

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

FORM APPROVED

OMB NO. 0938-0050

EXPIRES 09-30-2025

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0046	Period: From 09/01/2023 To 08/31/2024	Worksheet S Parts I-III Date/Time Prepared: 1/28/2025 2:38 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 1/28/2025	Time: 2:38 pm
	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 TERRE HAUTE REGIONAL (15-0046) for the cost reporting period beginning 09/01/2023 and ending 08/31/2024 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	Koreenna Power	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Koreenna Power		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	113,324	-40,813	0	1.00
2.00	SUBPROVIDER - IPF	0	1,985	0	0	2.00
3.00	SUBPROVIDER - IRF	0	-5,977	-15	0	3.00
5.00	SWING BED - SNF	0	0	0	0	5.00
6.00	SWING BED - NF	0			0	6.00
200.00	TOTAL	0	109,332	-40,828	0	200.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 15-0046		Period: From 09/01/2023 To 08/31/2024		Worksheet S-2 Part I Date/Time Prepared: 1/28/2025 2:38 pm	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 3901 HOSPITAL LANE			PO Box:				1.00		
2.00	City: TERRE HAUTE			State: IN		Zip Code: 47802		County: VIGO		
		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		TERRE HAUTE REGIONAL	150046	45460	1	07/01/1966	N	P	0
4.00	Subprovider - IPF		TERRE HAUTE PSYCHIATRIC	15S046	45460	4	09/01/1991	N	P	0
5.00	Subprovider - IRF		TERRE HAUTE REHAB UNIT	15T046	45460	5	09/01/2006	N	P	0
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF									
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC									
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						09/01/2023		08/31/2024	
21.00	Type of Control (see instructions)						4			
							1.00	2.00		3.00
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N			
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y			
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			
22.03	Did this hospital receive a geographic redesignation from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015 or FY2025? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		N	
22.04	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.									
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			

Worksheet S-2
Part I
Date/Time Prepared:
1/28/2025 2:38 pm

MCRIF32 - 23.1.179.0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0046	Period: From 09/01/2023 To 08/31/2024	Worksheet S-2 Part I Date/Time Prepared: 1/28/2025 2:38 pm		
			V 1.00	XVIII 2.00	XIX 3.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.				N	59.00
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
		1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N		60.00	
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N		0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)					61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)					61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)					61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).					61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)					61.05
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)					61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)				N	63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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Period:
From 09/01/2023
To 08/31/2024Worksheet S-2
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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 Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

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			1.00		
68.00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?			68.00	
			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			Y	70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N N 0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			Y	75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N N 0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87.00
			Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
			1.00	2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.			N 0	88.00
			Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge
			1.00	2.00	3.00
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.			0.00	0 89.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y 90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	Y 91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N 92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N 93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N 94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00 95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N 96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00 97.00

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			V 1.00	XIX 2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	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.	Y	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.	Y	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.	Y	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.	Y	Y		98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00
107.01	If this facility is a REH (line 3, column 4, is "12"), is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no. (see instructions)				107.01
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00
			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
			1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00

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		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	188,280	0	550,814
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	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	Y	123.00
124.00	Did the hospital incur cost, either directly or through a contract with an outside supplier, to establish and maintain access to no less than a 6-month buffer stock of one or more essential medicines according to 42 CFR 412.113(g)? Enter "Y" for yes or "N" for no.			124.00
Certified Transplant Center Information				
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	44H070	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: HOSPITAL CORP. OF AMERICA	Contractor's Name: PALMETTO	Contractor's Number: 10001	141.00
142.00	Street: ONE PARK PLAZA	PO Box:		142.00
143.00	City: NASHVILLE	State: TN	Zip Code: 37203	143.00
				1.00
144.00	Are provider based physicians' costs included in Worksheet A?		Y	144.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0046		Period: From 09/01/2023 To 08/31/2024		Worksheet S-2 Part I Date/Time Prepared: 1/28/2025 2:38 pm	
				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.	Y				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	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
				1.00			
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N				165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00
				1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y				167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	N				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)	N				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)	9.99				169.00	
				Beginning	Ending		
				1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					170.00	
				1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N				0171.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0046		Period: From 09/01/2023 To 08/31/2024		Worksheet S-2 Part II Date/Time Prepared: 1/28/2025 2:38 pm	
				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)	Y					3.00
		Y/N	Type	Date			
		1.00	2.00	3.00			
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N					4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N			13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.			N			14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N			15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, in columns 2 and 4, from the PS&R used to prepare this cost report, enter the "Paid Claims Verified Current As Of" date, if present, or the paid-through date.(see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, in columns 2 and 4, enter the "Paid Claims Verified Current As Of" date, if present, or the paid-through date. (see instructions)	Y	12/02/2024	Y	12/02/2024		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 15-0046

Period:
From 09/01/2023
To 08/31/2024Worksheet S-2
Part II
Date/Time Prepared:
1/28/2025 2:38 pm

		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.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		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?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		Y	12/31/2023	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TIMOTHY	WORTH		41.00
42.00	Enter the employer/company name of the cost report preparer.	HCA			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-830-5041	TIMOTHY.WORTH@HCAHEALTHCARE.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0046	Period: From 09/01/2023 To 08/31/2024	Worksheet S-2 Part II Date/Time Prepared: 1/28/2025 2:38 pm
		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.	REPORTING MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.	REIMBURSEMENT		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: 15-0046

Period:
From 09/01/2023
To 08/31/2024Worksheet S-3
Part I
Date/Time Prepared:
1/28/2025 2:38 pm

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
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	117	42,822	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)		117	42,822	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	18	6,588	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	NEONATAL INTENSIVE CARE UNIT	35.00	6	2,196	0.00	0	12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		141	51,606	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	19	6,954		0	16.00
17.00	SUBPROVIDER - IRF	41.00	12	4,392		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						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		172				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: 15-0046

Period:
From 09/01/2023
To 08/31/2024Worksheet S-3
Part I
Date/Time Prepared:
1/28/2025 2:38 pm

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)	3,384	759	11,271			1.00
2.00	HMO and other (see instructions)	4,771	2,192				2.00
3.00	HMO IPF Subprovider	483	0				3.00
4.00	HMO IRF Subprovider	489	230				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)	3,384	759	11,271			7.00
8.00	INTENSIVE CARE UNIT	1,039	0	3,233			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	NEONATAL INTENSIVE CARE UNIT	0	0	66			12.00
13.00	NURSERY		0	159			13.00
14.00	Total (see instructions)	4,423	759	14,729	0.00	357.79	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	369	4,191	5,558	0.00	25.54	16.00
17.00	SUBPROVIDER - IRF	918	290	2,219	0.00	11.75	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			72			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	395.08	27.00
28.00	Observation Bed Days		148	684			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	24	31			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			2			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: 15-0046

Period:
From 09/01/2023
To 08/31/2024Worksheet S-3
Part I
Date/Time Prepared:
1/28/2025 2:38 pm

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	1,060	176	3,627	1.00
2.00 HMO and other (see instructions)			1,014	621		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				19		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 NEONATAL INTENSIVE CARE UNIT						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,060	176	3,627	14.00
15.00 CAH visits						15.00
15.10 REH hours and visits						15.10
16.00 SUBPROVIDER - IPF	0.00	0	48	618	873	16.00
17.00 SUBPROVIDER - IRF	0.00	0	73	24	163	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01
34.00 Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0046

Period:
From 09/01/2023
To 08/31/2024Worksheet S-3
Part II
Date/Time Prepared:
1/28/2025 2:38 pm

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	29,747,059	0	29,747,059	821,779.00	36.20
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		3,745,657	0	3,745,657	119,907.00	31.24
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		0	0	0	0.00	0.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		255,818	0	255,818	1,566.00	163.36
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		8,030,441	0	8,030,441	168,094.36	47.77
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
15.01	Home office Physicians Part A - Administrative		0	0	0	0.00	0.00
15.02	Home office contract Physicians Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		7,117,773	0	7,117,773		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		1,025,200	0	1,025,200		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		1,450,269	0	1,450,269		
25.51	Related organization wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0046

Period:
From 09/01/2023
To 08/31/2024Worksheet S-3
Part II
Date/Time Prepared:
1/28/2025 2:38 pm

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.52	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	76,783	0	76,783	1,925.00	39.89	26.00
27.00	Administrative & General	5.00	3,506,644	0	3,506,644	78,855.00	44.47	27.00
28.00	Administrative & General under contract (see inst.)		1,106,269	0	1,106,269	1,849.20	598.24	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	393,141	0	393,141	17,211.00	22.84	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,066,892	0	1,066,892	56,080.00	19.02	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		805,158	0	805,158	26,614.00	30.25	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	569,693	0	569,693	11,377.00	50.07	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0046

Period:
From 09/01/2023
To 08/31/2024Worksheet S-3
Part III
Date/Time Prepared:
1/28/2025 2:38 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	31,658,486	0	31,658,486	850,242.20	37.23	1.00
2.00	Excluded area salaries (see instructions)	3,745,657	0	3,745,657	119,907.00	31.24	2.00
3.00	Subtotal salaries (line 1 minus line 2)	27,912,829	0	27,912,829	730,335.20	38.22	3.00
4.00	Subtotal other wages & related costs (see inst.)	8,286,259	0	8,286,259	169,660.36	48.84	4.00
5.00	Subtotal wage-related costs (see inst.)	8,568,042	0	8,568,042	0.00	30.70	5.00
6.00	Total (sum of lines 3 thru 5)	44,767,130	0	44,767,130	899,995.56	49.74	6.00
7.00	Total overhead cost (see instructions)	7,524,580	0	7,524,580	193,911.20	38.80	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 15-0046

Period:
From 09/01/2023
To 08/31/2024Worksheet S-3
Part IV
Date/Time Prepared:
1/28/2025 2:38 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	948,561	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	42,064	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	4,285,826	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	-11,649	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	33,252	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)	283,043	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	53,536	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	1,921,516	17.00
18.00	Medicare Taxes - Employers Portion Only	449,264	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	55,635	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	81,925	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	8,142,973	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: 15-0046

Period:
From 09/01/2023
To 08/31/2024Worksheet S-3
Part V
Date/Time Prepared:
1/28/2025 2:38 pm

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	0	8,142,973	1.00
2.00	Hospital	0	7,117,773	2.00
3.00	SUBPROVIDER - IPF	0	465,451	3.00
4.00	SUBPROVIDER - IRF	0	250,235	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			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I	0	0	17.00
18.00	Other	0	309,514	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 15-0046	Period: From 09/01/2023 To 08/31/2024	Worksheet S-10 Parts I & II Date/Time Prepared: 1/28/2025 2:38 pm
				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)		0.110156	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		19,013,550	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?		N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		738,554	5.00
6.00	Medicaid charges		155,651,738	6.00
7.00	Medicaid cost (line 1 times line 6)		17,145,973	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)		0	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)		0	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)	29,540,207	1,315,867	30,856,074
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	3,254,031	852,423	4,106,454
22.00	Payments received from patients for amounts previously written off as charity care	0	1,260	1,260
23.00	Cost of charity care (see instructions)	3,254,031	851,163	4,105,194
				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)		520,815	25.01
26.00	Bad debt amount (see instructions)		4,098,669	26.00
27.00	Medicare reimbursable bad debts (see instructions)		103,532	27.00
27.01	Medicare allowable bad debts (see instructions)		159,281	27.01
28.00	Non-Medicare bad debt amount (see instructions)		3,939,388	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)		489,696	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)		4,594,890	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		4,594,890	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 15-0046	Period: From 09/01/2023 To 08/31/2024	Worksheet S-10 Parts I & II Date/Time Prepared: 1/28/2025 2:38 pm
				1.00
PART II - HOSPITAL DATA				
Uncompensated and Indigent Care Cost-to-Charge Ratio				
1.00	Cost to charge ratio (see instructions)			0.106338 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)	23,894,366	1,218,305	25,112,671 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,540,879	825,650	3,366,529 21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	1,260	1,260 22.00
23.00	Cost of charity care (see instructions)	2,540,879	824,390	3,365,269 23.00
				1.00
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N 24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0 25.00
25.01	Charges for insured patients' liability (see instructions)			439,378 25.01
26.00	Bad debt amount (see instructions)			3,829,279 26.00
27.00	Medicare reimbursable bad debts (see instructions)			100,446 27.00
27.01	Medicare allowable bad debts (see instructions)			154,533 27.01
28.00	Non-Medicare bad debt amount (see instructions)			3,674,746 28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)			444,852 29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)			3,810,121 30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			3,810,121 31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0046

Period:
From 09/01/2023
To 08/31/2024

Worksheet A

Date/Time Prepared:
1/28/2025 2:38 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		3,008,085	3,008,085	80,429	3,088,514	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,470,133	2,470,133	296,888	2,767,021	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	76,783	5,870,121	5,946,904	106,566	6,053,470	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,506,644	-11,004,624	-7,497,980	-525,722	-8,023,702	5.00
7.00	00700	OPERATION OF PLANT	393,141	2,745,740	3,138,881	-4,386	3,134,495	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	364,059	364,059	0	364,059	8.00
9.00	00900	HOUSEKEEPING	1,066,892	445,711	1,512,603	-2,988	1,509,615	9.00
10.00	01000	DIETARY	0	2,100,389	2,100,389	-855,231	1,245,158	10.00
11.00	01100	CAFETERIA	0	0	0	855,231	855,231	11.00
13.00	01300	NURSING ADMINISTRATION	569,693	613,688	1,183,381	240,714	1,424,095	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	699,616	699,616	0	699,616	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,752,526	4,189,521	7,942,047	194,864	8,136,911	30.00
31.00	03100	INTENSIVE CARE UNIT	1,920,373	1,293,831	3,214,204	-120,660	3,093,544	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	416,585	294,371	710,956	-119	710,837	35.00
40.00	04000	SUBPROVIDER - IPF	1,700,566	578,200	2,278,766	-1,355	2,277,411	40.00
41.00	04100	SUBPROVIDER - IRF	914,256	325,570	1,239,826	-6,150	1,233,676	41.00
43.00	04300	NURSERY	112,934	27,359	140,293	-2,054	138,239	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,544,282	6,873,057	9,417,339	-272,814	9,144,525	50.00
51.00	05100	RECOVERY ROOM	197,366	91,683	289,049	-1,794	287,255	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	916,691	250,951	1,167,642	-1,769	1,165,873	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	699,156	681,547	1,380,703	-17,290	1,363,413	54.00
54.01	03630	ULTRA SOUND	170,497	48,396	218,893	-19,509	199,384	54.01
54.02	03440	MAMMOGRAPHY	90,255	16,994	107,249	-5	107,244	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	590,271	527,253	1,117,524	-22,600	1,094,924	55.00
56.00	05600	RADIOISOTOPE	21,356	383,810	405,166	-14	405,152	56.00
57.00	05700	CT SCAN	360,235	485,421	845,656	-3,152	842,504	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	167,456	89,791	257,247	0	257,247	58.00
59.00	05900	CARDIAC CATHETERIZATION	450,299	848,003	1,298,302	-196,963	1,101,339	59.00
60.00	06000	LABORATORY	1,079,646	1,564,840	2,644,486	-19,416	2,625,070	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	34,012	569,846	603,858	1,502,879	2,106,737	62.00
65.00	06500	RESPIRATORY THERAPY	659,328	592,987	1,252,315	-123,181	1,129,134	65.00
66.00	06600	PHYSICAL THERAPY	972,229	185,265	1,157,494	0	1,157,494	66.00
69.00	06900	ELECTROCARDIOLOGY	381,880	87,659	469,539	-109	469,430	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	19,102	8,122	27,224	0	27,224	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	198,340	3,025,557	3,223,897	657,317	3,881,214	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,028,509	2,028,509	263,716	2,292,225	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,128,279	11,675,334	12,803,613	-1,397,986	11,405,627	73.00
74.00	07400	RENAL DIALYSIS	0	539,426	539,426	-10,414	529,012	74.00
76.00	03950	LITHOTRIPSY	0	150,700	150,700	0	150,700	76.00
76.01	03330	ENDOSCOPY	239,549	253,776	493,325	-16,497	476,828	76.01
76.02	03040	PRISION CLINIC	209,245	22,080	231,325	-192	231,133	76.02
76.03	03050	WOUND CARE	82,987	665,437	748,424	-18,563	729,861	76.03
76.04	03060	OPIC	469,815	128,814	598,629	-15,940	582,689	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	2,503,555	4,910,759	7,414,314	-535,967	6,878,347	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,616,224	50,727,787	79,344,011	5,764	79,349,775	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	35	35	0	35	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	UNOCCUPATIONAL MEDICINE	580,982	106,558	687,540	-5,764	681,776	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0	0	0	0	194.01
194.02	07952	SITTERS	549,853	47,135	596,988	0	596,988	194.02
194.03	07953	UNLICENSED STAFF	0	0	0	0	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	29,747,059	50,881,515	80,628,574	0	80,628,574	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0046

Period:
From 09/01/2023
To 08/31/2024

Worksheet A

Date/Time Prepared:
1/28/2025 2:38 pm

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	234,256	3,322,770	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-40,530	2,726,491	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	311,345	6,364,815	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	24,787,856	16,764,154	5.00
7.00	00700	OPERATION OF PLANT	33,305	3,167,800	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	364,059	8.00
9.00	00900	HOUSEKEEPING	0	1,509,615	9.00
10.00	01000	DIETARY	0	1,245,158	10.00
11.00	01100	CAFETERIA	-165,895	689,336	11.00
13.00	01300	NURSING ADMINISTRATION	3,480	1,427,575	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	36,993	736,609	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,779,120	6,357,791	30.00
31.00	03100	INTENSIVE CARE UNIT	-28,033	3,065,511	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	-227,064	483,773	35.00
40.00	04000	SUBPROVIDER - IPF	-99,362	2,178,049	40.00
41.00	04100	SUBPROVIDER - IRF	-54,083	1,179,593	41.00
43.00	04300	NURSERY	-22	138,217	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-4,501,950	4,642,575	50.00
51.00	05100	RECOVERY ROOM	-2,124	285,131	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-4,948	1,160,925	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-128,391	1,235,022	54.00
54.01	03630	ULTRA SOUND	0	199,384	54.01
54.02	03440	MAMMOGRAPHY	0	107,244	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,094,924	55.00
56.00	05600	RADIOISOTOPE	8	405,160	56.00
57.00	05700	CT SCAN	-10,053	832,451	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	257,247	58.00
59.00	05900	CARDIAC CATHETERIZATION	-14,253	1,087,086	59.00
60.00	06000	LABORATORY	12,012	2,637,082	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	2,106,737	62.00
65.00	06500	RESPIRATORY THERAPY	-88,722	1,040,412	65.00
66.00	06600	PHYSICAL THERAPY	-29,935	1,127,559	66.00
69.00	06900	ELECTROCARDIOLOGY	-11,596	457,834	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	27,224	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,881,214	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,292,225	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,405,627	73.00
74.00	07400	RENAL DIALYSIS	-16,630	512,382	74.00
76.00	03950	LITHOTRIPSY	0	150,700	76.00
76.01	03330	ENDOSCOPY	-61,600	415,228	76.01
76.02	03040	PRISION CLINIC	0	231,133	76.02
76.03	03050	WOUND CARE	-11,596	718,265	76.03
76.04	03060	OPIC	-20,476	562,213	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-3,859,823	3,018,524	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,263,049	93,612,824	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	35	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	UNOCCUPATIONAL MEDICINE	0	681,776	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0	194.01
194.02	07952	SITTERS	-137	596,851	194.02
194.03	07953	UNLICENSED STAFF	0	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	14,262,912	94,891,486	200.00

RECLASSIFICATIONS

Provider CCN: 15-0046

Period:
From 09/01/2023
To 08/31/2024Worksheet A-6
Date/Time Prepared:
1/28/2025 2:38 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - LEASES					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	286,719		1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	53,387		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
	TOTALS		0	340,106		
	B - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	90,598		1.00
	TOTALS		0	90,598		
	C - EXECUTIVE COMP.					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	106,566		1.00
	TOTALS		0	106,566		
	D - CAFETERIA					
1.00	CAFETERIA	11.00	0	855,231		1.00
	TOTALS		0	855,231		
	E - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	865,391		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
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
	TOTALS		0	865,391		
	F - DRUG					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	61,003		1.00
2.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	0	1,502,879		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

RECLASSIFICATIONS

Provider CCN: 15-0046

Period:
From 09/01/2023
To 08/31/2024

Worksheet A-6

Date/Time Prepared:
1/28/2025 2:38 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	TOTALS		0	1,563,882		
	G - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO	72.00	0	358,668		1.00
	PATIENTS					
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	TOTALS		0	358,668		
	H - ER BEDHOLD					
1.00	ADULTS & PEDIATRICS	30.00	224,473	151,488		1.00
2.00	INTENSIVE CARE UNIT	31.00	24,888	16,796		2.00
	TOTALS		249,361	168,284		
	I - EQUIPMENT PROPERTY TAX					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	10,169		1.00
	TOTALS		0	10,169		
	J - LOST CHARGES					
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	10,827		1.00
	PATIENTS					
	TOTALS		0	10,827		
	K - CNO CONTRACT SALARY					
1.00	NURSING ADMINISTRATION	13.00	0	253,163		1.00
	TOTALS		0	253,163		
500.00	Grand Total: Increases		249,361	4,622,885		500.00

RECLASSIFICATIONS

Provider CCN: 15-0046

Period:
From 09/01/2023
To 08/31/2024Worksheet A-6
Date/Time Prepared:
1/28/2025 2:38 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - LEASES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	75,395	10		1.00
2.00	OPERATION OF PLANT	7.00	0	4,386	0		2.00
3.00	HOUSEKEEPING	9.00	0	2,988	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	12,449	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	106,477	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	55,014	0		6.00
7.00	OPERATING ROOM	50.00	0	30,794	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	10,143	0		8.00
9.00	ULTRA SOUND	54.01	0	18,008	0		9.00
10.00	LABORATORY	60.00	0	18,558	0		10.00
11.00	EMERGENCY	91.00	0	5,800	0		11.00
12.00	UNOCCUPATIONAL MEDICINE	194.00	0	94	0		12.00
	TOTALS		0	340,106			
	B - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	90,598	12		1.00
	TOTALS		0	90,598			
	C - EXECUTIVE COMP.						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	106,566	0		1.00
	TOTALS		0	106,566			
	D - CAFETERIA						
1.00	DIETARY	10.00	0	855,231	0		1.00
	TOTALS		0	855,231			
	E - MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	68,262	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	102,384	0		2.00
3.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	119	0		3.00
4.00	SUBPROVIDER - IPF	40.00	0	1,355	0		4.00
5.00	SUBPROVIDER - IRF	41.00	0	5,995	0		5.00
6.00	NURSERY	43.00	0	2,009	0		6.00
7.00	OPERATING ROOM	50.00	0	194,830	0		7.00
8.00	RECOVERY ROOM	51.00	0	1,324	0		8.00
9.00	DELIVERY ROOM & LABOR ROOM	52.00	0	1,638	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	6,106	0		10.00
11.00	ULTRA SOUND	54.01	0	1,501	0		11.00
12.00	RADIOISOTOPE	56.00	0	14	0		12.00
13.00	CT SCAN	57.00	0	1,564	0		13.00
14.00	CARDIAC CATHETERIZATION	59.00	0	83,200	0		14.00
15.00	LABORATORY	60.00	0	858	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	122,310	0		16.00
17.00	ELECTROCARDIOLOGY	69.00	0	109	0		17.00
18.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	94,952	0		18.00
19.00	DRUGS CHARGED TO PATIENTS	73.00	0	9,658	0		19.00
20.00	RENAL DIALYSIS	74.00	0	9,792	0		20.00
21.00	ENDOSCOPY	76.01	0	14,801	0		21.00
22.00	PRISION CLINIC	76.02	0	192	0		22.00
23.00	WOUND CARE	76.03	0	18,535	0		23.00
24.00	OPIC	76.04	0	14,602	0		24.00
25.00	EMERGENCY	91.00	0	103,621	0		25.00
26.00	UNOCCUPATIONAL MEDICINE	194.00	0	5,660	0		26.00
	TOTALS		0	865,391			
	F - DRUG						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,502,718	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	6,358	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	4,946	0		3.00
4.00	SUBPROVIDER - IRF	41.00	0	155	0		4.00
5.00	NURSERY	43.00	0	45	0		5.00
6.00	OPERATING ROOM	50.00	0	27,654	0		6.00
7.00	RECOVERY ROOM	51.00	0	470	0		7.00
8.00	DELIVERY ROOM & LABOR ROOM	52.00	0	131	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,041	0		9.00
10.00	MAMMOGRAPHY	54.02	0	5	0		10.00
11.00	CT SCAN	57.00	0	1,588	0		11.00
12.00	CARDIAC CATHETERIZATION	59.00	0	180	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	871	0		13.00
14.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	5,125	0		14.00
15.00	RENAL DIALYSIS	74.00	0	622	0		15.00
16.00	ENDOSCOPY	76.01	0	1,696	0		16.00
17.00	WOUND CARE	76.03	0	28	0		17.00
18.00	OPIC	76.04	0	1,338	0		18.00
19.00	EMERGENCY	91.00	0	8,901	0		19.00
20.00	UNOCCUPATIONAL MEDICINE	194.00	0	10	0		20.00

RECLASSIFICATIONS

Provider CCN: 15-0046

Period:
From 09/01/2023
To 08/31/2024

Worksheet A-6

Date/Time Prepared:
1/28/2025 2:38 pm

	Decreases				Wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other		
	6.00	7.00	8.00	9.00	10.00	
	TOTALS		0	1,563,882		
	G - IMPLANTABLE DEVICES					
1.00	OPERATING ROOM	50.00	0	8,709	0	1.00
2.00	RADIOLOGY-THERAPEUTIC	55.00	0	22,600	0	2.00
3.00	CARDIAC CATHETERIZATION	59.00	0	113,583	0	3.00
4.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	213,776	0	4.00
	TOTALS		0	358,668		
	H - ER BEDHOLD					
1.00	EMERGENCY	91.00	249,361	168,284	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		249,361	168,284		
	I - EQUIPMENT PROPERTY TAX					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	10,169	13	1.00
	TOTALS		0	10,169		
	J - LOST CHARGES					
1.00	OPERATING ROOM	50.00	0	10,827	0	1.00
	TOTALS		0	10,827		
	K - CNO CONTRACT SALARY					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	253,163	0	1.00
	TOTALS		0	253,163		
500.00	Grand Total: Decreases		249,361	4,622,885		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0046

Period:
From 09/01/2023
To 08/31/2024Worksheet A-7
Part I
Date/Time Prepared:
1/28/2025 2:38 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,262,718	0	0	0	0	1.00	
2.00	Land Improvements	3,238,473	0	0	0	0	2.00	
3.00	Buildings and Fixtures	38,668,254	21,554	0	21,554	0	3.00	
4.00	Building Improvements	9,587,944	0	0	0	0	4.00	
5.00	Fixed Equipment	35,120,542	2,199,921	0	2,199,921	0	5.00	
6.00	Movable Equipment	55,642,613	1,203,224	0	1,203,224	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	143,520,544	3,424,699	0	3,424,699	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	143,520,544	3,424,699	0	3,424,699	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,262,718	0				1.00	
2.00	Land Improvements	3,238,473	0				2.00	
3.00	Buildings and Fixtures	38,689,808	0				3.00	
4.00	Building Improvements	9,587,944	0				4.00	
5.00	Fixed Equipment	37,320,463	0				5.00	
6.00	Movable Equipment	56,845,837	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	146,945,243	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	146,945,243	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0046

Period:
From 09/01/2023
To 08/31/2024Worksheet A-7
Part II
Date/Time Prepared:
1/28/2025 2:38 pm

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	2,329,975	0	0	0	678,110	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,470,133	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,800,108	0	0	0	678,110	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
		PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2					
1.00	CAP REL COSTS-BLDG & FIXT	0	3,008,085				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,470,133				2.00
3.00	Total (sum of lines 1-2)	0	5,478,218				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0046

Period:
From 09/01/2023
To 08/31/2024Worksheet A-7
Part III
Date/Time Prepared:
1/28/2025 2:38 pm

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	90,099,405	0	90,099,405	0.613150	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	56,845,837	0	56,845,837	0.386850	0	2.00
3.00	Total (sum of lines 1-2)	146,945,242	0	146,945,242	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,564,231	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,429,603	286,719	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,993,834	286,719	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	90,598	667,941	0	3,322,770	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	10,169	0	2,726,491	2.00
3.00	Total (sum of lines 1-2)	0	90,598	678,110	0	6,049,261	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0046

Period:
From 09/01/2023
To 08/31/2024

Worksheet A-8

Date/Time Prepared:
1/28/2025 2:38 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-10,667,251			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	31,831,735			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-151,998	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-60	ADMINISTRATIVE & GENERAL	5.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-13,897	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	A	-120,470	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-39,834	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)	B	-83,889	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	INTEREST INCOME	B	-981	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0046

Period:
From 09/01/2023
To 08/31/2024

Worksheet A-8

Date/Time Prepared:
1/28/2025 2:38 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.01	OTHER REVENUE	B	-79,266	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	PATIENT TELEPHONES	A	-12,576	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.02
33.03	PATIENT TELEPHONES	A	-65,162	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	PATIENT TELEVISIONS	A	-696	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.04
33.05	PATIENT TELEVISIONS	A	-55,876	OPERATION OF PLANT	7.00	0	33.05
33.06	CONSULTING SERVICES	A	-126,540	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	ADMIN TRAVEL	A	-8,637	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	ADMIN MEALS	A	-12,971	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	NON-PATIENT GIFTS	A	-7,852	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	ALCOHOL	A	-183	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	COUNTRY CLUB DUES	A	-2,964	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	ADMIN MISC NON-ALLOWABLE	A	-150,039	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	MED STAFF MISC NON-ALLOWABLE	A	-95,741	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	EMERGENCY MISC NON-ALLOWABLE	A	-36,858	EMERGENCY	91.00	0	33.14
33.15	PUBLIC RELATIONS - DEPT. 920	A	-1,912	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	INDIANA HAF/HIP PROVIDER TAX	A	-5,988,379	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	LEGAL FEES	A	-1,838	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	LOBBYING DUES	A	-13,612	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	MOB ACCOUNTING	A	-1,494	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	MOB ACCOUNTING	A	-387	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.20
33.21	USEFUL LIFE ADJUSTMENT	A	172,540	CAP REL COSTS-BLDG & FIXT	1.00	9	33.21
33.22	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.22
33.23	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.23
33.24	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.24
33.25	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.25
33.26	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.26
33.27	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.27
33.28	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.28
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		14,262,912				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 15-0046

Period:
From 09/01/2023
To 08/31/2024

Worksheet A-8-1

Date/Time Prepared:
1/28/2025 2:38 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED						
HOME OFFICE COSTS:						
1.00	5.00	ADMINISTRATIVE & GENERAL	HPG	101,963	197,141	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	IT&S	1,967,620	2,014,268	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE COST	1,781,543	4,053,939	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE DIRECT COMP.	229,332	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE INTEREST	572,404	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	SSC	2,045,457	2,009,896	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	SSC - IDR	3,664	3,393	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	SSC - NSA	9,064	9,064	4.04
4.05	5.00	ADMINISTRATIVE & GENERAL	SSC - CLOUD MED	10,842	10,842	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	SSC - CREDENTIALING IT	8,754	9,607	4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	SSC - HIMS IT	68,232	66,222	4.07
4.08	5.00	ADMINISTRATIVE & GENERAL	SSC - PATIENT ACCOUNTING IT	290,845	290,238	4.08
4.09	5.00	ADMINISTRATIVE & GENERAL	SUPPLY CHAIN	1,506,550	1,478,403	4.09
4.10	5.00	ADMINISTRATIVE & GENERAL	SUPPLY CHAIN - FACILITIES MA	18,699	16,699	4.10
4.11	5.00	ADMINISTRATIVE & GENERAL	SUPPLY CHAIN - SUPPORT SERVI	28,577	26,787	4.11
4.12	5.00	ADMINISTRATIVE & GENERAL	CREDENTIALING	44,253	46,335	4.12
4.13	5.00	ADMINISTRATIVE & GENERAL	CAPITAL DIVISION IT&S	996,485	997,135	4.13
4.14	16.00	MEDICAL RECORDS & LIBRARY	HIM	563,663	525,360	4.14
4.15	5.00	ADMINISTRATIVE & GENERAL	PAYROLL SERVICE CENTER	17,657	20,914	4.15
4.16	60.00	LABORATORY	LSL	222,949	210,937	4.16
4.17	5.00	ADMINISTRATIVE & GENERAL	RICHMOND FSC	6,434	6,434	4.17
4.18	40.00	SUBPROVIDER - IPF	BEHAVIORAL HEALTH	337,600	309,071	4.18
4.19	5.00	ADMINISTRATIVE & GENERAL	HWS - NET REBATES	3,358	12,962	4.19
4.20	5.00	ADMINISTRATIVE & GENERAL	HWS - PLACEMENT	62,679	64,427	4.20
4.21	5.00	ADMINISTRATIVE & GENERAL	HWS - SCHEDULER	63,019	61,346	4.21
4.22	4.00	EMPLOYEE BENEFITS DEPARTMENT	HCA HR SERVICES	503,390	503,390	4.22
4.23	16.00	MEDICAL RECORDS & LIBRARY	CANCER REGISTRY-SARAH CANN	46,020	44,078	4.23
4.24	13.00	NURSING ADMINISTRATION	CLINICAL EDUCATION	496,442	492,860	4.24
4.25	5.00	ADMINISTRATIVE & GENERAL	CASE MGMT ALLOCATION	127,031	127,070	4.25
4.26	16.00	MEDICAL RECORDS & LIBRARY	HIM ABSTRACTING	126,288	129,540	4.26
4.27	5.00	ADMINISTRATIVE & GENERAL	TRANSFER CTR ALLOCATION	347,248	333,988	4.27
4.28	5.00	ADMINISTRATIVE & GENERAL	PRINT CENTER	7,943	7,943	4.28
4.29	5.00	ADMINISTRATIVE & GENERAL	MARK-UP DEPARTMENT 994	0	946,227	4.29
4.30	5.00	ADMINISTRATIVE & GENERAL	SELF INSURED	0	14,394	4.30
4.31	5.00	ADMINISTRATIVE & GENERAL	PHYSICIAN SALES	0	138,897	4.31
4.32	4.00	EMPLOYEE BENEFITS DEPARTMENT	BUDGET NEUTRAL FOR HEALTH IN	0	-326,608	4.32
4.33	5.00	ADMINISTRATIVE & GENERAL	INTERCOMPANY INTEREST	0	-34,389,565	4.33
4.34	4.00	EMPLOYEE BENEFITS DEPARTMENT	RESTORATION PLAN EXPENSE	0	2,300	4.34
4.35	5.00	ADMINISTRATIVE & GENERAL	CALL CENTER	0	52,041	4.35
4.36	5.00	ADMINISTRATIVE & GENERAL	PHYSICIAN RECRUITING - GL 90	0	168,382	4.36
4.37	5.00	ADMINISTRATIVE & GENERAL	PHYSICIAN RECRUITING - GL 95	0	890	4.37
4.38	5.00	ADMINISTRATIVE & GENERAL	HWS	271,971	282,534	4.38
4.39	7.00	OPERATION OF PLANT	HWS	150,109	155,939	4.39
4.40	13.00	NURSING ADMINISTRATION	HWS	2,608	2,710	4.40
4.41	30.00	ADULTS & PEDIATRICS	HWS	1,704,415	1,770,610	4.41
4.42	31.00	INTENSIVE CARE UNIT	HWS	721,807	749,840	4.42
4.43	35.00	NEONATAL INTENSIVE CARE UNIT	HWS	15,559	16,163	4.43
4.44	40.00	SUBPROVIDER - IPF	HWS	83,044	86,270	4.44
4.45	41.00	SUBPROVIDER - IRF	HWS	13,889	14,428	4.45
4.46	43.00	NURSERY	HWS	578	600	4.46
4.47	50.00	OPERATING ROOM	HWS	489,833	508,857	4.47
4.48	51.00	RECOVERY ROOM	HWS	54,697	56,821	4.48
4.49	52.00	DELIVERY ROOM & LABOR ROOM	HWS	127,403	132,351	4.49
4.50	54.00	RADIOLOGY-DIAGNOSTIC	HWS	170,984	177,625	4.50
4.51	56.00	RADIOISOTOPE	HWS	-180	-188	4.51
4.52	57.00	CT SCAN	HWS	258,865	268,918	4.52
4.53	59.00	CARDIAC CATHETERIZATION	HWS	367,006	381,259	4.53
4.54	65.00	RESPIRATORY THERAPY	HWS	153,773	159,745	4.54
4.55	66.00	PHYSICAL THERAPY	HWS	17,814	18,506	4.55
4.56	74.00	RENAL DIALYSIS	HWS	428,185	444,815	4.56
4.57	91.00	EMERGENCY	HWS	367,853	382,139	4.57
4.58	194.02	SITTERS	HWS	3,509	3,646	4.58
4.59	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE	331,515	550,814	4.59
4.60	1.00	CAP REL COSTS-BLDG & FIXT	POB SPACE	88,760	0	4.60
4.61	5.00	ADMINISTRATIVE & GENERAL	POB SPACE	54,702	0	4.61
4.62	7.00	OPERATION OF PLANT	POB SPACE	63,746	0	4.62
4.63	1.00	CAP REL COSTS-BLDG & FIXT	PAVILLION SPACE	93,426	0	4.63
4.64	5.00	ADMINISTRATIVE & GENERAL	PAVILLION SPACE	243	0	4.64
4.65	7.00	OPERATION OF PLANT	PAVILLION SPACE	31,265	0	4.65

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

Provider CCN: 15-0046

Period:
From 09/01/2023
To 08/31/2024

Worksheet A-8-1

Date/Time Prepared:
1/28/2025 2:38 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			18,683,384	-13,148,351	5.00

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

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

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	B		0.00	HCA HOME OFFICE	100.00	6.00
7.00	B		0.00	HPG	67.34	7.00
8.00	B		0.00	HCI	100.00	8.00
9.00	B		0.00	HCA - CAP DIV	100.00	9.00
10.00	B		0.00	HWS	100.00	10.00
10.01	B		0.00	HCA	100.00	10.01
10.02	B		0.00	POB/PAVILLION	100.00	10.02
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 15-0046

Period:
From 09/01/2023
To 08/31/2024

Worksheet A-8-1

Date/Time Prepared:
1/28/2025 2:38 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-95,178	0		1.00
2.00	-46,648	0		2.00
3.00	-2,272,396	0		3.00
4.00	229,332	0		4.00
4.01	572,404	0		4.01
4.02	35,561	0		4.02
4.03	271	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	-853	0		4.06
4.07	2,010	0		4.07
4.08	607	0		4.08
4.09	28,147	0		4.09
4.10	2,000	0		4.10
4.11	1,790	0		4.11
4.12	-2,082	0		4.12
4.13	-650	0		4.13
4.14	38,303	0		4.14
4.15	-3,257	0		4.15
4.16	12,012	0		4.16
4.17	0	0		4.17
4.18	28,529	0		4.18
4.19	-9,604	0		4.19
4.20	-1,748	0		4.20
4.21	1,673	0		4.21
4.22	0	0		4.22
4.23	1,942	0		4.23
4.24	3,582	0		4.24
4.25	-39	0		4.25
4.26	-3,252	0		4.26
4.27	13,260	0		4.27
4.28	0	0		4.28
4.29	-946,227	0		4.29
4.30	-14,394	0		4.30
4.31	-138,897	0		4.31
4.32	326,608	0		4.32
4.33	34,389,565	0		4.33
4.34	-2,300	0		4.34
4.35	-52,041	0		4.35
4.36	-168,382	0		4.36
4.37	-890	0		4.37
4.38	-10,563	0		4.38
4.39	-5,830	0		4.39
4.40	-102	0		4.40
4.41	-66,195	0		4.41
4.42	-28,033	0		4.42
4.43	-604	0		4.43
4.44	-3,226	0		4.44
4.45	-539	0		4.45
4.46	-22	0		4.46
4.47	-19,024	0		4.47
4.48	-2,124	0		4.48
4.49	-4,948	0		4.49
4.50	-6,641	0		4.50
4.51	8	0		4.51
4.52	-10,053	0		4.52
4.53	-14,253	0		4.53
4.54	-5,972	0		4.54
4.55	-692	0		4.55
4.56	-16,630	0		4.56
4.57	-14,286	0		4.57
4.58	-137	0		4.58
4.59	-219,299	0		4.59
4.60	88,760	9		4.60
4.61	54,702	0		4.61
4.62	63,746	0		4.62
4.63	93,426	9		4.63
4.64	243	0		4.64
4.65	31,265	0		4.65
5.00	31,831,735			5.00

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

Provider CCN: 15-0046

Period:
From 09/01/2023
To 08/31/2024

Worksheet A-8-1

Date/Time Prepared:
1/28/2025 2:38 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		

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

	Related Organization(s) and/or Home Office	
	Type of Business	
	6.00	

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	MANAGEMENT	6.00
7.00	PURCHASING	7.00
8.00	INSURANCE	8.00
9.00	MANAGEMENT	9.00
10.00	STAFFING	10.00
10.01	HOSPITAL MGT.	10.01
10.02	PROF. BUILDING	10.02
100.00		100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0046

Period:
From 09/01/2023
To 08/31/2024

Worksheet A-8-2

Date/Time Prepared:
1/28/2025 2:38 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,629,036	1,629,036	0	211,500	0	1.00
2.00	35.00	NEONATAL INTENSIVE CARE UNIT	246,041	198,041	48,000	169,700	240	2.00
3.00	40.00	SUBPROVIDER - IPF	137,391	115,476	21,915	181,300	146	3.00
4.00	41.00	SUBPROVIDER - IRF	53,544	53,544	0	211,500	0	4.00
5.00	50.00	OPERATING ROOM	4,482,926	4,482,926	0	246,200	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	121,750	121,750	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	82,750	82,750	0	211,500	0	7.00
8.00	66.00	PHYSICAL THERAPY	90,863	-75	90,938	211,500	606	8.00
9.00	69.00	ELECTROCARDIOLOGY	36,000	0	36,000	211,500	240	9.00
10.00	76.01	ENDOSCOPY	61,600	61,600	0	246,400	0	10.00
11.00	76.03	WOUND CARE	36,000	0	36,000	211,500	240	11.00
12.00	76.04	OPIC	44,880	0	44,880	211,500	240	12.00
13.00	91.00	EMERGENCY	3,808,679	3,808,679	0	211,500	0	13.00
14.00	5.00	ADMINISTRATIVE & GENERAL	2,930	2,930	0	211,500	0	14.00
200.00			10,834,390	10,556,657	277,733		1,712	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	35.00	NEONATAL INTENSIVE CARE UNIT	19,581	979	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	12,726	636	0	0	0	3.00
4.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	7.00
8.00	66.00	PHYSICAL THERAPY	61,620	3,081	0	0	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	24,404	1,220	0	0	0	9.00
10.00	76.01	ENDOSCOPY	0	0	0	0	0	10.00
11.00	76.03	WOUND CARE	24,404	1,220	0	0	0	11.00
12.00	76.04	OPIC	24,404	1,220	0	0	0	12.00
13.00	91.00	EMERGENCY	0	0	0	0	0	13.00
14.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	14.00
200.00			167,139	8,356	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,629,036		1.00
2.00	35.00	NEONATAL INTENSIVE CARE UNIT	0	19,581	28,419	226,460		2.00
3.00	40.00	SUBPROVIDER - IPF	0	12,726	9,189	124,665		3.00
4.00	41.00	SUBPROVIDER - IRF	0	0	0	53,544		4.00
5.00	50.00	OPERATING ROOM	0	0	0	4,482,926		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	121,750		6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	82,750		7.00
8.00	66.00	PHYSICAL THERAPY	0	61,620	29,318	29,243		8.00
9.00	69.00	ELECTROCARDIOLOGY	0	24,404	11,596	11,596		9.00
10.00	76.01	ENDOSCOPY	0	0	0	61,600		10.00
11.00	76.03	WOUND CARE	0	24,404	11,596	11,596		11.00
12.00	76.04	OPIC	0	24,404	20,476	20,476		12.00
13.00	91.00	EMERGENCY	0	0	0	3,808,679		13.00
14.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	2,930		14.00
200.00			0	167,139	110,594	10,667,251		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0046

Period:
From 09/01/2023
To 08/31/2024Worksheet B
Part I
Date/Time Prepared:
1/28/2025 2:38 pm

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,322,770	3,322,770				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,726,491		2,726,491			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,364,815	8,354	7,518	6,380,687		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	16,764,154	239,012	215,094	754,114	17,972,374	5.00
7.00	00700	OPERATION OF PLANT	3,167,800	907,257	816,469	84,546	4,976,072	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	364,059	28,353	25,516	0	417,928	8.00
9.00	00900	HOUSEKEEPING	1,509,615	32,295	29,063	229,438	1,800,411	9.00
10.00	01000	DIETARY	1,245,158	55,535	49,978	0	1,350,671	10.00
11.00	01100	CAFETERIA	689,336	29,320	26,386	0	745,042	11.00
13.00	01300	NURSING ADMINISTRATION	1,427,575	4,335	3,901	122,514	1,558,325	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	736,609	6,746	6,071	0	749,426	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,357,791	447,019	402,286	855,270	8,062,366	30.00
31.00	03100	INTENSIVE CARE UNIT	3,065,511	105,103	94,585	418,334	3,683,533	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	483,773	4,207	3,786	89,588	581,354	35.00
40.00	04000	SUBPROVIDER - IPF	2,178,049	93,799	84,412	365,712	2,721,972	40.00
41.00	04100	SUBPROVIDER - IRF	1,179,593	81,144	73,024	196,613	1,530,374	41.00
43.00	04300	NURSERY	138,217	13,458	12,112	24,287	188,074	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,642,575	247,588	222,812	547,155	5,660,130	50.00
51.00	05100	RECOVERY ROOM	285,131	13,544	12,189	42,444	353,308	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,160,925	42,804	38,520	197,137	1,439,386	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,235,022	101,828	91,638	150,356	1,578,844	54.00
54.01	03630	ULTRA SOUND	199,384	7,020	6,317	36,666	249,387	54.01
54.02	03440	MAMMOGRAPHY	107,244	22,642	20,376	19,410	169,672	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	1,094,924	36,451	32,803	126,940	1,291,118	55.00
56.00	05600	RADIOISOTOPE	405,160	6,524	5,871	4,593	422,148	56.00
57.00	05700	CT SCAN	832,451	11,492	10,342	77,470	931,755	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	257,247	11,808	10,627	36,012	315,694	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,087,086	16,468	14,820	96,838	1,215,212	59.00
60.00	06000	LABORATORY	2,637,082	55,125	49,609	232,181	2,973,997	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,106,737	2,676	2,408	7,314	2,119,135	62.00
65.00	06500	RESPIRATORY THERAPY	1,040,412	13,698	12,327	141,790	1,208,227	65.00
66.00	06600	PHYSICAL THERAPY	1,127,559	8,610	7,749	209,081	1,352,999	66.00
69.00	06900	ELECTROCARDIOLOGY	457,834	37,118	33,403	82,124	610,479	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	27,224	4,156	3,740	4,108	39,228	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,881,214	47,925	43,130	42,654	4,014,923	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,292,225	0	0	0	2,292,225	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,405,627	29,850	26,863	242,640	11,704,980	73.00
74.00	07400	RENAL DIALYSIS	512,382	11,928	10,734	0	535,044	74.00
76.00	03950	LITHOTRIPSY	150,700	0	0	0	150,700	76.00
76.01	03330	ENDOSCOPY	415,228	13,544	12,189	51,516	492,477	76.01
76.02	03040	PRISION CLINIC	231,133	37,896	34,104	44,999	348,132	76.02
76.03	03050	WOUND CARE	718,265	28,182	25,362	17,847	789,656	76.03
76.04	03060	OPIC	562,213	36,853	33,165	101,035	733,266	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	3,018,524	105,872	95,278	484,771	3,704,445	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	93,612,824	3,007,539	2,706,577	6,137,497	93,034,489	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	35	4,840	4,355	0	9,230	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	UNOCCUPATIONAL MEDICINE	681,776	17,289	15,559	124,942	839,566	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	293,102	0	0	293,102	194.01
194.02	07952	SITTERS	596,851	0	0	118,248	715,099	194.02
194.03	07953	UNLICENSED STAFF	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	94,891,486	3,322,770	2,726,491	6,380,687	94,891,486	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0046

Period:
From 09/01/2023
To 08/31/2024Worksheet B
Part I
Date/Time Prepared:
1/28/2025 2:38 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,972,374					5.00
7.00	00700	OPERATION OF PLANT	1,162,674	6,138,746				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	97,650	80,278	595,856			8.00
9.00	00900	HOUSEKEEPING	420,671	91,438	0	2,312,520		9.00
10.00	01000	DIETARY	315,588	157,239	0	70,782	1,894,280	10.00
11.00	01100	CAFETERIA	174,081	83,014	0	37,369	0	11.00
13.00	01300	NURSING ADMINISTRATION	364,107	12,274	0	5,525	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	175,106	19,101	0	8,598	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,883,796	1,265,662	299,761	569,746	908,948	30.00
31.00	03100	INTENSIVE CARE UNIT	860,669	297,580	85,205	133,957	158,471	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	135,835	11,911	1,739	5,362	0	35.00
40.00	04000	SUBPROVIDER - IPF	635,997	265,576	146,480	119,550	469,518	40.00
41.00	04100	SUBPROVIDER - IRF	357,576	229,746	58,481	103,421	280,291	41.00
43.00	04300	NURSERY	43,944	38,105	4,190	17,153	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,322,506	701,004	0	315,561	0	50.00
51.00	05100	RECOVERY ROOM	82,551	38,347	0	17,262	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	336,317	121,192	0	54,555	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	368,902	288,308	0	129,784	0	54.00
54.01	03630	ULTRA SOUND	58,270	19,876	0	8,947	0	54.01
54.02	03440	MAMMOGRAPHY	39,644	64,106	0	28,858	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	301,674	103,204	0	46,458	0	55.00
56.00	05600	RADIOISOTOPE	98,636	18,472	0	8,315	0	56.00
57.00	05700	CT SCAN	217,707	32,537	0	14,647	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	73,763	33,433	0	15,050	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	283,938	46,627	0	20,989	0	59.00
60.00	06000	LABORATORY	694,883	156,077	0	70,259	0	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	495,142	7,578	0	3,411	0	62.00
65.00	06500	RESPIRATORY THERAPY	282,306	38,783	0	17,458	0	65.00
66.00	06600	PHYSICAL THERAPY	316,132	24,379	0	10,974	0	66.00
69.00	06900	ELECTROCARDIOLOGY	142,640	105,092	0	47,308	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	9,166	11,766	0	5,296	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	938,099	135,693	0	61,083	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	535,585	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,734,898	84,515	0	38,045	0	73.00
74.00	07400	RENAL DIALYSIS	125,015	33,772	0	15,203	0	74.00
76.00	03950	LITHOTRIPSY	35,212	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	115,069	38,347	0	17,262	0	76.01
76.02	03040	PRISION CLINIC	81,342	107,296	0	48,300	0	76.02
76.03	03050	WOUND CARE	184,505	79,794	0	35,920	0	76.03
76.04	03060	OPIC	171,330	104,342	0	46,970	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	865,555	299,759	0	134,938	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,538,481	5,246,223	595,856	2,284,316	1,817,228	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,157	13,702	0	6,168	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	UNOCCUPATIONAL MEDICINE	196,167	48,951	0	22,036	0	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	68,484	829,870	0	0	77,052	194.01
194.02	07952	SITTERS	167,085	0	0	0	0	194.02
194.03	07953	UNLICENSED STAFF	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	17,972,374	6,138,746	595,856	2,312,520	1,894,280	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0046

Period:
From 09/01/2023
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,039,506					11.00
13.00	01300	NURSING ADMINISTRATION	23,972	1,964,203				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	952,231			16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	167,354	635,633	24,355	13,817,621	0	30.00
31.00	03100	INTENSIVE CARE UNIT	81,855	367,026	17,618	5,685,914	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	17,529	64,342	353	818,425	0	35.00
40.00	04000	SUBPROVIDER - IPF	71,558	151,699	39,608	4,621,958	0	40.00
41.00	04100	SUBPROVIDER - IRF	38,471	122,600	5,390	2,726,350	0	41.00
43.00	04300	NURSERY	4,752	9,185	435	305,838	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	107,061	0	107,539	8,213,801	0	50.00
51.00	05100	RECOVERY ROOM	8,305	0	10,734	510,507	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	38,573	119,968	1,967	2,111,958	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,420	0	14,949	2,410,207	0	54.00
54.01	03630	ULTRA SOUND	7,174	0	5,424	349,078	0	54.01
54.02	03440	MAMMOGRAPHY	3,798	0	2,435	308,513	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	24,838	0	17,771	1,785,063	0	55.00
56.00	05600	RADIOISOTOPE	899	0	15,422	563,892	0	56.00
57.00	05700	CT SCAN	15,158	0	97,791	1,309,595	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	7,046	0	10,251	455,237	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	18,948	88,425	44,951	1,719,090	0	59.00
60.00	06000	LABORATORY	45,430	0	89,320	4,029,966	0	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY				0		61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,431	0	8,230	2,634,927	0	62.00
65.00	06500	RESPIRATORY THERAPY	27,744	0	19,501	1,594,019	0	65.00
66.00	06600	PHYSICAL THERAPY	40,910	2,994	13,651	1,762,039	0	66.00
69.00	06900	ELECTROCARDIOLOGY	16,069	0	30,415	952,003	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	804	0	830	67,090	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,346	0	49,272	5,207,416	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	18,086	2,845,896	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	47,477	0	174,862	14,784,777	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	1,925	710,959	0	74.00
76.00	03950	LITHOTRIPSY	0	0	564	186,476	0	76.00
76.01	03330	ENDOSCOPY	10,080	0	16,792	690,027	0	76.01
76.02	03040	PRISION CLINIC	8,805	11,335	922	606,132	0	76.02
76.03	03050	WOUND CARE	3,492	0	5,812	1,099,179	0	76.03
76.04	03060	OPIC	19,769	48,843	7,762	1,132,282	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	94,854	340,929	97,294	5,537,774	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	991,922	1,962,979	952,231	91,554,009	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	31,257	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	UNOCCUPATIONAL MEDICINE	24,447	0	0	1,131,167	0	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0	0	1,268,508	0	194.01
194.02	07952	SITTERS	23,137	1,224	0	906,545	0	194.02
194.03	07953	UNLICENSED STAFF	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,039,506	1,964,203	952,231	94,891,486	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0046

Period:
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	35.00
40.00	04000	SUBPROVIDER - IPF	40.00
41.00	04100	SUBPROVIDER - IRF	41.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	03630	ULTRA SOUND	54.01
54.02	03440	MAMMOGRAPHY	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03950	LITHOTRIPSY	76.00
76.01	03330	ENDOSCOPY	76.01
76.02	03040	PRISION CLINIC	76.02
76.03	03050	WOUND CARE	76.03
76.04	03060	OPIC	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	77.00
OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
102.00	10200	OPIOID TREATMENT PROGRAM	102.00
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	UNOCCUPATIONAL MEDICINE	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	194.01
194.02	07952	SITTERS	194.02
194.03	07953	UNLICENSED STAFF	194.03
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0046

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	8,354	7,518	15,872	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,998,983	239,012	215,094	2,453,089	5.00
7.00	00700	OPERATION OF PLANT	381	907,257	816,469	1,724,107	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	28,353	25,516	53,869	8.00
9.00	00900	HOUSEKEEPING	0	32,295	29,063	61,358	9.00
10.00	01000	DIETARY	0	55,535	49,978	105,513	10.00
11.00	01100	CAFETERIA	0	29,320	26,386	55,706	11.00
13.00	01300	NURSING ADMINISTRATION	35,830	4,335	3,901	44,066	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,290	6,746	6,071	14,107	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,330	447,019	402,286	853,635	30.00
31.00	03100	INTENSIVE CARE UNIT	1,834	105,103	94,585	201,522	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	40	4,207	3,786	8,033	35.00
40.00	04000	SUBPROVIDER - IPF	211	93,799	84,412	178,422	40.00
41.00	04100	SUBPROVIDER - IRF	35	81,144	73,024	154,203	41.00
43.00	04300	NURSERY	1	13,458	12,112	25,571	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,244	247,588	222,812	471,644	50.00
51.00	05100	RECOVERY ROOM	139	13,544	12,189	25,872	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	324	42,804	38,520	81,648	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	434	101,828	91,638	193,900	54.00
54.01	03630	ULTRA SOUND	0	7,020	6,317	13,337	54.01
54.02	03440	MAMMOGRAPHY	0	22,642	20,376	43,018	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	36,451	32,803	69,254	55.00
56.00	05600	RADIOISOTOPE	0	6,524	5,871	12,395	56.00
57.00	05700	CT SCAN	658	11,492	10,342	22,492	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	11,808	10,627	22,435	58.00
59.00	05900	CARDIAC CATHETERIZATION	932	16,468	14,820	32,220	59.00
60.00	06000	LABORATORY	14,074	55,125	49,609	118,808	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY				0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	2,676	2,408	5,084	62.00
65.00	06500	RESPIRATORY THERAPY	391	13,698	12,327	26,416	65.00
66.00	06600	PHYSICAL THERAPY	45	8,610	7,749	16,404	66.00
69.00	06900	ELECTROCARDIOLOGY	0	37,118	33,403	70,521	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	4,156	3,740	7,896	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	47,925	43,130	91,055	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	29,850	26,863	56,713	73.00
74.00	07400	RENAL DIALYSIS	1,088	11,928	10,734	23,750	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0	13,544	12,189	25,733	76.01
76.02	03040	PRISION CLINIC	0	37,896	34,104	72,000	76.02
76.03	03050	WOUND CARE	0	28,182	25,362	53,544	76.03
76.04	03060	OPIC	0	36,853	33,165	70,018	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	935	105,872	95,278	202,085	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
OTHER REIMBURSABLE COST CENTERS							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,063,199	3,007,539	2,706,577	7,777,315	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,840	4,355	9,195	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	UNOCCUPATIONAL MEDICINE	0	17,289	15,559	32,848	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	293,102	0	293,102	194.01
194.02	07952	SITTERS	9	0	0	9	194.02
194.03	07953	UNLICENSED STAFF	0	0	0	0	194.03
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,063,208	3,322,770	2,726,491	8,112,469	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0046

Period:
From 09/01/2023
To 08/31/2024Worksheet B
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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,454,965					5.00
7.00	00700	OPERATION OF PLANT	158,816	1,883,133				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	13,339	24,626	91,834			8.00
9.00	00900	HOUSEKEEPING	57,462	28,050	0	147,441		9.00
10.00	01000	DIETARY	43,108	48,235	0	4,513	201,369	10.00
11.00	01100	CAFETERIA	23,779	25,465	0	2,383	0	11.00
13.00	01300	NURSING ADMINISTRATION	49,736	3,765	0	352	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	23,919	5,859	0	548	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	257,318	388,261	46,199	36,325	96,625	30.00
31.00	03100	INTENSIVE CARE UNIT	117,564	91,286	13,132	8,541	16,846	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	18,554	3,654	268	342	0	35.00
40.00	04000	SUBPROVIDER - IPF	86,874	81,469	22,576	7,622	49,911	40.00
41.00	04100	SUBPROVIDER - IRF	48,843	70,477	9,013	6,594	29,796	41.00
43.00	04300	NURSEY	6,003	11,689	646	1,094	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	180,649	215,041	0	20,119	0	50.00
51.00	05100	RECOVERY ROOM	11,276	11,764	0	1,101	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	45,939	37,177	0	3,478	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	50,390	88,442	0	8,275	0	54.00
54.01	03630	ULTRA SOUND	7,959	6,097	0	570	0	54.01
54.02	03440	MAMMOGRAPHY	5,415	19,665	0	1,840	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	41,207	31,659	0	2,962	0	55.00
56.00	05600	RADIOISOTOPE	13,473	5,666	0	530	0	56.00
57.00	05700	CT SCAN	29,738	9,981	0	934	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	10,076	10,256	0	960	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	38,785	14,303	0	1,338	0	59.00
60.00	06000	LABORATORY	94,918	47,879	0	4,480	0	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	67,634	2,324	0	217	0	62.00
65.00	06500	RESPIRATORY THERAPY	38,562	11,897	0	1,113	0	65.00
66.00	06600	PHYSICAL THERAPY	43,182	7,478	0	700	0	66.00
69.00	06900	ELECTROCARDIOLOGY	19,484	32,238	0	3,016	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,252	3,609	0	338	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	128,140	41,625	0	3,895	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	73,159	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	373,591	25,926	0	2,426	0	73.00
74.00	07400	RENAL DIALYSIS	17,076	10,360	0	969	0	74.00
76.00	03950	LITHOTRIPSY	4,810	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	15,718	11,764	0	1,101	0	76.01
76.02	03040	PRISION CLINIC	11,111	32,914	0	3,079	0	76.02
76.03	03050	WOUND CARE	25,203	24,478	0	2,290	0	76.03
76.04	03060	OPIC	23,403	32,008	0	2,995	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	118,231	91,955	0	8,603	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,395,696	1,609,342	91,834	145,643	193,178	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	295	4,203	0	393	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	UNOCCUPATIONAL MEDICINE	26,796	15,016	0	1,405	0	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	9,355	254,572	0	0	8,191	194.01
194.02	07952	SITTERS	22,823	0	0	0	0	194.02
194.03	07953	UNLICENSED STAFF	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,454,965	1,883,133	91,834	147,441	201,369	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0046

Period:
From 09/01/2023
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	107,333					11.00
13.00	01300	NURSING ADMINISTRATION	2,475	100,699				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	44,433			16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	17,276	32,585	1,126	1,731,477	0	30.00
31.00	03100	INTENSIVE CARE UNIT	8,452	18,817	815	478,016	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	1,810	3,299	16	36,199	0	35.00
40.00	04000	SUBPROVIDER - IPF	7,389	7,777	1,832	444,782	0	40.00
41.00	04100	SUBPROVIDER - IRF	3,972	6,285	249	329,921	0	41.00
43.00	04300	NURSERY	491	471	20	46,045	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,055	0	4,973	904,842	0	50.00
51.00	05100	RECOVERY ROOM	858	0	496	51,473	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,983	6,151	91	178,957	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,038	0	691	345,110	0	54.00
54.01	03630	ULTRA SOUND	741	0	251	29,046	0	54.01
54.02	03440	MAMMOGRAPHY	392	0	113	70,491	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	2,565	0	822	148,785	0	55.00
56.00	05600	RADIOISOTOPE	93	0	713	32,881	0	56.00
57.00	05700	CT SCAN	1,565	0	4,523	69,426	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	728	0	474	45,019	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,957	4,533	2,079	95,456	0	59.00
60.00	06000	LABORATORY	4,691	0	4,131	275,485	0	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY					0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	148	0	381	75,806	0	62.00
65.00	06500	RESPIRATORY THERAPY	2,865	0	902	82,108	0	65.00
66.00	06600	PHYSICAL THERAPY	4,224	154	631	73,293	0	66.00
69.00	06900	ELECTROCARDIOLOGY	1,659	0	1,407	128,529	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	83	0	38	13,226	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	862	0	2,279	267,962	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	836	73,995	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,902	0	8,481	472,643	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	89	52,244	0	74.00
76.00	03950	LITHOTRIPSY	0	0	26	4,836	0	76.00
76.01	03330	ENDOSCOPY	1,041	0	777	56,262	0	76.01
76.02	03040	PRISION CLINIC	909	581	43	120,749	0	76.02
76.03	03050	WOUND CARE	361	0	269	106,189	0	76.03
76.04	03060	OPIC	2,041	2,504	359	133,579	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	9,794	17,479	4,500	453,853	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	102,420	100,636	44,433	7,428,685	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	14,086	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	UNOCCUPATIONAL MEDICINE	2,524	0	0	78,900	0	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0	0	565,220	0	194.01
194.02	07952	SITTERS	2,389	63	0	25,578	0	194.02
194.03	07953	UNLICENSED STAFF	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	107,333	100,699	44,433	8,112,469	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0046

Period:
From 09/01/2023
To 08/31/2024Worksheet B
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	35.00
40.00	04000	SUBPROVIDER - IPF	40.00
41.00	04100	SUBPROVIDER - IRF	41.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	03630	ULTRA SOUND	54.01
54.02	03440	MAMMOGRAPHY	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03950	LITHOTRIPSY	76.00
76.01	03330	ENDOSCOPY	76.01
76.02	03040	PRISION CLINIC	76.02
76.03	03050	WOUND CARE	76.03
76.04	03060	OPIC	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	77.00
OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
102.00	10200	OPIOID TREATMENT PROGRAM	102.00
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	UNOCCUPATIONAL MEDICINE	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	194.01
194.02	07952	SITTERS	194.02
194.03	07953	UNLICENSED STAFF	194.03
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0046

Period:
From 09/01/2023
To 08/31/2024

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	388,606					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		354,327				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	977	977	29,670,276			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	27,953	27,953	3,506,644	-17,972,374	76,919,112	5.00
7.00	00700	OPERATION OF PLANT	106,106	106,106	393,141	0	4,976,072	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,316	3,316	0	0	417,928	8.00
9.00	00900	HOUSEKEEPING	3,777	3,777	1,066,892	0	1,800,411	9.00
10.00	01000	DIETARY	6,495	6,495	0	0	1,350,671	10.00
11.00	01100	CAFETERIA	3,429	3,429	0	0	745,042	11.00
13.00	01300	NURSING ADMINISTRATION	507	507	569,693	0	1,558,325	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	789	789	0	0	749,426	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	52,280	52,280	3,976,999	0	8,062,366	30.00
31.00	03100	INTENSIVE CARE UNIT	12,292	12,292	1,945,261	0	3,683,533	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	492	492	416,585	0	581,354	35.00
40.00	04000	SUBPROVIDER - IPF	10,970	10,970	1,700,566	0	2,721,972	40.00
41.00	04100	SUBPROVIDER - IRF	9,490	9,490	914,256	0	1,530,374	41.00
43.00	04300	NURSERY	1,574	1,574	112,934	0	188,074	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	28,956	28,956	2,544,282	0	5,660,130	50.00
51.00	05100	RECOVERY ROOM	1,584	1,584	197,366	0	353,308	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,006	5,006	916,691	0	1,439,386	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,909	11,909	699,156	0	1,578,844	54.00
54.01	03630	ULTRA SOUND	821	821	170,497	0	249,387	54.01
54.02	03440	MAMMOGRAPHY	2,648	2,648	90,255	0	169,672	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	4,263	4,263	590,271	0	1,291,118	55.00
56.00	05600	RADIOISOTOPE	763	763	21,356	0	422,148	56.00
57.00	05700	CT SCAN	1,344	1,344	360,235	0	931,755	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,381	1,381	167,456	0	315,694	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,926	1,926	450,299	0	1,215,212	59.00
60.00	06000	LABORATORY	6,447	6,447	1,079,646	0	2,973,997	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY				0		61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	313	313	34,012	0	2,119,135	62.00
65.00	06500	RESPIRATORY THERAPY	1,602	1,602	659,328	0	1,208,227	65.00
66.00	06600	PHYSICAL THERAPY	1,007	1,007	972,229	0	1,352,999	66.00
69.00	06900	ELECTROCARDIOLOGY	4,341	4,341	381,880	0	610,479	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	486	486	19,102	0	39,228	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,605	5,605	198,340	0	4,014,923	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2,292,225	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,491	3,491	1,128,279	0	11,704,980	73.00
74.00	07400	RENAL DIALYSIS	1,395	1,395	0	0	535,044	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	150,700	76.00
76.01	03330	ENDOSCOPY	1,584	1,584	239,549	0	492,477	76.01
76.02	03040	PRISION CLINIC	4,432	4,432	209,245	0	348,132	76.02
76.03	03050	WOUND CARE	3,296	3,296	82,987	0	789,656	76.03
76.04	03060	OPIC	4,310	4,310	469,815	0	733,266	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	12,382	12,382	2,254,194	0	3,704,445	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	351,739	351,739	28,539,441	-17,972,374	75,062,115	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	566	566	0	0	9,230	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	UNOCCUPATIONAL MEDICINE	2,022	2,022	580,982	0	839,566	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	34,279	0	0	0	293,102	194.01
194.02	07952	SITTERS	0	0	549,853	0	715,099	194.02
194.03	07953	UNLICENSED STAFF	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,322,770	2,726,491	6,380,687		17,972,374	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.550486	7.694844	0.215053		0.233653	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			15,872		2,454,965	204.00

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000535		0.031916	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: 15-0046

Period:
From 09/01/2023
To 08/31/2024

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FOOTAGE)	DIETARY (MEALS SERVED)	CAFETERIA (GROSS SALARIES)	
			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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	253,570					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,316	22,609				8.00
9.00	00900	HOUSEKEEPING	3,777	0	212,198			9.00
10.00	01000	DIETARY	6,495	0	6,495	70,705		10.00
11.00	01100	CAFETERIA	3,429	0	3,429	0	24,703,599	11.00
13.00	01300	NURSING ADMINISTRATION	507	0	507	0	569,693	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	789	0	789	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	52,280	11,374	52,280	33,927	3,976,999	30.00
31.00	03100	INTENSIVE CARE UNIT	12,292	3,233	12,292	5,915	1,945,261	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	492	66	492	0	416,585	35.00
40.00	04000	SUBPROVIDER - IPF	10,970	5,558	10,970	17,525	1,700,566	40.00
41.00	04100	SUBPROVIDER - IRF	9,490	2,219	9,490	10,462	914,256	41.00
43.00	04300	NURSERY	1,574	159	1,574	0	112,934	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	28,956	0	28,956	0	2,544,282	50.00
51.00	05100	RECOVERY ROOM	1,584	0	1,584	0	197,366	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,006	0	5,006	0	916,691	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,909	0	11,909	0	699,156	54.00
54.01	03630	ULTRA SOUND	821	0	821	0	170,497	54.01
54.02	03440	MAMMOGRAPHY	2,648	0	2,648	0	90,255	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	4,263	0	4,263	0	590,271	55.00
56.00	05600	RADIOISOTOPE	763	0	763	0	21,356	56.00
57.00	05700	CT SCAN	1,344	0	1,344	0	360,235	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,381	0	1,381	0	167,456	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,926	0	1,926	0	450,299	59.00
60.00	06000	LABORATORY	6,447	0	6,447	0	1,079,646	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	313	0	313	0	34,012	62.00
65.00	06500	RESPIRATORY THERAPY	1,602	0	1,602	0	659,328	65.00
66.00	06600	PHYSICAL THERAPY	1,007	0	1,007	0	972,229	66.00
69.00	06900	ELECTROCARDIOLOGY	4,341	0	4,341	0	381,880	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	486	0	486	0	19,102	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,605	0	5,605	0	198,340	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,491	0	3,491	0	1,128,279	73.00
74.00	07400	RENAL DIALYSIS	1,395	0	1,395	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	1,584	0	1,584	0	239,549	76.01
76.02	03040	PRISION CLINIC	4,432	0	4,432	0	209,245	76.02
76.03	03050	WOUND CARE	3,296	0	3,296	0	82,987	76.03
76.04	03060	OPIC	4,310	0	4,310	0	469,815	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	12,382	0	12,382	0	2,254,194	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	216,703	22,609	209,610	67,829	23,572,764	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	566	0	566	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	UNOCCUPATIONAL MEDICINE	2,022	0	2,022	0	580,982	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	34,279	0	0	2,876	0	194.01
194.02	07952	SITTERS	0	0	0	0	549,853	194.02
194.03	07953	UNLICENSED STAFF	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,138,746	595,856	2,312,520	1,894,280	1,039,506	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	24.209276	26.354814	10.897935	26.791316	0.042079	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,883,133	91,834	147,441	201,369	107,333	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.426482	4.061834	0.694827	2.848016	0.004345	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

Health Financial Systems			TERRE HAUTE REGIONAL			In Lieu of Form CMS-2552-10	
COST ALLOCATION - STATISTICAL BASIS				Provider CCN: 15-0046		Period: From 09/01/2023 To 08/31/2024	Worksheet B-1 Date/Time Prepared: 1/28/2025 2:38 pm
Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FOOTAGE)	DIETARY (MEALS SERVED)	CAFETERIA (GROSS SALARIES)
			7.00	8.00	9.00	10.00	11.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0046

Period:
From 09/01/2023
To 08/31/2024

Worksheet B-1

Date/Time Prepared:
1/28/2025 2:38 pm

Cost Center Description			NURSING ADMINISTRATION (DIRECT NURS. SALARIES)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			13.00	16.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	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	12,377,336		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	831,130,708	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	4,005,433	21,251,781	30.00
31.00	03100	INTENSIVE CARE UNIT	2,312,791	15,373,832	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	405,444	308,093	35.00
40.00	04000	SUBPROVIDER - IPF	955,919	34,562,058	40.00
41.00	04100	SUBPROVIDER - IRF	772,553	4,703,041	41.00
43.00	04300	NURSERY	57,881	379,688	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	93,838,282	50.00
51.00	05100	RECOVERY ROOM	0	9,366,564	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	755,972	1,716,020	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,044,493	54.00
54.01	03630	ULTRA SOUND	0	4,732,919	54.01
54.02	03440	MAMMOGRAPHY	0	2,124,809	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	15,507,270	55.00
56.00	05600	RADIOISOTOPE	0	13,457,672	56.00
57.00	05700	CT SCAN	0	85,332,434	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	8,944,863	58.00
59.00	05900	CARDIAC CATHETERIZATION	557,203	39,224,352	59.00
60.00	06000	LABORATORY	0	77,940,619	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY			61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	7,181,906	62.00
65.00	06500	RESPIRATORY THERAPY	0	17,016,319	65.00
66.00	06600	PHYSICAL THERAPY	18,869	11,911,710	66.00
69.00	06900	ELECTROCARDIOLOGY	0	26,540,191	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	723,936	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	42,994,868	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	15,782,061	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	152,798,916	73.00
74.00	07400	RENAL DIALYSIS	0	1,679,454	74.00
76.00	03950	LITHOTRIPSY	0	491,713	76.00
76.01	03330	ENDOSCOPY	0	14,652,772	76.01
76.02	03040	PRISION CLINIC	71,427	804,788	76.02
76.03	03050	WOUND CARE	0	5,071,339	76.03
76.04	03060	OPIC	307,783	6,773,554	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	2,148,345	84,898,391	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		12,369,620	831,130,708	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	UNOCCUPATIONAL MEDICINE	0	0	194.00
194.01	07951	UNOCCUPIED SPACE/NONALLOWABLE MEALS	0	0	194.01
194.02	07952	SITTERS	7,716	0	194.02
194.03	07953	UNLICENSED STAFF	0	0	194.03
200.00	Cross Foot Adjustments				200.00
201.00	Negative Cost Centers				201.00
202.00	Cost to be allocated (per Wkst. B, Part I)		1,964,203	952,231	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)		0.158694	0.001146	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)		100,699	44,433	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)		0.008136	0.000053	205.00

COST ALLOCATION - STATISTICAL BASIS			Provider CCN: 15-0046	Period: From 09/01/2023 To 08/31/2024	Worksheet B-1 Date/Time Prepared: 1/28/2025 2:38 pm
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Cost Center Description		NURSING ADMINISTRATION (DIRECT NURS. SALARIES)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		13.00	16.00	
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)			206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)			207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0046

Period:
From 09/01/2023
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			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE	Total Costs	
						Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,817,621		13,817,621	0	13,817,621	30.00
31.00	03100	INTENSIVE CARE UNIT	5,685,914		5,685,914	0	5,685,914	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	818,425		818,425	28,419	846,844	35.00
40.00	04000	SUBPROVIDER - IPF	4,621,958		4,621,958	9,189	4,631,147	40.00
41.00	04100	SUBPROVIDER - IRF	2,726,350		2,726,350	0	2,726,350	41.00
43.00	04300	NURSERY	305,838		305,838	0	305,838	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,213,801		8,213,801	0	8,213,801	50.00
51.00	05100	RECOVERY ROOM	510,507		510,507	0	510,507	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,111,958		2,111,958	0	2,111,958	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,410,207		2,410,207	0	2,410,207	54.00
54.01	03630	ULTRA SOUND	349,078		349,078	0	349,078	54.01
54.02	03440	MAMMOGRAPHY	308,513		308,513	0	308,513	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	1,785,063		1,785,063	0	1,785,063	55.00
56.00	05600	RADIOISOTOPE	563,892		563,892	0	563,892	56.00
57.00	05700	CT SCAN	1,309,595		1,309,595	0	1,309,595	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	455,237		455,237	0	455,237	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,719,090		1,719,090	0	1,719,090	59.00
60.00	06000	LABORATORY	4,029,966		4,029,966	0	4,029,966	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,634,927		2,634,927	0	2,634,927	62.00
65.00	06500	RESPIRATORY THERAPY	1,594,019	0	1,594,019	0	1,594,019	65.00
66.00	06600	PHYSICAL THERAPY	1,762,039	0	1,762,039	29,318	1,791,357	66.00
69.00	06900	ELECTROCARDIOLOGY	952,003		952,003	11,596	963,599	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	67,090		67,090	0	67,090	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,207,416		5,207,416	0	5,207,416	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,845,896		2,845,896	0	2,845,896	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,784,777		14,784,777	0	14,784,777	73.00
74.00	07400	RENAL DIALYSIS	710,959		710,959	0	710,959	74.00
76.00	03950	LITHOTRIPSY	186,476		186,476	0	186,476	76.00
76.01	03330	ENDOSCOPY	690,027		690,027	0	690,027	76.01
76.02	03040	PRISION CLINIC	606,132		606,132	0	606,132	76.02
76.03	03050	WOUND CARE	1,099,179		1,099,179	11,596	1,110,775	76.03
76.04	03060	OPIC	1,132,282		1,132,282	20,476	1,152,758	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	5,537,774		5,537,774	0	5,537,774	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	790,567		790,567	0	790,567	92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0		0	0	0	102.00
200.00		Subtotal (see instructions)	92,344,576	0	92,344,576	110,594	92,455,170	200.00
201.00		Less Observation Beds	790,567		790,567		790,567	201.00
202.00		Total (see instructions)	91,554,009	0	91,554,009	110,594	91,664,603	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0046

Period:
From 09/01/2023
To 08/31/2024Worksheet C
Part I
Date/Time Prepared:
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			Title XVIII			Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	20,200,480		20,200,480			30.00
31.00	03100	INTENSIVE CARE UNIT	15,373,832		15,373,832			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	308,093		308,093			35.00
40.00	04000	SUBPROVIDER - IPF	34,562,058		34,562,058			40.00
41.00	04100	SUBPROVIDER - IRF	4,703,041		4,703,041			41.00
43.00	04300	NURSERY	379,688		379,688			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	46,865,740	46,972,542	93,838,282	0.087531	0.000000	50.00
51.00	05100	RECOVERY ROOM	3,590,824	5,775,740	9,366,564	0.054503	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,691,567	24,453	1,716,020	1.230730	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,811,528	9,232,965	13,044,493	0.184768	0.000000	54.00
54.01	03630	ULTRA SOUND	1,445,924	3,286,995	4,732,919	0.073755	0.000000	54.01
54.02	03440	MAMMOGRAPHY	6,102	2,118,707	2,124,809	0.145196	0.000000	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	344,259	15,163,011	15,507,270	0.115111	0.000000	55.00
56.00	05600	RADIOISOTOPE	171,835	13,285,837	13,457,672	0.041901	0.000000	56.00
57.00	05700	CT SCAN	27,072,717	58,259,717	85,332,434	0.015347	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,500,168	5,444,695	8,944,863	0.050894	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	21,423,578	17,800,774	39,224,352	0.043827	0.000000	59.00
60.00	06000	LABORATORY	36,520,155	41,420,464	77,940,619	0.051706	0.000000	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000	0.000000	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	4,741,913	2,439,993	7,181,906	0.366884	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	16,322,649	693,670	17,016,319	0.093676	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	11,699,939	211,771	11,911,710	0.147925	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	15,344,485	11,195,706	26,540,191	0.035870	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	540,704	183,232	723,936	0.092674	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	26,627,458	16,367,410	42,994,868	0.121117	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,231,089	6,550,972	15,782,061	0.180325	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	85,718,595	67,080,321	152,798,916	0.096760	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,588,946	90,508	1,679,454	0.423327	0.000000	74.00
76.00	03950	LITHOTRIPSY	0	491,713	491,713	0.379237	0.000000	76.00
76.01	03330	ENDOSCOPY	1,382,331	13,270,441	14,652,772	0.047092	0.000000	76.01
76.02	03040	PRISION CLINIC	0	804,788	804,788	0.753157	0.000000	76.02
76.03	03050	WOUND CARE	50,655	5,020,684	5,071,339	0.216743	0.000000	76.03
76.04	03060	OPIC	21,278	6,752,276	6,773,554	0.167162	0.000000	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	22,374,435	62,523,956	84,898,391	0.065228	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	336,893	714,408	1,051,301	0.751989	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	417,952,959	413,177,749	831,130,708			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	417,952,959	413,177,749	831,130,708			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0046	Period: From 09/01/2023 To 08/31/2024	Worksheet C Part I Date/Time Prepared: 1/28/2025 2:38 pm
			Title XVIII	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio		
			11.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT			35.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.087531		50.00
51.00	05100	RECOVERY ROOM	0.054503		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.230730		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.184768		54.00
54.01	03630	ULTRA SOUND	0.073755		54.01
54.02	03440	MAMMOGRAPHY	0.145196		54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.115111		55.00
56.00	05600	RADIOISOTOPE	0.041901		56.00
57.00	05700	CT SCAN	0.015347		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.050894		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.043827		59.00
60.00	06000	LABORATORY	0.051706		60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000		61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.366884		62.00
65.00	06500	RESPIRATORY THERAPY	0.093676		65.00
66.00	06600	PHYSICAL THERAPY	0.150386		66.00
69.00	06900	ELECTROCARDIOLOGY	0.036307		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.092674		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.121117		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.180325		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.096760		73.00
74.00	07400	RENAL DIALYSIS	0.423327		74.00
76.00	03950	LITHOTRIPSY	0.379237		76.00
76.01	03330	ENDOSCOPY	0.047092		76.01
76.02	03040	PRISION CLINIC	0.753157		76.02
76.03	03050	WOUND CARE	0.219030		76.03
76.04	03060	OPIC	0.170185		76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000		77.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.065228		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.751989		92.00
OTHER REIMBURSABLE COST CENTERS					
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0046

Period:
From 09/01/2023
To 08/31/2024Worksheet C
Part I
Date/Time Prepared:
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			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE	Total Costs	
						Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,817,621		13,817,621	0	13,817,621	30.00
31.00	03100	INTENSIVE CARE UNIT	5,685,914		5,685,914	0	5,685,914	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	818,425		818,425	28,419	846,844	35.00
40.00	04000	SUBPROVIDER - IPF	4,621,958		4,621,958	9,189	4,631,147	40.00
41.00	04100	SUBPROVIDER - IRF	2,726,350		2,726,350	0	2,726,350	41.00
43.00	04300	NURSERY	305,838		305,838	0	305,838	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,213,801		8,213,801	0	8,213,801	50.00
51.00	05100	RECOVERY ROOM	510,507		510,507	0	510,507	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,111,958		2,111,958	0	2,111,958	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,410,207		2,410,207	0	2,410,207	54.00
54.01	03630	ULTRA SOUND	349,078		349,078	0	349,078	54.01
54.02	03440	MAMMOGRAPHY	308,513		308,513	0	308,513	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	1,785,063		1,785,063	0	1,785,063	55.00
56.00	05600	RADIOISOTOPE	563,892		563,892	0	563,892	56.00
57.00	05700	CT SCAN	1,309,595		1,309,595	0	1,309,595	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	455,237		455,237	0	455,237	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,719,090		1,719,090	0	1,719,090	59.00
60.00	06000	LABORATORY	4,029,966		4,029,966	0	4,029,966	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,634,927		2,634,927	0	2,634,927	62.00
65.00	06500	RESPIRATORY THERAPY	1,594,019	0	1,594,019	0	1,594,019	65.00
66.00	06600	PHYSICAL THERAPY	1,762,039	0	1,762,039	29,318	1,791,357	66.00
69.00	06900	ELECTROCARDIOLOGY	952,003		952,003	11,596	963,599	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	67,090		67,090	0	67,090	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,207,416		5,207,416	0	5,207,416	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,845,896		2,845,896	0	2,845,896	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,784,777		14,784,777	0	14,784,777	73.00
74.00	07400	RENAL DIALYSIS	710,959		710,959	0	710,959	74.00
76.00	03950	LITHOTRIPSY	186,476		186,476	0	186,476	76.00
76.01	03330	ENDOSCOPY	690,027		690,027	0	690,027	76.01
76.02	03040	PRISION CLINIC	606,132		606,132	0	606,132	76.02
76.03	03050	WOUND CARE	1,099,179		1,099,179	11,596	1,110,775	76.03
76.04	03060	OPIC	1,132,282		1,132,282	20,476	1,152,758	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	5,537,774		5,537,774	0	5,537,774	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	790,567		790,567	0	790,567	92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0		0	0	0	102.00
200.00		Subtotal (see instructions)	92,344,576	0	92,344,576	110,594	92,455,170	200.00
201.00		Less Observation Beds	790,567		790,567	0	790,567	201.00
202.00		Total (see instructions)	91,554,009	0	91,554,009	110,594	91,664,603	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0046

Period:
From 09/01/2023
To 08/31/2024Worksheet C
Part I
Date/Time Prepared:
1/28/2025 2:38 pm

			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	20,200,480		20,200,480			30.00
31.00	03100	INTENSIVE CARE UNIT	15,373,832		15,373,832			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	308,093		308,093			35.00
40.00	04000	SUBPROVIDER - IPF	34,562,058		34,562,058			40.00
41.00	04100	SUBPROVIDER - IRF	4,703,041		4,703,041			41.00
43.00	04300	NURSERY	379,688		379,688			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	46,865,740	46,972,542	93,838,282	0.087531	0.000000	50.00
51.00	05100	RECOVERY ROOM	3,590,824	5,775,740	9,366,564	0.054503	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,691,567	24,453	1,716,020	1.230730	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,811,528	9,232,965	13,044,493	0.184768	0.000000	54.00
54.01	03630	ULTRA SOUND	1,445,924	3,286,995	4,732,919	0.073755	0.000000	54.01
54.02	03440	MAMMOGRAPHY	6,102	2,118,707	2,124,809	0.145196	0.000000	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	344,259	15,163,011	15,507,270	0.115111	0.000000	55.00
56.00	05600	RADIOISOTOPE	171,835	13,285,837	13,457,672	0.041901	0.000000	56.00
57.00	05700	CT SCAN	27,072,717	58,259,717	85,332,434	0.015347	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,500,168	5,444,695	8,944,863	0.050894	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	21,423,578	17,800,774	39,224,352	0.043827	0.000000	59.00
60.00	06000	LABORATORY	36,520,155	41,420,464	77,940,619	0.051706	0.000000	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000	0.000000	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	4,741,913	2,439,993	7,181,906	0.366884	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	16,322,649	693,670	17,016,319	0.093676	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	11,699,939	211,771	11,911,710	0.147925	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	15,344,485	11,195,706	26,540,191	0.035870	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	540,704	183,232	723,936	0.092674	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	26,627,458	16,367,410	42,994,868	0.121117	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,231,089	6,550,972	15,782,061	0.180325	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	85,718,595	67,080,321	152,798,916	0.096760	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,588,946	90,508	1,679,454	0.423327	0.000000	74.00
76.00	03950	LITHOTRIPSY	0	491,713	491,713	0.379237	0.000000	76.00
76.01	03330	ENDOSCOPY	1,382,331	13,270,441	14,652,772	0.047092	0.000000	76.01
76.02	03040	PRISION CLINIC	0	804,788	804,788	0.753157	0.000000	76.02
76.03	03050	WOUND CARE	50,655	5,020,684	5,071,339	0.216743	0.000000	76.03
76.04	03060	OPIC	21,278	6,752,276	6,773,554	0.167162	0.000000	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	22,374,435	62,523,956	84,898,391	0.065228	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	336,893	714,408	1,051,301	0.751989	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	417,952,959	413,177,749	831,130,708			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	417,952,959	413,177,749	831,130,708			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0046

Period:
From 09/01/2023
To 08/31/2024Worksheet C
Part I
Date/Time Prepared:
1/28/2025 2:38 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT				35.00
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	03630	ULTRA SOUND	0.000000			54.01
54.02	03440	MAMMOGRAPHY	0.000000			54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000			55.00
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000			61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.00
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
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
74.00	07400	RENAL DIALYSIS	0.000000			74.00
76.00	03950	LITHOTRIPSY	0.000000			76.00
76.01	03330	ENDOSCOPY	0.000000			76.01
76.02	03040	PRISION CLINIC	0.000000			76.02
76.03	03050	WOUND CARE	0.000000			76.03
76.04	03060	OPIC	0.000000			76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000			77.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM				102.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-0046

Period:
From 09/01/2023
To 08/31/2024Worksheet D
Part I
Date/Time Prepared:
1/28/2025 2:38 pm

			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	1,731,477	0	1,731,477	11,955	144.83	30.00
31.00	INTENSIVE CARE UNIT	478,016		478,016	3,233	147.86	31.00
35.00	NEONATAL INTENSIVE CARE UNIT	36,199		36,199	66	548.47	35.00
40.00	SUBPROVIDER - IPF	444,782	0	444,782	5,558	80.03	40.00
41.00	SUBPROVIDER - IRF	329,921	0	329,921	2,219	148.68	41.00
43.00	NURSERY	46,045		46,045	159	289.59	43.00
200.00	Total (lines 30 through 199)	3,066,440		3,066,440	23,190		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	3,384	490,105				30.00
31.00	INTENSIVE CARE UNIT	1,039	153,627				31.00
35.00	NEONATAL INTENSIVE CARE UNIT	0	0				35.00
40.00	SUBPROVIDER - IPF	369	29,531				40.00
41.00	SUBPROVIDER - IRF	918	136,488				41.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	5,710	809,751				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0046

Period:
From 09/01/2023
To 08/31/2024Worksheet D
Part II
Date/Time Prepared:
1/28/2025 2:38 pm

				Title XVIII		Hospital	PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	904,842	93,838,282	0.009643	13,009,417	125,450	50.00
51.00	05100	RECOVERY ROOM	51,473	9,366,564	0.005495	1,045,119	5,743	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	178,957	1,716,020	0.104286	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	345,110	13,044,493	0.026456	1,175,830	31,108	54.00
54.01	03630	ULTRA SOUND	29,046	4,732,919	0.006137	443,706	2,723	54.01
54.02	03440	MAMMOGRAPHY	70,491	2,124,809	0.033175	2,112	70	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	148,785	15,507,270	0.009595	64,629	620	55.00
56.00	05600	RADIOISOTOPE	32,881	13,457,672	0.002443	98,107	240	56.00
57.00	05700	CT SCAN	69,426	85,332,434	0.000814	8,329,653	6,780	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	45,019	8,944,863	0.005033	1,024,425	5,156	58.00
59.00	05900	CARDIAC CATHETERIZATION	95,456	39,224,352	0.002434	7,016,876	17,079	59.00
60.00	06000	LABORATORY	275,485	77,940,619	0.003535	10,255,441	36,253	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	75,806	7,181,906	0.010555	1,634,575	17,253	62.00
65.00	06500	RESPIRATORY THERAPY	82,108	17,016,319	0.004825	4,440,599	21,426	65.00
66.00	06600	PHYSICAL THERAPY	73,293	11,911,710	0.006153	1,726,743	10,625	66.00
69.00	06900	ELECTROCARDIOLOGY	128,529	26,540,191	0.004843	4,910,740	23,783	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	13,226	723,936	0.018270	152,728	2,790	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	267,962	42,994,868	0.006232	8,050,531	50,171	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	73,995	15,782,061	0.004689	2,771,697	12,996	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	472,643	152,798,916	0.003093	22,834,290	70,626	73.00
74.00	07400	RENAL DIALYSIS	52,244	1,679,454	0.031108	494,150	15,372	74.00
76.00	03950	LITHOTRIPSY	4,836	491,713	0.009835	0	0	76.00
76.01	03330	ENDOSCOPY	56,262	14,652,772	0.003840	502,322	1,929	76.01
76.02	03040	PRISION CLINIC	120,749	804,788	0.150038	0	0	76.02
76.03	03050	WOUND CARE	106,189	5,071,339	0.020939	14,519	304	76.03
76.04	03060	OPIC	133,579	6,773,554	0.019721	13,577	268	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	453,853	84,898,391	0.005346	6,309,736	33,732	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	99,065	1,051,301	0.094231	82,535	7,777	92.00
200.00	Total (lines 50 through 199)		4,461,310	755,603,516		96,404,057	500,274	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 15-0046		Period: From 09/01/2023 To 08/31/2024		Worksheet D Part III Date/Time Prepared: 1/28/2025 2:38 pm	
					Title XVIII		Hospital		PPS	
Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00	
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	0	35.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	0	41.00	
43.00	04300	NURSERY	0	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days			
			4.00	5.00	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	11,955	0.00	3,384	30.00		
31.00	03100	INTENSIVE CARE UNIT		0	3,233	0.00	1,039	31.00		
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0	66	0.00	0	35.00		
40.00	04000	SUBPROVIDER - IPF	0	0	5,558	0.00	369	40.00		
41.00	04100	SUBPROVIDER - IRF	0	0	2,219	0.00	918	41.00		
43.00	04300	NURSERY		0	159	0.00	0	43.00		
200.00		Total (lines 30 through 199)		0	23,190		5,710	200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)							
			9.00							
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0						30.00	
31.00	03100	INTENSIVE CARE UNIT	0						31.00	
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0						35.00	
40.00	04000	SUBPROVIDER - IPF	0						40.00	
41.00	04100	SUBPROVIDER - IRF	0						41.00	
43.00	04300	NURSERY	0						43.00	
200.00		Total (lines 30 through 199)	0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 15-0046

Period:
From 09/01/2023
To 08/31/2024Worksheet D
Part IV
Date/Time Prepared:
1/28/2025 2:38 pm

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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
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
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	0	0	0	76.01
76.02	03040	PRISION CLINIC	0	0	0	0	0	76.02
76.03	03050	WOUND CARE	0	0	0	0	0	76.03
76.04	03060	OPIC	0	0	0	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
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
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 15-0046		Period: From 09/01/2023 To 08/31/2024		Worksheet D Part IV Date/Time Prepared: 1/28/2025 2:38 pm	
			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	93,838,282	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	9,366,564	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,716,020	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,044,493	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	4,732,919	0.000000	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	2,124,809	0.000000	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	15,507,270	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	13,457,672	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	85,332,434	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	8,944,863	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	39,224,352	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	77,940,619	0.000000	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	7,181,906	0.000000	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	17,016,319	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,911,710	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	26,540,191	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	723,936	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	42,994,868	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	15,782,061	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	152,798,916	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,679,454	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	491,713	0.000000	74.00
76.00	03950	LITHOTRIPSY	0	0	0	14,652,772	0.000000	76.00
76.01	03330	ENDOSCOPY	0	0	0	804,788	0.000000	76.01
76.02	03040	PRISION CLINIC	0	0	0	5,071,339	0.000000	76.02
76.03	03050	WOUND CARE	0	0	0	6,773,554	0.000000	76.03
76.04	03060	OPIC	0	0	0	0	0.000000	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	84,898,391	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,051,301	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	755,603,516		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 15-0046

Period:
From 09/01/2023
To 08/31/2024

Worksheet D
Part IV
Date/Time Prepared:
1/28/2025 2:38 pm

				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	13,009,417	0	10,241,429	0	50.00	
51.00	05100	RECOVERY ROOM	0.000000	1,045,119	0	1,255,042	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,175,830	0	1,217,190	0	54.00	
54.01	03630	ULTRA SOUND	0.000000	443,706	0	590,144	0	54.01	
54.02	03440	MAMMOGRAPHY	0.000000	2,112	0	140,099	0	54.02	
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	64,629	0	5,490,292	0	55.00	
56.00	05600	RADIOISOTOPE	0.000000	98,107	0	4,217,589	0	56.00	
57.00	05700	CT SCAN	0.000000	8,329,653	0	10,927,172	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	1,024,425	0	893,546	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.000000	7,016,876	0	6,820,921	0	59.00	
60.00	06000	LABORATORY	0.000000	10,255,441	0	5,207,763	0	60.00	
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	1,634,575	0	1,035,183	0	62.00	
65.00	06500	RESPIRATORY THERAPY	0.000000	4,440,599	0	99,090	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.000000	1,726,743	0	8,311	0	66.00	
69.00	06900	ELECTROCARDIOLOGY	0.000000	4,910,740	0	2,672,224	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	152,728	0	5,280	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	8,050,531	0	3,919,587	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	2,771,697	0	1,821,754	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	22,834,290	0	23,314,882	0	73.00	
74.00	07400	RENAL DIALYSIS	0.000000	494,150	0	19,472	0	74.00	
76.00	03950	LITHOTRIPSY	0.000000	0	0	91,246	0	76.00	
76.01	03330	ENDOSCOPY	0.000000	502,322	0	2,793,752	0	76.01	
76.02	03040	PRISION CLINIC	0.000000	0	0	0	0	76.02	
76.03	03050	WOUND CARE	0.000000	14,519	0	1,136,334	0	76.03	
76.04	03060	OPIC	0.000000	13,577	0	2,409,982	0	76.04	
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00	
	OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.000000	6,309,736	0	6,891,094	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	82,535	0	117,713	0	92.00	
200.00	Total (lines 50 through 199)			96,404,057	0	93,337,091	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0046

Period:
From 09/01/2023
To 08/31/2024Worksheet D
Part V
Date/Time Prepared:
1/28/2025 2:38 pm

			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	0.087531	10,241,429	0	0	896,443	50.00
51.00	05100	RECOVERY ROOM	0.054503	1,255,042	0	0	68,404	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.230730	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.184768	1,217,190	0	0	224,898	54.00
54.01	03630	ULTRA SOUND	0.073755	590,144	0	0	43,526	54.01
54.02	03440	MAMMOGRAPHY	0.145196	140,099	0	0	20,342	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.115111	5,490,292	0	0	631,993	55.00
56.00	05600	RADIOISOTOPE	0.041901	4,217,589	0	0	176,721	56.00
57.00	05700	CT SCAN	0.015347	10,927,172	0	0	167,699	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.050894	893,546	0	0	45,476	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.043827	6,820,921	0	0	298,941	59.00
60.00	06000	LABORATORY	0.051706	5,207,763	0	0	269,273	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000		0	0		61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.366884	1,035,183	0	0	379,792	62.00
65.00	06500	RESPIRATORY THERAPY	0.093676	99,090	0	0	9,282	65.00
66.00	06600	PHYSICAL THERAPY	0.147925	8,311	0	0	1,229	66.00
69.00	06900	ELECTROCARDIOLOGY	0.035870	2,672,224	0	0	95,853	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.092674	5,280	0	0	489	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.121117	3,919,587	0	0	474,729	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.180325	1,821,754	0	0	328,508	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.096760	23,314,882	0	8,347	2,255,948	73.00
74.00	07400	RENAL DIALYSIS	0.423327	19,472	0	0	8,243	74.00
76.00	03950	LITHOTRIPSY	0.379237	91,246	0	0	34,604	76.00
76.01	03330	ENDOSCOPY	0.047092	2,793,752	0	0	131,563	76.01
76.02	03040	PRISION CLINIC	0.753157	0	0	0	0	76.02
76.03	03050	WOUND CARE	0.216743	1,136,334	0	0	246,292	76.03
76.04	03060	OPIC	0.167162	2,409,982	0	0	402,857	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.065228	6,891,094	0	0	449,492	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.751989	117,713	0	0	88,519	92.00
200.00		Subtotal (see instructions)		93,337,091	0	8,347	7,751,116	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		93,337,091	0	8,347	7,751,116	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 15-0046		Period: From 09/01/2023 To 08/31/2024		Worksheet D Part V Date/Time Prepared: 1/28/2025 2:38 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0					50.00
51.00	05100	RECOVERY ROOM	0	0					51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0					52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
54.01	03630	ULTRA SOUND	0	0					54.01
54.02	03440	MAMMOGRAPHY	0	0					54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0					55.00
56.00	05600	RADIOISOTOPE	0	0					56.00
57.00	05700	CT SCAN	0	0					57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0					58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0					59.00
60.00	06000	LABORATORY	0	0					60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0						61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0					62.00
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
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	808					73.00
74.00	07400	RENAL DIALYSIS	0	0					74.00
76.00	03950	LITHOTRIPSY	0	0					76.00
76.01	03330	ENDOSCOPY	0	0					76.01
76.02	03040	PRISION CLINIC	0	0					76.02
76.03	03050	WOUND CARE	0	0					76.03
76.04	03060	OPIC	0	0					76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0					77.00
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0					92.00
200.00		Subtotal (see instructions)	0	808					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	0	808					202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 15-0046	Period: From 09/01/2023 To 08/31/2024	Worksheet D Part II Date/Time Prepared: 1/28/2025 2:38 pm	
				Component CCN: 15-S046			
				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	904,842	93,838,282	0.009643	0	0
51.00	05100	RECOVERY ROOM	51,473	9,366,564	0.005495	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	178,957	1,716,020	0.104286	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	345,110	13,044,493	0.026456	3,347	89
54.01	03630	ULTRA SOUND	29,046	4,732,919	0.006137	0	0
54.02	03440	MAMMOGRAPHY	70,491	2,124,809	0.033175	0	0
55.00	05500	RADIOLOGY-THERAPEUTIC	148,785	15,507,270	0.009595	0	0
56.00	05600	RADIOISOTOPE	32,881	13,457,672	0.002443	0	0
57.00	05700	CT SCAN	69,426	85,332,434	0.000814	14,163	12
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	45,019	8,944,863	0.005033	12,786	64
59.00	05900	CARDIAC CATHETERIZATION	95,456	39,224,352	0.002434	0	0
60.00	06000	LABORATORY	275,485	77,940,619	0.003535	106,369	376
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY					
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	75,806	7,181,906	0.010555	0	0
65.00	06500	RESPIRATORY THERAPY	82,108	17,016,319	0.004825	23,060	111
66.00	06600	PHYSICAL THERAPY	73,293	11,911,710	0.006153	6,590	41
69.00	06900	ELECTROCARDIOLOGY	128,529	26,540,191	0.004843	12,516	61
70.00	07000	ELECTROENCEPHALOGRAPHY	13,226	723,936	0.018270	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	267,962	42,994,868	0.006232	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	73,995	15,782,061	0.004689	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	472,643	152,798,916	0.003093	283,748	878
74.00	07400	RENAL DIALYSIS	52,244	1,679,454	0.031108	0	0
76.00	03950	LITHOTRIPSY	4,836	491,713	0.009835	0	0
76.01	03330	ENDOSCOPY	56,262	14,652,772	0.003840	0	0
76.02	03040	PRISION CLINIC	120,749	804,788	0.150038	0	0
76.03	03050	WOUND CARE	106,189	5,071,339	0.020939	0	0
76.04	03060	OPIC	133,579	6,773,554	0.019721	0	0
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	453,853	84,898,391	0.005346	95,647	511
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,051,301	0.000000	0	0
200.00		Total (lines 50 through 199)	4,362,245	755,603,516		558,226	2,143

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 15-0046 Component CCN: 15-S046		Period: From 09/01/2023 To 08/31/2024		Worksheet D Part IV Date/Time Prepared: 1/28/2025 2:38 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND		0	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY		0	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY		0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0	0	0	62.00
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
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
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY		0	0	0	0	0	76.00
76.01	03330	ENDOSCOPY		0	0	0	0	0	76.01
76.02	03040	PRISION CLINIC		0	0	0	0	0	76.02
76.03	03050	WOUND CARE		0	0	0	0	0	76.03
76.04	03060	OPIC		0	0	0	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION		0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS									
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
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 15-0046 Component CCN: 15-S046		Period: From 09/01/2023 To 08/31/2024		Worksheet D Part IV Date/Time Prepared: 1/28/2025 2:38 pm	
				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	93,838,282	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	9,366,564	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	1,716,020	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	13,044,493	0.000000	54.00
54.01	03630	ULTRA SOUND		0	0	0	4,732,919	0.000000	54.01
54.02	03440	MAMMOGRAPHY		0	0	0	2,124,809	0.000000	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	15,507,270	0.000000	55.00
56.00	05600	RADIOISOTOPE		0	0	0	13,457,672	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	85,332,434	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	8,944,863	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	39,224,352	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	77,940,619	0.000000	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY							61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0	7,181,906	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	17,016,319	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	11,911,710	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	26,540,191	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	723,936	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	42,994,868	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	15,782,061	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	152,798,916	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	1,679,454	0.000000	74.00
76.00	03950	LITHOTRIPSY		0	0	0	491,713	0.000000	76.00
76.01	03330	ENDOSCOPY		0	0	0	14,652,772	0.000000	76.01
76.02	03040	PRISION CLINIC		0	0	0	804,788	0.000000	76.02
76.03	03050	WOUND CARE		0	0	0	5,071,339	0.000000	76.03
76.04	03060	OPIC		0	0	0	6,773,554	0.000000	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION		0	0	0	0	0.000000	77.00
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY		0	0	0	84,898,391	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	1,051,301	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	755,603,516		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 15-0046 Component CCN: 15-S046		Period: From 09/01/2023 To 08/31/2024		Worksheet D Part IV Date/Time Prepared: 1/28/2025 2:38 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	3,347	0	0	0	54.00
54.01	03630	ULTRA SOUND		0.000000	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY		0.000000	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN		0.000000	14,163	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	12,786	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY		0.000000	106,369	0	0	0	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY							61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		0.000000	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY		0.000000	23,060	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	6,590	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	12,516	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	283,748	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY		0.000000	0	0	0	0	76.00
76.01	03330	ENDOSCOPY		0.000000	0	0	0	0	76.01
76.02	03040	PRISION CLINIC		0.000000	0	0	0	0	76.02
76.03	03050	WOUND CARE		0.000000	0	0	0	0	76.03
76.04	03060	OPIC		0.000000	0	0	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION		0.000000	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY		0.000000	95,647	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			558,226	0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 15-0046	Period: From 09/01/2023 To 08/31/2024	Worksheet D Part II Date/Time Prepared: 1/28/2025 2:38 pm		
				Component CCN: 15-T046				
				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	904,842	93,838,282	0.009643	36,270	350	50.00
51.00	05100	RECOVERY ROOM	51,473	9,366,564	0.005495	3,933	22	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	178,957	1,716,020	0.104286	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	345,110	13,044,493	0.026456	55,023	1,456	54.00
54.01	03630	ULTRA SOUND	29,046	4,732,919	0.006137	11,945	73	54.01
54.02	03440	MAMMOGRAPHY	70,491	2,124,809	0.033175	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	148,785	15,507,270	0.009595	0	0	55.00
56.00	05600	RADIOISOTOPE	32,881	13,457,672	0.002443	0	0	56.00
57.00	05700	CT SCAN	69,426	85,332,434	0.000814	105,249	86	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	45,019	8,944,863	0.005033	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	95,456	39,224,352	0.002434	9,782	24	59.00
60.00	06000	LABORATORY	275,485	77,940,619	0.003535	487,508	1,723	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	75,806	7,181,906	0.010555	39,289	415	62.00
65.00	06500	RESPIRATORY THERAPY	82,108	17,016,319	0.004825	103,639	500	65.00
66.00	06600	PHYSICAL THERAPY	73,293	11,911,710	0.006153	2,616,563	16,100	66.00
69.00	06900	ELECTROCARDIOLOGY	128,529	26,540,191	0.004843	93,080	451	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	13,226	723,936	0.018270	10,560	193	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	267,962	42,994,868	0.006232	265,780	1,656	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	73,995	15,782,061	0.004689	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	472,643	152,798,916	0.003093	1,621,361	5,015	73.00
74.00	07400	RENAL DIALYSIS	52,244	1,679,454	0.031108	79,301	2,467	74.00
76.00	03950	LITHOTRIPSY	4,836	491,713	0.009835	0	0	76.00
76.01	03330	ENDOSCOPY	56,262	14,652,772	0.003840	16,930	65	76.01
76.02	03040	PRISION CLINIC	120,749	804,788	0.150038	0	0	76.02
76.03	03050	WOUND CARE	106,189	5,071,339	0.020939	0	0	76.03
76.04	03060	OPIC	133,579	6,773,554	0.019721	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	453,853	84,898,391	0.005346	4,583	25	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,051,301	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	4,362,245	755,603,516		5,560,796	30,621	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 15-0046 Component CCN: 15-T046		Period: From 09/01/2023 To 08/31/2024		Worksheet D Part IV Date/Time Prepared: 1/28/2025 2:38 pm	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND		0	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY		0	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY		0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0	0	0	62.00
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
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
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY		0	0	0	0	0	76.00
76.01	03330	ENDOSCOPY		0	0	0	0	0	76.01
76.02	03040	PRISION CLINIC		0	0	0	0	0	76.02
76.03	03050	WOUND CARE		0	0	0	0	0	76.03
76.04	03060	OPIC		0	0	0	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION		0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS									
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
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 15-0046 Component CCN: 15-T046		Period: From 09/01/2023 To 08/31/2024		Worksheet D Part IV Date/Time Prepared: 1/28/2025 2:38 pm	
				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	93,838,282	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	9,366,564	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	1,716,020	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	13,044,493	0.000000	54.00
54.01	03630	ULTRA SOUND		0	0	0	4,732,919	0.000000	54.01
54.02	03440	MAMMOGRAPHY		0	0	0	2,124,809	0.000000	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	15,507,270	0.000000	55.00
56.00	05600	RADIOISOTOPE		0	0	0	13,457,672	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	85,332,434	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	8,944,863	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	39,224,352	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	77,940,619	0.000000	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY							61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0	7,181,906	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	17,016,319	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	11,911,710	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	26,540,191	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	723,936	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	42,994,868	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	15,782,061	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	152,798,916	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	1,679,454	0.000000	74.00
76.00	03950	LITHOTRIPSY		0	0	0	491,713	0.000000	76.00
76.01	03330	ENDOSCOPY		0	0	0	14,652,772	0.000000	76.01
76.02	03040	PRISION CLINIC		0	0	0	804,788	0.000000	76.02
76.03	03050	WOUND CARE		0	0	0	5,071,339	0.000000	76.03
76.04	03060	OPIC		0	0	0	6,773,554	0.000000	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION		0	0	0	0	0.000000	77.00
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY		0	0	0	84,898,391	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	1,051,301	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	755,603,516		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 15-0046 Component CCN: 15-T046		Period: From 09/01/2023 To 08/31/2024		Worksheet D Part IV Date/Time Prepared: 1/28/2025 2:38 pm	
				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	36,270	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	3,933	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	55,023	0	0	0	54.00
54.01	03630	ULTRA SOUND		0.000000	11,945	0	0	0	54.01
54.02	03440	MAMMOGRAPHY		0.000000	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN		0.000000	105,249	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	9,782	0	0	0	59.00
60.00	06000	LABORATORY		0.000000	487,508	0	0	0	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY							61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		0.000000	39,289	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY		0.000000	103,639	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	2,616,563	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	93,080	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	10,560	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.000000	265,780	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	1,621,361	0	266	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	79,301	0	0	0	74.00
76.00	03950	LITHOTRIPSY		0.000000	0	0	0	0	76.00
76.01	03330	ENDOSCOPY		0.000000	16,930	0	0	0	76.01
76.02	03040	PRISION CLINIC		0.000000	0	0	0	0	76.02
76.03	03050	WOUND CARE		0.000000	0	0	0	0	76.03
76.04	03060	OPIC		0.000000	0	0	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION		0.000000	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY		0.000000	4,583	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			5,560,796	0	266	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0046

Period:

Worksheet D

Component CCN: 15-T046

From 09/01/2023
To 08/31/2024Part V
Date/Time Prepared:
1/28/2025 2:38 pm

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	0.087531	0	0	0	0 50.00
51.00	05100 RECOVERY ROOM	0.054503	0	0	0	0 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.230730	0	0	0	0 52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.184768	0	0	0	0 54.00
54.01	03630 ULTRA SOUND	0.073755	0	0	0	0 54.01
54.02	03440 MAMMOGRAPHY	0.145196	0	0	0	0 54.02
55.00	05500 RADIOLOGY-THERAPEUTIC	0.115111	0	0	0	0 55.00
56.00	05600 RADIOISOTOPE	0.041901	0	0	0	0 56.00
57.00	05700 CT SCAN	0.015347	0	0	0	0 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.050894	0	0	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.043827	0	0	0	0 59.00
60.00	06000 LABORATORY	0.051706	0	0	0	0 60.00
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	0	0 61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.366884	0	0	0	0 62.00
65.00	06500 RESPIRATORY THERAPY	0.093676	0	0	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0.147925	0	0	0	0 66.00
69.00	06900 ELECTROCARDIOLOGY	0.035870	0	0	0	0 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.092674	0	0	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.121117	0	0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.180325	0	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.096760	266	0	153	26 73.00
74.00	07400 RENAL DIALYSIS	0.423327	0	0	0	0 74.00
76.00	03950 LITHOTRIPSY	0.379237	0	0	0	0 76.00
76.01	03330 ENDOSCOPY	0.047092	0	0	0	0 76.01
76.02	03040 PRISION CLINIC	0.753157	0	0	0	0 76.02
76.03	03050 WOUND CARE	0.216743	0	0	0	0 76.03
76.04	03060 OPIC	0.167162	0	0	0	0 76.04
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0 77.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0.065228	0	0	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.751989	0	0	0	0 92.00
200.00	Subtotal (see instructions)		266	0	153	26 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0 201.00
202.00	Net Charges (line 200 - line 201)		266	0	153	26 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0046	Period: From 09/01/2023 To 08/31/2024	Worksheet D Part V Date/Time Prepared: 1/28/2025 2:38 pm
		Component CCN: 15-T046		
		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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0		61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
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
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	15	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	76.01
76.02	03040	PRISION CLINIC	0	0	76.02
76.03	03050	WOUND CARE	0	0	76.03
76.04	03060	OPIC	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
	OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	15	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	15	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0046

Period:
From 09/01/2023
To 08/31/2024Worksheet D
Part V
Date/Time Prepared:
1/28/2025 2:38 pm

			Title XIX		Hospital		Cost		
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.087531	0	0	8,556,063	0	50.00	
51.00	05100	RECOVERY ROOM	0.054503	0	0	1,113,932	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.230730	0	0	1,603	0	52.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.184768	0	0	2,642,300	0	54.00	
54.01	03630	ULTRA SOUND	0.073755	0	0	773,982	0	54.01	
54.02	03440	MAMMOGRAPHY	0.145196	0	0	160,505	0	54.02	
55.00	05500	RADIOLOGY-THERAPEUTIC	0.115111	0	0	970,839	0	55.00	
56.00	05600	RADIOISOTOPE	0.041901	0	0	1,291,268	0	56.00	
57.00	05700	CT SCAN	0.015347	0	0	16,218,446	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.050894	0	0	589,185	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.043827	0	0	1,561,772	0	59.00	
60.00	06000	LABORATORY	0.051706	0	0	12,968,874	0	60.00	
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	0	0	61.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.366884	0	0	697,632	0	62.00	
65.00	06500	RESPIRATORY THERAPY	0.093676	0	0	175,222	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.147925	0	0	25,172	0	66.00	
69.00	06900	ELECTROCARDIOLOGY	0.035870	0	0	1,973,522	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.092674	0	0	62,576	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.121117	0	0	2,586,668	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.180325	0	0	774,118	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.096760	0	0	11,493,398	0	73.00	
74.00	07400	RENAL DIALYSIS	0.423327	0	0	0	0	74.00	
76.00	03950	LITHOTRIPSY	0.379237	0	0	87,866	0	76.00	
76.01	03330	ENDOSCOPY	0.047092	0	0	1,655,045	0	76.01	
76.02	03040	PRISION CLINIC	0.753157	0	0	6,870	0	76.02	
76.03	03050	WOUND CARE	0.216743	0	0	878,477	0	76.03	
76.04	03060	OPIC	0.167162	0	0	910,958	0	76.04	
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00	
	OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.065228	0	0	25,833,842	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.751989	0	0	0	0	92.00	
200.00		Subtotal (see instructions)		0	0	94,010,135	0	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00		Net Charges (line 200 - line 201)		0	0	94,010,135	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 15-0046		Period: From 09/01/2023 To 08/31/2024		Worksheet D Part V Date/Time Prepared: 1/28/2025 2:38 pm	
				Title XIX		Hospital		Cost	
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	748,921					50.00
51.00	05100	RECOVERY ROOM	0	60,713					51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,973					52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	488,212					54.00
54.01	03630	ULTRA SOUND	0	57,085					54.01
54.02	03440	MAMMOGRAPHY	0	23,305					54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	111,754					55.00
56.00	05600	RADIOISOTOPE	0	54,105					56.00
57.00	05700	CT SCAN	0	248,904					57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	29,986					58.00
59.00	05900	CARDIAC CATHETERIZATION	0	68,448					59.00
60.00	06000	LABORATORY	0	670,569					60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0						61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	255,950					62.00
65.00	06500	RESPIRATORY THERAPY	0	16,414					65.00
66.00	06600	PHYSICAL THERAPY	0	3,724					66.00
69.00	06900	ELECTROCARDIOLOGY	0	70,790					69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,799					70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	313,289					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	139,593					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,112,101					73.00
74.00	07400	RENAL DIALYSIS	0	0					74.00
76.00	03950	LITHOTRIPSY	0	33,322					76.00
76.01	03330	ENDOSCOPY	0	77,939					76.01
76.02	03040	PRISION CLINIC	0	5,174					76.02
76.03	03050	WOUND CARE	0	190,404					76.03
76.04	03060	OPIC	0	152,278					76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0					77.00
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	0	1,685,090					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0					92.00
200.00		Subtotal (see instructions)	0	6,625,842					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	0	6,625,842					202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0046	Period: From 09/01/2023 To 08/31/2024	Worksheet D-1 Date/Time Prepared: 1/28/2025 2:38 pm
		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)		11,955	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		11,955	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)		11,271	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		3,384	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)		13,817,621	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)		13,817,621	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)		13,817,621	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)		1,155.80	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,911,227	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		3,911,227	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0046	Period: From 09/01/2023 To 08/31/2024	Worksheet D-1 Date/Time Prepared: 1/28/2025 2:38 pm	
			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	5,685,914	3,233	1,758.71	1,039	1,827,300	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 NEONATAL INTENSIVE CARE UNIT	846,844	66	12,830.97	0	0	47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					8,339,378	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)					14,077,905	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)					643,732	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					500,274	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,144,006	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					12,933,899	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)					684	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,155.80	88.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0046		Period: From 09/01/2023 To 08/31/2024		Worksheet D-1 Date/Time Prepared: 1/28/2025 2:38 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description								1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					790,567		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		1,731,477	13,817,621	0.125309	790,567	99,065	90.00	
91.00	Nursing Program cost		0	13,817,621	0.000000	790,567	0	91.00	
92.00	Allied health cost		0	13,817,621	0.000000	790,567	0	92.00	
93.00	All other Medical Education		0	13,817,621	0.000000	790,567	0	93.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0046 Component CCN: 15-S046	Period: From 09/01/2023 To 08/31/2024	Worksheet D-1 Date/Time Prepared: 1/28/2025 2:38 pm
		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)		5,558	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,558	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)		5,558	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)		369	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)		4,631,147	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)		4,631,147	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)		4,631,147	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)		833.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		307,466	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)		307,466	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0046	Period: From 09/01/2023 To 08/31/2024	Worksheet D-1	
				Component CCN: 15-S046		Date/Time Prepared: 1/28/2025 2:38 pm	
				Title XVIII	Subprovider - IPF	PPS	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					44,285	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)					351,751	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)					29,531	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,143	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					31,674	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					320,077	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
55.01	Permanent adjustment amount per discharge					0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)					0.00	55.02
55.03	CAR T-cell amount paid as an interim payment						55.03
56.00	Target amount ((line 54 x sum of lines 55, 55.01, and 55.02) plus line 55.03)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0046 Component CCN: 15-S046	Period: From 09/01/2023 To 08/31/2024	Worksheet D-1 Date/Time Prepared: 1/28/2025 2:38 pm	
				Title XVIII	Subprovider - IPF	PPS	
Cost Center Description						1.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	444,782	4,631,147	0.096041	0	0	90.00
91.00	Nursing Program cost	0	4,631,147	0.000000	0	0	91.00
92.00	Allied health cost	0	4,631,147	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,631,147	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0046 Component CCN: 15-T046	Period: From 09/01/2023 To 08/31/2024	Worksheet D-1 Date/Time Prepared: 1/28/2025 2:38 pm
		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)	2,219	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,219	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)	2,219	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)	918	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)	2,726,350	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)	2,726,350	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)	2,726,350	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)	1,228.64	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,127,892	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)	1,127,892	41.00	

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0046	Period: From 09/01/2023 To 08/31/2024	Worksheet D-1	
				Component CCN: 15-T046		Date/Time Prepared: 1/28/2025 2:38 pm	
				Title XVIII	Subprovider - IRF	PPS	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					687,401	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)					1,815,293	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)					136,488	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					30,621	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					167,109	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,648,184	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
55.01	Permanent adjustment amount per discharge					0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)					0.00	55.02
55.03	CAR T-cell amount paid as an interim payment						55.03
56.00	Target amount ((line 54 x sum of lines 55, 55.01, and 55.02) plus line 55.03)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0046 Component CCN: 15-T046	Period: From 09/01/2023 To 08/31/2024	Worksheet D-1 Date/Time Prepared: 1/28/2025 2:38 pm	
				Title XVIII	Subprovider - IRF	PPS	
Cost Center Description						1.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	329,921	2,726,350	0.121012	0	0	90.00
91.00	Nursing Program cost	0	2,726,350	0.000000	0	0	91.00
92.00	Allied health cost	0	2,726,350	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,726,350	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0046	Period: From 09/01/2023 To 08/31/2024	Worksheet D-1 Date/Time Prepared: 1/28/2025 2:38 pm	
		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)			11,955	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			11,955	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)			11,271	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)			759	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)			159	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)			13,817,621	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)			13,817,621	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)			13,817,621	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)			1,155.80	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			877,252	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)			877,252	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0046

Period:
From 09/01/2023
To 08/31/2024

Worksheet D-1

Date/Time Prepared:
1/28/2025 2:38 pm

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Hospital Program Days	Program Cost (col. 3 x col. 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	305,838	159	1,923.51	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	5,685,914	3,233	1,758.71	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	NEONATAL INTENSIVE CARE UNIT	818,425	66	12,400.38	0	0	47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					5,925,902	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)					6,803,154	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)					684	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,155.80	88.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0046		Period: From 09/01/2023 To 08/31/2024		Worksheet D-1 Date/Time Prepared: 1/28/2025 2:38 pm	
				Title XIX		Hospital		Cost	
Cost Center Description								1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					790,567		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		1,731,477	13,817,621	0.125309	790,567	99,065	90.00	
91.00	Nursing Program cost		0	13,817,621	0.000000	790,567	0	91.00	
92.00	Allied health cost		0	13,817,621	0.000000	790,567	0	92.00	
93.00	All other Medical Education		0	13,817,621	0.000000	790,567	0	93.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0046 Component CCN: 15-S046	Period: From 09/01/2023 To 08/31/2024	Worksheet D-1 Date/Time Prepared: 1/28/2025 2:38 pm
		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)			5,558 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			5,558 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)			5,558 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)			4,191 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)			159 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)			4,621,958 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)			4,621,958 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)			4,621,958 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)			831.59 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			3,485,194 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			3,485,194 41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0046	Period: From 09/01/2023 To 08/31/2024	Worksheet D-1	
				Component CCN: 15-S046		Date/Time Prepared: 1/28/2025 2:38 pm	
				Title XIX		Subprovider - IPF	Cost
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					377,647	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					3,862,841	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
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0046 Component CCN: 15-S046	Period: From 09/01/2023 To 08/31/2024	Worksheet D-1 Date/Time Prepared: 1/28/2025 2:38 pm	
				Title XIX	Subprovider - IPF	Cost	
Cost Center Description						1.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	444,782	4,621,958	0.096232	0	0	90.00
91.00	Nursing Program cost	0	4,621,958	0.000000	0	0	91.00
92.00	Allied health cost	0	4,621,958	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,621,958	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0046 Component CCN: 15-T046	Period: From 09/01/2023 To 08/31/2024	Worksheet D-1 Date/Time Prepared: 1/28/2025 2:38 pm
		Title XIX	Subprovider - IRF	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			2,219 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			2,219 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)			2,219 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)			290 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)			159 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)			2,726,350 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)			2,726,350 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)			2,726,350 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)			1,228.64 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			356,306 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)			356,306 41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0046	Period: From 09/01/2023 To 08/31/2024	Worksheet D-1	
				Component CCN: 15-T046		Date/Time Prepared: 1/28/2025 2:38 pm	
				Title XIX		Subprovider - IRF	Cost
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00			
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					188,991	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)					545,297	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
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0046 Component CCN: 15-T046	Period: From 09/01/2023 To 08/31/2024	Worksheet D-1 Date/Time Prepared: 1/28/2025 2:38 pm	
				Title XIX	Subprovider - IRF	Cost	
Cost Center Description						1.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	329,921	2,726,350	0.121012	0	0	90.00
91.00	Nursing Program cost	0	2,726,350	0.000000	0	0	91.00
92.00	Allied health cost	0	2,726,350	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,726,350	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0046	Period: From 09/01/2023 To 08/31/2024	Worksheet D-3 Date/Time Prepared: 1/28/2025 2:38 pm	
Cost Center Description		Title XVIII	Hospital	PPS	
		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	5,878,968		30.00
31.00	03100	INTENSIVE CARE UNIT	4,902,170		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0		35.00
40.00	04000	SUBPROVIDER - IPF	0		40.00
41.00	04100	SUBPROVIDER - IRF	0		41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	13,009,417	1,138,727	50.00
51.00	05100	RECOVERY ROOM	1,045,119	56,962	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,175,830	217,256	54.00
54.01	03630	ULTRA SOUND	443,706	32,726	54.01
54.02	03440	MAMMOGRAPHY	2,112	307	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	64,629	7,440	55.00
56.00	05600	RADIOISOTOPE	98,107	4,111	56.00
57.00	05700	CT SCAN	8,329,653	127,835	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,024,425	52,137	58.00
59.00	05900	CARDIAC CATHETERIZATION	7,016,876	307,529	59.00
60.00	06000	LABORATORY	10,255,441	530,268	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,634,575	599,699	62.00
65.00	06500	RESPIRATORY THERAPY	4,440,599	415,978	65.00
66.00	06600	PHYSICAL THERAPY	1,726,743	259,678	66.00
69.00	06900	ELECTROCARDIOLOGY	4,910,740	178,294	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	152,728	14,154	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,050,531	975,056	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,771,697	499,806	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,834,290	2,209,446	73.00
74.00	07400	RENAL DIALYSIS	494,150	209,187	74.00
76.00	03950	LITHOTRIPSY	0	0	76.00
76.01	03330	ENDOSCOPY	502,322	23,655	76.01
76.02	03040	PRISION CLINIC	0	0	76.02
76.03	03050	WOUND CARE	14,519	3,180	76.03
76.04	03060	OPIC	13,577	2,311	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	6,309,736	411,571	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	82,535	62,065	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)	96,404,057	8,339,378	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)	96,404,057		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0046 Component CCN: 15-S046	Period: From 09/01/2023 To 08/31/2024	Worksheet D-3 Date/Time Prepared: 1/28/2025 2:38 pm	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT			35.00
40.00	04000	SUBPROVIDER - IPF	2,296,914		40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.087531	0	50.00
51.00	05100	RECOVERY ROOM	0.054503	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.230730	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.184768	3,347	54.00
54.01	03630	ULTRA SOUND	0.073755	0	54.01
54.02	03440	MAMMOGRAPHY	0.145196	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.115111	0	55.00
56.00	05600	RADIOISOTOPE	0.041901	0	56.00
57.00	05700	CT SCAN	0.015347	14,163	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.050894	12,786	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.043827	0	59.00
60.00	06000	LABORATORY	0.051706	106,369	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.366884	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.093676	23,060	65.00
66.00	06600	PHYSICAL THERAPY	0.150386	6,590	66.00
69.00	06900	ELECTROCARDIOLOGY	0.036307	12,516	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.092674	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.121117	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.180325	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.096760	283,748	73.00
74.00	07400	RENAL DIALYSIS	0.423327	0	74.00
76.00	03950	LITHOTRIPSY	0.379237	0	76.00
76.01	03330	ENDOSCOPY	0.047092	0	76.01
76.02	03040	PRISION CLINIC	0.753157	0	76.02
76.03	03050	WOUND CARE	0.219030	0	76.03
76.04	03060	OPIC	0.170185	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	77.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.065228	95,647	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.751989	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		558,226	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)		558,226	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0046 Component CCN: 15-T046	Period: From 09/01/2023 To 08/31/2024	Worksheet D-3 Date/Time Prepared: 1/28/2025 2:38 pm	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT				35.00
40.00	04000 SUBPROVIDER - IPF				40.00
41.00	04100 SUBPROVIDER - IRF		1,932,857		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.087531	36,270	3,175	50.00
51.00	05100 RECOVERY ROOM	0.054503	3,933	214	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.230730	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.184768	55,023	10,166	54.00
54.01	03630 ULTRA SOUND	0.073755	11,945	881	54.01
54.02	03440 MAMMOGRAPHY	0.145196	0	0	54.02
55.00	05500 RADIOLOGY-THERAPEUTIC	0.115111	0	0	55.00
56.00	05600 RADIOISOTOPE	0.041901	0	0	56.00
57.00	05700 CT SCAN	0.015347	105,249	1,615	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.050894	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.043827	9,782	429	59.00
60.00	06000 LABORATORY	0.051706	487,508	25,207	60.00
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.366884	39,289	14,415	62.00
65.00	06500 RESPIRATORY THERAPY	0.093676	103,639	9,708	65.00
66.00	06600 PHYSICAL THERAPY	0.150386	2,616,563	393,494	66.00
69.00	06900 ELECTROCARDIOLOGY	0.036307	93,080	3,379	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.092674	10,560	979	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.121117	265,780	32,190	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.180325	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.096760	1,621,361	156,883	73.00
74.00	07400 RENAL DIALYSIS	0.423327	79,301	33,570	74.00
76.00	03950 LITHOTRIPSY	0.379237	0	0	76.00
76.01	03330 ENDOSCOPY	0.047092	16,930	797	76.01
76.02	03040 PRISION CLINIC	0.753157	0	0	76.02
76.03	03050 WOUND CARE	0.219030	0	0	76.03
76.04	03060 OPIC	0.170185	0	0	76.04
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.065228	4,583	299	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.751989	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		5,560,796	687,401	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)		5,560,796		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0046	Period: From 09/01/2023 To 08/31/2024	Worksheet D-3 Date/Time Prepared: 1/28/2025 2:38 pm	
Cost Center Description		Title XIX	Hospital	Cost	
		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	3,888,656		30.00
31.00	03100	INTENSIVE CARE UNIT	2,968,425		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	165,092		35.00
40.00	04000	SUBPROVIDER - IPF	0		40.00
41.00	04100	SUBPROVIDER - IRF	0		41.00
43.00	04300	NURSERY	263,791		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	7,453,427	652,406	50.00
51.00	05100	RECOVERY ROOM	596,524	32,512	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,133,859	1,395,474	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	619,470	114,458	54.00
54.01	03630	ULTRA SOUND	259,675	19,152	54.01
54.02	03440	MAMMOGRAPHY	3,990	579	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	51,627	5,943	55.00
56.00	05600	RADIOISOTOPE	21,407	897	56.00
57.00	05700	CT SCAN	4,228,848	64,900	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	437,255	22,254	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,803,532	122,870	59.00
60.00	06000	LABORATORY	5,865,971	303,306	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	654,652	240,181	62.00
65.00	06500	RESPIRATORY THERAPY	4,107,473	384,772	65.00
66.00	06600	PHYSICAL THERAPY	660,448	97,697	66.00
69.00	06900	ELECTROCARDIOLOGY	2,281,980	81,855	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	62,576	5,799	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,831,323	342,921	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,356,160	244,550	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,911,089	1,442,797	73.00
74.00	07400	RENAL DIALYSIS	204,449	86,549	74.00
76.00	03950	LITHOTRIPSY	0	0	76.00
76.01	03330	ENDOSCOPY	105,109	4,950	76.01
76.02	03040	PRISION CLINIC	0	0	76.02
76.03	03050	WOUND CARE	26,523	5,749	76.03
76.04	03060	OPIC	0	0	76.04
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	3,883,771	253,331	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)	54,561,138	5,925,902	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)	54,561,138		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0046 Component CCN: 15-S046	Period: From 09/01/2023 To 08/31/2024	Worksheet D-3 Date/Time Prepared: 1/28/2025 2:38 pm	
		Title XIX	Subprovider - IPF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT				35.00
40.00	04000 SUBPROVIDER - IPF		20,614,724		40.00
41.00	04100 SUBPROVIDER - IRF				41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.087531	0	0	50.00
51.00	05100 RECOVERY ROOM	0.054503	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.230730	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.184768	29,416	5,435	54.00
54.01	03630 ULTRA SOUND	0.073755	1,709	126	54.01
54.02	03440 MAMMOGRAPHY	0.145196	0	0	54.02
55.00	05500 RADIOLOGY-THERAPEUTIC	0.115111	0	0	55.00
56.00	05600 RADIOISOTOPE	0.041901	0	0	56.00
57.00	05700 CT SCAN	0.015347	310,647	4,767	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.050894	16,645	847	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.043827	657	29	59.00
60.00	06000 LABORATORY	0.051706	1,219,292	63,045	60.00
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.366884	711	261	62.00
65.00	06500 RESPIRATORY THERAPY	0.093676	60,433	5,661	65.00
66.00	06600 PHYSICAL THERAPY	0.147925	21,324	3,154	66.00
69.00	06900 ELECTROCARDIOLOGY	0.035870	63,463	2,276	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.092674	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.121117	3,010	365	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.180325	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.096760	2,213,250	214,154	73.00
74.00	07400 RENAL DIALYSIS	0.423327	0	0	74.00
76.00	03950 LITHOTRIPSY	0.379237	0	0	76.00
76.01	03330 ENDOSCOPY	0.047092	0	0	76.01
76.02	03040 PRISION CLINIC	0.753157	0	0	76.02
76.03	03050 WOUND CARE	0.216743	0	0	76.03
76.04	03060 OPIC	0.167162	0	0	76.04
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.065228	1,188,547	77,527	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.751989	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		5,129,104	377,647	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)		5,129,104	0	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0046 Component CCN: 15-T046	Period: From 09/01/2023 To 08/31/2024	Worksheet D-3 Date/Time Prepared: 1/28/2025 2:38 pm	
		Title XIX	Subprovider - IRF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT				35.00
40.00	04000 SUBPROVIDER - IPF				40.00
41.00	04100 SUBPROVIDER - IRF		610,162		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.087531	26,619	2,330	50.00
51.00	05100 RECOVERY ROOM	0.054503	3,933	214	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.230730	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.184768	7,198	1,330	54.00
54.01	03630 ULTRA SOUND	0.073755	1,809	133	54.01
54.02	03440 MAMMOGRAPHY	0.145196	0	0	54.02
55.00	05500 RADIOLOGY-THERAPEUTIC	0.115111	0	0	55.00
56.00	05600 RADIOISOTOPE	0.041901	0	0	56.00
57.00	05700 CT SCAN	0.015347	28,927	444	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.050894	20,504	1,044	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.043827	10,439	458	59.00
60.00	06000 LABORATORY	0.051706	94,282	4,875	60.00
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.366884	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0.093676	8,913	835	65.00
66.00	06600 PHYSICAL THERAPY	0.147925	813,719	120,369	66.00
69.00	06900 ELECTROCARDIOLOGY	0.035870	18,352	658	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.092674	5,280	489	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.121117	51,572	6,246	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.180325	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.096760	512,253	49,566	73.00
74.00	07400 RENAL DIALYSIS	0.423327	0	0	74.00
76.00	03950 LITHOTRIPSY	0.379237	0	0	76.00
76.01	03330 ENDOSCOPY	0.047092	0	0	76.01
76.02	03040 PRISION CLINIC	0.753157	0	0	76.02
76.03	03050 WOUND CARE	0.216743	0	0	76.03
76.04	03060 OPIC	0.167162	0	0	76.04
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.065228	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.751989	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,603,800	188,991	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)		1,603,800	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0046	Period: From 09/01/2023 To 08/31/2024	Worksheet E Part A Date/Time Prepared: 1/28/2025 2:38 pm
		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)		941,460	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		10,207,675	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)		79,002	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		476,810	2.04
3.00	Managed Care Simulated Payments		10,658,697	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		138.93	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)		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	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)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		6.60	30.00
31.00	Percentage of Medicaid patient days (see instructions)		20.16	31.00
32.00	Sum of lines 30 and 31		26.76	32.00

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		Title XVIII	Hospital	PPS	
				1.00	
33.00	Allowable disproportionate share percentage (see instructions)			11.29	33.00
34.00	Disproportionate share adjustment (see instructions)			314,685	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)	6,874,403,459	5,938,006,757		35.00
35.01	Factor 3 (see instructions)	0.000176737	0.000156419		35.01
35.02	Hospital UCP, including supplemental UCP (see instructions)	1,214,960	928,815		35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	99,860	852,683		35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	952,543			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
		Before 1/1	On/After 1/1		
		1.00	1.01		
41.00	Total ESRD Medicare discharges (see instructions)	0	0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0	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	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)	12,972,175			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0			48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			12,972,175	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			969,980	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).			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	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 intructions)			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)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			13,942,155	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			13,942,155	61.00
62.00	Deductibles billed to program beneficiaries			1,237,312	62.00
63.00	Coinsurance billed to program beneficiaries			42,808	63.00
64.00	Allowable bad debts (see instructions)			80,673	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			52,437	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			17,719	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			12,714,472	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)				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)				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)			-62,069	70.93
70.94	HRR adjustment amount (see instructions)			-62,153	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0046	Period: From 09/01/2023 To 08/31/2024	Worksheet E Part A Date/Time Prepared: 1/28/2025 2:38 pm	
		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)		0	70.99	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		12,590,250	71.00	
71.01	Sequestration adjustment (see instructions)		251,805	71.01	
71.02	Demonstration payment adjustment amount after sequestration		0	71.02	
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03	
72.00	Interim payments		12,225,121	72.00	
72.01	Interim payments-PARHM		0	72.01	
73.00	Tentative settlement (for contractor use only)		0	73.00	
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01	
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		113,324	74.00	
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01	
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,454,386	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	0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	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)		0.0000	0.0000	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0046	Period: From 09/01/2023 To 08/31/2024	Worksheet E Part B Date/Time Prepared: 1/28/2025 2:38 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		808	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		7,751,116	2.00
3.00	OPPS or REH payments		9,796,781	3.00
4.00	Outlier payment (see instructions)		43,029	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)		808	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		8,347	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)		8,347	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)		8,347	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		7,539	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)		808	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		9,839,810	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,687,788	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)		8,152,830	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)		8,152,830	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		8,152,830	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)		73,860	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		48,009	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		44,753	36.00
37.00	Subtotal (see instructions)		8,200,839	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)		8,200,839	40.00
40.01	Sequestration adjustment (see instructions)		164,017	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		8,077,635	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)		-40,813	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		292,954	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		TERRE HAUTE REGIONAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0046	Period: From 09/01/2023 To 08/31/2024	Worksheet E Part B Date/Time Prepared: 1/28/2025 2:38 pm	
		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: 15-0046 Component CCN: 15-T046	Period: From 09/01/2023 To 08/31/2024	Worksheet E Part B Date/Time Prepared: 1/28/2025 2:38 pm
		Title XVIII	Subprovider - IRF	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		15	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		26	2.00
3.00	OPPS or REH payments		39	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)		15	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		153	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)		153	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		153	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		138	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)		15	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)		39	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)		54	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)		54	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		54	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)		54	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)		54	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		68	41.00
41.01	Interim payments-PARHM			41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)			42.01
43.00	Balance due provider/program (see instructions)		-15	43.00
43.01	Balance due provider/program-PARHM (see instructions)			43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00

Health Financial Systems		TERRE HAUTE REGIONAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0046	Period:	Worksheet E	
		Component CCN: 15-T046	From 09/01/2023	Part B	
			To 08/31/2024	Date/Time Prepared:	
		Title XVIII	Subprovider -	PPS	
			IRF		
				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: 15-0046

Period:
From 09/01/2023
To 08/31/2024Worksheet E-1
Part I
Date/Time Prepared:
1/28/2025 2:38 pm

		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		12,225,121		8,020,735	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	04/24/2024	56,900	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		56,900	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)		12,225,121		8,077,635	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		113,324		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		40,813	6.02	
7.00	Total Medicare program liability (see instructions)		12,338,445		8,036,822	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: 15-0046

Period:

Worksheet E-1

Component CCN: 15-S046

From 09/01/2023
To 08/31/2024Part I
Date/Time Prepared:
1/28/2025 2:38 pm

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		274,704		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		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)		274,704		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		1,985		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		276,689		0	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: 15-0046
 Component CCN: 15-T046

 Period:
 From 09/01/2023
 To 08/31/2024

 Worksheet E-1
 Part I
 Date/Time Prepared:
 1/28/2025 2:38 pm

		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		1,878,828		68		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)		0		0		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)		1,878,828		68		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		5,977		15		6.02
7.00	Total Medicare program liability (see instructions)		1,872,851		53		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0046	Period: From 09/01/2023 To 08/31/2024	Worksheet E-1 Part II Date/Time Prepared: 1/28/2025 2:38 pm
		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: 15-0046 Component CCN: 15-S046	Period: From 09/01/2023 To 08/31/2024	Worksheet E-3 Part II Date/Time Prepared: 1/28/2025 2:38 pm
		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)			328,983 1.00
2.00	Net IPF PPS Outlier Payments			0 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			15.185792 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1)\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			328,983 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)			328,983 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			328,983 18.00
19.00	Deductibles			47,040 19.00
20.00	Subtotal (line 18 minus line 19)			281,943 20.00
21.00	Coinsurance			1,632 21.00
22.00	Subtotal (line 20 minus line 21)			280,311 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			3,116 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			2,025 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			1,632 25.00
26.00	Subtotal (sum of lines 22 and 24)			282,336 26.00
27.00	Direct graduate medical education payments (see instructions)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.98	Recovery of accelerated depreciation.			0 30.98
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			282,336 31.00
31.01	Sequestration adjustment (see instructions)			5,647 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			274,704 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			1,985 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: 15-0046 Component CCN: 15-T046	Period: From 09/01/2023 To 08/31/2024	Worksheet E-3 Part III Date/Time Prepared: 1/28/2025 2:38 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			1,682,269 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0443 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			86,469 3.00
4.00	Outlier Payments			162,377 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)			6.062842 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)			1,931,115 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)			1,931,115 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			1,931,115 19.00
20.00	Deductibles			9,760 20.00
21.00	Subtotal (line 19 minus line 20)			1,921,355 21.00
22.00	Coinsurance			11,344 22.00
23.00	Subtotal (line 21 minus line 22)			1,910,011 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			1,632 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			1,061 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			1,632 26.00
27.00	Subtotal (sum of lines 23 and 25)			1,911,072 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)			0 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)			1,911,072 32.00
32.01	Sequestration adjustment (see instructions)			38,221 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			1,878,828 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)			-5,977 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			162,377 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: 15-0046	Period: From 09/01/2023 To 08/31/2024	Worksheet E-3 Part VII Date/Time Prepared: 1/28/2025 2:38 pm
		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	6,803,154		1.00
2.00	Medical and other services		6,625,842	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	6,803,154	6,625,842	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)	6,803,154	6,625,842	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	7,285,964		8.00
9.00	Ancillary service charges	54,561,138	94,010,135	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)	61,847,102	94,010,135	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)	61,847,102	94,010,135	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	55,043,948	87,384,293	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)	6,803,154	6,625,842	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	6,803,154	6,625,842	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)	6,803,154	6,625,842	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)	6,803,154	6,625,842	36.00
37.00	TO ZERO OUT MEDICAID SETTLEMENT	2,222,132	728,399	37.00
38.00	Subtotal (line 36 ± line 37)	9,025,286	7,354,241	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)	9,025,286	7,354,241	40.00
41.00	Interim payments	9,025,286	7,354,241	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0046 Component CCN: 15-S046	Period: From 09/01/2023 To 08/31/2024	Worksheet E-3 Part VII Date/Time Prepared: 1/28/2025 2:38 pm
		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		3,862,841	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)		3,862,841	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)		3,862,841	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		20,614,724	8.00
9.00	Ancillary service charges		5,129,104	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)		25,743,828	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		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	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	15.00
16.00	Total customary charges (see instructions)		25,743,828	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		21,880,987	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	18.00
19.00	Interns and Residents (see instructions)		0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		3,862,841	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments		0	22.00
23.00	Outlier payments		0	23.00
24.00	Program capital payments		0	24.00
25.00	Capital exception payments (see instructions)		0	25.00
26.00	Routine and Ancillary service other pass through costs		0	26.00
27.00	Subtotal (sum of lines 22 through 26)		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)		3,862,841	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		3,862,841	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)		3,862,841	36.00
37.00	TO ZERO OUT MEDICAID SETTLEMENT		-1,594,154	37.00
38.00	Subtotal (line 36 ± line 37)		2,268,687	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)		2,268,687	40.00
41.00	Interim payments		2,268,687	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0046 Component CCN: 15-T046	Period: From 09/01/2023 To 08/31/2024	Worksheet E-3 Part VII Date/Time Prepared: 1/28/2025 2:38 pm	
		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		545,297		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)		545,297	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)		545,297	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		610,162		8.00
9.00	Ancillary service charges		1,603,800	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)		2,213,962	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)		2,213,962	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		1,668,665	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)		545,297	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	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		545,297	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)		545,297		31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		545,297	0	36.00
37.00	TO ZERO OUT MEDICAID SETTLEMENT		-178,664		37.00
38.00	Subtotal (line 36 ± line 37)		366,633	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)		366,633	0	40.00
41.00	Interim payments		366,633		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

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT		Provider CCN: 15-0046	Period: From 09/01/2023 To 08/31/2024	Worksheet E-5 Date/Time Prepared: 1/28/2025 2:38 pm
		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: 15-0046

Period:
From 09/01/2023
To 08/31/2024

Worksheet G

Date/Time Prepared:
1/28/2025 2:38 pm

		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	6,989	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	21,801,735	0	0	0	4.00
5.00	Other receivable	-3,325	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-5,540,659	0	0	0	6.00
7.00	Inventory	6,413,797	0	0	0	7.00
8.00	Prepaid expenses	561,207	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	4,373	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	23,244,117	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,262,718	0	0	0	12.00
13.00	Land improvements	3,238,473	0	0	0	13.00
14.00	Accumulated depreciation	-3,178,011	0	0	0	14.00
15.00	Buildings	38,689,807	0	0	0	15.00
16.00	Accumulated depreciation	-31,605,773	0	0	0	16.00
17.00	Leasehold improvements	9,587,944	0	0	0	17.00
18.00	Accumulated depreciation	-8,831,397	0	0	0	18.00
19.00	Fixed equipment	37,320,462	0	0	0	19.00
20.00	Accumulated depreciation	-28,046,641	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	48,447,865	0	0	0	23.00
24.00	Accumulated depreciation	-43,071,560	0	0	0	24.00
25.00	Minor equipment depreciable	8,397,972	0	0	0	25.00
26.00	Accumulated depreciation	-6,686,235	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	2,154,419	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	27,680,043	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	3,063,197	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	2,445,521	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,508,718	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	56,432,878	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,688,355	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,447,055	0	0	0	38.00
39.00	Payroll taxes payable	2,794,787	0	0	0	39.00
40.00	Notes and loans payable (short term)	280,131	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	27,580	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,237,908	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	207,170	0	0	0	47.00
48.00	Unsecured loans	-348,100,331	0	0	0	48.00
49.00	Other long term liabilities	88,186	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-347,804,975	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-339,567,067	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	395,999,945	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	395,999,945	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	56,432,878	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0046

Period:
From 09/01/2023
To 08/31/2024

Worksheet G-1

Date/Time Prepared:
1/28/2025 2:38 pm

		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		368,057,779		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		33,074,772				2.00
3.00	Total (sum of line 1 and line 2)		401,132,551		0		3.00
4.00	ROUNDING	11		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)		11		0		10.00
11.00	Subtotal (line 3 plus line 10)		401,132,562		0		11.00
12.00	FEDERAL TAX LIABILITY ENTRY	5,132,617		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)		5,132,617		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		395,999,945		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	ROUNDING		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	FEDERAL TAX LIABILITY ENTRY		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: 15-0046

Period:
From 09/01/2023
To 08/31/2024Worksheet G-2
Parts I & II
Date/Time Prepared:
1/28/2025 2:38 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	20,905,981		20,905,981	1.00
2.00	SUBPROVIDER - IPF	34,562,058		34,562,058	2.00
3.00	SUBPROVIDER - IRF	4,703,041		4,703,041	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)	60,171,080		60,171,080	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	15,377,277		15,377,277	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	NEONATAL INTENSIVE CARE UNIT	308,093		308,093	15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	15,685,370		15,685,370	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	75,856,450		75,856,450	17.00
18.00	Ancillary services	319,714,439	350,661,428	670,375,867	18.00
19.00	Outpatient services	22,374,435	62,523,956	84,898,391	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OCCUPATIONAL MEDICINE	0	275,374	275,374	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	417,945,324	413,460,758	831,406,082	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		80,628,574		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	HITECH INCOME	0			37.00
38.00	ROUNDING	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)		80,628,574		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0046

Period:
From 09/01/2023
To 08/31/2024

Worksheet G-3

Date/Time Prepared:
1/28/2025 2:38 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	831,406,082	1.00
2.00	Less contractual allowances and discounts on patients' accounts	717,948,952	2.00
3.00	Net patient revenues (line 1 minus line 2)	113,457,130	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	80,628,574	4.00
5.00	Net income from service to patients (line 3 minus line 4)	32,828,556	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	151,998	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	-60	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	13,897	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	80,394	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	246,229	25.00
26.00	Total (line 5 plus line 25)	33,074,785	26.00
27.00	ROUNDING	13	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	13	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	33,074,772	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0046	Period: From 09/01/2023 To 08/31/2024	Worksheet L Parts I-III Date/Time Prepared: 1/28/2025 2:38 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		856,991	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		65,255	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)		39.89	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	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)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		6.60	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		20.16	8.00
9.00	Sum of lines 7 and 8		26.76	9.00
10.00	Allowable disproportionate share percentage (see instructions)		5.57	10.00
11.00	Disproportionate share adjustment (see instructions)		47,734	11.00
12.00	Total prospective capital payments (see instructions)		969,980	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