

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0011	Period: From 07/01/2023 To 06/30/2024	Worksheet S Parts I-III Date/Time Prepared: 11/26/2024 3:43 pm
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report 2. ☐ Manually prepared cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report 4. ☒ Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.		
Contractor use only	5. ☒ Cost Report Status	6. Date Received:	10. NPR Date:
	(1) As Submitted	7. Contractor No.	11. Contractor's Vendor Code: 4
	(2) Settled without Audit	8. ☐ Initial Report for this Provider CCN	12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.
	(3) Settled with Audit	9. ☐ Final Report for this Provider CCN	
	(4) Reopened		
(5) Amended			

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 MARION GENERAL HOSPITAL (15-0011) for the cost reporting period beginning 07/01/2023 and ending 06/30/2024 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	Tony Roberts	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	Tony Roberts		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	73,439	-31,299	0	-851,879 1.00
2.00	SUBPROVIDER - IPF	0	0	0	0	0 2.00
3.00	SUBPROVIDER - IRF	0	-22,098	0	0	34,353 3.00
4.00	SUBPROVIDER (OTHER)	0	0	0	0	0 4.00
5.00	SWING BED - SNF	0	0	0	0	0 5.00
6.00	SWING BED - NF	0	0	0	0	0 6.00
200.00	TOTAL	0	51,341	-31,299	0	-817,526 200.00

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: 15-0011		Period: From 07/01/2023 To 06/30/2024		Worksheet S-2 Part I Date/Time Prepared: 11/26/2024 3:43 pm		
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 441 WABASH AVENUE			PO Box:				1.00			
2.00	City: MARION			State: IN		Zip Code: 46952-		County: GRANT			
		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			MARION GENERAL HOSPITAL	150011	99915	1	07/01/1966	N	P	O
4.00	Subprovider - IPF										
5.00	Subprovider - IRF			MARION GENERAL HOSPITAL REHAB	15T011	99915	5	07/01/2005	N	P	O
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)						07/01/2023		06/30/2024		
21.00	Type of Control (see instructions)						2				
							1.00		2.00		
							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)					N	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 reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N			
22.04	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				

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	517	59	0	0	3,730	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	14	19	0	0	149		25.00
					Urban/Rural S	Date of Geogr	
					1.00	2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					1		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					07/01/2023	06/30/2024	36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N	Y/N	
					1.00	2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					Y	Y	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	Y	40.00
					V	XVIII	XIX
					1.00	2.00	3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					N		
57.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.							
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		

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							V	XVIII	XIX	
							1.00	2.00	3.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.						N			59.00
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code					
			1.00	2.00	3.00					
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.			N					60.00	
			Y/N	IME	Direct GME	IME	Direct GME			
			1.00	2.00	3.00	4.00	5.00			
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)					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	

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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

Health Financial Systems		MARION GENERAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0011	Period: From 07/01/2023 To 06/30/2024	Worksheet S-2 Part I Date/Time Prepared: 11/26/2024 3:43 pm	
			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.			N	70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			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
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0011	Period: From 07/01/2023 To 06/30/2024	Worksheet S-2 Part I Date/Time Prepared: 11/26/2024 3:43 pm
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	1,037,862	0	0
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	Y	N	123.00
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)	N		140.00
		1.00	2.00	3.00
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.				
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00
		1.00	2.00	
144.00	Are provider based physicians' costs included in Worksheet A?		Y	144.00
		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0011		Period: From 07/01/2023 To 06/30/2024		Worksheet S-2 Part I Date/Time Prepared: 11/26/2024 3:43 pm		
						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)							168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00
		Beginning		Ending				
		1.00		2.00				
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							170.00
		1.00		2.00				
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0011		Period: From 07/01/2023 To 06/30/2024		Worksheet S-2 Part II Date/Time Prepared: 11/26/2024 3:43 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.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N			13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.			N			14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			Y			15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (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, enter the paid-through date in columns 2 and 4. (see instructions)	Y	10/08/2024	Y	10/08/2024		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: 15-0011

Period:
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Part II
Date/Time Prepared:
11/26/2024 3:43 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				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
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.	TINA	SEVERS		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO., LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7946	TSEVERS@BLUEANDCO.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024Worksheet S-3
Part I
Date/Time Prepared:
11/26/2024 3:43 pm

Component		Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	11/26/2024 3:43 pm	
						I/P Days / O/P Visits / Trips	
						Title V	
		1.00	2.00	3.00	4.00	5.00	
PART I - STATISTICAL DATA							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	76	27,816	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)		76	27,816	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	19	6,954	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		95	34,770	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	0	0		0	16.00
17.00	SUBPROVIDER - IRF	41.00	18	6,588		0	17.00
18.00	SUBPROVIDER	42.00	0	0		0	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)		113				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: 15-0011

Period:
From 07/01/2023
To 06/30/2024Worksheet S-3
Part I
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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)	3,303	517	8,997			1.00
2.00	HMO and other (see instructions)	4,553	3,789				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	375	168				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)	3,303	517	8,997			7.00
8.00	INTENSIVE CARE UNIT	319	0	4,611			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	1,413			13.00
14.00	Total (see instructions)	3,622	517	15,021	0.00	699.43	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	0	0	0	0.00	0.00	16.00
17.00	SUBPROVIDER - IRF	1,269	14	2,237	0.00	11.17	17.00
18.00	SUBPROVIDER		0	0	0.00	0.00	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)			80			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	710.60	27.00
28.00	Observation Bed Days		911	3,815			28.00
29.00	Ambulance Trips	956					29.00
30.00	Employee discount days (see instruction)			171			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024Worksheet S-3
Part I
Date/Time Prepared:
11/26/2024 3:43 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	1,058	148	3,893	1.00
2.00 HMO and other (see instructions)			1,102	1,189		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				18		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,058	148	3,893	14.00
15.00 CAH visits						15.00
15.10 REH hours and visits						15.10
16.00 SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00 SUBPROVIDER - IRF	0.00	0	127	1	213	17.00
18.00 SUBPROVIDER	0.00	0		0	0	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: 15-0011

Period:
From 07/01/2023
To 06/30/2024Worksheet S-3
Part II
Date/Time Prepared:
11/26/2024 3:43 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	60,801,570	23,391,627	84,193,197	1,827,173.00	46.08
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		654,809	0	654,809	2,839.96	230.57
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		5,380,908	0	5,380,908	27,150.20	198.19
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)		10,595,058	15,930,740	26,525,798	449,491.00	59.01
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		5,251,691	0	5,251,691	56,372.04	93.16
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		186,775	0	186,775	950.50	196.50
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		0	0	0	0.00	0.00
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
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)		15,462,820	0	15,462,820		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		5,869,776	0	5,869,776		
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		77,131	0	77,131		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		675,112	0	675,112		
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)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024Worksheet S-3
Part II
Date/Time Prepared:
11/26/2024 3:43 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	
25.53	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	1,393,741	31,203	1,424,944	35,118.00	40.58	26.00
27.00	Administrative & General	5.00	11,086,139	2,294,921	13,381,060	323,318.00	41.39	27.00
28.00	Administrative & General under contract (see inst.)		1,047,534	0	1,047,534	8,437.00	124.16	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,059,018	14,338	1,073,356	43,653.00	24.59	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1,337,965	0	1,337,965	95,920.00	13.95	33.00
34.00	Dietary	10.00	22,474	0	22,474	314.00	71.57	34.00
35.00	Dietary under contract (see instructions)		376,247	0	376,247	20,646.00	18.22	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,426,828	-398,464	1,028,364	17,114.00	60.09	38.00
39.00	Central Services and Supply	14.00	149,678	14,713	164,391	7,935.00	20.72	39.00
40.00	Pharmacy	15.00	2,426,363	9,153	2,435,516	57,383.00	42.44	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: 15-0011

Period:
From 07/01/2023
To 06/30/2024Worksheet S-3
Part III
Date/Time Prepared:
11/26/2024 3:43 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)	58,182,408	23,391,627	81,574,035	1,925,025.80	42.38	1.00
2.00	Excluded area salaries (see instructions)	10,595,058	15,930,740	26,525,798	449,491.00	59.01	2.00
3.00	Subtotal salaries (line 1 minus line 2)	47,587,350	7,460,887	55,048,237	1,475,534.80	37.31	3.00
4.00	Subtotal other wages & related costs (see inst.)	5,438,466	0	5,438,466	57,322.54	94.87	4.00
5.00	Subtotal wage-related costs (see inst.)	15,539,951	0	15,539,951	0.00	28.23	5.00
6.00	Total (sum of lines 3 thru 5)	68,565,767	7,460,887	76,026,654	1,532,857.34	49.60	6.00
7.00	Total overhead cost (see instructions)	20,325,987	1,965,864	22,291,851	609,838.00	36.55	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024Worksheet S-3
Part IV
Date/Time Prepared:
11/26/2024 3:43 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	1,737,705	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)	2,000,000	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	1,876,206	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)	9,880,630	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	30,001	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)	319,111	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	558,349	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	5,526,938	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	7,159	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	148,741	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	22,084,840	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: 15-0011

Period:
From 07/01/2023
To 06/30/2024Worksheet S-3
Part V
Date/Time Prepared:
11/26/2024 3:43 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	5,251,691	22,084,840	1.00
2.00	Hospital	5,251,691	22,084,840	2.00
3.00	SUBPROVIDER - IPF	0	0	3.00
4.00	SUBPROVIDER - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 15-0011	Period: From 07/01/2023 To 06/30/2024	Worksheet S-10 Parts I & II Date/Time Prepared: 11/26/2024 3:43 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)		0.251694	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		5,017,162	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		122,241,853	6.00
7.00	Medicaid cost (line 1 times line 6)		30,767,541	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)		25,750,379	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)		25,750,379	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)	8,670,470	2,448,562	11,119,032
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,182,305	2,448,562	4,630,867
22.00	Payments received from patients for amounts previously written off as charity care	83	3,646	3,729
23.00	Cost of charity care (see instructions)	2,182,222	2,444,916	4,627,138
				1.00
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
25.01	Charges for insured patients' liability (see instructions)		0	25.01
26.00	Bad debt amount (see instructions)		10,749,663	26.00
27.00	Medicare reimbursable bad debts (see instructions)		229,444	27.00
27.01	Medicare allowable bad debts (see instructions)		352,990	27.01
28.00	Non-Medicare bad debt amount (see instructions)		10,396,673	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)		2,740,326	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)		7,367,464	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		33,117,843	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 15-0011	Period: From 07/01/2023 To 06/30/2024	Worksheet S-10 Parts I & II Date/Time Prepared: 11/26/2024 3:43 pm
				1.00
PART II - HOSPITAL DATA				
Uncompensated and Indigent Care Cost-to-Charge Ratio				
1.00	Cost to charge ratio (see instructions)		0.245612	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)	8,565,840	2,445,269	11,011,109
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,103,873	2,445,269	4,549,142
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (see instructions)	2,103,873	2,445,269	4,549,142
				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
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0
25.01	Charges for insured patients' liability (see instructions)			0
26.00	Bad debt amount (see instructions)			10,672,491
27.00	Medicare reimbursable bad debts (see instructions)			229,444
27.01	Medicare allowable bad debts (see instructions)			352,990
28.00	Non-Medicare bad debt amount (see instructions)			10,319,501
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)			2,658,139
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)			7,207,281
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			7,207,281

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024

Worksheet A

Date/Time Prepared:
11/26/2024 3:43 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		12,359,989	12,359,989	-1,110,245	11,249,744
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,393,741	20,449,072	21,842,813	31,203	21,874,016
5.00	00500	ADMINISTRATIVE & GENERAL	11,086,139	33,538,889	44,625,028	184,864	44,809,892
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0
6.01	00601	CAFETERIA	0	0	0	1,963,867	1,963,867
6.02	00602	CAFETERIA	0	0	0	0	0
7.00	00700	OPERATION OF PLANT	1,059,018	5,876,132	6,935,150	422,006	7,357,156
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	289,392	289,392
9.00	00900	HOUSEKEEPING	0	3,432,630	3,432,630	-281,978	3,150,652
10.00	01000	DIETARY	22,474	2,590,817	2,613,291	-2,024,618	588,673
13.00	01300	NURSING ADMINISTRATION	1,426,828	84,620	1,511,448	-398,464	1,112,984
14.00	01400	CENTRAL SERVICES & SUPPLY	149,678	368,392	518,070	14,713	532,783
15.00	01500	PHARMACY	2,426,363	15,144,369	17,570,732	-13,631,256	3,939,476
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	31,588	473,125	504,713	-504,713	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,246,554	1,514,869	8,761,423	-1,388,773	7,372,650
31.00	03100	INTENSIVE CARE UNIT	2,340,982	1,864,786	4,205,768	-26,308	4,179,460
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0
41.00	04100	SUBPROVIDER - IRF	827,829	1,398,192	2,226,021	0	2,226,021
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	0	0	1,656,299	1,656,299
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,525,702	8,029,194	11,554,896	272,569	11,827,465
51.00	05100	RECOVERY ROOM	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,698,777	3,821,945	7,520,722	-1,470,548	6,050,174
57.00	05700	CT SCAN	0	0	0	1,226,029	1,226,029
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	631,133	631,133
59.00	05900	CARDIAC CATHETERIZATION	855,632	1,780,764	2,636,396	36,013	2,672,409
60.00	06000	LABORATORY	2,887,706	6,551,261	9,438,967	18,384	9,457,351
60.01	06001	ONCOLOGY	1,167,160	650,757	1,817,917	12,602	1,830,519
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	1,750,988	1,918,334	3,669,322	69,289	3,738,611
66.00	06600	PHYSICAL THERAPY	1,944,361	694,616	2,638,977	71,399	2,710,376
69.00	06900	ELECTROCARDIOLOGY	884,393	229,238	1,113,631	87,399	1,201,030
69.01	06901	CARDIAC REHAB	182,775	49,109	231,884	29,883	261,767
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	13,640,409	13,640,409
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	336,797	661,873	998,670	52,085	1,050,755
91.00	09100	EMERGENCY	5,788,856	6,852,949	12,641,805	-48,050	12,593,755
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,576,175	244,145	1,820,320	38,280	1,858,600
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	52,610,516	130,580,067	183,190,583	-137,135	183,053,448
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,249	7,249	16,316	23,565
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	PACT REV PHYSICIANS	145,724	952,926	1,098,650	-230,703	867,947
192.02	19202	VISITOR MEALS	0	0	0	0	0
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	0	0	0
192.04	19204	LIFELINE	0	0	0	0	0
192.05	19205	OWNED PROPERTIES	0	2,457,077	2,457,077	-1,290,692	1,166,385
192.06	19206	UROLOGY	355,316	1,093,045	1,448,361	39,970	1,488,331
192.07	19207	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.08	19211	PARISH NURSING	31,289	10,954	42,243	3,639	45,882
192.09	19212	BIOTERRORISM GRANT	0	0	0	0	0
192.10	19214	BREAST PUMPS	0	0	0	0	0
192.11	19208	MGH EMERGENCY PHYSICIANS	0	0	0	10,000	10,000
192.12	19209	LUNG CENTER	97,355	414,300	511,655	27,023	538,678
192.13	19213	MGH EXPRESS	660,534	1,220,810	1,881,344	100,858	1,982,202
192.14	19210	MGH PHYS PRACT MGMT	1,672,603	1,022,387	2,694,990	137,106	2,832,096
192.15	19215	MGH MARION SURGEONS	420,704	1,892,068	2,312,772	70,526	2,383,298
192.16	19216	MGH MGH MED ONC	0	1,678,856	1,678,856	0	1,678,856

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024

Worksheet A

Date/Time Prepared:
11/26/2024 3:43 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	
192.17	19217	MGH FMC SOUTH	619,767	1,361,075	1,980,842	274,790	2,255,632	192.17
192.18	19218	MGH FAIRM MED ASSOC	199,561	324,594	524,155	23,629	547,784	192.18
192.19	19219	MGH FMC MARION	265,045	459,364	724,409	59,445	783,854	192.19
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	373,069	940,568	1,313,637	25,954	1,339,591	193.01
193.02	19302	MGH FMC GAS CITY	317,041	865,747	1,182,788	81,443	1,264,231	193.02
193.03	19303	MGH HOSPITALISTS	3,813	3,580,966	3,584,779	30,000	3,614,779	193.03
193.04	19304	MGH MAR FAM PRACT	1,127,703	2,750,070	3,877,773	98,102	3,975,875	193.04
193.05	19305	MGH FMC SWAYZEE	83,573	176,332	259,905	21,256	281,161	193.05
193.06	19306	MGH PEDIATRIC CTR	279,627	885,178	1,164,805	57,093	1,221,898	193.06
193.07	19307	MGH SPECIALTY PHYS	46,127	173,649	219,776	13,332	233,108	193.07
193.08	19308	MGH FMC CONVERSE	128,712	261,012	389,724	307	390,031	193.08
193.09	19309	MGH UPLAND HEALTH	0	0	0	0	0	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	0	193.11
193.12	19312	OB/GYN	463,404	2,240,159	2,703,563	192,664	2,896,227	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
193.16	19316	MGH NEONATOLOGY	0	890,400	890,400	0	890,400	193.16
193.18	19318	MGH WOUND CARE	0	30,546	30,546	0	30,546	193.18
194.00	07963	HEART FAILURE CLINIC	0	60,053	60,053	0	60,053	194.00
194.01	07950	MOW	0	0	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	0	0	0	194.02
194.03	07952	ADVERTISING	0	0	0	359,908	359,908	194.03
194.04	07953	MGH WORK SOLUTIONS	343,449	442,223	785,672	56,859	842,531	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	0	0	194.05
194.06	07955	OPIOID IMPL GRANT	0	3,956	3,956	0	3,956	194.06
194.07	07956	ASTHMA GRANT	0	0	0	0	0	194.07
194.08	07957	MGH SMMP BLDG	0	0	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	0	0	194.10
194.11	07960	FAIRMOUNT	0	0	0	0	0	194.11
194.12	07961	GAS CITY	0	0	0	0	0	194.12
194.13	07969	LYONS	0	0	0	0	0	194.13
194.14	07964	WABASH	0	0	0	0	0	194.14
194.15	07965	TOBACCO GRANT	360	15,506	15,866	0	15,866	194.15
194.16	07966	HRSA NETWORK DEV PLANNING	0	0	0	0	0	194.16
194.17	07967	HRSA OPIOID PLANNING	0	0	0	0	0	194.17
194.18	07962	ECHO GRANT	0	0	0	0	0	194.18
194.19	07968	RURAL QI GRANT	8,182	53,600	61,782	0	61,782	194.19
194.20	07970	MGH DIABETES GRANT	0	0	0	0	0	194.20
194.21	07971	MGH MGH ORTHO	0	0	0	0	0	194.21
194.22	07972	MGH BELLA BLDG	0	0	0	0	0	194.22
194.23	07973	DIABETES GRANT	0	0	0	0	0	194.23
194.24	07974	HEALTH SYS GRANT	0	0	0	0	0	194.24
194.25	07975	MGH MGH ORTHO	466,445	1,642,602	2,109,047	-45,480	2,063,567	194.25
194.26	07976	FIMR GRANT - 8841	13,376	0	13,376	3,790	17,166	194.26
194.27	07978	OTHER NONREIMURSABLE COST CENTERS	0	0	0	0	0	194.27
194.28	07977	MGH HEALTH ISS GNT	68,275	14,333	82,608	0	82,608	194.28
194.29	07980	OTHER NONREIMURSABLE COST CENTERS	0	0	0	0	0	194.29
200.00		TOTAL (SUM OF LINES 118 through 199)	60,801,570	158,501,672	219,303,242	0	219,303,242	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024

Worksheet A

Date/Time Prepared:
11/26/2024 3:43 pm

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-705,920	10,543,824	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-3,239,638	18,634,378	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-19,928,894	24,880,998	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
6.01	00601	CAFETERIA	-4,456	1,959,411	6.01
6.02	00602	CAFETERIA	0	0	6.02
7.00	00700	OPERATION OF PLANT	-169,123	7,188,033	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-2,395	286,997	8.00
9.00	00900	HOUSEKEEPING	-222	3,150,430	9.00
10.00	01000	DIETARY	-280	588,393	10.00
13.00	01300	NURSING ADMINISTRATION	1	1,112,985	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-1,249	531,534	14.00
15.00	01500	PHARMACY	-37,566	3,901,910	15.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-13,724	7,358,926	30.00
31.00	03100	INTENSIVE CARE UNIT	-4,237	4,175,223	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	-147,951	2,078,070	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	1,656,299	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-2,838,059	8,989,406	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,363,309	4,686,865	54.00
57.00	05700	CT SCAN	0	1,226,029	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	631,133	58.00
59.00	05900	CARDIAC CATHETERIZATION	-121,347	2,551,062	59.00
60.00	06000	LABORATORY	-124,584	9,332,767	60.00
60.01	06001	ONCOLOGY	-2,573	1,827,946	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	60.02
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	-5,413	3,733,198	65.00
66.00	06600	PHYSICAL THERAPY	-423	2,709,953	66.00
69.00	06900	ELECTROCARDIOLOGY	-53,321	1,147,709	69.00
69.01	06901	CARDIAC REHAB	-128	261,639	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,640,409	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	78.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-3,056	1,047,699	90.00
91.00	09100	EMERGENCY	-5,383,075	7,210,680	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	92.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-66,313	1,792,287	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-34,217,255	148,836,193	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23,565	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	PACT REV PHYSICIANS	-19,798	848,149	192.01
192.02	19202	VISITOR MEALS	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	192.03
192.04	19204	LIFELINE	0	0	192.04
192.05	19205	OWNED PROPERTIES	0	1,166,385	192.05
192.06	19206	UROLOGY	-77,529	1,410,802	192.06
192.07	19207	PHYSICIANS' PRIVATE OFFICES	0	0	192.07
192.08	19211	PARISH NURSING	0	45,882	192.08
192.09	19212	BIOTERRORISM GRANT	0	0	192.09
192.10	19214	BREAST PUMPS	0	0	192.10
192.11	19208	MGH EMERGENCY PHYSICIANS	0	10,000	192.11
192.12	19209	LUNG CENTER	-61,194	477,484	192.12
192.13	19213	MGH EXPRESS	-55,276	1,926,926	192.13
192.14	19210	MGH PHYS PRACT MGMT	-78,442	2,753,654	192.14
192.15	19215	MGH MARION SURGEONS	-145,746	2,237,552	192.15
192.16	19216	MGH MGH MED ONC	0	1,678,856	192.16
192.17	19217	MGH FMC SOUTH	-409,752	1,845,880	192.17
192.18	19218	MGH FAIRM MED ASSOC	-32,880	514,904	192.18

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024Worksheet A
Date/Time Prepared:
11/26/2024 3:43 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
192.19	19219	MGH FMC MARION	-131,622	652,232	192.19
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	-58,818	1,280,773	193.01
193.02	19302	MGH FMC GAS CITY	-175,655	1,088,576	193.02
193.03	19303	MGH HOSPITALISTS	0	3,614,779	193.03
193.04	19304	MGH MAR FAM PRACT	-226,204	3,749,671	193.04
193.05	19305	MGH FMC SWAYZEE	-27,450	253,711	193.05
193.06	19306	MGH PEDIATRIC CTR	-83,623	1,138,275	193.06
193.07	19307	MGH SPECIALTY PHYS	-23,483	209,625	193.07
193.08	19308	MGH FMC CONVERSE	0	390,031	193.08
193.09	19309	MGH UPLAND HEALTH	0	0	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	193.11
193.12	19312	OB/GYN	-198,349	2,697,878	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	193.15
193.16	19316	MGH NEONATOLOGY	0	890,400	193.16
193.18	19318	MGH WOUND CARE	0	30,546	193.18
194.00	07963	HEART FAILURE CLINIC	0	60,053	194.00
194.01	07950	MOW	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	194.02
194.03	07952	ADVERTISING	0	359,908	194.03
194.04	07953	MGH WORK SOLUTIONS	-79,631	762,900	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	194.05
194.06	07955	OPIOID IMPL GRANT	0	3,956	194.06
194.07	07956	ASTHMA GRANT	0	0	194.07
194.08	07957	MGH SMMP BLDG	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	194.10
194.11	07960	FAIRMOUNT	0	0	194.11
194.12	07961	GAS CITY	0	0	194.12
194.13	07969	LYONS	0	0	194.13
194.14	07964	WABASH	0	0	194.14
194.15	07965	TOBACCO GRANT	0	15,866	194.15
194.16	07966	HRSA NETWORK DEV PLANNING	0	0	194.16
194.17	07967	HRSA OPIOID PLANNING	0	0	194.17
194.18	07962	ECHO GRANT	0	0	194.18
194.19	07968	RURAL QI GRANT	0	61,782	194.19
194.20	07970	MGH DIABETES GRANT	0	0	194.20
194.21	07971	MGH MGH ORTHO	0	0	194.21
194.22	07972	MGH BELLA BLDG	0	0	194.22
194.23	07973	DIABETES GRANT	0	0	194.23
194.24	07974	HEALTH SYS GRANT	0	0	194.24
194.25	07975	MGH MGH ORTHO	0	2,063,567	194.25
194.26	07976	FIMR GRANT - 8841	0	17,166	194.26
194.27	07978	OTHER NONREIMURSABLE COST CENTERS	0	0	194.27
194.28	07977	MGH HEALTH ISS GNT	0	82,608	194.28
194.29	07980	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.29
200.00		TOTAL (SUM OF LINES 118 through 199)	-36,102,707	183,200,535	200.00

RECLASSIFICATIONS

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024

Worksheet A-6

Date/Time Prepared:
11/26/2024 3:43 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - SATELLITE OFFICE RECLASS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	60,019	8,679		1.00
2.00	ELECTROCARDIOLOGY	69.00	6,758	1,001		2.00
	TOTALS		66,777	9,680		
	B - CAFETERIA RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	85,746		1.00
2.00	CAFETERIA	6.01	0	1,963,867		2.00
	TOTALS		0	2,049,613		
	C - ADMIN DIRECTOR RECLASS					
1.00	CENTRAL SERVICES & SUPPLY	14.00	11,106	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	253,884	0		2.00
3.00	OPERATING ROOM	50.00	99,951	0		3.00
4.00	CARDIAC CATHETERIZATION	59.00	32,185	0		4.00
5.00	RESPIRATORY THERAPY	65.00	45,033	0		5.00
6.00	ELECTROCARDIOLOGY	69.00	64,371	0		6.00
7.00	CARDIAC REHAB	69.01	16,093	0		7.00
8.00	AMBULANCE SERVICES	95.00	30,853	0		8.00
9.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	16,316	0		9.00
10.00	PARISH NURSING	192.08	0	0		10.00
11.00	MGH EXPRESS	192.13	46,280	0		11.00
12.00	MGH MARION SURGEONS	192.15	0	0		12.00
13.00	OB/GYN	193.12	59,813	0		13.00
	TOTALS		675,885	0		
	D - ADVERTISING RECLASS					
1.00	ADVERTISING	194.03	160,440	199,468		1.00
	TOTALS		160,440	199,468		
	E - LEASED PROPERTY RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	97,915		1.00
2.00	OPERATION OF PLANT	7.00	0	405,846		2.00
3.00	HOUSEKEEPING	9.00	0	7,015		3.00
4.00	DIETARY	10.00	0	24,319		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	3,790		5.00
6.00	OPERATING ROOM	50.00	0	161,617		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	218,103		7.00
8.00	CT SCAN	57.00	0	15,262		8.00
9.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	17,212		9.00
10.00	LABORATORY	60.00	0	72,579		10.00
11.00	RESPIRATORY THERAPY	65.00	0	20,519		11.00
12.00	PHYSICAL THERAPY	66.00	0	55,841		12.00
13.00	ELECTROCARDIOLOGY	69.00	0	15,269		13.00
14.00	CARDIAC REHAB	69.01	0	13,790		14.00
15.00	CLINIC	90.00	0	52,085		15.00
16.00	PACT REV PHYSICIANS	192.01	0	8,268		16.00
17.00	UROLOGY	192.06	0	39,970		17.00
18.00	PARISH NURSING	192.08	0	3,639		18.00
19.00	LUNG CENTER	192.12	0	27,023		19.00
20.00	MGH EXPRESS	192.13	0	54,578		20.00
21.00	MGH PHYS PRACT MGMT	192.14	0	114,157		21.00
22.00	MGH MARION SURGEONS	192.15	0	70,526		22.00
23.00	MGH FMC SOUTH	192.17	0	246,662		23.00
24.00	MGH FAIRM MED ASSOC	192.18	0	23,629		24.00
25.00	MGH FMC MARION	192.19	0	59,445		25.00
26.00	MGH FMC NORTHWOOD	193.01	0	25,954		26.00
27.00	MGH FMC GAS CITY	193.02	0	81,443		27.00
28.00	MGH MAR FAM PRACT	193.04	0	98,102		28.00
29.00	MGH FMC SWAYZEE	193.05	0	21,256		29.00
30.00	MGH PEDIATRIC CTR	193.06	0	57,093		30.00
31.00	MGH SPECIALTY PHYS	193.07	0	13,332		31.00
32.00	MGH FMC CONVERSE	193.08	0	307		32.00
33.00	OB/GYN	193.12	0	132,851		33.00
34.00	MGH WORK SOLUTIONS	194.04	0	56,859		34.00
35.00	OPIOID IMPL GRANT	194.06	0	0		35.00
36.00	TOBACCO GRANT	194.15	0	0		36.00
37.00	FIMR GRANT - 8841	194.26	0	3,790		37.00
	TOTALS		0	2,320,046		
	F - PHARMACY RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	13,640,409		1.00
	TOTALS		0	13,640,409		
	G - CT/MRI RECLASS					
1.00	CT SCAN	57.00	597,726	611,283		1.00
2.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	302,539	309,401		2.00

RECLASSIFICATIONS

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024

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	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	TOTALS		900,265	920,684	
	H - SHORT TERM DISABILITY RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	9,958	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	1,771	2.00
3.00	OPERATING ROOM	50.00	0	0	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	11,237	4.00
5.00	LABORATORY	60.00	0	2,906	5.00
6.00	ONCOLOGY	60.01	0	0	6.00
7.00	MGH EXPRESS	192.13	0	0	7.00
8.00	MGH PHYS PRACT MGMT	192.14	0	0	8.00
	TOTALS		0	25,872	
	I - NURSERY RECLASS				
1.00	NURSERY	43.00	1,440,139	216,160	1.00
	TOTALS		1,440,139	216,160	
	J - SMMP HOUSEKEEPING RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	17,755	1.00
2.00	OPERATION OF PLANT	7.00	0	1,822	2.00
3.00	HOUSEKEEPING	9.00	0	399	3.00
4.00	DIETARY	10.00	0	676	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	25,194	5.00
6.00	CT SCAN	57.00	0	1,758	6.00
7.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	1,981	7.00
8.00	LABORATORY	60.00	0	3,178	8.00
9.00	MGH FMC SOUTH	192.17	0	28,128	9.00
	TOTALS		0	80,891	
	K - LAUNDRY RECLASS				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	289,392	1.00
	TOTALS		0	289,392	
	L - PHYSICIAN MEDICAL DIRECTOR RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	238,971	0	1.00
	TOTALS		238,971	0	
	M - PHYSICIAN SALARY RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	2,656,868	0	1.00
2.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00	301,873	0	2.00
3.00	SUBPROVIDER - IRF	41.00	130,332	0	3.00
4.00	RESPIRATORY THERAPY	65.00	5,822	0	4.00
5.00	PHYSICAL THERAPY	66.00	1,912	0	5.00
6.00	CARDIAC REHAB	69.01	18,357	0	6.00
7.00	EMERGENCY	91.00	4,663,334	0	7.00
8.00	PACT REV PHYSICIANS	192.01	731,592	0	8.00
9.00	UROLOGY	192.06	655,739	0	9.00
10.00	LUNG CENTER	192.12	292,362	0	10.00
11.00	MGH EXPRESS	192.13	628,308	0	11.00
12.00	MGH MARION SURGEONS	192.15	1,430,277	0	12.00
13.00	MGH MGH MED ONC	192.16	1,421,409	0	13.00
14.00	MGH FMC SOUTH	192.17	629,986	0	14.00
15.00	MGH FAIRM MED ASSOC	192.18	199,218	0	15.00
16.00	MGH FMC MARION	192.19	213,774	0	16.00
17.00	MGH FMC NORTHWOOD	193.01	596,511	0	17.00
18.00	MGH FMC GAS CITY	193.02	360,262	0	18.00
19.00	MGH HOSPITALISTS	193.03	3,011,874	0	19.00
20.00	MGH MAR FAM PRACT	193.04	1,677,420	0	20.00
21.00	MGH FMC SWAYZEE	193.05	110,443	0	21.00
22.00	MGH PEDIATRIC CTR	193.06	526,564	0	22.00
23.00	MGH SPECIALTY PHYS	193.07	115,720	0	23.00
24.00	MGH FMC CONVERSE	193.08	134,991	0	24.00
25.00	OB/GYN	193.12	1,433,046	0	25.00
26.00	MGH WOUND CARE	193.18	25,882	0	26.00
27.00	HEART FAILURE CLINIC	194.00	38,289	0	27.00
28.00	MGH WORK SOLUTIONS	194.04	136,233	0	28.00
29.00	MGH MGH ORTHO	194.25	1,269,101	0	29.00
	TOTALS		23,417,499	0	
	N - LIABILITY INSURANCE RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	61,780	1.00
	TOTALS		0	61,780	
	O - MANAGEMENT BONUS RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	31,203	0	1.00
2.00	OPERATION OF PLANT	7.00	14,338	0	2.00
3.00	NURSING ADMINISTRATION	13.00	138,939	0	3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	3,607	0	4.00
5.00	PHARMACY	15.00	9,153	0	5.00
6.00	ADULTS & PEDIATRICS	30.00	9,852	0	6.00

RECLASSIFICATIONS

Provider CCN: 15-0011

Period:
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Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
7.00	INTENSIVE CARE UNIT	31.00	18,725	0	7.00
8.00	SUBPROVIDER - IRF	41.00	0	0	8.00
9.00	OPERATING ROOM	50.00	11,001	0	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	38,406	0	10.00
11.00	CARDIAC CATHETERIZATION	59.00	3,828	0	11.00
12.00	LABORATORY	60.00	19,084	0	12.00
13.00	ONCOLOGY	60.01	12,602	0	13.00
14.00	RESPIRATORY THERAPY	65.00	3,737	0	14.00
15.00	PHYSICAL THERAPY	66.00	15,558	0	15.00
16.00	EMERGENCY	91.00	29,083	0	16.00
17.00	AMBULANCE SERVICES	95.00	7,427	0	17.00
18.00	MGH EMERGENCY PHYSICIANS	192.11	10,000	0	18.00
19.00	MGH PHYS PRACT MGMT	192.14	22,949	0	19.00
20.00	MGH HOSPITALISTS	193.03	30,000	0	20.00
21.00	MGH MGH ORTHO	194.25	16,300	0	21.00
	TOTALS		445,792	0	
P - INTERNS & RESIDENTS RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	31,588	473,125	1.00
	TOTALS		31,588	473,125	
500.00	Grand Total: Increases		27,377,356	20,287,120	500.00

RECLASSIFICATIONS

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024Worksheet A-6
Date/Time Prepared:
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		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
A - SATELLITE OFFICE RECLASS							
1.00	LABORATORY	60.00	66,777	9,680	0		1.00
2.00		0.00	0	0	0		2.00
TOTALS			66,777	9,680			
B - CAFETERIA RECLASS							
1.00	DIETARY	10.00	0	2,049,613	0		1.00
2.00		0.00	0	0	0		2.00
TOTALS			0	2,049,613			
C - ADMIN DIRECTOR RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	16,316	0	0		1.00
2.00	NURSING ADMINISTRATION	13.00	537,403	0	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	45,033	0	0		3.00
4.00	EMERGENCY	91.00	77,133	0	0		4.00
5.00	MGH MGH ORTHO	194.25	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
TOTALS			675,885	0			
D - ADVERTISING RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	160,440	199,468	0		1.00
TOTALS			160,440	199,468			
E - LEASED PROPERTY RECLASS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,110,245	10		1.00
2.00	OWNED PROPERTIES	192.05	0	1,209,801	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
27.00		0.00	0	0	0		27.00
28.00		0.00	0	0	0		28.00
29.00		0.00	0	0	0		29.00
30.00		0.00	0	0	0		30.00
31.00		0.00	0	0	0		31.00
32.00		0.00	0	0	0		32.00
33.00		0.00	0	0	0		33.00
34.00		0.00	0	0	0		34.00
35.00		0.00	0	0	0		35.00
36.00		0.00	0	0	0		36.00
37.00		0.00	0	0	0		37.00
TOTALS			0	2,320,046			
F - PHARMACY RECLASS							
1.00	PHARMACY	15.00	0	13,640,409	0		1.00
TOTALS			0	13,640,409			
G - CT/MRI RECLASS							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	900,265	920,684	0		1.00
2.00		0.00	0	0	0		2.00
TOTALS			900,265	920,684			

RECLASSIFICATIONS

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024

Worksheet A-6

Date/Time Prepared:
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	Decreases						11/26/2024 3:43 pm
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	H - SHORT TERM DISABILITY RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	9,958	0	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	1,771	0	0		2.00
3.00	OPERATING ROOM	50.00	0	0	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	11,237	0	0		4.00
5.00	LABORATORY	60.00	2,906	0	0		5.00
6.00	ONCOLOGY	60.01	0	0	0		6.00
7.00	GREAT BEGINNINGS/MATERNAL	192.03	0	0	0		7.00
8.00	MGH PHYS PRACT MGMT	192.14	0	0	0		8.00
	TOTALS		25,872	0			
	I - NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	1,440,139	216,160	0		1.00
	TOTALS		1,440,139	216,160			
	J - SMMP HOUSEKEEPING RECLASS						
1.00	OWNED PROPERTIES	192.05	0	80,891	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
	TOTALS		0	80,891			
	K - LAUNDRY RECLASS						
1.00	HOUSEKEEPING	9.00	0	289,392	0		1.00
	TOTALS		0	289,392			
	L - PHYSICIAN MEDICAL DIRECTOR RECLASS						
1.00	PACT REV PHYSICIANS	192.01	238,971	0	0		1.00
	TOTALS		238,971	0			
	M - PHYSICIAN SALARY RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,656,868	0		1.00
2.00	I&R SERVICES-OTHER PRGM.	22.00	0	301,873	0		2.00
	COSTS APPRVD						
3.00	SUBPROVIDER - IRF	41.00	0	130,332	0		3.00
4.00	RESPIRATORY THERAPY	65.00	0	5,822	0		4.00
5.00	PHYSICAL THERAPY	66.00	0	1,912	0		5.00
6.00	CARDIAC REHAB	69.01	0	18,357	0		6.00
7.00	EMERGENCY	91.00	0	4,663,334	0		7.00
8.00	PACT REV PHYSICIANS	192.01	0	731,592	0		8.00
9.00	UROLOGY	192.06	0	655,739	0		9.00
10.00	LUNG CENTER	192.12	0	292,362	0		10.00
11.00	MGH EXPRESS	192.13	0	628,308	0		11.00
12.00	MGH MARION SURGEONS	192.15	0	1,430,277	0		12.00
13.00	MGH MGH MED ONC	192.16	0	1,421,409	0		13.00
14.00	MGH FMC SOUTH	192.17	0	629,986	0		14.00
15.00	MGH FAIRM MED ASSOC	192.18	0	199,218	0		15.00
16.00	MGH FMC MARION	192.19	0	213,774	0		16.00
17.00	MGH FMC NORTHWOOD	193.01	0	596,511	0		17.00
18.00	MGH FMC GAS CITY	193.02	0	360,262	0		18.00
19.00	MGH HOSPITALISTS	193.03	0	3,011,874	0		19.00
20.00	MGH MAR FAM PRACT	193.04	0	1,677,420	0		20.00
21.00	MGH FMC SWAYZEE	193.05	0	110,443	0		21.00
22.00	MGH PEDIATRIC CTR	193.06	0	526,564	0		22.00
23.00	MGH SPECIALTY PHYS	193.07	0	115,720	0		23.00
24.00	MGH FMC CONVERSE	193.08	0	134,991	0		24.00
25.00	OB/GYN	193.12	0	1,433,046	0		25.00
26.00	MGH WOUND CARE	193.18	0	25,882	0		26.00
27.00	HEART FAILURE CLINIC	194.00	0	38,289	0		27.00
28.00	MGH WORK SOLUTIONS	194.04	0	136,233	0		28.00
29.00	MGH MGH ORTHO	194.25	0	1,269,101	0		29.00
	TOTALS		0	23,417,499			
	N - LIABILITY INSURANCE RECLASS						
1.00	MGH MGH ORTHO	194.25	0	61,780	0		1.00
	TOTALS		0	61,780			
	O - MANAGEMENT BONUS RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	445,792	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00

RECLASSIFICATIONS

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024

Worksheet A-6

Date/Time Prepared:
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Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
11.00		0.00	0	0	0	11.00
12.00		0.00	0	0	0	12.00
13.00		0.00	0	0	0	13.00
14.00		0.00	0	0	0	14.00
15.00		0.00	0	0	0	15.00
16.00		0.00	0	0	0	16.00
17.00		0.00	0	0	0	17.00
18.00		0.00	0	0	0	18.00
19.00		0.00	0	0	0	19.00
20.00		0.00	0	0	0	20.00
21.00		0.00	0	0	0	21.00
TOTALS			445,792	0		
P - INTERNS & RESIDENTS RECLASS						
1.00	I&R SERVICES-OTHER PRGM.	22.00	31,588	473,125	0	1.00
	COSTS APPRVD					
	TOTALS		31,588	473,125		
500.00	Grand Total: Decreases		3,985,729	43,678,747		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024Worksheet A-7
Part I
Date/Time Prepared:
11/26/2024 3:43 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	12,819,426	0	0	0	0	1.00	
2.00	Land Improvements	3,369,169	44,219	0	44,219	0	2.00	
3.00	Buildings and Fixtures	155,179,213	2,538,611	0	2,538,611	0	3.00	
4.00	Building Improvements	1,004,506	0	0	0	0	4.00	
5.00	Fixed Equipment	3,509,531	0	0	0	0	5.00	
6.00	Movable Equipment	154,850,034	11,956,911	0	11,956,911	2,153,474	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	330,731,879	14,539,741	0	14,539,741	2,153,474	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	330,731,879	14,539,741	0	14,539,741	2,153,474	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	12,819,426	0				1.00	
2.00	Land Improvements	3,413,388	0				2.00	
3.00	Buildings and Fixtures	157,717,824	0				3.00	
4.00	Building Improvements	1,004,506	0				4.00	
5.00	Fixed Equipment	3,509,531	0				5.00	
6.00	Movable Equipment	164,653,471	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	343,118,146	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	343,118,146	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS	Provider CCN: 15-0011	Period: From 07/01/2023 To 06/30/2024	Worksheet A-7 Part II Date/Time Prepared: 11/26/2024 3:43 pm
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Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	12,359,989	0	0	0	0	1.00
3.00	Total (sum of lines 1-2)	12,359,989	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	12,359,989				1.00
3.00	Total (sum of lines 1-2)	0	12,359,989				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024Worksheet A-7
Part III
Date/Time Prepared:
11/26/2024 3:43 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	NEW CAP REL COSTS-BLDG & FIXT	343,118,146	0	343,118,146	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	343,118,146	0	343,118,146	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	12,359,989	-1,110,245	1.00
3.00	Total (sum of lines 1-2)	0	0	0	12,359,989	-1,110,245	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	NEW CAP REL COSTS-BLDG & FIXT	-705,920	0	0	0	10,543,824	1.00
3.00	Total (sum of lines 1-2)	-705,920	0	0	0	10,543,824	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024

Worksheet A-8

Date/Time Prepared:
11/26/2024 3:43 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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0 NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0 *** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)			0	0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)			0	0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)			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	-9,617,954			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)			0	0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1		0		0	12.00
13.00	Laundry and linen service			0	0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-1,487	CAFETERIA	6.01	0	14.00
15.00	Rental of quarters to employee and others			0	0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients			0	0.00	0	16.00
17.00	Sale of drugs to other than patients			0	0.00	0	17.00
18.00	Sale of medical records and abstracts			0	0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)			0	0.00	0	19.00
20.00	Vending machines			0	0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)			0	0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0	0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0 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 - NEW CAP REL COSTS-BLDG & FIXT			0 NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0 *** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist			0 *** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant			0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0 *** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0 ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0 *** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0	0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024

Worksheet A-8

Date/Time Prepared:
11/26/2024 3:43 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #	Wkst. A-7 Ref.	
				Cost Center				
		1.00	2.00	3.00		4.00	5.00	
33.00	FINANCE BANK SERVICE CHARGES	A	-270,868	ADMINISTRATIVE & GENERAL		5.00		0 33.00
33.01	FINANCE DISCOUNT PAYMENTS	A	72,314	ADMINISTRATIVE & GENERAL		5.00		0 33.01
33.02	GAIN ON DISPOSAL	A	268,432	ADMINISTRATIVE & GENERAL		5.00		0 33.02
33.03	XIX ASSESSMENT FEE A/C	A	-16,221,785	ADMINISTRATIVE & GENERAL		5.00		0 33.03
33.04	SELF INSURANCE EXPENSE	A	-3,239,581	EMPLOYEE BENEFITS DEPARTMENT		4.00		0 33.04
33.05	DEPOSITION-OTHER	B		ADMINISTRATIVE & GENERAL		5.00		0 33.05
33.06	RETURNED CHECK FEE	B	-660	ADMINISTRATIVE & GENERAL		5.00		0 33.06
33.07	PHYSICIAN PRIV APPLICATION	B	-3,550	ADMINISTRATIVE & GENERAL		5.00		0 33.07
33.08	SALE OF MEDICAL RECORDS & ABSTRACTS	B	-90,644	ADMINISTRATIVE & GENERAL		5.00		0 33.08
33.09	CHILD SEAT SAFETY INSPECTION	B	-290	ADMINISTRATIVE & GENERAL		5.00		0 33.09
33.10	HEALTH SCREENING FEES - LAB	B	-14,559	LABORATORY		60.00		0 33.10
33.11	HEALTH SCREENING FEES - RAD	B	-28,147	RADIOLOGY-DIAGNOSTIC		54.00		0 33.11
33.12	MED STAFF OTHER SCREENING - MED STAF	B	684	ADMINISTRATIVE & GENERAL		5.00		0 33.12
33.13	HEALTH SCREENS	B	-15,000	LABORATORY		60.00		0 33.13
33.14	HEALTH SCREENS	B	1,360	LABORATORY		60.00		0 33.14
33.15	REBATE	B	-89,846	ADMINISTRATIVE & GENERAL		5.00		0 33.15
33.16	REBATE	B	-74,250	ADMINISTRATIVE & GENERAL		5.00		0 33.16
33.17	RENTAL OF PROVIDER SPACE BY SUPPLIER	B	-1,440	ADMINISTRATIVE & GENERAL		5.00		0 33.17
33.18	RENT SPACE UPLAND	B	0	LABORATORY		60.00		0 33.18
33.19	PAGER RENTAL	B	-770	ADMINISTRATIVE & GENERAL		5.00		0 33.19
33.20	SALE OF SCRAP, WASTE, ETC.	B	-1,254	ADMINISTRATIVE & GENERAL		5.00		0 33.20
33.21	PCC MARKETING AG	B	0	ADMINISTRATIVE & GENERAL		5.00		0 33.21
33.22	EDUCATIONAL WORKSHOP	B	-78	ADMINISTRATIVE & GENERAL		5.00		0 33.22
33.23	OPT HEALTH LINEN SEV	B	-2,395	LAUNDRY & LINEN SERVICE		8.00		0 33.23
33.24	AMBULANCE SVC - ASSISTS	B	-54,125	AMBULANCE SERVICES		95.00		0 33.24
33.25	AMBULANCE SVC - CORONER SVC	B	0	AMBULANCE SERVICES		95.00		0 33.25
33.26	AMBULANCE SVC - LINEN SERVICES	B	-5,804	AMBULANCE SERVICES		95.00		0 33.26
33.27	AMBULANCE SVC - COMMUNITY	B	-4,832	AMBULANCE SERVICES		95.00		0 33.27
33.28	CONTRACT ARU OTH ARU MEDICAL DIRECTO	B	-72,441	SUBPROVIDER - IRF		41.00		0 33.28
33.29	MGH UNCLAIMED OTH 125 MED/CHILD	B	-12,643	ADMINISTRATIVE & GENERAL		5.00		0 33.29
33.30	SCHOOL PHYS OTHER SCHOOL PHYS	B	-11,340	ADMINISTRATIVE & GENERAL		5.00		0 33.30
33.31	PHLEBOTOMY	B	-10,920	LABORATORY		60.00		0 33.31
33.32	CPR TRAIN OTH AHA COMMUNITY	B	-7,918	ADMINISTRATIVE & GENERAL		5.00		0 33.32
33.33	CLINICAL STUDY - OTHER	B	0	ONCOLOGY		60.01		0 33.33
33.34	SICK CHILD CARE PROGRAM	B	-828	ADULTS & PEDIATRICS		30.00		0 33.34
33.35	ONC. QUAL	B	0	ADMINISTRATIVE & GENERAL		5.00		0 33.35
33.36	SETTLEMENTS	B	0	ADMINISTRATIVE & GENERAL		5.00		0 33.36
33.37	UNCLAIMED OTHER MONIES RECOVERED	B	-84,696	ADMINISTRATIVE & GENERAL		5.00		0 33.37
33.38	VENDING MACHINES	B	-2,969	CAFETERIA		6.01		0 33.38
33.39	MISCELLANEOUS OTHER REVENUE	B	-867	ADMINISTRATIVE & GENERAL		5.00		0 33.39
33.40	COVID OTHER REVENUE	B	-614	ADMINISTRATIVE & GENERAL		5.00		0 33.40
33.41	DIABETES OTHER REVENUE	B	0	LABORATORY		60.00		0 33.41
33.42	RENT BILLB OTHER REVENUE	B	-9,184	ADMINISTRATIVE & GENERAL		5.00		0 33.42
33.43	STAT RADIOLOGY OTHER REVENUE	B	-2,250	RADIOLOGY-DIAGNOSTIC		54.00		0 33.43
33.44	HEALTH SCREENINGS - FLU SHOT	B	0	LABORATORY		60.00		0 33.44
33.45	MISC REV	B	-867	ADMINISTRATIVE & GENERAL		5.00		0 33.45
33.46	TELEVISION AND RADIO SERVICE	A	-31,282	OPERATION OF PLANT		7.00		0 33.46
33.47	TELEPHONE SERVICES	A	-137,582	OPERATION OF PLANT		7.00		0 33.47
33.48	OPERATING INTEREST INCOME	B	-705,920	NEW CAP REL COSTS-BLDG & FIXT		1.00	11	33.48
33.49	LOBBYING COSTS	A	-23	EMPLOYEE BENEFITS DEPARTMENT		4.00		0 33.49
33.50	LOBBYING COSTS	A	-36,227	ADMINISTRATIVE & GENERAL		5.00		0 33.50
33.51	LOBBYING COSTS	A	-93	OPERATION OF PLANT		7.00		0 33.51
33.52	LOBBYING COSTS	A	-1	HOUSEKEEPING		9.00		0 33.52
33.53	LOBBYING COSTS	A	-11	DIETARY		10.00		0 33.53
33.54	LOBBYING COSTS	A	-299	PHARMACY		15.00		0 33.54
33.55	LOBBYING COSTS	A	-12	ADULTS & PEDIATRICS		30.00		0 33.55
33.56	LOBBYING COSTS	A	-1	INTENSIVE CARE UNIT		31.00		0 33.56
33.57	LOBBYING COSTS	A	-14	RADIOLOGY-DIAGNOSTIC		54.00		0 33.57
33.58	LOBBYING COSTS	A	-7	CARDIAC CATHETERIZATION		59.00		0 33.58
33.59	LOBBYING COSTS	A	-373	LABORATORY		60.00		0 33.59
33.60	LOBBYING COSTS	A	-178	ONCOLOGY		60.01		0 33.60
33.61	LOBBYING COSTS	A	-5	RESPIRATORY THERAPY		65.00		0 33.61

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024

Worksheet A-8

Date/Time Prepared:
11/26/2024 3:43 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #	Wkst. A-7 Ref.
				Cost Center			
		1.00	2.00	3.00		4.00	5.00
33.62	LOBBYING COSTS	A	-20	PHYSICAL THERAPY		66.00	0 33.62
33.63	LOBBYING COSTS	A	-12	ELECTROCARDIOLOGY		69.00	0 33.63
33.64	LOBBYING COSTS	A	-1	CARDIAC REHAB		69.01	0 33.64
33.65	LOBBYING COSTS	A	-23	CLINIC		90.00	0 33.65
33.66	LOBBYING COSTS	A	6	EMERGENCY		91.00	0 33.66
33.67	LOBBYING COSTS	A	-5	AMBULANCE SERVICES		95.00	0 33.67
33.68	ELIMINATING ENTRIES	A	-78,442	MGH PHYS PRACT MGMT		192.14	0 33.68
33.69	ELIMINATING ENTRIES	A	-61,194	LUNG CENTER		192.12	0 33.69
33.70	ELIMINATING ENTRIES	A	-145,746	MGH MARION SURGEONS		192.15	0 33.70
33.71	ELIMINATING ENTRIES	A	-409,752	MGH FMC SOUTH		192.17	0 33.71
33.72	ELIMINATING ENTRIES	A	-32,880	MGH FAIRM MED ASSOC		192.18	0 33.72
33.73	ELIMINATING ENTRIES	A	-131,622	MGH FMC MARION		192.19	0 33.73
33.74	ELIMINATING ENTRIES	A	-175,655	MGH FMC GAS CITY		193.02	0 33.74
33.75	ELIMINATING ENTRIES	A	-27,450	MGH FMC SWAYZEE		193.05	0 33.75
33.76	ELIMINATING ENTRIES	A	-83,623	MGH PEDIATRIC CTR		193.06	0 33.76
33.77	ELIMINATING ENTRIES	A	-77,529	UROLOGY		192.06	0 33.77
33.78	ELIMINATING ENTRIES	A	-23,483	MGH SPECIALTY PHYS		193.07	0 33.78
33.79	ELIMINATING ENTRIES	A	-58,818	MGH FMC NORTHWOOD		193.01	0 33.79
33.80	ELIMINATING ENTRIES	A	-226,204	MGH MAR FAM PRACT		193.04	0 33.80
33.81	ELIMINATING ENTRIES	A	-198,349	OB/GYN		193.12	0 33.81
33.82	ELIMINATING ENTRIES	A	-79,631	MGH WORK SOLUTIONS		194.04	0 33.82
33.83	ELIMINATING ENTRIES	A	-55,276	MGH EXPRESS		192.13	0 33.83
33.84	PHYSICIAN RECRUITMENT	A	-797,624	ADMINISTRATIVE & GENERAL		5.00	0 33.84
33.85	ENTERTAINMENT EXP	A	-147	ADMINISTRATIVE & GENERAL		5.00	0 33.85
33.86	EMPLOYEE USE OF AUTO	A	-2,117	ADMINISTRATIVE & GENERAL		5.00	0 33.86
33.87	DONATIONS	A	-144,660	ADMINISTRATIVE & GENERAL		5.00	0 33.87
33.88	VHA OPPORTUNITY	A	-34	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.88
33.89	VHA OPPORTUNITY	A	-7,102	ADMINISTRATIVE & GENERAL		5.00	0 33.89
33.90	VHA OPPORTUNITY	A	-166	OPERATION OF PLANT		7.00	0 33.90
33.91	VHA OPPORTUNITY	A	-221	HOUSEKEEPING		9.00	0 33.91
33.92	VHA OPPORTUNITY	A	-269	DIETARY		10.00	0 33.92
33.93	VHA OPPORTUNITY	A	1	NURSING ADMINISTRATION		13.00	0 33.93
33.94	VHA OPPORTUNITY	A	-1,249	CENTRAL SERVICES & SUPPLY		14.00	0 33.94
33.95	VHA OPPORTUNITY	A	-37,267	PHARMACY		15.00	0 33.95
33.96	VHA OPPORTUNITY	A	-12,884	ADULTS & PEDIATRICS		30.00	0 33.96
33.97	VHA OPPORTUNITY	A	-4,236	INTENSIVE CARE UNIT		31.00	0 33.97
33.98	VHA OPPORTUNITY	A	-485	SUBPROVIDER - IRF		41.00	0 33.98
33.99	VHA OPPORTUNITY	A	-64,751	OPERATING ROOM		50.00	0 33.99
34.00	VHA OPPORTUNITY	A	-22,459	RADIOLOGY-DIAGNOSTIC		54.00	0 34.00
34.01	VHA OPPORTUNITY	A	-96,643	CARDIAC CATHETERIZATION		59.00	0 34.01
34.02	VHA OPPORTUNITY	A	-76,892	LABORATORY		60.00	0 34.02
34.03	VHA OPPORTUNITY	A	-2,395	ONCOLOGY		60.01	0 34.03
34.04	VHA OPPORTUNITY	A	-5,408	RESPIRATORY THERAPY		65.00	0 34.04
34.05	VHA OPPORTUNITY	A	-403	PHYSICAL THERAPY		66.00	0 34.05
34.06	VHA OPPORTUNITY	A	493	ELECTROCARDIOLOGY		69.00	0 34.06
34.07	VHA OPPORTUNITY	A	-127	CARDIAC REHAB		69.01	0 34.07
34.08	VHA OPPORTUNITY	A	-3,033	CLINIC		90.00	0 34.08
34.09	VHA OPPORTUNITY	A	-10,598	EMERGENCY		91.00	0 34.09
34.10	VHA OPPORTUNITY	A	-1,547	AMBULANCE SERVICES		95.00	0 34.10
34.11	ED ON CALL SVC A/C 7000.2512	A	-1,875,970	ADMINISTRATIVE & GENERAL		5.00	0 34.11
34.12	MID LEVEL PROV COMMIT BONUS	A	-18,200	ADMINISTRATIVE & GENERAL		5.00	0 34.12
34.13	RENT LAND OTHER-FARM LAND	B		ADMINISTRATIVE & GENERAL		5.00	0 34.13
34.14	ELIMINATING ENTRIES	A	-19,798	PACT REV PHYSICIANS		192.01	0 34.14
34.15	INTERNS & RESIDENTS COST	A	-504,713	ADMINISTRATIVE & GENERAL		5.00	0 34.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-36,102,707				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024

Worksheet A-8-2

Date/Time Prepared:
11/26/2024 3:43 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	41.00	SUBPROVIDER - IRF	75,025	75,025	0	0	0	1.00
2.00	50.00	OPERATING ROOM	2,773,308	2,773,308	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	1,310,439	1,310,439	0	0	0	3.00
4.00	59.00	CARDIAC CATHETERIZATION	24,697	24,697	0	0	0	4.00
5.00	60.00	LABORATORY	8,200	8,200	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	53,802	53,802	0	0	0	6.00
7.00	91.00	EMERGENCY	5,372,483	5,372,483	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			9,617,954	9,617,954	0	0	0	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	41.00	SUBPROVIDER - IRF	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	41.00	SUBPROVIDER - IRF	0	0	0	75,025		1.00
2.00	50.00	OPERATING ROOM	0	0	0	2,773,308		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,310,439		3.00
4.00	59.00	CARDIAC CATHETERIZATION	0	0	0	24,697		4.00
5.00	60.00	LABORATORY	0	0	0	8,200		5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	53,802		6.00
7.00	91.00	EMERGENCY	0	0	0	5,372,483		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	9,617,954		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	
			NEW BLDG & FIXT				
		0	1.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	10,543,824	10,543,824			1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	18,634,378	255,815	18,890,193		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	24,880,998	3,319,244	3,065,603	31,265,845	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
6.01	00601	CAFETERIA	1,959,411	113,408	0	403,376	6.01
6.02	00602	CAFETERIA	0	0	0	0	6.02
7.00	00700	OPERATION OF PLANT	7,188,033	2,109,867	245,909	1,964,597	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	286,997	49,337	0	58,675	8.00
9.00	00900	HOUSEKEEPING	3,150,430	76,119	0	674,802	9.00
10.00	01000	DIETARY	588,393	156,254	5,149	177,701	10.00
13.00	01300	NURSING ADMINISTRATION	1,112,985	16,251	235,601	280,831	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	531,534	55,641	37,662	128,610	14.00
15.00	01500	PHARMACY	3,901,910	71,682	557,984	932,622	15.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,358,926	992,322	1,390,284	2,004,607	30.00
31.00	03100	INTENSIVE CARE UNIT	4,175,223	255,068	530,299	1,020,895	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	2,078,070	223,803	219,518	518,935	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	1,656,299	0	329,940	408,699	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,989,406	804,454	833,168	2,187,239	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,686,865	483,004	661,123	1,200,002	54.00
57.00	05700	CT SCAN	1,226,029	35,141	136,941	287,740	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	631,133	41,655	69,313	152,731	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,551,062	117,681	204,279	591,334	59.00
60.00	06000	LABORATORY	9,332,767	330,509	649,990	2,122,757	60.00
60.01	06001	ONCOLOGY	1,827,946	0	270,287	431,791	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	60.02
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	3,733,198	156,487	413,664	885,662	65.00
66.00	06600	PHYSICAL THERAPY	2,709,953	163,375	449,461	683,777	66.00
69.00	06900	ELECTROCARDIOLOGY	1,147,709	185,720	218,913	319,442	69.00
69.01	06901	CARDIAC REHAB	261,639	30,261	49,767	70,307	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,640,409	0	0	2,808,042	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,047,699	114,295	77,161	255,053	90.00
91.00	09100	EMERGENCY	7,210,680	258,500	2,383,620	2,026,911	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,792,287	96,900	369,876	464,840	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	148,836,193	10,512,793	13,405,512	23,061,978	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	23,565	31,031	3,738	12,007	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	PACT REV PHYSICIANS	848,149	0	146,247	204,624	192.01
192.02	19202	VISITOR MEALS	0	0	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	0	0	192.03
192.04	19204	LIFELINE	0	0	0	0	192.04
192.05	19205	OWNED PROPERTIES	1,166,385	0	0	240,119	192.05
192.06	19206	UROLOGY	1,410,802	0	231,636	337,982	192.06
192.07	19207	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.07
192.08	19211	PARISH NURSING	45,882	0	7,168	10,917	192.08
192.09	19212	BIOTERRORISM GRANT	0	0	0	0	192.09
192.10	19214	BREAST PUMPS	0	0	0	0	192.10
192.11	19208	MGH EMERGENCY PHYSICIANS	10,000	0	2,291	2,529	192.11
192.12	19209	LUNG CENTER	477,484	0	89,285	116,624	192.12
192.13	19213	MGH EXPRESS	1,926,926	0	305,880	459,473	192.13

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	
				NEW BLDG & FIXT				
			0	1.00	4.00	5.00	6.00	
192.14	19210	MGH PHYS PRACT MGMT	2,753,654	0	388,456	646,618	0	192.14
192.15	19215	MGH MARION SURGEONS	2,237,552	0	424,065	547,679	0	192.15
192.16	19216	MGH MGH MED ONC	1,678,856	0	325,649	412,462	0	192.16
192.17	19217	MGH FMC SOUTH	1,845,880	0	286,322	438,774	0	192.17
192.18	19218	MGH FAIRM MED ASSOC	514,904	0	91,361	124,754	0	192.18
192.19	19219	MGH FMC MARION	652,232	0	109,699	156,789	0	192.19
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	1,280,773	0	222,134	309,263	0	193.01
193.02	19302	MGH FMC GAS CITY	1,088,576	0	155,172	255,951	0	193.02
193.03	19303	MGH HOSPITALISTS	3,614,779	0	697,776	887,385	0	193.03
193.04	19304	MGH MAR FAM PRACT	3,749,671	0	642,662	903,842	0	193.04
193.05	19305	MGH FMC SWAYZEE	253,711	0	44,450	61,354	0	193.05
193.06	19306	MGH PEDIATRIC CTR	1,138,275	0	184,701	272,244	0	193.06
193.07	19307	MGH SPECIALTY PHYS	209,625	0	37,080	50,766	0	193.07
193.08	19308	MGH FMC CONVERSE	390,031	0	60,415	92,695	0	193.08
193.09	19309	MGH UPLAND HEALTH	0	0	0	0	0	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	0	193.11
193.12	19312	OB/GYN	2,697,878	0	448,186	647,396	0	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
193.16	19316	MGH NEONATOLOGY	890,400	0	0	183,303	0	193.16
193.18	19318	MGH WOUND CARE	30,546	0	5,930	7,505	0	193.18
194.00	07963	HEART FAILURE CLINIC	60,053	0	8,772	14,163	0	194.00
194.01	07950	MOW	0	0	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	0	0	0	194.02
194.03	07952	ADVERTISING	359,908	0	36,757	81,638	0	194.03
194.04	07953	MGH WORK SOLUTIONS	762,900	0	109,897	179,613	0	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	0	0	194.05
194.06	07955	OPIOID IMPL GRANT	3,956	0	0	814	0	194.06
194.07	07956	ASTHMA GRANT	0	0	0	0	0	194.07
194.08	07957	MGH SMMP BLDG	0	0	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	0	0	194.10
194.11	07960	FAIRMOUNT	0	0	0	0	0	194.11
194.12	07961	GAS CITY	0	0	0	0	0	194.12
194.13	07969	LYONS	0	0	0	0	0	194.13
194.14	07964	WABASH	0	0	0	0	0	194.14
194.15	07965	TOBACCO GRANT	15,866	0	15,724	23,500	0	194.15
194.16	07966	HRSA NETWORK DEV PLANNING	0	0	0	0	0	194.16
194.17	07967	HRSA OPIOID PLANNING	0	0	0	0	0	194.17
194.18	07962	ECHO GRANT	0	0	0	0	0	194.18
194.19	07968	RURAL QI GRANT	61,782	0	1,875	13,104	0	194.19
194.20	07970	MGH DIABETES GRANT	0	0	0	0	0	194.20
194.21	07971	MGH MGH ORTHO	0	0	0	0	0	194.21
194.22	07972	MGH BELLA BLDG	0	0	0	0	0	194.22
194.23	07973	DIABETES GRANT	0	0	0	0	0	194.23
194.24	07974	HEALTH SYS GRANT	0	0	0	0	0	194.24
194.25	07975	MGH MGH ORTHO	2,063,567	0	401,353	507,200	0	194.25
194.26	07976	FIMR GRANT - 8841	17,166	0	0	780	0	194.26
194.27	07978	OTHER NONREIMURSABLE COST CENTERS	0	0	0	0	0	194.27
194.28	07977	MGH HEALTH ISS GNT	82,608	0	0	0	0	194.28
194.29	07980	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.29
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	183,200,535	10,543,824	18,890,193	31,265,845	0	202.00

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Cost Center Description		CAFETERIA	CAFETERIA	OPERATION OF	LAUNDRY &	HOUSEKEEPING	
		6.01	6.02	PLANT	LINEN SERVICE	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
6.01	00601	CAFETERIA	2,476,195				6.01
6.02	00602	CAFETERIA	2,439,020	2,439,020			6.02
7.00	00700	OPERATION OF PLANT	0	91,302	11,599,708		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	120,598	515,607	8.00
9.00	00900	HOUSEKEEPING	0	0	186,062	0	9.00
10.00	01000	DIETARY	0	657	381,941	54,578	10.00
13.00	01300	NURSING ADMINISTRATION	0	35,795	39,724	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	16,596	136,008	7	14.00
15.00	01500	PHARMACY	0	120,019	175,218	0	15.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	306,341	2,425,598	98,032	30.00
31.00	03100	INTENSIVE CARE UNIT	0	110,868	623,479	25,839	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	48,616	547,056	8,757	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	0	69,004	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	213,961	1,966,378	46,645	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	166,725	1,180,637	35,295	54.00
57.00	05700	CT SCAN	0	35,903	85,897	16,671	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	18,171	101,820	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	48,794	287,654	6,542	59.00
60.00	06000	LABORATORY	0	205,845	807,886	153	60.00
60.01	06001	ONCOLOGY	0	0	0	1,437	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	60.02
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	66,977	382,511	4,240	65.00
66.00	06600	PHYSICAL THERAPY	0	50,998	399,348	10,183	66.00
69.00	06900	ELECTROCARDIOLOGY	0	71,884	453,968	4,247	69.00
69.01	06901	CARDIAC REHAB	0	11,713	73,968	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	22,969	279,378	1,994	90.00
91.00	09100	EMERGENCY	0	300,331	631,869	184,975	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	121,945	236,858	14,305	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,439,020	2,135,414	11,523,856	513,900	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,740	75,852	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	PACT REV PHYSICIANS	0	7,122	0	0	192.01
192.02	19202	VISITOR MEALS	37,175	0	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	0	0	192.03
192.04	19204	LIFELINE	0	0	0	0	192.04
192.05	19205	OWNED PROPERTIES	0	0	0	0	192.05
192.06	19206	UROLOGY	0	32,622	0	0	192.06
192.07	19207	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.07
192.08	19211	PARISH NURSING	0	1,772	0	0	192.08
192.09	19212	BIOTERRORISM GRANT	0	0	0	0	192.09
192.10	19214	BREAST PUMPS	0	0	0	0	192.10
192.11	19208	MGH EMERGENCY PHYSICIANS	0	0	0	0	192.11
192.12	19209	LUNG CENTER	0	9,393	0	0	192.12
192.13	19213	MGH EXPRESS	0	0	0	821	192.13
192.14	19210	MGH PHYS PRACT MGMT	0	139,746	0	0	192.14
192.15	19215	MGH MARION SURGEONS	0	36,267	0	66	192.15
192.16	19216	MGH MGH MED ONC	0	0	0	0	192.16
192.17	19217	MGH FMC SOUTH	0	0	0	0	192.17
192.18	19218	MGH FAIRM MED ASSOC	0	0	0	31	192.18

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Cost Center Description			CAFETERIA	CAFETERIA	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			6.01	6.02	7.00	8.00	9.00	
192.19	19219	MGH FMC MARION	0	25,716	0	0	0	192.19
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	0	0	0	0	0	193.01
193.02	19302	MGH FMC GAS CITY	0	0	0	141	0	193.02
193.03	19303	MGH HOSPITALISTS	0	0	0	0	0	193.03
193.04	19304	MGH MAR FAM PRACT	0	0	0	430	0	193.04
193.05	19305	MGH FMC SWAYZEE	0	0	0	0	0	193.05
193.06	19306	MGH PEDIATRIC CTR	0	28,637	0	24	0	193.06
193.07	19307	MGH SPECIALTY PHYS	0	5,327	0	0	0	193.07
193.08	19308	MGH FMC CONVERSE	0	0	0	69	0	193.08
193.09	19309	MGH UPLAND HEALTH	0	0	0	85	0	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	0	193.11
193.12	19312	OB/GYN	0	0	0	30	0	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
193.16	19316	MGH NEONATOLOGY	0	0	0	0	0	193.16
193.18	19318	MGH WOUND CARE	0	0	0	0	0	193.18
194.00	07963	HEART FAILURE CLINIC	0	0	0	0	0	194.00
194.01	07950	MOW	0	0	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	0	0	0	194.02
194.03	07952	ADVERTISING	0	10,067	0	0	0	194.03
194.04	07953	MGH WORK SOLUTIONS	0	0	0	10	0	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	0	0	194.05
194.06	07955	OPIOID IMPL GRANT	0	0	0	0	0	194.06
194.07	07956	ASTHMA GRANT	0	0	0	0	0	194.07
194.08	07957	MGH SMMP BLDG	0	0	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	0	0	194.10
194.11	07960	FAIRMOUNT	0	0	0	0	0	194.11
194.12	07961	GAS CITY	0	0	0	0	0	194.12
194.13	07969	LYONS	0	0	0	0	0	194.13
194.14	07964	WABASH	0	0	0	0	0	194.14
194.15	07965	TOBACCO GRANT	0	29	0	0	0	194.15
194.16	07966	HRSA NETWORK DEV PLANNING	0	0	0	0	0	194.16
194.17	07967	HRSA OPIOID PLANNING	0	0	0	0	0	194.17
194.18	07962	ECHO GRANT	0	0	0	0	0	194.18
194.19	07968	RURAL QI GRANT	0	550	0	0	0	194.19
194.20	07970	MGH DIABETES GRANT	0	0	0	0	0	194.20
194.21	07971	MGH MGH ORTHO	0	0	0	0	0	194.21
194.22	07972	MGH BELLA BLDG	0	0	0	0	0	194.22
194.23	07973	DIABETES GRANT	0	0	0	0	0	194.23
194.24	07974	HEALTH SYS GRANT	0	0	0	0	0	194.24
194.25	07975	MGH MGH ORTHO	0	0	0	0	0	194.25
194.26	07976	FIMR GRANT - 8841	0	774	0	0	0	194.26
194.27	07978	OTHER NONREIMURSABLE COST CENTERS	0	0	0	0	0	194.27
194.28	07977	MGH HEALTH ISS GNT	0	3,844	0	0	0	194.28
194.29	07980	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.29
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)	2,476,195	2,439,020	11,599,708	515,607	4,087,413	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024Worksheet B
Part I
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Cost Center Description			DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS	
			10.00	13.00	14.00	15.00	22.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
6.01	00601	CAFETERIA						6.01
6.02	00602	CAFETERIA						6.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,424,180					10.00
13.00	01300	NURSING ADMINISTRATION	0	1,743,502				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	18,041	1,035,675			14.00
15.00	01500	PHARMACY	0	0	0	5,811,504		15.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	655,336	333,002	134,638	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	235,848	120,517	41,427	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	119,299	52,847	10,357	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	75,009	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	232,581	227,844	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	20,714	0	0	54.00
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	53,040	103,568	0	0	59.00
60.00	06000	LABORATORY	0	0	10,357	0	0	60.00
60.01	06001	ONCOLOGY	0	84,840	10,357	0	0	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	83,374	10,357	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	55,436	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	78,140	31,070	0	0	69.00
69.01	06901	CARDIAC REHAB	0	12,732	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,811,504	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	24,968	0	0	0	90.00
91.00	09100	EMERGENCY	58,476	326,468	51,784	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	132,558	10,357	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,068,959	1,683,553	662,830	5,811,504	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PACT REV PHYSICIANS	0	0	0	0	0	192.01
192.02	19202	VISITOR MEALS	0	0	0	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	0	0	0	192.03
192.04	19204	LIFELINE	0	0	0	0	0	192.04
192.05	19205	OWNED PROPERTIES	0	0	0	0	0	192.05
192.06	19206	UROLOGY	0	0	31,070	0	0	192.06
192.07	19207	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.07
192.08	19211	PARISH NURSING	0	0	0	0	0	192.08
192.09	19212	BIOTERRORISM GRANT	0	0	0	0	0	192.09
192.10	19214	BREAST PUMPS	0	0	0	0	0	192.10
192.11	19208	MGH EMERGENCY PHYSICIANS	0	0	0	0	0	192.11
192.12	19209	LUNG CENTER	0	0	0	0	0	192.12
192.13	19213	MGH EXPRESS	0	59,949	10,357	0	0	192.13
192.14	19210	MGH PHYS PRACT MGMT	0	0	0	0	0	192.14
192.15	19215	MGH MARION SURGEONS	0	0	31,070	0	0	192.15

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
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Cost Center Description			DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS	
			10.00	13.00	14.00	15.00	22.00	
192.16	19216	MGH MGH MED ONC	0	0	0	0	0	192.16
192.17	19217	MGH FMC SOUTH	0	0	31,070	0	0	192.17
192.18	19218	MGH FAIRM MED ASSOC	0	0	0	0	0	192.18
192.19	19219	MGH FMC MARION	0	0	31,070	0	0	192.19
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	0	0	10,357	0	0	193.01
193.02	19302	MGH FMC GAS CITY	0	0	10,357	0	0	193.02
193.03	19303	MGH HOSPITALISTS	0	0	0	0	0	193.03
193.04	19304	MGH MAR FAM PRACT	0	0	41,427	0	0	193.04
193.05	19305	MGH FMC SWAYZEE	0	0	10,357	0	0	193.05
193.06	19306	MGH PEDIATRIC CTR	0	0	10,357	0	0	193.06
193.07	19307	MGH SPECIALTY PHYS	0	0	0	0	0	193.07
193.08	19308	MGH FMC CONVERSE	0	0	10,357	0	0	193.08
193.09	19309	MGH UPLAND HEALTH	0	0	0	0	0	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	0	193.11
193.12	19312	OB/GYN	0	0	103,568	0	0	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
193.16	19316	MGH NEONATOLOGY	0	0	0	0	0	193.16
193.18	19318	MGH WOUND CARE	0	0	0	0	0	193.18
194.00	07963	HEART FAILURE CLINIC	0	0	0	0	0	194.00
194.01	07950	MOW	239,239	0	0	0	0	194.01
194.02	07951	MENTAL HEALTH	115,982	0	0	0	0	194.02
194.03	07952	ADVERTISING	0	0	0	0	0	194.03
194.04	07953	MGH WORK SOLUTIONS	0	0	10,357	0	0	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	0	0	194.05
194.06	07955	OPIOID IMPL GRANT	0	0	0	0	0	194.06
194.07	07956	ASTHMA GRANT	0	0	0	0	0	194.07
194.08	07957	MGH SMMP BLDG	0	0	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	0	0	194.10
194.11	07960	FAIRMOUNT	0	0	0	0	0	194.11
194.12	07961	GAS CITY	0	0	10,357	0	0	194.12
194.13	07969	LYONS	0	0	0	0	0	194.13
194.14	07964	WABASH	0	0	0	0	0	194.14
194.15	07965	TOBACCO GRANT	0	0	0	0	0	194.15
194.16	07966	HRSA NETWORK DEV PLANNING	0	0	0	0	0	194.16
194.17	07967	HRSA OPIOID PLANNING	0	0	0	0	0	194.17
194.18	07962	ECHO GRANT	0	0	0	0	0	194.18
194.19	07968	RURAL QI GRANT	0	0	0	0	0	194.19
194.20	07970	MGH DIABETES GRANT	0	0	0	0	0	194.20
194.21	07971	MGH MGH ORTHO	0	0	0	0	0	194.21
194.22	07972	MGH BELLA BLDG	0	0	0	0	0	194.22
194.23	07973	DIABETES GRANT	0	0	0	0	0	194.23
194.24	07974	HEALTH SYS GRANT	0	0	0	0	0	194.24
194.25	07975	MGH MGH ORTHO	0	0	20,714	0	0	194.25
194.26	07976	FIMR GRANT - 8841	0	0	0	0	0	194.26
194.27	07978	OTHER NONREIMURSABLE COST CENTERS	0	0	0	0	0	194.27
194.28	07977	MGH HEALTH ISS GNT	0	0	0	0	0	194.28
194.29	07980	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.29
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,424,180	1,743,502	1,035,675	5,811,504	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024Worksheet B
Part I
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
6.01	00601	CAFETERIA				6.01
6.02	00602	CAFETERIA				6.02
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD				22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,799,973	0	16,799,973	30.00
31.00	03100	INTENSIVE CARE UNIT	7,347,739	0	7,347,739	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	4,005,780	0	4,005,780	41.00
42.00	04200	SUBPROVIDER	0	0	0	42.00
43.00	04300	NURSERY	2,538,951	0	2,538,951	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,052,119	0	16,052,119	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,672,395	0	8,672,395	54.00
57.00	05700	CT SCAN	1,898,706	0	1,898,706	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,014,823	0	1,014,823	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,075,530	0	4,075,530	59.00
60.00	06000	LABORATORY	13,668,540	0	13,668,540	60.00
60.01	06001	ONCOLOGY	2,626,658	0	2,626,658	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	60.02
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	5,892,677	0	5,892,677	65.00
66.00	06600	PHYSICAL THERAPY	4,522,531	0	4,522,531	66.00
69.00	06900	ELECTROCARDIOLOGY	2,644,985	0	2,644,985	69.00
69.01	06901	CARDIAC REHAB	621,963	0	621,963	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,259,955	0	22,259,955	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,897,901	0	1,897,901	90.00
91.00	09100	EMERGENCY	14,028,688	0	14,028,688	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,269,680	0	3,269,680	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	133,839,594	0	133,839,594	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	159,091	0	159,091	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
192.01	19201	PACT REV PHYSICIANS	1,206,142	0	1,206,142	192.01
192.02	19202	VISITOR MEALS	37,175	0	37,175	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	0	192.03
192.04	19204	LIFELINE	0	0	0	192.04
192.05	19205	OWNED PROPERTIES	1,406,504	0	1,406,504	192.05
192.06	19206	UROLOGY	2,044,112	0	2,044,112	192.06
192.07	19207	PHYSICIANS' PRIVATE OFFICES	14,877	0	14,877	192.07
192.08	19211	PARISH NURSING	73,177	0	73,177	192.08
192.09	19212	BIOTERRORISM GRANT	0	0	0	192.09
192.10	19214	BREAST PUMPS	0	0	0	192.10
192.11	19208	MGH EMERGENCY PHYSICIANS	14,820	0	14,820	192.11
192.12	19209	LUNG CENTER	692,786	0	692,786	192.12
192.13	19213	MGH EXPRESS	2,763,406	0	2,763,406	192.13
192.14	19210	MGH PHYS PRACT MGMT	3,965,666	0	3,965,666	192.14
192.15	19215	MGH MARION SURGEONS	3,276,699	0	3,276,699	192.15

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024Worksheet B
Part I
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11/26/2024 3:43 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
192.16	19216	MGH MGH MED ONC	2,416,967	0	2,416,967	192.16
192.17	19217	MGH FMC SOUTH	2,602,046	0	2,602,046	192.17
192.18	19218	MGH FAIRM MED ASSOC	731,050	0	731,050	192.18
192.19	19219	MGH FMC MARION	975,506	0	975,506	192.19
193.00	19300	NONPAID WORKERS	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	1,822,527	0	1,822,527	193.01
193.02	19302	MGH FMC GAS CITY	1,510,197	0	1,510,197	193.02
193.03	19303	MGH HOSPITALISTS	5,199,940	0	5,199,940	193.03
193.04	19304	MGH MAR FAM PRACT	5,338,032	0	5,338,032	193.04
193.05	19305	MGH FMC SWAYZEE	369,872	0	369,872	193.05
193.06	19306	MGH PEDIATRIC CTR	1,634,238	0	1,634,238	193.06
193.07	19307	MGH SPECIALTY PHYS	302,798	0	302,798	193.07
193.08	19308	MGH FMC CONVERSE	553,567	0	553,567	193.08
193.09	19309	MGH UPLAND HEALTH	85	0	85	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	193.11
193.12	19312	OB/GYN	3,897,058	0	3,897,058	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	193.15
193.16	19316	MGH NEONATOLOGY	1,073,703	0	1,073,703	193.16
193.18	19318	MGH WOUND CARE	43,981	0	43,981	193.18
194.00	07963	HEART FAILURE CLINIC	82,988	0	82,988	194.00
194.01	07950	MOW	239,239	0	239,239	194.01
194.02	07951	MENTAL HEALTH	115,982	0	115,982	194.02
194.03	07952	ADVERTISING	488,370	0	488,370	194.03
194.04	07953	MGH WORK SOLUTIONS	1,062,777	0	1,062,777	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	194.05
194.06	07955	OPIOID IMPL GRANT	4,770	0	4,770	194.06
194.07	07956	ASTHMA GRANT	0	0	0	194.07
194.08	07957	MGH SMMP BLDG	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	194.10
194.11	07960	FAIRMOUNT	0	0	0	194.11
194.12	07961	GAS CITY	10,357	0	10,357	194.12
194.13	07969	LYONS	0	0	0	194.13
194.14	07964	WABASH	0	0	0	194.14
194.15	07965	TOBACCO GRANT	55,119	0	55,119	194.15
194.16	07966	HRSA NETWORK DEV PLANNING	0	0	0	194.16
194.17	07967	HRSA OPIOID PLANNING	0	0	0	194.17
194.18	07962	ECHO GRANT	0	0	0	194.18
194.19	07968	RURAL QI GRANT	77,311	0	77,311	194.19
194.20	07970	MGH DIABETES GRANT	0	0	0	194.20
194.21	07971	MGH MGH ORTHO	0	0	0	194.21
194.22	07972	MGH BELLA BLDG	0	0	0	194.22
194.23	07973	DIABETES GRANT	0	0	0	194.23
194.24	07974	HEALTH SYS GRANT	0	0	0	194.24
194.25	07975	MGH MGH ORTHO	2,992,834	0	2,992,834	194.25
194.26	07976	FIMR GRANT - 8841	18,720	0	18,720	194.26
194.27	07978	OTHER NONREIMURSABLE COST CENTERS	0	0	0	194.27
194.28	07977	MGH HEALTH ISS GNT	86,452	0	86,452	194.28
194.29	07980	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.29
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	183,200,535	0	183,200,535	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0011

Period:
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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			NEW BLDG & FIXT				
		0	1.00	2A	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	255,815	255,815	255,815		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,319,244	3,319,244	41,483	3,360,727	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
6.01	00601	CAFETERIA	113,408	113,408	0	43,358	6.01
6.02	00602	CAFETERIA	0	0	0	0	6.02
7.00	00700	OPERATION OF PLANT	2,109,867	2,109,867	3,331	211,169	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	49,337	49,337	0	6,307	8.00
9.00	00900	HOUSEKEEPING	76,119	76,119	0	72,533	9.00
10.00	01000	DIETARY	156,254	156,254	70	19,101	10.00
13.00	01300	NURSING ADMINISTRATION	16,251	16,251	3,191	30,186	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	55,641	55,641	510	13,824	14.00
15.00	01500	PHARMACY	71,682	71,682	7,557	100,245	15.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	992,322	992,322	18,830	215,470	30.00
31.00	03100	INTENSIVE CARE UNIT	255,068	255,068	7,182	109,733	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	223,803	223,803	2,973	55,779	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	4,469	43,930	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	804,454	804,454	11,285	235,101	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	483,004	483,004	8,954	128,985	54.00
57.00	05700	CT SCAN	35,141	35,141	1,855	30,928	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	41,655	41,655	939	16,417	58.00
59.00	05900	CARDIAC CATHETERIZATION	117,681	117,681	2,767	63,561	59.00
60.00	06000	LABORATORY	330,509	330,509	8,804	228,170	60.00
60.01	06001	ONCOLOGY	0	0	3,661	46,412	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	60.02
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	156,487	156,487	5,603	95,198	65.00
66.00	06600	PHYSICAL THERAPY	163,375	163,375	6,088	73,497	66.00
69.00	06900	ELECTROCARDIOLOGY	185,720	185,720	2,965	34,336	69.00
69.01	06901	CARDIAC REHAB	30,261	30,261	674	7,557	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	301,868	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	114,295	114,295	1,045	27,415	90.00
91.00	09100	EMERGENCY	258,500	258,500	32,284	217,867	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	96,900	96,900	5,010	49,964	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,512,793	10,512,793	181,530	2,478,911	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	31,031	31,031	51	1,291	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	PACT REV PHYSICIANS	0	0	1,981	21,994	192.01
192.02	19202	VISITOR MEALS	0	0	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	0	0	192.03
192.04	19204	LIFELINE	0	0	0	0	192.04
192.05	19205	OWNED PROPERTIES	0	0	0	25,810	192.05
192.06	19206	UROLOGY	0	0	3,137	36,329	192.06
192.07	19207	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.07
192.08	19211	PARISH NURSING	0	0	97	1,173	192.08
192.09	19212	BIOTERRORISM GRANT	0	0	0	0	192.09
192.10	19214	BREAST PUMPS	0	0	0	0	192.10
192.11	19208	MGH EMERGENCY PHYSICIANS	0	0	31	272	192.11
192.12	19209	LUNG CENTER	0	0	1,209	12,536	192.12
192.13	19213	MGH EXPRESS	0	0	4,143	49,388	192.13
192.14	19210	MGH PHYS PRACT MGMT	0	0	5,261	69,503	192.14

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
				NEW BLDG & FIXT					
			0	1.00		2A	4.00	5.00	
192.15	19215	MGH MARION SURGEONS	0	0	0	0	5,744	58,869	192.15
192.16	19216	MGH MGH MED ONC	0	0	0	0	4,411	44,334	192.16
192.17	19217	MGH FMC SOUTH	0	0	0	0	3,878	47,163	192.17
192.18	19218	MGH FAIRM MED ASSOC	0	0	0	0	1,237	13,409	192.18
192.19	19219	MGH FMC MARION	0	0	0	0	1,486	16,853	192.19
193.00	19300	NONPAID WORKERS	0	0	0	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	0	0	0	0	3,009	33,242	193.01
193.02	19302	MGH FMC GAS CITY	0	0	0	0	2,102	27,512	193.02
193.03	19303	MGH HOSPITALISTS	0	0	0	0	9,451	95,383	193.03
193.04	19304	MGH MAR FAM PRACT	0	0	0	0	8,704	97,152	193.04
193.05	19305	MGH FMC SWAYZEE	0	0	0	0	602	6,595	193.05
193.06	19306	MGH PEDIATRIC CTR	0	0	0	0	2,502	29,263	193.06
193.07	19307	MGH SPECIALTY PHYS	0	0	0	0	502	5,457	193.07
193.08	19308	MGH FMC CONVERSE	0	0	0	0	818	9,964	193.08
193.09	19309	MGH UPLAND HEALTH	0	0	0	0	0	0	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	0	0	193.11
193.12	19312	OB/GYN	0	0	0	0	6,070	69,587	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	0	193.15
193.16	19316	MGH NEONATOLOGY	0	0	0	0	0	19,703	193.16
193.18	19318	MGH WOUND CARE	0	0	0	0	80	807	193.18
194.00	07963	HEART FAILURE CLINIC	0	0	0	0	119	1,522	194.00
194.01	07950	MOW	0	0	0	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	0	0	0	0	194.02
194.03	07952	ADVERTISING	0	0	0	0	498	8,775	194.03
194.04	07953	MGH WORK SOLUTIONS	0	0	0	0	1,488	19,306	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	0	0	0	194.05
194.06	07955	OPIOID IMPL GRANT	0	0	0	0	0	88	194.06
194.07	07956	ASTHMA GRANT	0	0	0	0	0	0	194.07
194.08	07957	MGH SMMP BLDG	0	0	0	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	0	0	0	194.10
194.11	07960	FAIRMOUNT	0	0	0	0	0	0	194.11
194.12	07961	GAS CITY	0	0	0	0	0	0	194.12
194.13	07969	LYONS	0	0	0	0	0	0	194.13
194.14	07964	WABASH	0	0	0	0	0	0	194.14
194.15	07965	TOBACCO GRANT	0	0	0	0	213	2,526	194.15
194.16	07966	HRSA NETWORK DEV PLANNING	0	0	0	0	0	0	194.16
194.17	07967	HRSA OPIOID PLANNING	0	0	0	0	0	0	194.17
194.18	07962	ECHO GRANT	0	0	0	0	0	0	194.18
194.19	07968	RURAL QI GRANT	0	0	0	0	25	1,408	194.19
194.20	07970	MGH DIABETES GRANT	0	0	0	0	0	0	194.20
194.21	07971	MGH MGH ORTHO	0	0	0	0	0	0	194.21
194.22	07972	MGH BELLA BLDG	0	0	0	0	0	0	194.22
194.23	07973	DIABETES GRANT	0	0	0	0	0	0	194.23
194.24	07974	HEALTH SYS GRANT	0	0	0	0	0	0	194.24
194.25	07975	MGH MGH ORTHO	0	0	0	0	5,436	54,518	194.25
194.26	07976	FIMR GRANT - 8841	0	0	0	0	0	84	194.26
194.27	07978	OTHER NONREIMURSABLE COST CENTERS	0	0	0	0	0	0	194.27
194.28	07977	MGH HEALTH ISS GNT	0	0	0	0	0	0	194.28
194.29	07980	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	0	194.29
200.00		Cross Foot Adjustments				0			200.00
201.00		Negative Cost Centers		0		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	10,543,824	10,543,824	255,815	3,360,727		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0011

Period:
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Cost Center Description		MAINTENANCE & REPAIRS	CAFETERIA	CAFETERIA	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		6.00	6.01	6.02	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	0				6.00
6.01	00601	CAFETERIA	0	156,766			6.01
6.02	00602	CAFETERIA	0	154,412	154,412		6.02
7.00	00700	OPERATION OF PLANT	0	0	5,780	2,330,147	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	24,226	79,870
9.00	00900	HOUSEKEEPING	0	0	0	37,376	0
10.00	01000	DIETARY	0	0	42	76,724	8,454
13.00	01300	NURSING ADMINISTRATION	0	0	2,266	7,980	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,051	27,321	1
15.00	01500	PHARMACY	0	0	7,598	35,198	0
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	19,394	487,252	15,186
31.00	03100	INTENSIVE CARE UNIT	0	0	7,019	125,244	4,003
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0
41.00	04100	SUBPROVIDER - IRF	0	0	3,078	109,893	1,356
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	0	4,369	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	13,546	395,006	7,226
51.00	05100	RECOVERY ROOM	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	10,555	237,166	5,467
57.00	05700	CT SCAN	0	0	2,273	17,255	2,582
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	1,150	20,454	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	3,089	57,784	1,013
60.00	06000	LABORATORY	0	0	13,032	162,288	24
60.01	06001	ONCOLOGY	0	0	0	0	223
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	4,240	76,839	657
66.00	06600	PHYSICAL THERAPY	0	0	3,229	80,221	1,577
69.00	06900	ELECTROCARDIOLOGY	0	0	4,551	91,193	658
69.01	06901	CARDIAC REHAB	0	0	742	14,859	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	1,454	56,121	309
91.00	09100	EMERGENCY	0	0	19,014	126,930	28,652
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	7,720	47,580	2,216
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	154,412	135,192	2,314,910	79,604
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	110	15,237	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	PACT REV PHYSICIANS	0	0	451	0	0
192.02	19202	VISITOR MEALS	0	2,354	0	0	0
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	0	0	0
192.04	19204	LIFELINE	0	0	0	0	0
192.05	19205	OWNED PROPERTIES	0	0	0	0	0
192.06	19206	UROLOGY	0	0	2,065	0	0
192.07	19207	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.08	19211	PARISH NURSING	0	0	112	0	0
192.09	19212	BIOTERRORISM GRANT	0	0	0	0	0
192.10	19214	BREAST PUMPS	0	0	0	0	0
192.11	19208	MGH EMERGENCY PHYSICIANS	0	0	0	0	0
192.12	19209	LUNG CENTER	0	0	595	0	0
192.13	19213	MGH EXPRESS	0	0	0	0	127
192.14	19210	MGH PHYS PRACT MGMT	0	0	8,847	0	0
192.15	19215	MGH MARION SURGEONS	0	0	2,296	0	10
192.16	19216	MGH MGH MED ONC	0	0	0	0	0
192.17	19217	MGH FMC SOUTH	0	0	0	0	0
192.18	19218	MGH FAIRM MED ASSOC	0	0	0	0	5

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			MAINTENANCE & REPAIRS	CAFETERIA	CAFETERIA	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			6.00	6.01	6.02	7.00	8.00	
192.19	19219	MGH FMC MARION	0	0	1,628	0	0	192.19
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	0	0	0	0	0	193.01
193.02	19302	MGH FMC GAS CITY	0	0	0	0	22	193.02
193.03	19303	MGH HOSPITALISTS	0	0	0	0	0	193.03
193.04	19304	MGH MAR FAM PRACT	0	0	0	0	67	193.04
193.05	19305	MGH FMC SWAYZEE	0	0	0	0	0	193.05
193.06	19306	MGH PEDIATRIC CTR	0	0	1,813	0	4	193.06
193.07	19307	MGH SPECIALTY PHYS	0	0	337	0	0	193.07
193.08	19308	MGH FMC CONVERSE	0	0	0	0	11	193.08
193.09	19309	MGH UPLAND HEALTH	0	0	0	0	13	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	0	193.11
193.12	19312	OB/GYN	0	0	0	0	5	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
193.16	19316	MGH NEONATOLOGY	0	0	0	0	0	193.16
193.18	19318	MGH WOUND CARE	0	0	0	0	0	193.18
194.00	07963	HEART FAILURE CLINIC	0	0	0	0	0	194.00
194.01	07950	MOW	0	0	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	0	0	0	194.02
194.03	07952	ADVERTISING	0	0	637	0	0	194.03
194.04	07953	MGH WORK SOLUTIONS	0	0	0	0	2	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	0	0	194.05
194.06	07955	OPIOID IMPL GRANT	0	0	0	0	0	194.06
194.07	07956	ASTHMA GRANT	0	0	0	0	0	194.07
194.08	07957	MGH SMMP BLDG	0	0	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	0	0	194.10
194.11	07960	FAIRMOUNT	0	0	0	0	0	194.11
194.12	07961	GAS CITY	0	0	0	0	0	194.12
194.13	07969	LYONS	0	0	0	0	0	194.13
194.14	07964	WABASH	0	0	0	0	0	194.14
194.15	07965	TOBACCO GRANT	0	0	2	0	0	194.15
194.16	07966	HRSA NETWORK DEV PLANNING	0	0	0	0	0	194.16
194.17	07967	HRSA OPIOID PLANNING	0	0	0	0	0	194.17
194.18	07962	ECHO GRANT	0	0	0	0	0	194.18
194.19	07968	RURAL QI GRANT	0	0	35	0	0	194.19
194.20	07970	MGH DIABETES GRANT	0	0	0	0	0	194.20
194.21	07971	MGH MGH ORTHO	0	0	0	0	0	194.21
194.22	07972	MGH BELLA BLDG	0	0	0	0	0	194.22
194.23	07973	DIABETES GRANT	0	0	0	0	0	194.23
194.24	07974	HEALTH SYS GRANT	0	0	0	0	0	194.24
194.25	07975	MGH MGH ORTHO	0	0	0	0	0	194.25
194.26	07976	FIMR GRANT - 8841	0	0	49	0	0	194.26
194.27	07978	OTHER NONREIMURSABLE COST CENTERS	0	0	0	0	0	194.27
194.28	07977	MGH HEALTH ISS GNT	0	0	243	0	0	194.28
194.29	07980	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.29
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	156,766	154,412	2,330,147	79,870	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
6.00	00600 MAINTENANCE & REPAIRS						6.00
6.01	00601 CAFETERIA						6.01
6.02	00602 CAFETERIA						6.02
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING	186,028					9.00
10.00	01000 DIETARY	2,708	263,353				10.00
13.00	01300 NURSING ADMINISTRATION	1,016	0	60,890			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	5,078		630	104,056		14.00
15.00	01500 PHARMACY	2,370	0	0	0	224,650	15.00
22.00	02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	50,105	121,182	11,628	13,527	0	30.00
31.00	03100 INTENSIVE CARE UNIT	9,479	43,612	4,209	4,162	0	31.00
40.00	04000 SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100 SUBPROVIDER - IRF	8,125	22,060	1,846	1,041	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300 NURSERY	0	0	2,620	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	25,052	0	8,123	22,885	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	10,833	0	0	2,081	0	54.00
57.00	05700 CT SCAN	3,385	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	5,078	0	1,852	10,406	0	59.00
60.00	06000 LABORATORY	9,479	0	0	1,041	0	60.00
60.01	06001 ONCOLOGY	0	0	2,963	1,041	0	60.01
60.02	06002 RADIATION ONCOLOGY	0	0	0	0	0	60.02
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	7,109	0	2,912	1,041	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	1,936	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	6,094	0	2,729	3,122	0	69.00
69.01	06901 CARDIAC REHAB	5,078	0	445	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	224,650	73.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	3,385	0	872	0	0	90.00
91.00	09100 EMERGENCY	27,083	10,813	11,402	5,203	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	1,354	0	4,629	1,041	0	95.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	182,811	197,667	58,796	66,591	224,650	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	508	0	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201 PACT REV PHYSICIANS	0	0	0	0	0	192.01
192.02	19202 VISITOR MEALS	0	0	0	0	0	192.02
192.03	19203 GREAT BEGINNINGS/MATERNAL	0	0	0	0	0	192.03
192.04	19204 LIFELINE	0	0	0	0	0	192.04
192.05	19205 OWNED PROPERTIES	0	0	0	0	0	192.05
192.06	19206 UROLOGY	0	0	0	3,122	0	192.06
192.07	19207 PHYSICIANS' PRIVATE OFFICES	677	0	0	0	0	192.07
192.08	19211 PARISH NURSING	339	0	0	0	0	192.08
192.09	19212 BIOTERRORISM GRANT	0	0	0	0	0	192.09
192.10	19214 BREAST PUMPS	0	0	0	0	0	192.10
192.11	19208 MGH EMERGENCY PHYSICIANS	0	0	0	0	0	192.11
192.12	19209 LUNG CENTER	0	0	0	0	0	192.12
192.13	19213 MGH EXPRESS	0	0	2,094	1,041	0	192.13
192.14	19210 MGH PHYS PRACT MGMT	1,693	0	0	0	0	192.14
192.15	19215 MGH MARION SURGEONS	0	0	0	3,122	0	192.15
192.16	19216 MGH MGH MED ONC	0	0	0	0	0	192.16
192.17	19217 MGH FMC SOUTH	0	0	0	3,122	0	192.17

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024Worksheet B
Part II
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Cost Center Description			HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			9.00	10.00	13.00	14.00	15.00	
192.18	19218	MGH FAIRM MED ASSOC	0	0	0	0	0	192.18
192.19	19219	MGH FMC MARION	0	0	0	3,122	0	192.19
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	0	0	0	1,041	0	193.01
193.02	19302	MGH FMC GAS CITY	0	0	0	1,041	0	193.02
193.03	19303	MGH HOSPITALISTS	0	0	0	0	0	193.03
193.04	19304	MGH MAR FAM PRACT	0	0	0	4,162	0	193.04
193.05	19305	MGH FMC SWAYZEE	0	0	0	1,041	0	193.05
193.06	19306	MGH PEDIATRIC CTR	0	0	0	1,041	0	193.06
193.07	19307	MGH SPECIALTY PHYS	0	0	0	0	0	193.07
193.08	19308	MGH FMC CONVERSE	0	0	0	1,041	0	193.08
193.09	19309	MGH UPLAND HEALTH	0	0	0	0	0	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	0	193.11
193.12	19312	OB/GYN	0	0	0	10,406	0	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
193.16	19316	MGH NEONATOLOGY	0	0	0	0	0	193.16
193.18	19318	MGH WOUND CARE	0	0	0	0	0	193.18
194.00	07963	HEART FAILURE CLINIC	0	0	0	0	0	194.00
194.01	07950	MOW	0	44,239	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	21,447	0	0	0	194.02
194.03	07952	ADVERTISING	0	0	0	0	0	194.03
194.04	07953	MGH WORK SOLUTIONS	0	0	0	1,041	0	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	0	0	194.05
194.06	07955	OPIOID IMPL GRANT	0	0	0	0	0	194.06
194.07	07956	ASTHMA GRANT	0	0	0	0	0	194.07
194.08	07957	MGH SMMP BLDG	0	0	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	0	0	194.10
194.11	07960	FAIRMOUNT	0	0	0	0	0	194.11
194.12	07961	GAS CITY	0	0	0	1,041	0	194.12
194.13	07969	LYONS	0	0	0	0	0	194.13
194.14	07964	WABASH	0	0	0	0	0	194.14
194.15	07965	TOBACCO GRANT	0	0	0	0	0	194.15
194.16	07966	HRSA NETWORK DEV PLANNING	0	0	0	0	0	194.16
194.17	07967	HRSA OPIOID PLANNING	0	0	0	0	0	194.17
194.18	07962	ECHO GRANT	0	0	0	0	0	194.18
194.19	07968	RURAL QI GRANT	0	0	0	0	0	194.19
194.20	07970	MGH DIABETES GRANT	0	0	0	0	0	194.20
194.21	07971	MGH MGH ORTHO	0	0	0	0	0	194.21
194.22	07972	MGH BELLA BLDG	0	0	0	0	0	194.22
194.23	07973	DIABETES GRANT	0	0	0	0	0	194.23
194.24	07974	HEALTH SYS GRANT	0	0	0	0	0	194.24
194.25	07975	MGH MGH ORTHO	0	0	0	2,081	0	194.25
194.26	07976	FIMR GRANT - 8841	0	0	0	0	0	194.26
194.27	07978	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.27
194.28	07977	MGH HEALTH ISS GNT	0	0	0	0	0	194.28
194.29	07980	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.29
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)	186,028	263,353	60,890	104,056	224,650	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024Worksheet B
Part II
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Cost Center Description			INTERNS & RESIDENTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			SERVICES-OTHER PRGM. COSTS				
			22.00				
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
6.01	00601	CAFETERIA					6.01
6.02	00602	CAFETERIA					6.02
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0				22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		1,944,896	0	1,944,896	30.00
31.00	03100	INTENSIVE CARE UNIT		569,711	0	569,711	31.00
40.00	04000	SUBPROVIDER - IPF		0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF		429,954	0	429,954	41.00
42.00	04200	SUBPROVIDER		0	0	0	42.00
43.00	04300	NURSERY		55,388	0	55,388	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		1,522,678	0	1,522,678	50.00
51.00	05100	RECOVERY ROOM		0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		887,045	0	887,045	54.00
57.00	05700	CT SCAN		93,419	0	93,419	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		80,615	0	80,615	58.00
59.00	05900	CARDIAC CATHETERIZATION		263,231	0	263,231	59.00
60.00	06000	LABORATORY		753,347	0	753,347	60.00
60.01	06001	ONCOLOGY		54,300	0	54,300	60.01
60.02	06002	RADIATION ONCOLOGY		0	0	0	60.02
64.00	06400	INTRAVENOUS THERAPY		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		350,086	0	350,086	65.00
66.00	06600	PHYSICAL THERAPY		329,923	0	329,923	66.00
69.00	06900	ELECTROCARDIOLOGY		331,368	0	331,368	69.00
69.01	06901	CARDIAC REHAB		59,616	0	59,616	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		526,518	0	526,518	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY		0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC		204,896	0	204,896	90.00
91.00	09100	EMERGENCY		737,748	0	737,748	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)		0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES		216,414	0	216,414	95.00
102.00	10200	OPIOID TREATMENT PROGRAM		0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	9,411,153	0	9,411,153	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		48,228	0	48,228	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		0	0	0	192.00
192.01	19201	PACT REV PHYSICIANS		24,426	0	24,426	192.01
192.02	19202	VISITOR MEALS		2,354	0	2,354	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL		0	0	0	192.03
192.04	19204	LIFELINE		0	0	0	192.04
192.05	19205	OWNED PROPERTIES		25,810	0	25,810	192.05
192.06	19206	UROLOGY		44,653	0	44,653	192.06
192.07	19207	PHYSICIANS' PRIVATE OFFICES		677	0	677	192.07
192.08	19211	PARISH NURSING		1,721	0	1,721	192.08
192.09	19212	BIOTERRORISM GRANT		0	0	0	192.09
192.10	19214	BREAST PUMPS		0	0	0	192.10
192.11	19208	MGH EMERGENCY PHYSICIANS		303	0	303	192.11
192.12	19209	LUNG CENTER		14,340	0	14,340	192.12
192.13	19213	MGH EXPRESS		56,793	0	56,793	192.13

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0011

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Part II
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Cost Center Description			INTERNS & RESIDENTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			SERVICES-OTHER PRGM. COSTS					
			22.00	24.00	25.00	26.00		
192.14	19210	MGH PHYS PRACT MGMT		85,304	0	85,304		192.14
192.15	19215	MGH MARION SURGEONS		70,041	0	70,041		192.15
192.16	19216	MGH MGH MED ONC		48,745	0	48,745		192.16
192.17	19217	MGH FMC SOUTH		54,163	0	54,163		192.17
192.18	19218	MGH FAIRM MED ASSOC		14,651	0	14,651		192.18
192.19	19219	MGH FMC MARION		23,089	0	23,089		192.19
193.00	19300	NONPAID WORKERS		0	0	0		193.00
193.01	19301	MGH FMC NORTHWOOD		37,292	0	37,292		193.01
193.02	19302	MGH FMC GAS CITY		30,677	0	30,677		193.02
193.03	19303	MGH HOSPITALISTS		104,834	0	104,834		193.03
193.04	19304	MGH MAR FAM PRACT		110,085	0	110,085		193.04
193.05	19305	MGH FMC SWAYZEE		8,238	0	8,238		193.05
193.06	19306	MGH PEDIATRIC CTR		34,623	0	34,623		193.06
193.07	19307	MGH SPECIALTY PHYS		6,296	0	6,296		193.07
193.08	19308	MGH FMC CONVERSE		11,834	0	11,834		193.08
193.09	19309	MGH UPLAND HEALTH		13	0	13		193.09
193.10	19310	MGH MGH WOMENS CTR		0	0	0		193.10
193.11	19311	MGH MGH PSYCHIATRY		0	0	0		193.11
193.12	19312	OB/GYN		86,068	0	86,068		193.12
193.15	19315	MGH RIVER VIEW BLDG		0	0	0		193.15
193.16	19316	MGH NEONATOLOGY		19,703	0	19,703		193.16
193.18	19318	MGH WOUND CARE		887	0	887		193.18
194.00	07963	HEART FAILURE CLINIC		1,641	0	1,641		194.00
194.01	07950	MOW		44,239	0	44,239		194.01
194.02	07951	MENTAL HEALTH		21,447	0	21,447		194.02
194.03	07952	ADVERTISING		9,910	0	9,910		194.03
194.04	07953	MGH WORK SOLUTIONS		21,837	0	21,837		194.04
194.05	07954	MGH TAYLOR UNIVERSITY		0	0	0		194.05
194.06	07955	OPIOID IMPL GRANT		88	0	88		194.06
194.07	07956	ASTHMA GRANT		0	0	0		194.07
194.08	07957	MGH SMMP BLDG		0	0	0		194.08
194.09	07958	MGH AMBUCARE BLDG		0	0	0		194.09
194.10	07959	MGH 106 LYONS BLDG		0	0	0		194.10
194.11	07960	FAIRMOUNT		0	0	0		194.11
194.12	07961	GAS CITY		1,041	0	1,041		194.12
194.13	07969	LYONS		0	0	0		194.13
194.14	07964	WABASH		0	0	0		194.14
194.15	07965	TOBACCO GRANT		2,741	0	2,741		194.15
194.16	07966	HRSA NETWORK DEV PLANNING		0	0	0		194.16
194.17	07967	HRSA OPIOID PLANNING		0	0	0		194.17
194.18	07962	ECHO GRANT		0	0	0		194.18
194.19	07968	RURAL QI GRANT		1,468	0	1,468		194.19
194.20	07970	MGH DIABETES GRANT		0	0	0		194.20
194.21	07971	MGH MGH ORTHO		0	0	0		194.21
194.22	07972	MGH BELLA BLDG		0	0	0		194.22
194.23	07973	DIABETES GRANT		0	0	0		194.23
194.24	07974	HEALTH SYS GRANT		0	0	0		194.24
194.25	07975	MGH MGH ORTHO		62,035	0	62,035		194.25
194.26	07976	FIMR GRANT - 8841		133	0	133		194.26
194.27	07978	OTHER NONREIMURSABLE COST CENTERS		0	0	0		194.27
194.28	07977	MGH HEALTH ISS GNT		243	0	243		194.28
194.29	07980	OTHER NONREIMBURSABLE COST CENTERS		0	0	0		194.29
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	10,543,824	0	10,543,824		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024

Worksheet B-1

Date/Time Prepared:
11/26/2024 3:43 pm

Cost Center Description		CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	CAFETERIA (MEALS SERVED)	
		NEW BLDG & FIXT (SQUARE FEET)					
		1.00	4.00	5.00	6.00	6.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	451,569				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	10,956	82,453,004			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	142,156	13,381,060	151,874,691		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	298,457		6.00
6.01	00601	CAFETERIA	4,857	0	1,959,411	4,857	270,764
6.02	00602	CAFETERIA	0	0	0	0	266,699
7.00	00700	OPERATION OF PLANT	90,361	1,073,356	9,543,085	90,361	0
8.00	00800	LAUNDRY & LINEN SERVICE	2,113	0	285,015	2,113	0
9.00	00900	HOUSEKEEPING	3,260	0	3,277,868	3,260	0
10.00	01000	DIETARY	6,692	22,474	863,188	6,692	0
13.00	01300	NURSING ADMINISTRATION	696	1,028,364	1,364,143	696	0
14.00	01400	CENTRAL SERVICES & SUPPLY	2,383	164,391	624,727	2,383	0
15.00	01500	PHARMACY	3,070	2,435,516	4,530,240	3,070	0
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	42,499	6,068,380	9,737,436	42,499	0
31.00	03100	INTENSIVE CARE UNIT	10,924	2,314,674	4,959,027	10,924	0
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0
41.00	04100	SUBPROVIDER - IRF	9,585	958,161	2,520,744	9,585	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	1,440,139	1,985,267	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	34,453	3,636,654	10,624,574	34,453	0
51.00	05100	RECOVERY ROOM	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,686	2,885,700	5,829,044	20,686	0
57.00	05700	CT SCAN	1,505	597,726	1,397,707	1,505	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,784	302,539	741,896	1,784	0
59.00	05900	CARDIAC CATHETERIZATION	5,040	891,645	2,872,420	5,040	0
60.00	06000	LABORATORY	14,155	2,837,107	10,311,351	14,155	0
60.01	06001	ONCOLOGY	0	1,179,762	2,097,437	0	0
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	6,702	1,805,580	4,302,130	6,702	0
66.00	06600	PHYSICAL THERAPY	6,997	1,961,831	3,321,465	6,997	0
69.00	06900	ELECTROCARDIOLOGY	7,954	955,522	1,551,697	7,954	0
69.01	06901	CARDIAC REHAB	1,296	217,225	341,520	1,296	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	13,640,101	0	0
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	4,895	336,797	1,238,928	4,895	0
91.00	09100	EMERGENCY	11,071	10,404,140	9,845,777	11,071	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	4,150	1,614,455	2,257,974	4,150	0
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	450,240	58,513,198	112,024,172	297,128	266,699
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,329	16,316	58,323	1,329	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	PACT REV PHYSICIANS	0	638,345	993,965	0	0
192.02	19202	VISITOR MEALS	0	0	0	0	4,065
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	0	0	0
192.04	19204	LIFELINE	0	0	0	0	0
192.05	19205	OWNED PROPERTIES	0	0	1,166,385	0	0
192.06	19206	UROLOGY	0	1,011,055	1,641,755	0	0
192.07	19207	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.08	19211	PARISH NURSING	0	31,289	53,029	0	0
192.09	19212	BIOTERRORISM GRANT	0	0	0	0	0
192.10	19214	BREAST PUMPS	0	0	0	0	0
192.11	19208	MGH EMERGENCY PHYSICIANS	0	10,000	12,284	0	0
192.12	19209	LUNG CENTER	0	389,717	566,506	0	0
192.13	19213	MGH EXPRESS	0	1,335,122	2,231,905	0	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024

Worksheet B-1

Date/Time Prepared:
11/26/2024 3:43 pm

Cost Center Description			CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	CAFETERIA (MEALS SERVED)	
			NEW BLDG & FIXT (SQUARE FEET)					
			1.00	4.00	5.00	6.00	6.01	
192.14	19210	MGH PHYS PRACT MGMT	0	1,695,552	3,140,966	0	0	192.14
192.15	19215	MGH MARION SURGEONS	0	1,850,981	2,660,368	0	0	192.15
192.16	19216	MGH MGH MED ONC	0	1,421,409	2,003,546	0	0	192.16
192.17	19217	MGH FMC SOUTH	0	1,249,753	2,131,359	0	0	192.17
192.18	19218	MGH FAIRM MED ASSOC	0	398,779	605,996	0	0	192.18
192.19	19219	MGH FMC MARION	0	478,819	761,608	0	0	192.19
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	0	969,580	1,502,252	0	0	193.01
193.02	19302	MGH FMC GAS CITY	0	677,303	1,243,291	0	0	193.02
193.03	19303	MGH HOSPITALISTS	0	3,045,687	4,310,499	0	0	193.03
193.04	19304	MGH MAR FAM PRACT	0	2,805,123	4,390,440	0	0	193.04
193.05	19305	MGH FMC SWAYZEE	0	194,016	298,030	0	0	193.05
193.06	19306	MGH PEDIATRIC CTR	0	806,191	1,322,432	0	0	193.06
193.07	19307	MGH SPECIALTY PHYS	0	161,847	246,595	0	0	193.07
193.08	19308	MGH FMC CONVERSE	0	263,703	450,268	0	0	193.08
193.09	19309	MGH UPLAND HEALTH	0	0	0	0	0	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	0	193.11
193.12	19312	OB/GYN	0	1,956,263	3,144,743	0	0	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
193.16	19316	MGH NEONATOLOGY	0	0	890,400	0	0	193.16
193.18	19318	MGH WOUND CARE	0	25,882	36,458	0	0	193.18
194.00	07963	HEART FAILURE CLINIC	0	38,289	68,799	0	0	194.00
194.01	07950	MOW	0	0	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	0	0	0	194.02
194.03	07952	ADVERTISING	0	160,440	396,557	0	0	194.03
194.04	07953	MGH WORK SOLUTIONS	0	479,682	872,473	0	0	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	0	0	194.05
194.06	07955	OPIOID IMPL GRANT	0	0	3,956	0	0	194.06
194.07	07956	ASTHMA GRANT	0	0	0	0	0	194.07
194.08	07957	MGH SMMP BLDG	0	0	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	0	0	194.10
194.11	07960	FAIRMOUNT	0	0	0	0	0	194.11
194.12	07961	GAS CITY	0	0	0	0	0	194.12
194.13	07969	LYONS	0	0	0	0	0	194.13
194.14	07964	WABASH	0	0	0	0	0	194.14
194.15	07965	TOBACCO GRANT	0	68,635	114,152	0	0	194.15
194.16	07966	HRSA NETWORK DEV PLANNING	0	0	0	0	0	194.16
194.17	07967	HRSA OPIOID PLANNING	0	0	0	0	0	194.17
194.18	07962	ECHO GRANT	0	0	0	0	0	194.18
194.19	07968	RURAL QI GRANT	0	8,182	63,651	0	0	194.19
194.20	07970	MGH DIABETES GRANT	0	0	0	0	0	194.20
194.21	07971	MGH MGH ORTHO	0	0	0	0	0	194.21
194.22	07972	MGH BELLA BLDG	0	0	0	0	0	194.22
194.23	07973	DIABETES GRANT	0	0	0	0	0	194.23
194.24	07974	HEALTH SYS GRANT	0	0	0	0	0	194.24
194.25	07975	MGH MGH ORTHO	0	1,751,846	2,463,738	0	0	194.25
194.26	07976	FIMR GRANT - 8841	0	0	3,790	0	0	194.26
194.27	07978	OTHER NONREIMURSABLE COST CENTERS	0	0	0	0	0	194.27
194.28	07977	MGH HEALTH ISS GNT	0	0	0	0	0	194.28
194.29	07980	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.29
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)	10,543,824	18,890,193	31,265,845	0	2,476,195	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.349309	0.229103	0.205866	0.000000	9.145215	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		255,815	3,360,727	0	156,766	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.003103	0.022128	0.000000	0.578977	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: 15-0011

Period:
From 07/01/2023
To 06/30/2024

Worksheet B-1

Date/Time Prepared:
11/26/2024 3:43 pm

Cost Center Description			CAFETERIA (HOURS WORKED)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			6.02	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
6.01	00601	CAFETERIA						6.01
6.02	00602	CAFETERIA	1,166,135					6.02
7.00	00700	OPERATION OF PLANT	43,653	203,239				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,113	745,973			8.00
9.00	00900	HOUSEKEEPING	0	3,260	0	57,148		9.00
10.00	01000	DIETARY	314	6,692	78,963	832	77,716	10.00
13.00	01300	NURSING ADMINISTRATION	17,114	696	0	312	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,935	2,383	10	1,560	0	14.00
15.00	01500	PHARMACY	57,383	3,070	0	728	0	15.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	146,466	42,499	141,832	15,392	35,761	30.00
31.00	03100	INTENSIVE CARE UNIT	53,008	10,924	37,384	2,912	12,870	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	23,244	9,585	12,669	2,496	6,510	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	32,992	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	102,298	34,453	67,486	7,696	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	79,714	20,686	51,064	3,328	0	54.00
57.00	05700	CT SCAN	17,166	1,505	24,120	1,040	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	8,688	1,784	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	23,329	5,040	9,465	1,560	0	59.00
60.00	06000	LABORATORY	98,418	14,155	222	2,912	0	60.00
60.01	06001	ONCOLOGY	0	0	2,079	0	0	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	32,023	6,702	6,134	2,184	0	65.00
66.00	06600	PHYSICAL THERAPY	24,383	6,997	14,733	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	34,369	7,954	6,144	1,872	0	69.00
69.01	06901	CARDIAC REHAB	5,600	1,296	0	1,560	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	10,982	4,895	2,885	1,040	0	90.00
91.00	09100	EMERGENCY	143,593	11,071	267,618	8,320	3,191	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	58,304	4,150	20,696	416	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,020,976	201,910	743,504	56,160	58,332	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	832	1,329	0	156	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PACT REV PHYSICIANS	3,405	0	0	0	0	192.01
192.02	19202	VISITOR MEALS	0	0	0	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	0	0	0	192.03
192.04	19204	LIFELINE	0	0	0	0	0	192.04
192.05	19205	OWNED PROPERTIES	0	0	0	0	0	192.05
192.06	19206	UROLOGY	15,597	0	0	0	0	192.06
192.07	19207	PHYSICIANS' PRIVATE OFFICES	0	0	0	208	0	192.07
192.08	19211	PARISH NURSING	847	0	0	104	0	192.08
192.09	19212	BIOTERRORISM GRANT	0	0	0	0	0	192.09
192.10	19214	BREAST PUMPS	0	0	0	0	0	192.10
192.11	19208	MGH EMERGENCY PHYSICIANS	0	0	0	0	0	192.11
192.12	19209	LUNG CENTER	4,491	0	0	0	0	192.12
192.13	19213	MGH EXPRESS	0	0	1,188	0	0	192.13
192.14	19210	MGH PHYS PRACT MGMT	66,815	0	0	520	0	192.14
192.15	19215	MGH MARION SURGEONS	17,340	0	95	0	0	192.15
192.16	19216	MGH MGH MED ONC	0	0	0	0	0	192.16

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024

Worksheet B-1

Date/Time Prepared:
11/26/2024 3:43 pm

Cost Center Description			CAFETERIA (HOURS WORKED)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			6.02	7.00	8.00	9.00	10.00	
192.17	19217	MGH FMC SOUTH	0	0	0	0	0	192.17
192.18	19218	MGH FAIRM MED ASSOC	0	0	45	0	0	192.18
192.19	19219	MGH FMC MARION	12,295	0	0	0	0	192.19
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	0	0	0	0	0	193.01
193.02	19302	MGH FMC GAS CITY	0	0	204	0	0	193.02
193.03	19303	MGH HOSPITALISTS	0	0	0	0	0	193.03
193.04	19304	MGH MAR FAM PRACT	0	0	622	0	0	193.04
193.05	19305	MGH FMC SWAYZEE	0	0	0	0	0	193.05
193.06	19306	MGH PEDIATRIC CTR	13,692	0	34	0	0	193.06
193.07	19307	MGH SPECIALTY PHYS	2,547	0	0	0	0	193.07
193.08	19308	MGH FMC CONVERSE	0	0	100	0	0	193.08
193.09	19309	MGH UPLAND HEALTH	0	0	123	0	0	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	0	193.11
193.12	19312	OB/GYN	0	0	43	0	0	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
193.16	19316	MGH NEONATOLOGY	0	0	0	0	0	193.16
193.18	19318	MGH WOUND CARE	0	0	0	0	0	193.18
194.00	07963	HEART FAILURE CLINIC	0	0	0	0	0	194.00
194.01	07950	MOW	0	0	0	0	13,055	194.01
194.02	07951	MENTAL HEALTH	0	0	0	0	6,329	194.02
194.03	07952	ADVERTISING	4,813	0	0	0	0	194.03
194.04	07953	MGH WORK SOLUTIONS	0	0	15	0	0	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	0	0	194.05
194.06	07955	OPIOID IMPL GRANT	0	0	0	0	0	194.06
194.07	07956	ASTHMA GRANT	0	0	0	0	0	194.07
194.08	07957	MGH SMMP BLDG	0	0	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	0	0	194.10
194.11	07960	FAIRMOUNT	0	0	0	0	0	194.11
194.12	07961	GAS CITY	0	0	0	0	0	194.12
194.13	07969	LYONS	0	0	0	0	0	194.13
194.14	07964	WABASH	0	0	0	0	0	194.14
194.15	07965	TOBACCO GRANT	14	0	0	0	0	194.15
194.16	07966	HRSA NETWORK DEV PLANNING	0	0	0	0	0	194.16
194.17	07967	HRSA OPIOID PLANNING	0	0	0	0	0	194.17
194.18	07962	ECHO GRANT	0	0	0	0	0	194.18
194.19	07968	RURAL QI GRANT	263	0	0	0	0	194.19
194.20	07970	MGH DIABETES GRANT	0	0	0	0	0	194.20
194.21	07971	MGH MGH ORTHO	0	0	0	0	0	194.21
194.22	07972	MGH BELLA BLDG	0	0	0	0	0	194.22
194.23	07973	DIABETES GRANT	0	0	0	0	0	194.23
194.24	07974	HEALTH SYS GRANT	0	0	0	0	0	194.24
194.25	07975	MGH MGH ORTHO	0	0	0	0	0	194.25
194.26	07976	FIMR GRANT - 8841	370	0	0	0	0	194.26
194.27	07978	OTHER NONREIMURSABLE COST CENTERS	0	0	0	0	0	194.27
194.28	07977	MGH HEALTH ISS GNT	1,838	0	0	0	0	194.28
194.29	07980	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.29
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,439,020	11,599,708	515,607	4,087,413	1,424,180	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.091542	57.074223	0.691187	71.523290	18.325441	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	154,412	2,330,147	79,870	186,028	263,353	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.132413	11.465058	0.107068	3.255197	3.388659	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: 15-0011

Period:
From 07/01/2023
To 06/30/2024

Worksheet B-1

Date/Time Prepared:
11/26/2024 3:43 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY (COSTED REQUIS.)	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)		
		(DIRECT NRSING HRS)	(COSTED REQUIS.)				
		13.00	14.00	15.00	22.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
6.01	00601	CAFETERIA					6.01
6.02	00602	CAFETERIA					6.02
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
13.00	01300	NURSING ADMINISTRATION	766,858				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,935	100			14.00
15.00	01500	PHARMACY	0	0	100		15.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0		22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	146,466	13	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	53,008	4	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	23,244	1	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	32,992	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	102,298	22	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	23,329	10	0	0	59.00
60.00	06000	LABORATORY	0	1	0	0	60.00
60.01	06001	ONCOLOGY	37,316	1	0	0	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	60.02
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	36,671	1	0	0	65.00
66.00	06600	PHYSICAL THERAPY	24,383	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	34,369	3	0	0	69.00
69.01	06901	CARDIAC REHAB	5,600	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	10,982	0	0	0	90.00
91.00	09100	EMERGENCY	143,593	5	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	58,304	1	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	740,490	64	100	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	PACT REV PHYSICIANS	0	0	0	0	192.01
192.02	19202	VISITOR MEALS	0	0	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	0	0	192.03
192.04	19204	LIFELINE	0	0	0	0	192.04
192.05	19205	OWNED PROPERTIES	0	0	0	0	192.05
192.06	19206	UROLOGY	0	3	0	0	192.06
192.07	19207	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.07
192.08	19211	PARISH NURSING	0	0	0	0	192.08
192.09	19212	BIOTERRORISM GRANT	0	0	0	0	192.09
192.10	19214	BREAST PUMPS	0	0	0	0	192.10
192.11	19208	MGH EMERGENCY PHYSICIANS	0	0	0	0	192.11
192.12	19209	LUNG CENTER	0	0	0	0	192.12
192.13	19213	MGH EXPRESS	26,368	1	0	0	192.13

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024

Worksheet B-1

Date/Time Prepared:
11/26/2024 3:43 pm

Cost Center Description			NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)	
			13.00	14.00	15.00	22.00	
192.14	19210	MGH PHYS PRACT MGMT	0	0	0	0	192.14
192.15	19215	MGH MARION SURGEONS	0	3	0	0	192.15
192.16	19216	MGH MGH MED ONC	0	0	0	0	192.16
192.17	19217	MGH FMC SOUTH	0	3	0	0	192.17
192.18	19218	MGH FAIRM MED ASSOC	0	0	0	0	192.18
192.19	19219	MGH FMC MARION	0	3	0	0	192.19
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	0	1	0	0	193.01
193.02	19302	MGH FMC GAS CITY	0	1	0	0	193.02
193.03	19303	MGH HOSPITALISTS	0	0	0	0	193.03
193.04	19304	MGH MAR FAM PRACT	0	4	0	0	193.04
193.05	19305	MGH FMC SWAYZEE	0	1	0	0	193.05
193.06	19306	MGH PEDIATRIC CTR	0	1	0	0	193.06
193.07	19307	MGH SPECIALTY PHYS	0	0	0	0	193.07
193.08	19308	MGH FMC CONVERSE	0	1	0	0	193.08
193.09	19309	MGH UPLAND HEALTH	0	0	0	0	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	193.11
193.12	19312	OB/GYN	0	10	0	0	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	193.15
193.16	19316	MGH NEONATOLOGY	0	0	0	0	193.16
193.18	19318	MGH WOUND CARE	0	0	0	0	193.18
194.00	07963	HEART FAILURE CLINIC	0	0	0	0	194.00
194.01	07950	MOW	0	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	0	0	194.02
194.03	07952	ADVERTISING	0	0	0	0	194.03
194.04	07953	MGH WORK SOLUTIONS	0	1	0	0	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	0	194.05
194.06	07955	OPIOID IMPL GRANT	0	0	0	0	194.06
194.07	07956	ASTHMA GRANT	0	0	0	0	194.07
194.08	07957	MGH SMMP BLDG	0	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	0	194.10
194.11	07960	FAIRMOUNT	0	0	0	0	194.11
194.12	07961	GAS CITY	0	1	0	0	194.12
194.13	07969	LYONS	0	0	0	0	194.13
194.14	07964	WABASH	0	0	0	0	194.14
194.15	07965	TOBACCO GRANT	0	0	0	0	194.15
194.16	07966	HRSA NETWORK DEV PLANNING	0	0	0	0	194.16
194.17	07967	HRSA OPIOID PLANNING	0	0	0	0	194.17
194.18	07962	ECHO GRANT	0	0	0	0	194.18
194.19	07968	RURAL QI GRANT	0	0	0	0	194.19
194.20	07970	MGH DIABETES GRANT	0	0	0	0	194.20
194.21	07971	MGH MGH ORTHO	0	0	0	0	194.21
194.22	07972	MGH BELLA BLDG	0	0	0	0	194.22
194.23	07973	DIABETES GRANT	0	0	0	0	194.23
194.24	07974	HEALTH SYS GRANT	0	0	0	0	194.24
194.25	07975	MGH MGH ORTHO	0	2	0	0	194.25
194.26	07976	FIMR GRANT - 8841	0	0	0	0	194.26
194.27	07978	OTHER NONREIMURSABLE COST CENTERS	0	0	0	0	194.27
194.28	07977	MGH HEALTH ISS GNT	0	0	0	0	194.28
194.29	07980	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.29
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)	1,743,502	1,035,675	5,811,504	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.273566	10,356.750000	58,115.040000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	60,890	104,056	224,650	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.079402	1,040.560000	2,246.500000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024Worksheet C
Part I
Date/Time Prepared:
11/26/2024 3:43 pm

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	16,799,973		16,799,973	0	16,799,973	30.00
31.00	03100	INTENSIVE CARE UNIT	7,347,739		7,347,739	0	7,347,739	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	4,005,780		4,005,780	0	4,005,780	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	2,538,951		2,538,951	0	2,538,951	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	16,052,119		16,052,119	0	16,052,119	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,672,395		8,672,395	0	8,672,395	54.00
57.00	05700	CT SCAN	1,898,706		1,898,706	0	1,898,706	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,014,823		1,014,823	0	1,014,823	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,075,530		4,075,530	0	4,075,530	59.00
60.00	06000	LABORATORY	13,668,540		13,668,540	0	13,668,540	60.00
60.01	06001	ONCOLOGY	2,626,658		2,626,658	0	2,626,658	60.01
60.02	06002	RADIATION ONCOLOGY	0		0	0	0	60.02
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	5,892,677	0	5,892,677	0	5,892,677	65.00
66.00	06600	PHYSICAL THERAPY	4,522,531	0	4,522,531	0	4,522,531	66.00
69.00	06900	ELECTROCARDIOLOGY	2,644,985		2,644,985	0	2,644,985	69.00
69.01	06901	CARDIAC REHAB	621,963		621,963	0	621,963	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,259,955		22,259,955	0	22,259,955	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,897,901		1,897,901	0	1,897,901	90.00
91.00	09100	EMERGENCY	14,028,688		14,028,688	0	14,028,688	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,002,495		5,002,495		5,002,495	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0		0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	3,269,680		3,269,680	0	3,269,680	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	138,842,089	0	138,842,089	0	138,842,089	200.00
201.00		Less Observation Beds	5,002,495		5,002,495		5,002,495	201.00
202.00		Total (see instructions)	133,839,594	0	133,839,594	0	133,839,594	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024Worksheet C
Part I
Date/Time Prepared:
11/26/2024 3:43 pm

			Title XVIII		Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	13,574,299		13,574,299			30.00
31.00	03100	INTENSIVE CARE UNIT	7,797,904		7,797,904			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
41.00	04100	SUBPROVIDER - IRF	3,141,056		3,141,056			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	2,705,140		2,705,140			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	30,553,180	95,016,508	125,569,688	0.127834	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,325,070	34,027,222	36,352,292	0.238565	0.000000	54.00
57.00	05700	CT SCAN	5,331,076	37,895,649	43,226,725	0.043924	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	404,822	3,668,970	4,073,792	0.249110	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,244,322	9,812,951	14,057,273	0.289923	0.000000	59.00
60.00	06000	LABORATORY	3,761,150	16,685,182	20,446,332	0.668508	0.000000	60.00
60.01	06001	ONCOLOGY	31,163	7,245,046	7,276,209	0.360993	0.000000	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0.000000	0.000000	60.02
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	2,634,344	7,686,022	10,320,366	0.570976	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,708,484	7,048,258	11,756,742	0.384676	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	4,095,254	11,175,355	15,270,609	0.173208	0.000000	69.00
69.01	06901	CARDIAC REHAB	500	1,333,727	1,334,227	0.466160	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,905,612	80,065,739	86,971,351	0.255946	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	9,120	4,305,027	4,314,147	0.439925	0.000000	90.00
91.00	09100	EMERGENCY	16,016,066	88,254,226	104,270,292	0.134542	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	542,750	11,348,235	11,890,985	0.420696	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0.000000	0.000000	92.01
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	7,405,476	7,405,476	0.441522	0.000000	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	108,781,312	422,973,593	531,754,905			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	108,781,312	422,973,593	531,754,905			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024Worksheet C
Part I
Date/Time Prepared:
11/26/2024 3:43 pm

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF				41.00
42.00	04200	SUBPROVIDER				42.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.127834			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.238565			54.00
57.00	05700	CT SCAN	0.043924			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.249110			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.289923			59.00
60.00	06000	LABORATORY	0.668508			60.00
60.01	06001	ONCOLOGY	0.360993			60.01
60.02	06002	RADIATION ONCOLOGY	0.000000			60.02
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500	RESPIRATORY THERAPY	0.570976			65.00
66.00	06600	PHYSICAL THERAPY	0.384676			66.00
69.00	06900	ELECTROCARDIOLOGY	0.173208			69.00
69.01	06901	CARDIAC REHAB	0.466160			69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.255946			73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000			77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000			78.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.439925			90.00
91.00	09100	EMERGENCY	0.134542			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.420696			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000			92.01
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.441522			95.00
102.00	10200	OPIOID TREATMENT PROGRAM				102.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

Worksheet C
Part I
Date/Time Prepared:
11/26/2024 3:43 pm

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COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024Worksheet C
Part I
Date/Time Prepared:
11/26/2024 3:43 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	13,574,299		13,574,299			30.00
31.00	03100	INTENSIVE CARE UNIT	7,797,904		7,797,904			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
41.00	04100	SUBPROVIDER - IRF	3,141,056		3,141,056			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	2,705,140		2,705,140			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	30,553,180	95,016,508	125,569,688	0.127834	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,325,070	34,027,222	36,352,292	0.238565	0.000000	54.00
57.00	05700	CT SCAN	5,331,076	37,895,649	43,226,725	0.043924	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	404,822	3,668,970	4,073,792	0.249110	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,244,322	9,812,951	14,057,273	0.289923	0.000000	59.00
60.00	06000	LABORATORY	3,761,150	16,685,182	20,446,332	0.668508	0.000000	60.00
60.01	06001	ONCOLOGY	31,163	7,245,046	7,276,209	0.360993	0.000000	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0.000000	0.000000	60.02
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	2,634,344	7,686,022	10,320,366	0.570976	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,708,484	7,048,258	11,756,742	0.384676	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	4,095,254	11,175,355	15,270,609	0.173208	0.000000	69.00
69.01	06901	CARDIAC REHAB	500	1,333,727	1,334,227	0.466160	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,905,612	80,065,739	86,971,351	0.255946	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	9,120	4,305,027	4,314,147	0.439925	0.000000	90.00
91.00	09100	EMERGENCY	16,016,066	88,254,226	104,270,292	0.134542	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	542,750	11,348,235	11,890,985	0.420696	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0.000000	0.000000	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	7,405,476	7,405,476	0.441522	0.000000	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	108,781,312	422,973,593	531,754,905			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	108,781,312	422,973,593	531,754,905			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024Worksheet C
Part I
Date/Time Prepared:
11/26/2024 3:43 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
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF				41.00
42.00	04200	SUBPROVIDER				42.00
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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
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
60.01	06001	ONCOLOGY	0.000000			60.01
60.02	06002	RADIATION ONCOLOGY	0.000000			60.02
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
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
69.01	06901	CARDIAC REHAB	0.000000			69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000			77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000			78.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000			92.01
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000			95.00
102.00	10200	OPIOID TREATMENT PROGRAM				102.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024Worksheet D
Part I
Date/Time Prepared:
11/26/2024 3:43 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	1,944,896	0	1,944,896	12,812	151.80	30.00
31.00	INTENSIVE CARE UNIT	569,711		569,711	4,611	123.55	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
41.00	SUBPROVIDER - IRF	429,954	0	429,954	2,237	192.20	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	55,388		55,388	1,413	39.20	43.00
200.00	Total (lines 30 through 199)	2,999,949		2,999,949	21,073		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	3,303	501,395				30.00
31.00	INTENSIVE CARE UNIT	319	39,412				31.00
40.00	SUBPROVIDER - IPF	0	0				40.00
41.00	SUBPROVIDER - IRF	1,269	243,902				41.00
42.00	SUBPROVIDER	0	0				42.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	4,891	784,709				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024Worksheet D
Part II
Date/Time Prepared:
11/26/2024 3:43 pm

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)	Hospital Inpatient Program Charges	PPS Capital Costs (column 3 x column 4)	
				1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,522,678	125,569,688	0.012126	7,128,748	86,443	50.00	
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	887,045	36,352,292	0.024401	819,290	19,991	54.00	
57.00	05700	CT SCAN	93,419	43,226,725	0.002161	2,386,504	5,157	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	80,615	4,073,792	0.019789	134,607	2,664	58.00	
59.00	05900	CARDIAC CATHETERIZATION	263,231	14,057,273	0.018726	1,214,443	22,742	59.00	
60.00	06000	LABORATORY	753,347	20,446,332	0.036845	1,171,853	43,177	60.00	
60.01	06001	ONCOLOGY	54,300	7,276,209	0.007463	15,651	117	60.01	
60.02	06002	RADIATION ONCOLOGY	0	0	0.000000	0	0	60.02	
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	350,086	10,320,366	0.033922	614,560	20,847	65.00	
66.00	06600	PHYSICAL THERAPY	329,923	11,756,742	0.028062	625,029	17,540	66.00	
69.00	06900	ELECTROCARDIOLOGY	331,368	15,270,609	0.021700	1,482,248	32,165	69.00	
69.01	06901	CARDIAC REHAB	59,616	1,334,227	0.044682	0	0	69.01	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	526,518	86,971,351	0.006054	2,100,279	12,715	73.00	
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00	
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	204,896	4,314,147	0.047494	0	0	90.00	
91.00	09100	EMERGENCY	737,748	104,270,292	0.007075	4,635,406	32,795	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	579,129	11,890,985	0.048703	526,698	25,652	92.00	
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000	0	0	92.01	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES						95.00	
200.00		Total (lines 50 through 199)	6,773,919	497,131,030		22,855,316	322,005	200.00	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0011	Period: From 07/01/2023 To 06/30/2024	Worksheet D Part III Date/Time Prepared: 11/26/2024 3:43 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	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	12,812	0.00	3,303	30.00
31.00	03100	INTENSIVE CARE UNIT		0	4,611	0.00	319	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0.00	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	2,237	0.00	1,269	41.00
42.00	04200	SUBPROVIDER	0	0	0	0.00	0	42.00
43.00	04300	NURSERY		0	1,413	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	21,073		4,891	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					
31.00	03100	INTENSIVE CARE UNIT	0					
40.00	04000	SUBPROVIDER - IPF	0					
41.00	04100	SUBPROVIDER - IRF	0					
42.00	04200	SUBPROVIDER	0					
43.00	04300	NURSERY	0					
200.00		Total (lines 30 through 199)	0					

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 15-0011		Period: From 07/01/2023 To 06/30/2024		Worksheet D Part IV Date/Time Prepared: 11/26/2024 3:43 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
60.01	06001	ONCOLOGY	0	0	0	0	0	0	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0	0	60.02
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 15-0011		Period: From 07/01/2023 To 06/30/2024		Worksheet D Part IV Date/Time Prepared: 11/26/2024 3:43 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	125,569,688	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	36,352,292	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	43,226,725	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	4,073,792	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	14,057,273	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	20,446,332	0.000000	60.00
60.01	06001	ONCOLOGY	0	0	0	7,276,209	0.000000	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0.000000	60.02
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,320,366	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	11,756,742	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	15,270,609	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	0	0	1,334,227	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	86,971,351	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	4,314,147	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	104,270,292	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	11,890,985	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0.000000	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0.000000	95.00
200.00		Total (lines 50 through 199)	0	0	0	497,131,030		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 15-0011		Period: From 07/01/2023 To 06/30/2024		Worksheet D Part IV Date/Time Prepared: 11/26/2024 3:43 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		7,128,748	0	11,964,473	0	50.00
51.00	05100	RECOVERY ROOM	0.000000		0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		819,290	0	6,735,190	0	54.00
57.00	05700	CT SCAN	0.000000		2,386,504	0	6,226,247	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		134,607	0	772,978	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		1,214,443	0	2,751,400	0	59.00
60.00	06000	LABORATORY	0.000000		1,171,853	0	1,300,328	0	60.00
60.01	06001	ONCOLOGY	0.000000		15,651	0	2,250,584	0	60.01
60.02	06002	RADIATION ONCOLOGY	0.000000		0	0	0	0	60.02
64.00	06400	INTRAVENOUS THERAPY	0.000000		0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		614,560	0	1,234,043	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000		625,029	0	15,091	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		1,482,248	0	2,057,169	0	69.00
69.01	06901	CARDIAC REHAB	0.000000		0	0	472,130	0	69.01
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		2,100,279	0	26,360,756	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000		0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000		0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000		0	0	991,255	0	90.00
91.00	09100	EMERGENCY	0.000000		4,635,406	0	10,098,460	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		526,698	0	809,880	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000		0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)			22,855,316	0	74,039,984	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024Worksheet D
Part V
Date/Time Prepared:
11/26/2024 3:43 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	0.127834	11,964,473	0	0	1,529,466	50.00	
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.238565	6,735,190	0	0	1,606,781	54.00	
57.00	05700	CT SCAN	0.043924	6,226,247	0	0	273,482	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.249110	772,978	0	0	192,557	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.289923	2,751,400	0	0	797,694	59.00	
60.00	06000	LABORATORY	0.668508	1,300,328	2,106	0	869,280	60.00	
60.01	06001	ONCOLOGY	0.360993	2,250,584	0	0	812,445	60.01	
60.02	06002	RADIATION ONCOLOGY	0.000000	0	0	0	0	60.02	
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0.570976	1,234,043	0	0	704,609	65.00	
66.00	06600	PHYSICAL THERAPY	0.384676	15,091	0	0	5,805	66.00	
69.00	06900	ELECTROCARDIOLOGY	0.173208	2,057,169	0	0	356,318	69.00	
69.01	06901	CARDIAC REHAB	0.466160	472,130	0	0	220,088	69.01	
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	0.255946	26,360,756	0	3,200	6,746,930	73.00	
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00	
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.439925	991,255	0	0	436,078	90.00	
91.00	09100	EMERGENCY	0.134542	10,098,460	0	129	1,358,667	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.420696	809,880	0	0	340,713	92.00	
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	92.01	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0.441522		0			95.00	
200.00		Subtotal (see instructions)		74,039,984	2,106	3,329	16,250,913	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00		Net Charges (line 200 - line 201)		74,039,984	2,106	3,329	16,250,913	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 15-0011		Period: From 07/01/2023 To 06/30/2024		Worksheet D Part V Date/Time Prepared: 11/26/2024 3:43 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
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	1,408	0					60.00
60.01	06001	ONCOLOGY	0	0					60.01
60.02	06002	RADIATION ONCOLOGY	0	0					60.02
64.00	06400	INTRAVENOUS THERAPY	0	0					64.00
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
69.01	06901	CARDIAC REHAB	0	0					69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	819					73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0					77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0					78.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0					90.00
91.00	09100	EMERGENCY	0	17					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0					92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0					92.01
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0						95.00
200.00		Subtotal (see instructions)	1,408	836					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	1,408	836					202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 15-0011 Component CCN: 15-T011	Period: From 07/01/2023 To 06/30/2024	Worksheet D Part II Date/Time Prepared: 11/26/2024 3:43 pm	
				Title XVIII	Subprovider - IRF	PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,522,678	125,569,688	0.012126	3,800	46
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	887,045	36,352,292	0.024401	24,694	603
57.00	05700	CT SCAN	93,419	43,226,725	0.002161	81,032	175
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	80,615	4,073,792	0.019789	20,788	411
59.00	05900	CARDIAC CATHETERIZATION	263,231	14,057,273	0.018726	3,906	73
60.00	06000	LABORATORY	753,347	20,446,332	0.036845	66,731	2,459
60.01	06001	ONCOLOGY	54,300	7,276,209	0.007463	160	1
60.02	06002	RADIATION ONCOLOGY	0	0	0.000000	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0
65.00	06500	RESPIRATORY THERAPY	350,086	10,320,366	0.033922	25,055	850
66.00	06600	PHYSICAL THERAPY	329,923	11,756,742	0.028062	1,657,959	46,526
69.00	06900	ELECTROCARDIOLOGY	331,368	15,270,609	0.021700	40,508	879
69.01	06901	CARDIAC REHAB	59,616	1,334,227	0.044682	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	526,518	86,971,351	0.006054	172,334	1,043
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	204,896	4,314,147	0.047494	0	0
91.00	09100	EMERGENCY	737,748	104,270,292	0.007075	30,974	219
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	11,890,985	0.000000	0	0
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000	0	0
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES					
200.00		Total (lines 50 through 199)	6,194,790	497,131,030		2,127,941	53,285

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 15-0011 Component CCN: 15-T011		Period: From 07/01/2023 To 06/30/2024		Worksheet D Part IV Date/Time Prepared: 11/26/2024 3:43 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
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
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
60.01	06001	ONCOLOGY		0	0	0	0	0	60.01
60.02	06002	RADIATION ONCOLOGY		0	0	0	0	0	60.02
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0	64.00
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
69.01	06901	CARDIAC REHAB		0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION		0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY		0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
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
92.01	09201	OBSERVATION BEDS (DISTINCT PART)		0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
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: 15-0011 Component CCN: 15-T011		Period: From 07/01/2023 To 06/30/2024		Worksheet D Part IV Date/Time Prepared: 11/26/2024 3:43 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	125,569,688	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	36,352,292	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	43,226,725	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	4,073,792	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	14,057,273	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	20,446,332	0.000000	60.00
60.01	06001	ONCOLOGY	0	0	0	7,276,209	0.000000	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0.000000	60.02
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,320,366	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	11,756,742	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	15,270,609	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	0	0	1,334,227	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	86,971,351	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	4,314,147	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	104,270,292	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	11,890,985	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0.000000	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	497,131,030		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 15-0011 Component CCN: 15-T011		Period: From 07/01/2023 To 06/30/2024		Worksheet D Part IV Date/Time Prepared: 11/26/2024 3:43 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		3,800	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000		0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		24,694	0	0	0	54.00
57.00	05700	CT SCAN	0.000000		81,032	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		20,788	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		3,906	0	0	0	59.00
60.00	06000	LABORATORY	0.000000		66,731	0	0	0	60.00
60.01	06001	ONCOLOGY	0.000000		160	0	0	0	60.01
60.02	06002	RADIATION ONCOLOGY	0.000000		0	0	0	0	60.02
64.00	06400	INTRAVENOUS THERAPY	0.000000		0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		25,055	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000		1,657,959	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		40,508	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0.000000		0	0	0	0	69.01
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		172,334	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000		0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000		0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000		0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000		30,974	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000		0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)			2,127,941	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0011	Period: From 07/01/2023 To 06/30/2024	Worksheet D-1 Date/Time Prepared: 11/26/2024 3:43 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)		12,812	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		12,812	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)		8,997	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)		3,303	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)		16,799,973	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)		16,799,973	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)		16,799,973	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)		1,311.27	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,331,125	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		4,331,125	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024

Worksheet D-1

Date/Time Prepared:

11/26/2024 3:43 pm

Cost Center Description		Title XVIII			Hospital		PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
	Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	7,347,739	4,611	1,593.52	319	508,333		43.00
44.00	CORONARY CARE UNIT							44.00
45.00	BURN INTENSIVE CARE UNIT							45.00
46.00	SURGICAL INTENSIVE CARE UNIT							46.00
47.00	OTHER SPECIAL CARE (SPECIFY)							47.00
	Cost Center Description							
						1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					4,617,110		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)					9,456,568		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)					540,807		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					322,005		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					862,812		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					8,593,756		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0		54.00
55.00	Target amount per discharge					0.00		55.00
55.01	Permanent adjustment amount per discharge					0.00		55.01
55.02	Adjustment amount per discharge (contractor use only)					0.00		55.02
55.03	CAR T-cell amount paid as an interim payment					0		55.03
56.00	Target amount ((line 54 x sum of lines 55, 55.01, and 55.02) plus line 55.03)					0		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00	Bonus payment (see instructions)					0		58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00		59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00		60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0		61.00
62.00	Relief payment (see instructions)					0		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					0		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00	Program capital-related costs (line 9 x line 76)							77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					3,815		87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,311.27		88.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0011		Period: From 07/01/2023 To 06/30/2024		Worksheet D-1 Date/Time Prepared: 11/26/2024 3:43 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description								1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)						5,002,495	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	1,944,896	16,799,973	0.115768	5,002,495	579,129	90.00		
91.00	Nursing Program cost	0	16,799,973	0.000000	5,002,495	0	91.00		
92.00	Allied health cost	0	16,799,973	0.000000	5,002,495	0	92.00		
93.00	All other Medical Education	0	16,799,973	0.000000	5,002,495	0	93.00		

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0011 Component CCN: 15-T011	Period: From 07/01/2023 To 06/30/2024	Worksheet D-1 Date/Time Prepared: 11/26/2024 3:43 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)		2,237	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,237	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)		2,237	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,269	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)		4,005,780	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)		4,005,780	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)		4,005,780	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)		1,790.69	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,272,386	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,272,386	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0011 Component CCN: 15-T011	Period: From 07/01/2023 To 06/30/2024	Worksheet D-1 Date/Time Prepared: 11/26/2024 3:43 pm
			Title XVIII	Subprovider - IRF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0
44.00 CORONARY CARE UNIT					
45.00 BURN INTENSIVE CARE UNIT					
46.00 SURGICAL INTENSIVE CARE UNIT					
47.00 OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					768,288
48.01 Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0
49.00 Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					3,040,674
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					243,902
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					53,285
52.00 Total Program excludable cost (sum of lines 50 and 51)					297,187
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,743,487
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
55.01 Permanent adjustment amount per discharge					0.00
55.02 Adjustment amount per discharge (contractor use only)					0.00
55.03 CAR T-cell amount paid as an interim payment					
56.00 Target amount ((line 54 x sum of lines 55, 55.01, and 55.02) plus line 55.03)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
59.00 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00
60.00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00
61.00 Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0
62.00 Relief payment (see instructions)					0
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					0
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					0

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0011 Component CCN: 15-T011	Period: From 07/01/2023 To 06/30/2024	Worksheet D-1 Date/Time Prepared: 11/26/2024 3:43 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	429,954	4,005,780	0.107333	0	0	90.00
91.00	Nursing Program cost	0	4,005,780	0.000000	0	0	91.00
92.00	Allied health cost	0	4,005,780	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,005,780	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024

Worksheet D-1

Date/Time Prepared:
11/26/2024 3:43 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)	12,812	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,812	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)	8,997	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)	517	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)	1,413	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)	16,799,973	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)	16,799,973	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)	16,799,973	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)	1,311.27	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	677,927	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)	677,927	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024

Worksheet D-1

Date/Time Prepared:
11/26/2024 3:43 pm

Cost Center Description		Title XIX		Hospital		Cost	
		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)	2,538,951	1,413	1,796.85	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	7,347,739	4,611	1,593.52	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					533,861	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)					1,211,788	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
55.01	Permanent adjustment amount per discharge					0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)					0.00	55.02
55.03	CAR T-cell amount paid as an interim payment					0	55.03
56.00	Target amount ((line 54 x sum of lines 55, 55.01, and 55.02) plus line 55.03)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					3,815	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,311.27	88.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0011		Period: From 07/01/2023 To 06/30/2024		Worksheet D-1 Date/Time Prepared: 11/26/2024 3:43 pm	
				Title XIX		Hospital		Cost	
Cost Center Description								1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					5,002,495		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	1,944,896	16,799,973	0.115768	5,002,495	579,129	90.00		
91.00	Nursing Program cost	0	16,799,973	0.000000	5,002,495	0	91.00		
92.00	Allied health cost	0	16,799,973	0.000000	5,002,495	0	92.00		
93.00	All other Medical Education	0	16,799,973	0.000000	5,002,495	0	93.00		

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0011 Component CCN: 15-T011	Period: From 07/01/2023 To 06/30/2024	Worksheet D-1 Date/Time Prepared: 11/26/2024 3:43 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)		2,237	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,237	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)		2,237	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)		14	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)		1,413	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)		4,005,780	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)		4,005,780	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)		4,005,780	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)		1,790.69	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		25,070	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)		25,070	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0011 Component CCN: 15-T011	Period: From 07/01/2023 To 06/30/2024	Worksheet D-1 Date/Time Prepared: 11/26/2024 3:43 pm	
				Title XIX	Subprovider - IRF	Cost	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					9,283	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)					34,353	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: 15-0011 Component CCN: 15-T011	Period: From 07/01/2023 To 06/30/2024	Worksheet D-1 Date/Time Prepared: 11/26/2024 3:43 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	429,954	4,005,780	0.107333	0	0	90.00
91.00	Nursing Program cost	0	4,005,780	0.000000	0	0	91.00
92.00	Allied health cost	0	4,005,780	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,005,780	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 15-0011	Period: From 07/01/2023 To 06/30/2024	Worksheet D-3 Date/Time Prepared: 11/26/2024 3:43 pm
			Title XVIII	Hospital	PPS
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		4,608,351	30.00
31.00	03100	INTENSIVE CARE UNIT		770,332	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.127834	7,128,748	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.238565	819,290	54.00
57.00	05700	CT SCAN	0.043924	2,386,504	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.249110	134,607	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.289923	1,214,443	59.00
60.00	06000	LABORATORY	0.668508	1,171,853	60.00
60.01	06001	ONCOLOGY	0.360993	15,651	60.01
60.02	06002	RADIATION ONCOLOGY	0.000000	0	60.02
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.570976	614,560	65.00
66.00	06600	PHYSICAL THERAPY	0.384676	625,029	66.00
69.00	06900	ELECTROCARDIOLOGY	0.173208	1,482,248	69.00
69.01	06901	CARDIAC REHAB	0.466160	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.255946	2,100,279	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	78.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.439925	0	90.00
91.00	09100	EMERGENCY	0.134542	4,635,406	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.420696	526,698	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	92.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		22,855,316	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)		22,855,316	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0011 Component CCN: 15-T011	Period: From 07/01/2023 To 06/30/2024	Worksheet D-3 Date/Time Prepared: 11/26/2024 3:43 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
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF		1,823,919	41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.127834	3,800	486 50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0 51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.238565	24,694	5,891 54.00
57.00	05700	CT SCAN	0.043924	81,032	3,559 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.249110	20,788	5,178 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.289923	3,906	1,132 59.00
60.00	06000	LABORATORY	0.668508	66,731	44,610 60.00
60.01	06001	ONCOLOGY	0.360993	160	58 60.01
60.02	06002	RADIATION ONCOLOGY	0.000000	0	0 60.02
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0.570976	25,055	14,306 65.00
66.00	06600	PHYSICAL THERAPY	0.384676	1,657,959	637,777 66.00
69.00	06900	ELECTROCARDIOLOGY	0.173208	40,508	7,016 69.00
69.01	06901	CARDIAC REHAB	0.466160	0	0 69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.255946	172,334	44,108 73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0 77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0 78.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.439925	0	0 90.00
91.00	09100	EMERGENCY	0.134542	30,974	4,167 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.420696	0	0 92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0 92.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,127,941	768,288 200.00
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)		2,127,941	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 15-0011	Period: From 07/01/2023 To 06/30/2024	Worksheet D-3 Date/Time Prepared: 11/26/2024 3:43 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		726,457	30.00
31.00	03100	INTENSIVE CARE UNIT		291,432	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.127834	930,886	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.238565	80,258	54.00
57.00	05700	CT SCAN	0.043924	155,624	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.249110	10,562	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.289923	219,094	59.00
60.00	06000	LABORATORY	0.668508	171,633	60.00
60.01	06001	ONCOLOGY	0.360993	0	60.01
60.02	06002	RADIATION ONCOLOGY	0.000000	0	60.02
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.570976	88,933	65.00
66.00	06600	PHYSICAL THERAPY	0.384676	24,620	66.00
69.00	06900	ELECTROCARDIOLOGY	0.173208	104,622	69.00
69.01	06901	CARDIAC REHAB	0.466160	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.255946	220,978	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	78.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.439925	0	90.00
91.00	09100	EMERGENCY	0.134542	543,032	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.420696	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	92.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,550,242	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		2,550,242	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0011 Component CCN: 15-T011	Period: From 07/01/2023 To 06/30/2024	Worksheet D-3 Date/Time Prepared: 11/26/2024 3:43 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
40.00	04000 SUBPROVIDER - IPF				40.00
41.00	04100 SUBPROVIDER - IRF		19,936		41.00
42.00	04200 SUBPROVIDER				42.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.127834	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.238565	0	0	54.00
57.00	05700 CT SCAN	0.043924	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.249110	990	247	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.289923	0	0	59.00
60.00	06000 LABORATORY	0.668508	203	136	60.00
60.01	06001 ONCOLOGY	0.360993	0	0	60.01
60.02	06002 RADIATION ONCOLOGY	0.000000	0	0	60.02
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.570976	1,190	679	65.00
66.00	06600 PHYSICAL THERAPY	0.384676	18,601	7,155	66.00
69.00	06900 ELECTROCARDIOLOGY	0.173208	0	0	69.00
69.01	06901 CARDIAC REHAB	0.466160	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.255946	4,164	1,066	73.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.439925	0	0	90.00
91.00	09100 EMERGENCY	0.134542	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.420696	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	92.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		25,148	9,283	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)		25,148		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024Worksheet E
Part A
Date/Time Prepared:
11/26/2024 3:43 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)			2,285,360	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			6,532,264	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)			17,035	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			58,779	2.04
3.00	Managed Care Simulated Payments			0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			84.36	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
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 8.27 (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)			5.81	30.00
31.00	Percentage of Medicaid patient days (see instructions)			28.34	31.00
32.00	Sum of lines 30 and 31			34.15	32.00
33.00	Allowable disproportionate share percentage (see instructions)			17.39	33.00
34.00	Disproportionate share adjustment (see instructions)			383,346	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0011	Period: From 07/01/2023 To 06/30/2024	Worksheet E Part A Date/Time Prepared: 11/26/2024 3:43 pm	
		Title XVIII	Hospital	PPS	
			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)		0.000316018	0.000290227	35.01
35.02	Hospital UCP, including supplemental UCP (see instructions)		2,172,435	1,723,372	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)		547,573	1,290,175	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)		1,837,748		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)		11,114,532		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		10,128,462		48.00
			Amount		
			1.00		
49.00	Total payment for inpatient operating costs (see instructions)		11,114,532		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		687,446		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 instructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		11,801,978		59.00
60.00	Primary payer payments		14,761		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		11,787,217		61.00
62.00	Deductibles billed to program beneficiaries		1,280,480		62.00
63.00	Coinsurance billed to program beneficiaries		6,528		63.00
64.00	Allowable bad debts (see instructions)		63,118		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		41,027		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		6,965		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		10,541,236		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
70.87	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)		-92,932		70.93
70.94	HRR adjustment amount (see instructions)		-10,484		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024Worksheet E
Part A
Date/Time Prepared:
11/26/2024 3:43 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)	2023	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)	2024	73,621		70.97
70.98	Low Volume Payment-3	0	0		70.98
70.99	HAC adjustment amount (see instructions)		86,485		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		10,424,956		71.00
71.01	Sequestration adjustment (see instructions)		208,499		71.01
71.02	Demonstration payment adjustment amount after sequestration		0		71.02
71.03	Sequestration adjustment-PARHM pass-throughs				71.03
72.00	Interim payments		10,143,018		72.00
72.01	Interim payments-PARHM				72.01
73.00	Tentative settlement (for contractor use only)		0		73.00
73.01	Tentative settlement-PARHM (for contractor use only)				73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		73,439		74.00
74.01	Balance due provider/program-PARHM (see instructions)				74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		279,052		75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00
		Prior to 10/1	On/After 10/1		
		1.00	2.00		
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0		100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000		101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		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		104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/26/2024 3:43 pm

					Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)		
		0	1.00	2.00	3.00	4.00	5.00		
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00	
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,285,360	0	2,285,360		2,285,360	1.01	
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	6,532,264	0		6,532,264	6,532,264	1.02	
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03	
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04	
2.00	Outlier payments for discharges (see instructions)	2.00						2.00	
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01	
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	17,035	0	17,035		17,035	2.02	
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	58,779	0		58,779	58,779	2.03	
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00	
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00	
Indirect Medical Education Adjustment									
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00	
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01	
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA									
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00	
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01	
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00	
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01	
Disproportionate Share Adjustment									
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1739	0.1739	0.1739	0.1739		10.00	
11.00	Disproportionate share adjustment (see instructions)	34.00	383,346	0	99,356	283,990	383,346	11.00	
11.01	Uncompensated care payments	36.00	1,837,748	0	547,573	1,290,175	1,837,748	11.01	
Additional payment for high percentage of ESRD beneficiary discharges									
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00	
13.00	Subtotal (see instructions)	47.00	11,114,532	0	2,949,324	8,165,208	11,114,532	13.00	
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00	
15.00	Total payment for inpatient operating costs (see instructions)	49.00	11,114,532	0	2,949,324	8,165,208	11,114,532	15.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	687,446	0	175,004	512,442	687,446	16.00	

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/26/2024 3:43 pm

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	3,124,328	8,677,650	11,801,978	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	677,285	0	173,084	504,201	677,285	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	10,161	0	1,920	8,241	10,161	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	687,446	0	175,004	512,442	687,446	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.008484		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				73,621	73,621	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/26/2024 3:43 pm

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,285,360	2,285,360		2,285,360	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	6,532,264		6,532,264	6,532,264	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	17,035	17,035		17,035	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	58,779		58,779	58,779	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1739	0.1739	0.1739		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	383,346	99,356	283,990	383,346	11.00
11.01	Uncompensated care payments	36.00	1,837,748	547,573	1,290,175	1,837,748	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	11,114,532	2,949,324	8,165,208	11,114,532	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	11,114,532	2,949,324	8,165,208	11,114,532	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	687,446	175,004	512,442	687,446	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			3,124,328	8,677,650	11,801,978	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/26/2024 3:43 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	677,285	173,084	504,201	677,285	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	10,161	1,920	8,241	10,161	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	687,446	175,004	512,442	687,446	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	73,621		73,621	73,621	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-92,932	0	-92,932	-92,932	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-10,484	-686	-9,798	-10,484	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	86,485	86,485	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0011	Period: From 07/01/2023 To 06/30/2024	Worksheet E Part B Date/Time Prepared: 11/26/2024 3:43 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		2,244	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		16,250,913	2.00
3.00	OPPS or REH payments		14,441,376	3.00
4.00	Outlier payment (see instructions)		124,072	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)		2,244	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		5,435	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)		5,435	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)		5,435	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		3,191	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)		2,244	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)		14,565,448	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)		2,609,962	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)		11,957,730	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)		11,957,730	30.00
31.00	Primary payer payments		1,516	31.00
32.00	Subtotal (line 30 minus line 31)		11,956,214	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)		289,872	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		188,417	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		179,687	36.00
37.00	Subtotal (see instructions)		12,144,631	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-11	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)		12,144,642	40.00
40.01	Sequestration adjustment (see instructions)		242,893	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		11,933,048	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)		-31,299	43.00
43.01	Balance due provider/program-PARHM (see instructions)			43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024Worksheet E-1
Part I
Date/Time Prepared:
11/26/2024 3:43 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		10,113,155		11,716,027	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	06/30/2024	29,863	06/30/2024	217,021	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		29,863		217,021	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)		10,143,018		11,933,048	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		73,439		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		31,299	6.02
7.00	Total Medicare program liability (see instructions)		10,216,457		11,901,749	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: 15-0011

Period:

Worksheet E-1

Component CCN: 15-T011

From 07/01/2023
To 06/30/2024Part I
Date/Time Prepared:
11/26/2024 3:43 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				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		2,895,651		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)		2,895,651		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		22,098		0	6.02
7.00	Total Medicare program liability (see instructions)		2,873,553		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0011	Period: From 07/01/2023 To 06/30/2024	Worksheet E-1 Part II Date/Time Prepared: 11/26/2024 3:43 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: 15-0011 Component CCN: 15-T011	Period: From 07/01/2023 To 06/30/2024	Worksheet E-3 Part III Date/Time Prepared: 11/26/2024 3:43 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			2,785,309 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0238 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			89,965 3.00
4.00	Outlier Payments			89,883 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)			6.112022 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)			2,965,157 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)			2,965,157 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			2,965,157 19.00
20.00	Deductibles			22,560 20.00
21.00	Subtotal (line 19 minus line 20)			2,942,597 21.00
22.00	Coinsurance			10,400 22.00
23.00	Subtotal (line 21 minus line 22)			2,932,197 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			0 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			2,932,197 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)			2,932,197 32.00
32.01	Sequestration adjustment (see instructions)			58,644 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			2,895,651 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)			-22,098 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			89,883 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: 15-0011	Period: From 07/01/2023 To 06/30/2024	Worksheet E-3 Part VII Date/Time Prepared: 11/26/2024 3:43 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	1,211,788		1.00	
2.00	Medical and other services		0	2.00	
3.00	Organ acquisition (certified transplant programs only)	0		3.00	
4.00	Subtotal (sum of lines 1, 2 and 3)	1,211,788	0	4.00	
5.00	Inpatient primary payer payments	0		5.00	
6.00	Outpatient primary payer payments		0	6.00	
7.00	Subtotal (line 4 less sum of lines 5 and 6)	1,211,788	0	7.00	
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges	1,017,889		8.00	
9.00	Ancillary service charges	2,550,242	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)	3,568,131	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)	3,568,131	0	16.00	
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	2,356,343	0	17.00	
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00	
19.00	Interns and Residents (see instructions)	0	0	19.00	
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00	
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	1,211,788	0	21.00	
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments	0	0	22.00	
23.00	Outlier payments	0	0	23.00	
24.00	Program capital payments	0		24.00	
25.00	Capital exception payments (see instructions)	0		25.00	
26.00	Routine and Ancillary service other pass through costs	0	0	26.00	
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00	
28.00	Customary charges (title V or XIX PPS covered services only)	0		28.00	
29.00	Titles V or XIX (sum of lines 21 and 27)	1,211,788	0	29.00	
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)	0	0	30.00	
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	1,211,788	0	31.00	
32.00	Deductibles	0		32.00	
33.00	Coinurance	0		33.00	
34.00	Allowable bad debts (see instructions)	0		34.00	
35.00	Utilization review	0		35.00	
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	1,211,788	0	36.00	
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		37.00	
38.00	Subtotal (line 36 ± line 37)	1,211,788	0	38.00	
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00	
40.00	Total amount payable to the provider (sum of lines 38 and 39)	1,211,788	0	40.00	
41.00	Interim payments	2,063,667	0	41.00	
42.00	Balance due provider/program (line 40 minus line 41)	-851,879	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: 15-0011 Component CCN: 15-T011	Period: From 07/01/2023 To 06/30/2024	Worksheet E-3 Part VII Date/Time Prepared: 11/26/2024 3:43 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		34,353		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)		34,353	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)		34,353	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		19,936		8.00
9.00	Ancillary service charges		25,148	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)		45,084	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)		45,084	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		10,731	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)		34,353	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)		34,353	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)		34,353		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)		34,353	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		37.00
38.00	Subtotal (line 36 ± line 37)		34,353	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)		34,353	0	40.00
41.00	Interim payments		0		41.00
42.00	Balance due provider/program (line 40 minus line 41)		34,353	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: 15-0011	Period: From 07/01/2023 To 06/30/2024	Worksheet E-5 Date/Time Prepared: 11/26/2024 3:43 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: 15-0011

Period:
From 07/01/2023
To 06/30/2024

Worksheet G

Date/Time Prepared:
11/26/2024 3:43 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	14,258,388	0	0	0	1.00
2.00	Temporary investments	6,485,382	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	60,935,616	0	0	0	4.00
5.00	Other receivable	3,747,644	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-37,267,634	0	0	0	6.00
7.00	Inventory	2,126,143	0	0	0	7.00
8.00	Prepaid expenses	3,762,002	0	0	0	8.00
9.00	Other current assets	874,275	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	54,921,816	0	0	0	11.00
FIXED ASSETS						
12.00	Land	12,819,425	0	0	0	12.00
13.00	Land improvements	3,413,388	0	0	0	13.00
14.00	Accumulated depreciation	-3,255,498	0	0	0	14.00
15.00	Buildings	157,717,822	0	0	0	15.00
16.00	Accumulated depreciation	-110,696,944	0	0	0	16.00
17.00	Leasehold improvements	1,004,506	0	0	0	17.00
18.00	Accumulated depreciation	-814,426	0	0	0	18.00
19.00	Fixed equipment	3,509,530	0	0	0	19.00
20.00	Accumulated depreciation	-1,795,566	0	0	0	20.00
21.00	Automobiles and trucks	1,164,404	0	0	0	21.00
22.00	Accumulated depreciation	-797,159	0	0	0	22.00
23.00	Major movable equipment	74,310,566	0	0	0	23.00
24.00	Accumulated depreciation	-64,007,212	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	89,178,501	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	161,751,337	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	307,015,677	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	9,763,403	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	316,779,080	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	533,452,233	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	10,117,710	0	0	0	37.00
38.00	Salaries, wages, and fees payable	9,342,949	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	12,033,042	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	31,493,701	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	139,949,426	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	139,949,426	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	171,443,127	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	362,009,106				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	362,009,106	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	533,452,233	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024

Worksheet G-1

Date/Time Prepared:
11/26/2024 3:43 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		352,776,580		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		9,232,526				2.00
3.00	Total (sum of line 1 and line 2)		362,009,106		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		362,009,106		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		362,009,106		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024Worksheet G-2
Parts I & II
Date/Time Prepared:
11/26/2024 3:43 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	15,522,632		15,522,632	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	3,182,352		3,182,352	3.00
4.00	SUBPROVIDER	0		0	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)	18,704,984		18,704,984	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	7,809,984		7,809,984	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	7,809,984		7,809,984	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	26,514,968		26,514,968	17.00
18.00	Ancillary services	82,848,201		82,848,201	18.00
19.00	Outpatient services	0	420,034,034	420,034,034	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	7,483,008	7,483,008	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN PRACTICE	0	41,465,060	41,465,060	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	109,363,169	468,982,102	578,345,271	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		219,303,242		29.00
30.00	ROUNDING	18			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)		18		36.00
37.00	ELIMINATIONS	1,889,503			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		1,889,503		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		217,413,757		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024

Worksheet G-3

Date/Time Prepared:
11/26/2024 3:43 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	578,345,271	1.00
2.00	Less contractual allowances and discounts on patients' accounts	383,809,551	2.00
3.00	Net patient revenues (line 1 minus line 2)	194,535,720	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	217,413,757	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-22,878,037	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	28,873,729	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	3,245,113	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	32,118,842	25.00
26.00	Total (line 5 plus line 25)	9,240,805	26.00
27.00	BAD DEBT EXPENSE	8,279	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	8,279	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	9,232,526	29.00

CALCULATION OF CAPITAL PAYMENT

Provider CCN: 15-0011

Period:
From 07/01/2023
To 06/30/2024Worksheet L
Parts I-III
Date/Time Prepared:
11/26/2024 3:43 pm

Title XVIII		Hospital	PPS
			1.00
PART I - FULLY PROSPECTIVE METHOD			
CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier	677,285	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	10,161	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)	37.65	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)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	687,446	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