424,173	29.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0042

Period:

Worksheet 0

Hospice CCN: 15-1526

From 01/01/2024
To 12/31/2024Date/Time Prepared:
4/10/2025 8:15 am

		Hospice I				
		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI- CATIONS	SUBTOTAL
		1.00	2.00	3.00	4.00	5.00
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	184,429	184,429	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	103,481	263,078	366,559	-184,429	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	19,420	19,420	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	19,474	19,474	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	13.00
14.00	PHARMACY*	0	941	941	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES					17.00
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	25.00
26.00	PHYSICIAN SERVICES**	20,550	22,438	42,988	0	26.00
27.00	NURSE PRACTITIONER**	17,951	0	17,951	0	27.00
28.00	REGISTERED NURSE**	313,663	0	313,663	0	28.00
29.00	LPN/LVN**	13,566	0	13,566	0	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	126,748	0	126,748	0	33.00
34.00	SPIRITUAL COUNSELING**	0	0	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	50,698	0	50,698	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	46.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	71.00
100.00	TOTAL	646,657	509,780	1,156,437	-184,429	972,008

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0042

Period:

Worksheet 0

Hospice CCN: 15-1526

From 01/01/2024
To 12/31/2024Date/Time Prepared:
4/10/2025 8:15 am

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	Hospice I
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	184,429	3.00
4.00	ADMINISTRATIVE & GENERAL*	0	182,130	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	19,420	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	6.00
7.00	HOUSEKEEPING*	0	0	7.00
8.00	DIETARY*	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	19,474	10.00
11.00	MEDICAL RECORDS*	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	13.00
14.00	PHARMACY*	0	941	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			17.00
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	42,988	26.00
27.00	NURSE PRACTITIONER**	0	17,951	27.00
28.00	REGISTERED NURSE**	0	313,663	28.00
29.00	LPN/LVN**	0	13,566	29.00
30.00	PHYSICAL THERAPY**	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	126,748	33.00
34.00	SPIRITUAL COUNSELING**	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	50,698	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	39.00
40.00	IMAGING SERVICES**	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	46.00
NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	61.00
62.00	FUNDRAISING*	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	66.00
67.00	ADVERTISING*	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	68.00
69.00	THRIFT STORE*	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	71.00
100.00	TOTAL	0	972,008	100.00

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE CONTINUOUS HOME CARE

Provider CCN: 15-0042

Period:

Worksheet 0-1

Hospice CCN: 15-1526

From 01/01/2024
To 12/31/2024Date/Time Prepared:
4/10/2025 8:15 am

				Hospice I		7/10/2020 0:10 am	
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS							
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	0	0	0	0	0	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	0	0	0	0	0	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 50.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED			25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	0	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	0	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 50.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE		Provider CCN: 15-0042	Period: From 01/01/2024 To 12/31/2024	Worksheet 0-2
		Hospice CCN: 15-1526		Date/Time Prepared: 4/10/2025 8:15 am

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	Hospice I RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS							
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	19,391	0	19,391	0	19,391	26.00
27.00	NURSE PRACTITIONER	16,938	0	16,938	0	16,938	27.00
28.00	REGISTERED NURSE	295,969	0	295,969	0	295,969	28.00
29.00	LPN/LVN	12,801	0	12,801	0	12,801	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	119,599	0	119,599	0	119,599	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	47,838	0	47,838	0	47,838	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	512,536	0	512,536	0	512,536	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED			25.00
26.00	PHYSICIAN SERVICES	0	19,391	26.00
27.00	NURSE PRACTITIONER	0	16,938	27.00
28.00	REGISTERED NURSE	0	295,969	28.00
29.00	LPN/LVN	0	12,801	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	119,599	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	47,838	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	512,536	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT
RESPIRE CARE

Provider CCN: 15-0042

Period:

Worksheet 0-3

Hospice CCN: 15-1526

From 01/01/2024
To 12/31/2024Date/Time Prepared:
4/10/2025 8:15 am

				Hospice I		7/10/2020 0:10 am	
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS							
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	16	0	16	0	16	26.00
27.00	NURSE PRACTITIONER	14	0	14	0	14	27.00
28.00	REGISTERED NURSE	241	0	241	0	241	28.00
29.00	LPN/LVN	10	0	10	0	10	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	97	0	97	0	97	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	39	0	39	0	39	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	417	0	417	0	417	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	16	26.00
27.00	NURSE PRACTITIONER	0	14	27.00
28.00	REGISTERED NURSE	0	241	28.00
29.00	LPN/LVN	0	10	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	97	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	39	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	417	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

					Hospice I		Hospice II	
	SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL			
	1.00	2.00	3.00	4.00	5.00			

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET
EXPENSES FOR ALLOCATION

Provider CCN: 15-0042

Period:

Worksheet 0-5

Hospice CCN: 15-1526

From 01/01/2024
To 12/31/2024Date/Time Prepared:
4/10/2025 8:15 am

Descriptions		Hospice I			
		HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
			1.00	2.00	
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	109,187	109,187	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	184,429	201,541	385,970	3.00
4.00	ADMINISTRATIVE & GENERAL	182,130	164,863	346,993	4.00
5.00	PLANT OPERATION & MAINTENANCE	19,420	127,944	147,364	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	70,978	70,978	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	124,116	124,116	9.00
10.00	ROUTINE MEDICAL SUPPLIES	19,474	1,797	21,271	10.00
11.00	MEDICAL RECORDS	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0	13.00
14.00	PHARMACY	941	168	1,109	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0	17.00
LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	512,536		512,536	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	417		417	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	52,661		52,661	53.00
NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	972,008	800,594	1,772,602	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0042

Period:

Worksheet 0-6

Hospice CCN: 15-1526

From 01/01/2024
To 12/31/2024Part I
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Descriptions		TOTAL EXPENSES		CAP REL BLDG & FIX		CAP REL MVBLE EQUIP		EMPLOYEE BENEFITS DEPARTMENT		SUBTOTAL	
		0	1.00	2.00	3.00	3A					
GENERAL SERVICE COST CENTERS											
1.00	CAP REL COSTS-BLDG & FIXT	109,187	109,187								1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		0							2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	385,970	0	0	385,970						3.00
4.00	ADMINISTRATIVE & GENERAL	346,993	0	0	0	346,993					4.00
5.00	PLANT OPERATION & MAINTENANCE	147,364	0	0	0	147,364					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0					6.00
7.00	HOUSEKEEPING	70,978	0	0	0	70,978					7.00
8.00	DIETARY	0	0	0	0	0					8.00
9.00	NURSING ADMINISTRATION	124,116	0	0	0	124,116					9.00
10.00	ROUTINE MEDICAL SUPPLIES	21,271	0	0	0	21,271					10.00
11.00	MEDICAL RECORDS	0	0	0	0	0					11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0					12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0					13.00
14.00	PHARMACY	1,109	0	0	0	1,109					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0					15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0					16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	0					17.00
LEVEL OF CARE											
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	512,536			364,197	876,733					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	417	1,970	0	297	2,684					52.00
53.00	HOSPICE GENERAL INPATIENT CARE	52,661	107,217	0	21,476	181,354					53.00
NONREIMBURSABLE COST CENTERS											
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0					60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0					61.00
62.00	FUNDRAISING	0	0	0	0	0					62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0					63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0					64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0					65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0					66.00
67.00	ADVERTISING	0	0	0	0	0					67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0					68.00
69.00	THRIFT STORE	0	0	0	0	0					69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0					71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0					99.00
100.00	TOTAL	1,772,602	109,187	0	385,970	1,772,602					100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0042

Period:

Worksheet 0-6

Hospice CCN: 15-1526

From 01/01/2024
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Descriptions		Hospice I		DIETARY	
		ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	
		4.00	5.00	6.00	7.00
					8.00
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT				1.00
2.00	CAP REL COSTS-MVBLE EQUIP				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT				3.00
4.00	ADMINISTRATIVE & GENERAL	346,993			4.00
5.00	PLANT OPERATION & MAINTENANCE	35,868	183,232		5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	17,276	0		7.00
8.00	DIETARY	0	0	88,254	8.00
9.00	NURSING ADMINISTRATION	30,210	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	5,177	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	13.00
14.00	PHARMACY	270	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	17.00
LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	213,397			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	653	3,306	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	44,142	179,926	0	53.00
NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	66.00
67.00	ADVERTISING	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	99.00
100.00	TOTAL	346,993	183,232	0	88,254

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0042

Period:

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Hospice CCN: 15-1526

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Descriptions		Hospice I					
		NURSING ADMINISTRATIO N	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATIO N	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	154,326					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	26,448				10.00
11.00	MEDICAL RECORDS	0		0			11.00
12.00	STAFF TRANSPORTATION	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	145,615	24,956	0	0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	123	20	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	8,588	1,472	0	0	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	154,326	26,448	0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0042

Period:

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Hospice CCN: 15-1526

From 01/01/2024
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Descriptions		Hospice I				TOTAL	
		PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES		
		14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	1,379					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	1,301	0	0		1,262,002	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1	0	0	0	8,379	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	77	0	0	0	502,221	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	1,379	0	0	0	1,772,602	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0042

Period:

Worksheet 0-6

Hospice CCN: 15-1526

From 01/01/2024
To 12/31/2024Part II
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Cost Center Descriptions		CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATIO N	ADMINISTRATIV E & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	388					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	513,668			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	0	-346,993	1,425,609	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	147,364	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	70,978	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	124,116	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	21,271	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	1,109	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			484,692	0	876,733	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	7	0	395	0	2,684	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	381	0	28,581	0	181,354	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	109,187	0	385,970		346,993	100.00
101.00	UNIT COST MULTIPLIER	281.409794	0.000000	0.751400		0.243400	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0042

Period:

Worksheet 0-6

Hospice CCN: 15-1526

From 01/01/2024
To 12/31/2024Part II
Date/Time Prepared:
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Cost Center Descriptions		Hospice I					
		PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATIO N (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	388					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		388			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		16,298	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					15,378	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	7	0	7	0	13	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	381	0	381	0	907	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	183,232	0	88,254	0	154,326	100.00
101.00	UNIT COST MULTIPLIER	472.247423	0.000000	227.458763	0.000000	9.469015	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0042

Period:

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Hospice CCN: 15-1526

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Cost Center Descriptions		ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)		MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	Hospice I VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00		11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT							1.00
2.00	CAP REL COSTS-MVBLE EQUIP							2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT							3.00
4.00	ADMINISTRATIVE & GENERAL							4.00
5.00	PLANT OPERATION & MAINTENANCE							5.00
6.00	LAUNDRY & LINEN SERVICE							6.00
7.00	HOUSEKEEPING							7.00
8.00	DIETARY							8.00
9.00	NURSING ADMINISTRATION							9.00
10.00	ROUTINE MEDICAL SUPPLIES	3,900						10.00
11.00	MEDICAL RECORDS		0					11.00
12.00	STAFF TRANSPORTATION				0			12.00
13.00	VOLUNTEER SERVICE COORDINATION				0	0		13.00
14.00	PHARMACY				0	0	6,108	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES				0	0	0	15.00
16.00	OTHER GENERAL SERVICE				0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES							17.00
LEVEL OF CARE								
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	3,680	0	0	0	0	5,763	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	3	0	0	0	0	5	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	217	0	0	0	0	340	53.00
NONREIMBURSABLE COST CENTERS								
60.00	BEREAVEMENT PROGRAM				0	0	0	60.00
61.00	VOLUNTEER PROGRAM				0	0	0	61.00
62.00	FUNDRAISING				0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS				0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM				0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES				0	0	0	65.00
66.00	RESIDENTIAL CARE				0	0	0	66.00
67.00	ADVERTISING				0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING				0	0	0	68.00
69.00	THRIFT STORE				0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD							70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)				0	0	0	71.00
99.00	NEGATIVE COST CENTER							99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	26,448	0	0	0	0	1,379	100.00
101.00	UNIT COST MULTIPLIER	6.781538	0.000000	0.000000	0.000000	0.000000	0.225769	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0042

Period:

Worksheet 0-6

Hospice CCN: 15-1526

From 01/01/2024
To 12/31/2024Part II
Date/Time Prepared:
4/10/2025 8:15 am

Cost Center Descriptions		PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)	Hospice I	
		15.00	16.00	17.00		
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0				15.00
16.00	OTHER GENERAL SERVICE		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0		17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0		53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	0	0		100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000		101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY
LEVEL OF CARE

Provider CCN: 15-0042
Hospice CCN: 15-1526

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

Worksheet 0-7
Date/Time Prepared:
4/10/2025 8:15 am

Cost Center Descriptions		From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records)			
				HCHC	HRHC	HIRC	
				0	1.00	2.00	
1.00	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.340301	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00					2.00
3.00	SPEECH PATHOLOGY	68.00					3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.288146	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0.511436	0	0	0	5.00
6.00	LABORATORY	60.00	0.140278	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.769694	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00	0.194533	0	0	0	9.00
10.00	MH ANCILLARY OUTPATIENT	76.00	0.000000	0	0	0	10.00
10.01	INPATIENT DIALYSIS	76.01	0.960645	0	0	0	10.01
11.00	Totals (sum of lines 1-11)						11.00
Cost Center Descriptions		Charges by LOC (from Provider Records)	Shared Service Costs by LOC				
		HGIP	HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
1.00	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY						2.00
3.00	SPEECH PATHOLOGY						3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	9.00
10.00	MH ANCILLARY OUTPATIENT	0	0	0	0	0	10.00
10.01	INPATIENT DIALYSIS	0	0	0	0	0	10.01
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-0042

Period:

Worksheet 0-8

Hospice CCN: 15-1526

From 01/01/2024
To 12/31/2024Date/Time Prepared:
4/10/2025 8:15 am

		Hospice I			
		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
HOSPICE CONTINUOUS HOME CARE					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
HOSPICE ROUTINE HOME CARE					
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, line 11)			1,262,002	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			3,680	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			342.94	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	3,383	90		9.00
10.00	Program cost (line 8 times line 9)	1,160,166	30,865		10.00
HOSPICE INPATIENT RESPITE CARE					
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11)			8,379	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			3	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			2,793.00	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	3	0		14.00
15.00	Program cost (line 13 times line 14)	8,379	0		15.00
HOSPICE GENERAL INPATIENT CARE					
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11)			502,221	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			217	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			2,314.38	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	217	0		19.00
20.00	Program cost (line 18 times line 19)	502,220	0		20.00
TOTAL HOSPICE CARE					
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			1,772,602	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			3,900	22.00
23.00	Average cost per diem (line 21 divided by line 22)			454.51	23.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0042	Period: From 01/01/2024 To 12/31/2024	Worksheet L Parts I-III Date/Time Prepared: 4/10/2025 8:15 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,202,095	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		13,189	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)		42.11	3.00
4.00	Number of interns & residents (see instructions)		32.68	4.00
5.00	Indirect medical education percentage (see instructions)		24.48	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)		294,273	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)		1,509,557	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

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0042

Period:

Worksheet M-1

Component CCN: 15-8577

From 01/01/2024
To 12/31/2024Date/Time Prepared:
4/10/2025 8:15 am

				RHC I		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	901,771	8,333	910,104	0	910,104	1.00
2.00	Physician Assistant	188,059	0	188,059	0	188,059	2.00
3.00	Nurse Practitioner	152,215	0	152,215	0	152,215	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	528,872	0	528,872	0	528,872	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist	0	0	0	0	0	7.10
7.11	Mental Health Counselor	0	0	0	0	0	7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,770,917	8,333	1,779,250	0	1,779,250	10.00
11.00	Physician Services Under Agreement	0	181,849	181,849	0	181,849	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	181,849	181,849	0	181,849	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,770,917	190,182	1,961,099	0	1,961,099	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	10,574	10,574	0	10,574	29.00
30.00	Administrative Costs	142,375	470,503	612,878	-442,853	170,025	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	142,375	481,077	623,452	-442,853	180,599	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,913,292	671,259	2,584,551	-442,853	2,141,698	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0042

Period:

Worksheet M-1

Component CCN: 15-8577

From 01/01/2024
To 12/31/2024Date/Time Prepared:
4/10/2025 8:15 am

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC I	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	910,104		1.00
2.00	Physician Assistant	0	188,059		2.00
3.00	Nurse Practitioner	0	152,215		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	528,872		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
7.10	Marriage and Family Therapist	0	0		7.10
7.11	Mental Health Counselor	0	0		7.11
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,779,250		10.00
11.00	Physician Services Under Agreement	0	181,849		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	181,849		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,961,099		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	10,574		29.00
30.00	Administrative Costs	0	170,025		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	180,599		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	2,141,698		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0042

Period:

Worksheet M-1

Component CCN: 15-8583

From 01/01/2024
To 12/31/2024Date/Time Prepared:
4/10/2025 8:15 am

		RHC II		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	264,672	2,500	267,172	0	267,172
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	123,128	0	123,128	0	123,128
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	119,073	0	119,073	0	119,073
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
7.10	Marriage and Family Therapist	0	0	0	0	0
7.11	Mental Health Counselor	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	506,873	2,500	509,373	0	509,373
11.00	Physician Services Under Agreement	0	72,591	72,591	0	72,591
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	72,591	72,591	0	72,591
15.00	Medical Supplies	0	0	0	0	0
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	506,873	75,091	581,964	0	581,964
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	6,248	6,248	0	6,248
30.00	Administrative Costs	67,267	205,191	272,458	-201,962	70,496
31.00	Total Facility Overhead (sum of lines 29 and 30)	67,267	211,439	278,706	-201,962	76,744
32.00	Total facility costs (sum of lines 22, 28 and 31)	574,140	286,530	860,670	-201,962	658,708

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0042

Period:

Worksheet M-1

Component CCN: 15-8583

From 01/01/2024
To 12/31/2024Date/Time Prepared:
4/10/2025 8:15 am

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC II	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	267,172		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	123,128		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	119,073		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
7.10	Marriage and Family Therapist	0	0		7.10
7.11	Mental Health Counselor	0	0		7.11
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	509,373		10.00
11.00	Physician Services Under Agreement	0	72,591		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	72,591		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	581,964		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	6,248		29.00
30.00	Administrative Costs	0	70,496		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	76,744		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	658,708		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0042

Period:

Worksheet M-1

Component CCN: 15-8585

From 01/01/2024
To 12/31/2024Date/Time Prepared:
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				RHC III		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	355,438	14,300	369,738	0	369,738	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	110,810	0	110,810	0	110,810	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	132,115	0	132,115	0	132,115	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist	0	0	0	0	0	7.10
7.11	Mental Health Counselor	0	0	0	0	0	7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	598,363	14,300	612,663	0	612,663	10.00
11.00	Physician Services Under Agreement	0	19,798	19,798	0	19,798	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	19,798	19,798	0	19,798	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	598,363	34,098	632,461	0	632,461	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	9,541	9,541	0	9,541	29.00
30.00	Administrative Costs	52,517	230,034	282,551	-232,601	49,950	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	52,517	239,575	292,092	-232,601	59,491	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	650,880	273,673	924,553	-232,601	691,952	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0042

Period:

Worksheet M-1

Component CCN: 15-8585

From 01/01/2024
To 12/31/2024Date/Time Prepared:
4/10/2025 8:15 am

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC III	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	369,738		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	110,810		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	132,115		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
7.10	Marriage and Family Therapist	0	0		7.10
7.11	Mental Health Counselor	0	0		7.11
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	612,663		10.00
11.00	Physician Services Under Agreement	0	19,798		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	19,798		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	632,461		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	9,541		29.00
30.00	Administrative Costs	0	49,950		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	59,491		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	691,952		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0042

Period:

Worksheet M-1

Component CCN: 15-8584

From 01/01/2024
To 12/31/2024Date/Time Prepared:
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		RHC IV		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	106,839	2,917	109,756	0	109,756
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	137,105	0	137,105	0	137,105
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	139,857	0	139,857	0	139,857
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
7.10	Marriage and Family Therapist	0	0	0	0	0
7.11	Mental Health Counselor	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	383,801	2,917	386,718	0	386,718
11.00	Physician Services Under Agreement	0	17,459	17,459	0	17,459
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	17,459	17,459	0	17,459
15.00	Medical Supplies	0	0	0	0	0
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	383,801	20,376	404,177	0	404,177
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	7,088	7,088	0	7,088
30.00	Administrative Costs	49,676	188,639	238,315	-182,486	55,829
31.00	Total Facility Overhead (sum of lines 29 and 30)	49,676	195,727	245,403	-182,486	62,917
32.00	Total facility costs (sum of lines 22, 28 and 31)	433,477	216,103	649,580	-182,486	467,094

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0042

Period:

Worksheet M-1

Component CCN: 15-8584

From 01/01/2024
To 12/31/2024Date/Time Prepared:
4/10/2025 8:15 am

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC IV	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	109,756		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	137,105		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	139,857		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
7.10	Marriage and Family Therapist	0	0		7.10
7.11	Mental Health Counselor	0	0		7.11
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	386,718		10.00
11.00	Physician Services Under Agreement	0	17,459		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	17,459		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	404,177		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	7,088		29.00
30.00	Administrative Costs	0	55,829		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	62,917		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	467,094		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0042

Period:

Worksheet M-1

Component CCN: 15-8582

From 01/01/2024
To 12/31/2024Date/Time Prepared:
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		RHC V		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	135,202	2,604	137,806	0	137,806
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	78,442	0	78,442	0	78,442
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	113,160	0	113,160	0	113,160
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
7.10	Marriage and Family Therapist	0	0	0	0	0
7.11	Mental Health Counselor	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	326,804	2,604	329,408	0	329,408
11.00	Physician Services Under Agreement	0	234,129	234,129	0	234,129
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	234,129	234,129	0	234,129
15.00	Medical Supplies	0	0	0	0	0
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	326,804	236,733	563,537	0	563,537
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	5,106	5,106	0	5,106
30.00	Administrative Costs	27,047	135,697	162,744	-174,296	-11,552
31.00	Total Facility Overhead (sum of lines 29 and 30)	27,047	140,803	167,850	-174,296	-6,446
32.00	Total facility costs (sum of lines 22, 28 and 31)	353,851	377,536	731,387	-174,296	557,091

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0042

Period:

Worksheet M-1

Component CCN: 15-8582

From 01/01/2024
To 12/31/2024Date/Time Prepared:
4/10/2025 8:15 am

RHC V

Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
	6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	137,806
2.00	Physician Assistant	0	0
3.00	Nurse Practitioner	0	78,442
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	113,160
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
7.10	Marriage and Family Therapist	0	0
7.11	Mental Health Counselor	0	0
8.00	Laboratory Technician	0	0
9.00	Other Facility Health Care Staff Costs	0	0
10.00	Subtotal (sum of lines 1 through 9)	0	329,408
11.00	Physician Services Under Agreement	0	234,129
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	234,129
15.00	Medical Supplies	0	0
16.00	Transportation (Health Care Staff)	0	0
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	0
19.00	Other Health Care Costs	0	0
20.00	Allowable GME Costs	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	0
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	563,537
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0
24.00	Dental	0	0
25.00	Optometry	0	0
25.01	Telehealth	0	0
25.02	Chronic Care Management	0	0
26.00	All other nonreimbursable costs	0	0
27.00	Nonallowable GME costs	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0
FACILITY OVERHEAD			
29.00	Facility Costs	0	5,106
30.00	Administrative Costs	0	-11,552
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	-6,446
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	557,091

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0042

Period:

Worksheet M-1

Component CCN: 15-8580

From 01/01/2024
To 12/31/2024Date/Time Prepared:
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		RHC VI		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	490,090	2,500	492,590	0	492,590
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	84,633	0	84,633	0	84,633
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	299,955	0	299,955	0	299,955
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
7.10	Marriage and Family Therapist	0	0	0	0	0
7.11	Mental Health Counselor	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	874,678	2,500	877,178	0	877,178
11.00	Physician Services Under Agreement	0	79,872	79,872	0	79,872
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	79,872	79,872	0	79,872
15.00	Medical Supplies	0	0	0	0	0
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	874,678	82,372	957,050	0	957,050
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	16,877	16,877	0	16,877
30.00	Administrative Costs	81,324	230,909	312,233	-238,863	73,370
31.00	Total Facility Overhead (sum of lines 29 and 30)	81,324	247,786	329,110	-238,863	90,247
32.00	Total facility costs (sum of lines 22, 28 and 31)	956,002	330,158	1,286,160	-238,863	1,047,297

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0042

Period:

Worksheet M-1

Component CCN: 15-8580

From 01/01/2024
To 12/31/2024Date/Time Prepared:
4/10/2025 8:15 am

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC VI	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	492,590		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	84,633		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	299,955		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
7.10	Marriage and Family Therapist	0	0		7.10
7.11	Mental Health Counselor	0	0		7.11
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	877,178		10.00
11.00	Physician Services Under Agreement	0	79,872		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	79,872		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	957,050		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	16,877		29.00
30.00	Administrative Costs	0	73,370		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	90,247		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,047,297		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0042

Period:

Worksheet M-2

Component CCN: 15-8577

From 01/01/2024
To 12/31/2024Date/Time Prepared:
4/10/2025 8:15 am

		RHC I		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	2.47	9,293	4,200	10,374	1.00
2.00	Physician Assistant	0.97	3,245	2,100	2,037	2.00
3.00	Nurse Practitioner	0.92	3,106	2,100	1,932	3.00
4.00	Subtotal (sum of lines 1 through 3)	4.36	15,644		14,343	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
7.03	Marriage and Family Therapist	0.00	0		0	7.03
7.04	Mental Health Counselor	0.00	0		0	7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	4.36	15,644		15,644	8.00
9.00	Physician Services Under Agreements		0		0	9.00
						1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				1,961,099	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				1,961,099	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				180,599	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				1,105,288	15.00
16.00	Total overhead (sum of lines 14 and 15)				1,285,887	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				1,285,887	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				1,285,887	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				3,246,986	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES			Provider CCN: 15-0042 Component CCN: 15-8583		Period: From 01/01/2024 To 12/31/2024		Worksheet M-2 Date/Time Prepared: 4/10/2025 8:15 am	
			RHC II		Cost			
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4			
	1.00	2.00	3.00	4.00	5.00			
VISITS AND PRODUCTIVITY								
Positions								
1.00	Physician	0.79	2,899	4,200	3,318			1.00
2.00	Physician Assistant	0.00	0	2,100	0			2.00
3.00	Nurse Practitioner	0.70	2,258	2,100	1,470			3.00
4.00	Subtotal (sum of lines 1 through 3)	1.49	5,157		4,788		5,157	4.00
5.00	Visiting Nurse	0.00	0				0	5.00
6.00	Clinical Psychologist	0.00	0				0	6.00
7.00	Clinical Social Worker	0.00	0				0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0				0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0				0	7.02
7.03	Marriage and Family Therapist	0.00	0				0	7.03
7.04	Mental Health Counselor	0.00	0				0	7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.49	5,157				5,157	8.00
9.00	Physician Services Under Agreements		0				0	9.00
							1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES								
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)						581,964	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)						0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)						581,964	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)						1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)						76,744	14.00
15.00	Parent provider overhead allocated to facility (see instructions)						411,005	15.00
16.00	Total overhead (sum of lines 14 and 15)						487,749	16.00
17.00	Allowable GME overhead (see instructions)						0	17.00
18.00	Enter the amount from line 16						487,749	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)						487,749	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)						1,069,713	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0042

Period:

Worksheet M-2

Component CCN: 15-8585

From 01/01/2024
To 12/31/2024Date/Time Prepared:
4/10/2025 8:15 am

		RHC III		Cost	
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4
	1.00	2.00	3.00	4.00	5.00
VISITS AND PRODUCTIVITY					
Positions					
1.00	Physician	0.79	5,417	4,200	3,318
2.00	Physician Assistant	0.00	0	2,100	0
3.00	Nurse Practitioner	0.76	1,202	2,100	1,596
4.00	Subtotal (sum of lines 1 through 3)	1.55	6,619	4,914	6,619
5.00	Visiting Nurse	0.00	0		0
6.00	Clinical Psychologist	0.00	0		0
7.00	Clinical Social Worker	0.00	0		0
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0
7.03	Marriage and Family Therapist	0.00	0		0
7.04	Mental Health Counselor	0.00	0		0
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.55	6,619		6,619
9.00	Physician Services Under Agreements		0		0
					1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES					
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				632,461
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				632,461
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				1.000000
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				59,491
15.00	Parent provider overhead allocated to facility (see instructions)				410,337
16.00	Total overhead (sum of lines 14 and 15)				469,828
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				469,828
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				469,828
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				1,102,289

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0042

Period:

Worksheet M-2

Component CCN: 15-8584

From 01/01/2024
To 12/31/2024

Date/Time Prepared:

4/10/2025 8:15 am

				RHC IV		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.64	1,191	4,200	2,688		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.77	1,869	2,100	1,617		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.41	3,060		4,305	4,305	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
7.03	Marriage and Family Therapist	0.00	0			0	7.03
7.04	Mental Health Counselor	0.00	0			0	7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.41	3,060			4,305	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					404,177	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					404,177	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					62,917	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					369,842	15.00
16.00	Total overhead (sum of lines 14 and 15)					432,759	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					432,759	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					432,759	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					836,936	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0042

Period:

Worksheet M-2

Component CCN: 15-8582

From 01/01/2024
To 12/31/2024Date/Time Prepared:
4/10/2025 8:15 am

		RHC V		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.71	2,653	4,200	2,982	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.55	1,869	2,100	1,155	3.00
4.00	Subtotal (sum of lines 1 through 3)	1.26	4,522		4,137	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
7.03	Marriage and Family Therapist	0.00	0		0	7.03
7.04	Mental Health Counselor	0.00	0		0	7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.26	4,522		4,522	8.00
9.00	Physician Services Under Agreements		0		0	9.00
						1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				563,537	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				563,537	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				-6,446	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				415,096	15.00
16.00	Total overhead (sum of lines 14 and 15)				408,650	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				408,650	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				408,650	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				972,187	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-0042 Component CCN: 15-8580		Period: From 01/01/2024 To 12/31/2024		Worksheet M-2 Date/Time Prepared: 4/10/2025 8:15 am	
		RHC VI		Cost			
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4		
	1.00	2.00	3.00	4.00	5.00		
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	1.49	7,135	4,200	6,258		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.57	993	2,100	1,197		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.06	8,128		7,455	8,128	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
7.03	Marriage and Family Therapist	0.00	0			0	7.03
7.04	Mental Health Counselor	0.00	0			0	7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.06	8,128			8,128	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					957,050	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					957,050	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					90,247	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					662,503	15.00
16.00	Total overhead (sum of lines 14 and 15)					752,750	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					752,750	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					752,750	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,709,800	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-0042 Component CCN: 15-8577	Period: From 01/01/2024 To 12/31/2024	Worksheet M-3 Date/Time Prepared: 4/10/2025 8:15 am	
			Title XVIII	RHC I	Cost
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			3,246,986	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			77,210	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			3,169,776	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			15,644	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			15,644	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			202.62	7.00
			Calculation of Limit (1)		
			Rate Period N/A	Rate Period 1 (01/01/2024 through 12/31/2024)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	139.00	8.00
9.00	Rate for Program covered visits (see instructions)		0.00	139.00	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	3,424	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	475,936	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	475,936	16.00
16.01	Total program charges (see instructions)(from contractor's records)			628,563	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			10,771	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			8,156	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			339,982	16.04
16.05	Total program cost (see instructions)		0	348,138	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			42,802	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			114,222	19.00
20.00	Net program cost excluding injections/infusions (see instructions)			348,138	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			28,544	21.00
21.50	Total program IOP OPPS payments (see instructions)			0	21.50
			Program IOP Visits	Program IOP Cost	
			1.00	2.00	
21.55	Total program IOP visits and cost (see instructions)		0	0	21.55
21.60	Program IOP deductible and coinsurance (see instructions)			0	21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)			376,682	22.00
23.00	Allowable bad debts (see instructions)			1,273	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			827	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			664	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			377,509	26.00
26.01	Sequestration adjustment (see instructions)			7,550	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			339,884	27.00
28.00	Tentative settlement (for contractor use only)			0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)			30,075	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-0042 Component CCN: 15-8583	Period: From 01/01/2024 To 12/31/2024	Worksheet M-3 Date/Time Prepared: 4/10/2025 8:15 am	
		Title XVIII	RHC II	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,069,713	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			18,819	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,050,894	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			5,157	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			5,157	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			203.78	7.00
			Calculation of Limit (1)		
			Rate Period N/A	Rate Period 1 (01/01/2024 through 12/31/2024)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	139.00	8.00
9.00	Rate for Program covered visits (see instructions)		0.00	139.00	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	192	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	26,688	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	26,688	16.00
16.01	Total program charges (see instructions)(from contractor's records)			31,356	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			20,393	16.04
16.05	Total program cost (see instructions)		0	20,393	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			1,197	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			6,032	19.00
20.00	Net program cost excluding injections/infusions (see instructions)			20,393	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			6,789	21.00
21.50	Total program IOP OPPS payments (see instructions)			0	21.50
			Program IOP Visits	Program IOP Cost	
			1.00	2.00	
21.55	Total program IOP visits and cost (see instructions)		0	0	21.55
21.60	Program IOP deductible and coinsurance (see instructions)			0	21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)			27,182	22.00
23.00	Allowable bad debts (see instructions)			32	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			21	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			27,203	26.00
26.01	Sequestration adjustment (see instructions)			544	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			19,972	27.00
28.00	Tentative settlement (for contractor use only)			0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)			6,687	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-0042 Component CCN: 15-8585	Period: From 01/01/2024 To 12/31/2024	Worksheet M-3 Date/Time Prepared: 4/10/2025 8:15 am	
		Title XVIII	RHC III	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,102,289	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			25,012	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,077,277	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			6,619	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			6,619	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			162.76	7.00
			Calculation of Limit (1)		
			Rate Period N/A	Rate Period 1 (01/01/2024 through 12/31/2024)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	139.00	8.00
9.00	Rate for Program covered visits (see instructions)		0.00	139.00	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	734	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	102,026	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	102,026	16.00
16.01	Total program charges (see instructions)(from contractor's records)			112,034	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			1,830	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			1,666	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			79,038	16.04
16.05	Total program cost (see instructions)		0	80,704	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			1,563	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			21,728	19.00
20.00	Net program cost excluding injections/infusions (see instructions)			80,704	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			16,715	21.00
21.50	Total program IOP OPPS payments (see instructions)			0	21.50
			Program IOP Visits	Program IOP Cost	
			1.00	2.00	
21.55	Total program IOP visits and cost (see instructions)		0	0	21.55
21.60	Program IOP deductible and coinsurance (see instructions)			0	21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)			97,419	22.00
23.00	Allowable bad debts (see instructions)			92	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			60	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			97,479	26.00
26.01	Sequestration adjustment (see instructions)			1,950	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			79,067	27.00
28.00	Tentative settlement (for contractor use only)			0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)			16,462	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-0042 Component CCN: 15-8584	Period: From 01/01/2024 To 12/31/2024	Worksheet M-3 Date/Time Prepared: 4/10/2025 8:15 am	
		Title XVIII	RHC IV	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			836,936	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			17,433	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			819,503	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			4,305	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			4,305	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			190.36	7.00
			Calculation of Limit (1)		
			Rate Period N/A	Rate Period 1 (01/01/2024 through 12/31/2024)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	139.00	8.00
9.00	Rate for Program covered visits (see instructions)		0.00	139.00	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	523	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	72,697	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	72,697	16.00
16.01	Total program charges (see instructions)(from contractor's records)			80,726	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			2,250	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			2,026	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			54,881	16.04
16.05	Total program cost (see instructions)		0	56,907	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			2,070	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			15,281	19.00
20.00	Net program cost excluding injections/infusions (see instructions)			56,907	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			11,418	21.00
21.50	Total program IOP OPPS payments (see instructions)			0	21.50
			Program IOP Visits	Program IOP Cost	
			1.00	2.00	
21.55	Total program IOP visits and cost (see instructions)		0	0	21.55
21.60	Program IOP deductible and coinsurance (see instructions)			0	21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)			68,325	22.00
23.00	Allowable bad debts (see instructions)			71	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			46	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			68,371	26.00
26.01	Sequestration adjustment (see instructions)			1,367	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			55,653	27.00
28.00	Tentative settlement (for contractor use only)			0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)			11,351	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-0042 Component CCN: 15-8582	Period: From 01/01/2024 To 12/31/2024	Worksheet M-3 Date/Time Prepared: 4/10/2025 8:15 am
		Title XVIII	RHC V	Cost
				1.00
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		972,187	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		0	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		972,187	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		4,522	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		4,522	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		214.99	7.00
		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2024 through 12/31/2024)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	139.00	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	139.00	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	0	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	0	16.00
16.01	Total program charges (see instructions)(from contractor's records)		0	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		0	16.04
16.05	Total program cost (see instructions)	0	0	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		0	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		0	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
21.50	Total program IOP OPPS payments (see instructions)		0	21.50
		Program IOP Visits	Program IOP Cost	
		1.00	2.00	
21.55	Total program IOP visits and cost (see instructions)	0	0	21.55
21.60	Program IOP deductible and coinsurance (see instructions)		0	21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		0	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		0	26.00
26.01	Sequestration adjustment (see instructions)		0	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		0	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		0	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-0042 Component CCN: 15-8580	Period: From 01/01/2024 To 12/31/2024	Worksheet M-3 Date/Time Prepared: 4/10/2025 8:15 am	
		Title XVIII	RHC VI	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,709,800	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			64,928	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,644,872	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			8,128	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			8,128	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			202.37	7.00
			Calculation of Limit (1)		
			Rate Period N/A	Rate Period 1 (01/01/2024 through 12/31/2024)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	139.00	8.00
9.00	Rate for Program covered visits (see instructions)		0.00	139.00	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	2,397	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	333,183	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	333,183	16.00
16.01	Total program charges (see instructions)(from contractor's records)			393,608	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			16,890	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			14,297	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			240,880	16.04
16.05	Total program cost (see instructions)		0	255,177	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			17,786	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			71,130	19.00
20.00	Net program cost excluding injections/infusions (see instructions)			255,177	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			35,351	21.00
21.50	Total program IOP OPPS payments (see instructions)			0	21.50
			Program IOP Visits	Program IOP Cost	
			1.00	2.00	
21.55	Total program IOP visits and cost (see instructions)		0	0	21.55
21.60	Program IOP deductible and coinsurance (see instructions)			0	21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)			290,528	22.00
23.00	Allowable bad debts (see instructions)			1,045	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			679	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			798	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			291,207	26.00
26.01	Sequestration adjustment (see instructions)			5,824	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			249,240	27.00
28.00	Tentative settlement (for contractor use only)			0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)			36,143	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0042

Period:

Worksheet M-4

Component CCN: 15-8577

From 01/01/2024
To 12/31/2024Date/Time Prepared:
4/10/2025 8:15 am

		Title XVIII		RHC I	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,779,250	1,779,250	1,779,250	1,779,250	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000092	0.011890	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	164	21,155	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	1,168	24,146	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	1,332	45,301	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,961,099	1,961,099	1,961,099	1,961,099	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,285,887	1,285,887	1,285,887	1,285,887	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000679	0.023100	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	873	29,704	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	2,205	75,005	0	0	10.00
11.00	Total number of injections/infusions (from your records)	5	647	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	441.00	115.93	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	4	231	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	1,764	26,780	0	0	14.00
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATIO N	
				1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)				77,210	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)				28,544	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0042

Period:

Worksheet M-4

Component CCN: 15-8583

From 01/01/2024
To 12/31/2024Date/Time Prepared:
4/10/2025 8:15 am

		Title XVIII		RHC II	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	509,373	509,373	509,373	509,373	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000323	0.007207	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	165	3,671	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	1,401	5,001	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	1,566	8,672	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	581,964	581,964	581,964	581,964	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	487,749	487,749	487,749	487,749	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.002691	0.014901	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	1,313	7,268	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	2,879	15,940	0	0	10.00
11.00	Total number of injections/infusions (from your records)	6	134	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	479.83	118.96	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	2	49	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	960	5,829	0	0	14.00
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
				1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)				18,819	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)				6,789	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0042

Period:

Worksheet M-4

Component CCN: 15-8585

From 01/01/2024
To 12/31/2024Date/Time Prepared:
4/10/2025 8:15 am

		Title XVIII		RHC III	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	612,663	612,663	612,663	612,663	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000000	0.010753	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	0	6,588	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	7,763	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	0	14,351	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	632,461	632,461	632,461	632,461	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	469,828	469,828	469,828	469,828	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.022691	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	0	10,661	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	0	25,012	0	0	10.00
11.00	Total number of injections/infusions (from your records)	0	208	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	0.00	120.25	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	139	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	16,715	0	0	14.00
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATIO N	
				1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)				25,012	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)				16,715	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0042

Period:

Worksheet M-4

Component CCN: 15-8584

From 01/01/2024
To 12/31/2024Date/Time Prepared:
4/10/2025 8:15 am

		Title XVIII		RHC IV	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	386,718	386,718	386,718	386,718	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000000	0.008069	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	0	3,120	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	5,299	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	0	8,419	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	404,177	404,177	404,177	404,177	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	432,759	432,759	432,759	432,759	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.020830	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	0	9,014	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	0	17,433	0	0	10.00
11.00	Total number of injections/infusions (from your records)	0	142	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	0.00	122.77	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	93	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	11,418	0	0	14.00
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATIO N	
				1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)				17,433	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)				11,418	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0042

Period:

Worksheet M-4

Component CCN: 15-8580

From 01/01/2024
To 12/31/2024Date/Time Prepared:
4/10/2025 8:15 am

		Title XVIII		RHC VI	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	877,178	877,178	877,178	877,178	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000194	0.019059	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	170	16,718	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	1,168	18,287	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	1,338	35,005	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	957,050	957,050	957,050	957,050	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	752,750	752,750	752,750	752,750	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.001398	0.036576	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	1,052	27,533	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	2,390	62,538	0	0	10.00
11.00	Total number of injections/infusions (from your records)	5	490	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	478.00	127.63	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	4	262	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	1,912	33,439	0	0	14.00
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATIO N	
				1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)				64,928	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)				35,351	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 15-0042 Component CCN: 15-8577	Period: From 01/01/2024 To 12/31/2024	Worksheet M-5 Date/Time Prepared: 4/10/2025 8:15 am	
			RHC I	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			339,884	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	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	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
Provider to Program					
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			339,884	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	5.01
5.02				0	5.02
5.03				0	5.03
Provider to Program					
5.50				0	5.50
5.51				0	5.51
5.52				0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER			30,075	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			369,959	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 15-0042 Component CCN: 15-8583	Period: From 01/01/2024 To 12/31/2024	Worksheet M-5 Date/Time Prepared: 4/10/2025 8:15 am	
			RHC II	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			19,972	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	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	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
Provider to Program					
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			19,972	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	5.01
5.02				0	5.02
5.03				0	5.03
Provider to Program					
5.50				0	5.50
5.51				0	5.51
5.52				0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER			6,687	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			26,659	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 15-0042 Component CCN: 15-8585	Period: From 01/01/2024 To 12/31/2024	Worksheet M-5 Date/Time Prepared: 4/10/2025 8:15 am	
			RHC III	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			79,067	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	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	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
Provider to Program					
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			79,067	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	5.01
5.02				0	5.02
5.03				0	5.03
Provider to Program					
5.50				0	5.50
5.51				0	5.51
5.52				0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER			16,462	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			95,529	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 15-0042 Component CCN: 15-8584	Period: From 01/01/2024 To 12/31/2024	Worksheet M-5 Date/Time Prepared: 4/10/2025 8:15 am	
			RHC IV	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			55,653	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	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	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
Provider to Program					
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			55,653	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	5.01
5.02				0	5.02
5.03				0	5.03
Provider to Program					
5.50				0	5.50
5.51				0	5.51
5.52				0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER			11,351	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			67,004	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 15-0042 Component CCN: 15-8580	Period: From 01/01/2024 To 12/31/2024	Worksheet M-5 Date/Time Prepared: 4/10/2025 8:15 am	
		RHC VI	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		249,240	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	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	3.01	
3.02			0	3.02	
3.03			0	3.03	
3.04			0	3.04	
3.05			0	3.05	
Provider to Program					
3.50			0	3.50	
3.51			0	3.51	
3.52			0	3.52	
3.53			0	3.53	
3.54			0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		249,240	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	5.01	
5.02			0	5.02	
5.03			0	5.03	
Provider to Program					
5.50			0	5.50	
5.51			0	5.51	
5.52			0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00	
6.01	SETTLEMENT TO PROVIDER		36,143	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		285,383	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00 2.00		
8.00	Name of Contractor				8.00