

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-2013	Period: From 09/01/2023 To 08/31/2024	Worksheet S Parts I-III Date/Time Prepared: 11/20/2024 3:28 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 11/20/2024	Time: 3:28 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by Kindred Hospital Indianapolis North (15-2013) for the cost reporting period beginning 09/01/2023 and ending 08/31/2024 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1	2		
1	Todd Flowers	☒	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	Todd Flowers		2
3	Signatory Title	CHIEF FINANCIAL OFFICER		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	-2,881	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0	0	2.00
3.00	SUBPROVIDER - IRF	0	0	0	0	3.00
5.00	SWING BED - SNF	0	0	0	0	5.00
6.00	SWING BED - NF	0	0	0	0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0	0	7.00
200.00	TOTAL	0	-2,881	0	0	200.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 15-2013		Period: From 09/01/2023 To 08/31/2024		Worksheet S-2 Part I Date/Time Prepared: 11/20/2024 3:28 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 8060 Knue Road			PO Box:				1.00	
2.00	City: Indianapolis			State: IN		Zip Code: 46250		County: Marion	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			Kindred Hospital Indianapolis North	152013	26900	2	09/01/1996	N P P
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						09/01/2023	08/31/2024	20.00
21.00	Type of Control (see instructions)						4		21.00
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		22.00
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic 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	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.								22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					0			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-2013		Period: From 09/01/2023 To 08/31/2024		Worksheet S-2 Part I Date/Time Prepared: 11/20/2024 3:28 pm			
		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.	0	0	0	0	0	0	24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00	
					Urban/Rural 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.	1						26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1						27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0						35.00	
					Beginning:	Ending:			
					1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
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)	N					N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N					N	40.00	
					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	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N					N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.	N					N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N					N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N							56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.								57.00

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							V	XVIII	XIX	
							1.00	2.00	3.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.									58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.						N			59.00
					NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
					1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.				N				60.00	
					Y/N	IME	Direct GME	IME	Direct GME	
					1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				N			0.00	0.00	
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)								61.01	
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)								61.02	
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)								61.03	
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).								61.04	
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)								61.05	
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)								61.06	
					Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
					1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						0.00	0.00	61.20	
									1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)										
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)							0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)							0.00	62.01	
Teaching Hospitals that Claim Residents in Nonprovider Settings										
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)							N	63.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 15-2013

Period:
From 09/01/2023
To 08/31/2024Worksheet S-2
Part I
Date/Time Prepared:
11/20/2024 3:28 pm

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

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			1.00		
68.00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?			68.00	
			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			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.			N	75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			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.			Y	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	N 91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N 92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N 93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	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)			106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00	
107.01	If this facility is a REH (line 3, column 4, is "12"), is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no. (see instructions)			107.01	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.		N	110.00	
		1.00	2.00		
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.		N	111.00	
		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00	
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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: 15-2013	Period: From 09/01/2023 To 08/31/2024	Worksheet S-2 Part I Date/Time Prepared: 11/20/2024 3:28 pm
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	79,548	0	86,578
		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)	Y	HB1754	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: KINDRED HEALTHCARE OPERATING LLC	Contractor's Name: WISCONSIN PHYSICIANS SERVICES		Contractor's Number: 05901
142.00	Street: 680 SOUTH FOURTH STREET	PO Box:		
143.00	City: LOUISVILLE	State: KY	Zip Code: 40202	
		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.	Y		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-2013		Period: From 09/01/2023 To 08/31/2024		Worksheet S-2 Part I Date/Time Prepared: 11/20/2024 3:28 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	166.00
166.01							0.00	166.01
166.02							0.00	166.02
166.03							0.00	166.03
						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.						N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00
				Beginning	Ending			
				1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)						170.00	
				1.00	2.00			
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)				N		0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-2013	Period: From 09/01/2023 To 08/31/2024	Worksheet S-2 Part II Date/Time Prepared: 11/20/2024 3:28 pm
			Y/N 1.00	Date 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 1.00	Date 2.00	V/I 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 1.00	Type 2.00	Date 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	03/31/2025 4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00 Date 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)	Y	10/31/2024	Y 10/31/2024 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)	N		N 17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N 18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N 19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 15-2013

Period:
From 09/01/2023
To 08/31/2024Worksheet S-2
Part II
Date/Time Prepared:
11/20/2024 3:28 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?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		Y	12/31/2024	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	Jeff	Branyon		41.00
42.00	Enter the employer/company name of the cost report preparer.	KINDRED HEALTHCARE OPERATING LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5025967231	KindredReimbursement@kindred.com		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-2013	Period: From 09/01/2023 To 08/31/2024	Worksheet S-2 Part II Date/Time Prepared: 11/20/2024 3:28 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	Reimbursement 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: 15-2013

Period:
From 09/01/2023
To 08/31/2024Worksheet S-3
Part I
Date/Time Prepared:
11/20/2024 3:28 pm

Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	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	45	16,470	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)		45	16,470	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	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						13.00
14.00 Total (see instructions)		45	16,470	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						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	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)		45				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: 15-2013

Period:
From 09/01/2023
To 08/31/2024Worksheet S-3
Part I
Date/Time Prepared:
11/20/2024 3:28 pm

		I/P Days / O/P Visits / Trips			Full Time Equivalents		
Component		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)	1,889	43	7,159			1.00
2.00	HMO and other (see instructions)	1,170	1,858				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			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)	1,889	43	7,159			7.00
8.00	INTENSIVE CARE UNIT	0	0	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						13.00
14.00	Total (see instructions)	1,889	43	7,159	0.00	81.40	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						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	81.40	27.00
28.00	Observation Bed Days		0	0			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	25					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: 15-2013

Period:
From 09/01/2023
To 08/31/2024Worksheet S-3
Part I
Date/Time Prepared:
11/20/2024 3:28 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	74	2	242	1.00
2.00 HMO and other (see instructions)			35	59		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	74	2	242	14.00
15.00 CAH visits						15.00
15.10 REH hours and visits						15.10
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					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

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-2013

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

Worksheet A

Date/Time Prepared:
11/20/2024 3:28 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,791,506	1,791,506	58,022	1,849,528
2.00	00200	CAP REL COSTS-MVBLE EQUIP		319,579	319,579	113,573	433,152
3.00	00300	OTHER CAP REL COSTS		171,595	171,595	-171,595	0
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,041,288	1,041,288	0	1,041,288
5.00	00500	ADMINISTRATIVE & GENERAL	782,842	2,278,780	3,061,622	1,051	3,062,673
7.00	00700	OPERATION OF PLANT	0	707,690	707,690	-53,593	654,097
8.00	00800	LAUNDRY & LINEN SERVICE	0	54,183	54,183	0	54,183
9.00	00900	HOUSEKEEPING	250	311,158	311,408	188	311,596
10.00	01000	DIETARY	430,040	151,791	581,831	14	581,845
11.00	01100	CAFETERIA	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	802,678	457	803,135	0	803,135
14.00	01400	CENTRAL SERVICES & SUPPLY	31,878	616	32,494	242	32,736
15.00	01500	PHARMACY	449,438	42,915	492,353	349	492,702
16.00	01600	MEDICAL RECORDS & LIBRARY	255,016	63,851	318,867	58	318,925
17.00	01700	SOCIAL SERVICE	250,397	20,947	271,344	-1,323	270,021
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,647,044	1,440,794	4,087,838	6,555	4,094,393
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	140,124	184,856	324,980	65	325,045
54.00	05400	RADIOLOGY-DIAGNOSTIC	137,404	21,484	158,888	53,630	212,518
60.00	06000	LABORATORY	0	174,608	174,608	220	174,828
65.00	06500	RESPIRATORY THERAPY	1,016,121	125,810	1,141,931	2,485	1,144,416
66.00	06600	PHYSICAL THERAPY	0	465,863	465,863	290	466,153
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,983	11,983	-11,983	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	472,861	472,861	-66	472,795
74.00	07400	RENAL DIALYSIS	234,858	286,721	521,579	495	522,074
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,178,090	10,141,336	17,319,426	-1,323	17,318,103
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	NONALLOWABLE CASE MANAGER	0	0	0	1,323	1,323
194.01	07951	IDLE SPACE	0	0	0	0	0
194.02	07952	REGION	0	0	0	0	0
194.03	07953	REGIONAL SALES	0	0	0	0	0
194.04	07954	VERILY LEASE	0	0	0	0	0
194.05	07955	BHN	0	0	0	0	0
194.06	07956	PHYSICIANS DINING ROOM	0	0	0	0	0
194.07	07957	HR MANAGED CARE	0	0	0	0	0
194.08	07959	SALES & MARKETING	0	0	0	0	0
194.09	07958	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.10	07962	NONREIMBURSABLE PROJECTS	0	1,107	1,107	0	1,107
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0
194.12	07960	VISITOR MEALS	0	0	0	0	0
200.00		TOTAL (SUM OF LINES 118 through 199)	7,178,090	10,142,443	17,320,533	0	17,320,533

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 15-2013	Period: From 09/01/2023 To 08/31/2024	Worksheet A Date/Time Prepared: 11/20/2024 3:28 pm
Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	-102,457	1,747,071	1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP	16,465	449,617	2.00	
3.00	00300	OTHER CAP REL COSTS	0	0	3.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	154,300	1,195,588	4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	-943,287	2,119,386	5.00	
7.00	00700	OPERATION OF PLANT	-720	653,377	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	54,183	8.00	
9.00	00900	HOUSEKEEPING	0	311,596	9.00	
10.00	01000	DIETARY	-20,134	561,711	10.00	
11.00	01100	CAFETERIA	0	0	11.00	
13.00	01300	NURSING ADMINISTRATION	0	803,135	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	0	32,736	14.00	
15.00	01500	PHARMACY	0	492,702	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	-552	318,373	16.00	
17.00	01700	SOCIAL SERVICE	0	270,021	17.00	
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	-183,023	3,911,370	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	325,045	50.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	212,518	54.00	
60.00	06000	LABORATORY	0	174,828	60.00	
65.00	06500	RESPIRATORY THERAPY	0	1,144,416	65.00	
66.00	06600	PHYSICAL THERAPY	0	466,153	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	472,795	73.00	
74.00	07400	RENAL DIALYSIS	-208,300	313,774	74.00	
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	90.00	
91.00	09100	EMERGENCY	0	0	91.00	
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	95.00	
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	98.00	
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		-1,287,708	16,030,395	118.00	
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00	
194.00	07950	NONALLOWABLE CASE MANAGER	0	1,323	194.00	
194.01	07951	IDLE SPACE	0	0	194.01	
194.02	07952	REGION	0	0	194.02	
194.03	07953	REGIONAL SALES	0	0	194.03	
194.04	07954	VERILY LEASE	0	0	194.04	
194.05	07955	BHN	0	0	194.05	
194.06	07956	PHYSICIANS DINING ROOM	0	0	194.06	
194.07	07957	HR MANAGED CARE	0	0	194.07	
194.08	07959	SALES & MARKETING	0	0	194.08	
194.09	07958	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.09	
194.10	07962	NONREIMBURSABLE PROJECTS	0	1,107	194.10	
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	194.11	
194.12	07960	VISITOR MEALS	0	0	194.12	
200.00	TOTAL (SUM OF LINES 118 through 199)		-1,287,708	16,032,825	200.00	

RECLASSIFICATIONS

Provider CCN: 15-2013

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

Worksheet A-6

Date/Time Prepared:
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	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
1.00	A - RECLASS NON ALLOWABLE CASE MANAGER				1.00
	NONALLOWABLE CASE MANAGER	194.00	1,186	137	
	TOTALS		1,186	137	
1.00	B - RECLASS SALES & MARKETING SALARIES				1.00
	SALES & MARKETING	194.08			
			0	0	
1.00	C - PHILIPS IMAGING				1.00
	RADIOLOGY-DIAGNOSTIC	54.00		53,593	
			0	53,593	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	D - MED SUPPLY RECLASS				1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
	ADMINISTRATIVE & GENERAL	5.00	0	1,051	
	HOUSEKEEPING	9.00	0	188	
	DIETARY	10.00	0	14	
	CENTRAL SERVICES & SUPPLY	14.00	0	242	
	PHARMACY	15.00	0	349	
	ADULTS & PEDIATRICS	30.00	0	6,615	
	OPERATING ROOM	50.00	0	65	
	RADIOLOGY-DIAGNOSTIC	54.00	0	37	
	LABORATORY	60.00	0	154	
	RESPIRATORY THERAPY	65.00	0	2,485	
	PHYSICAL THERAPY	66.00	0	290	
	RENAL DIALYSIS	74.00	0	495	
	TOTALS		0	11,985	
	1.00	E - CENTRAL SUPPLY			
MEDICAL RECORDS & LIBRARY		16.00	0	60	
TOTALS			0	60	
1.00	F - PHARMACY SUPPLY				1.00
	LABORATORY	60.00	0	66	
	TOTALS		0	66	
500.00	Grand Total: Increases		1,186	65,841	500.00

RECLASSIFICATIONS

Provider CCN: 15-2013

Period:
From 09/01/2023
To 08/31/2024Worksheet 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		
1.00	A - RECLASS NON ALLOWABLE CASE MANAGER						
	SOCIAL SERVICE	17.00	1,186	137	0		1.00
	TOTALS		1,186	137			
1.00	B - RECLASS SALES & MARKETING SALARIES						
	SOCIAL SERVICE	17.00					1.00
			0	0			
1.00	C - PHILIPS IMAGING						
	OPERATION OF PLANT	7.00		53,593			1.00
			0	53,593			
1.00	D - MED SUPPLY RECLASS						
	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	11,983	0		1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	0	2	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
	TOTALS		0	11,985			
1.00	E - CENTRAL SUPPLY						
	ADULTS & PEDIATRICS	30.00	0	60	0		1.00
	TOTALS		0	60			
1.00	F - PHARMACY SUPPLY						
	DRUGS CHARGED TO PATIENTS	73.00	0	66	0		1.00
	TOTALS		0	66			
500.00	Grand Total: Decreases		1,186	65,841			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-2013

Period:
From 09/01/2023
To 08/31/2024Worksheet A-7
Part I
Date/Time Prepared:
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		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	308,447	287,157	0	287,157	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	1,136,733	29,110	0	29,110	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	1,445,180	316,267	0	316,267	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	1,445,180	316,267	0	316,267	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	595,604	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	1,165,843	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	1,761,447	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	1,761,447	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-2013

Period:
From 09/01/2023
To 08/31/2024Worksheet A-7
Part II
Date/Time Prepared:
11/20/2024 3:28 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	153,437	1,638,069	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	176,247	143,332	0	0	0	2.00
3.00	Total (sum of lines 1-2)	329,684	1,781,401	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,791,506				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	319,579				2.00
3.00	Total (sum of lines 1-2)	0	2,111,085				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-2013

Period:
From 09/01/2023
To 08/31/2024Worksheet A-7
Part III
Date/Time Prepared:
11/20/2024 3:28 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	595,603	0	595,603	0.338133	17,968	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,165,843	0	1,165,843	0.661867	35,171	2.00
3.00	Total (sum of lines 1-2)	1,761,446	0	1,761,446	1.000000	53,139	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Relat ed Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	40,054	0	58,022	63,733	1,638,069	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	78,402	0	113,573	192,712	143,332	2.00
3.00	Total (sum of lines 1-2)	118,456	0	171,595	256,445	1,781,401	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Relat ed Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	5,215	40,054	0	1,747,071	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	35,171	78,402	0	449,617	2.00
3.00	Total (sum of lines 1-2)	0	40,386	118,456	0	2,196,688	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-2013

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

Worksheet A-8

Date/Time Prepared:
11/20/2024 3:28 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 #		
				3.00	4.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-173	ADMINISTRATIVE & GENERAL	5.00	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)	A	-4,307	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-720	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-391,322			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	-713,202			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-20,134	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-552	MEDICAL RECORDS & LIBRARY	16.00	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 - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-2013

Period:
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Worksheet A-8

Date/Time Prepared:
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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	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
33.01	MISCELLANEOUS INCOME	B	-1,793	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.02
33.03	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.03
33.04	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.04
33.05	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.05
33.06	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.06
33.07	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.07
33.08	MEDICARE BAD DEBT - PART A	A	-115,854	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.09
33.10	OTHER MEDICARE NON ALLOWABLE	A	-42,967	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	OTHER OPERATING - PATIENT RELATIONS	A	-1,390	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.12
33.13	OTHER OPERATING - MARKETING	A	-28,112	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	OTHER OPERATING - INTEREST	A	-2,119	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.15
33.16	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.16
33.17	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.17
33.18	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.18
33.19	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.19
33.20	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.20
33.21	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.21
33.22	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.22
33.23	CHARITABLE CONTRIBUTIONS	A	-15,000	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.24
33.25	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.25
33.26	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.26
33.27	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.27
33.28	AGGREGATE CAPITAL EROSION	A	-11,538	ADMINISTRATIVE & GENERAL	5.00	0	33.28
33.29	CABLE TV AND SATELLITE	A	-9,510	ADMINISTRATIVE & GENERAL	5.00	0	33.29
33.30	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.30
33.31	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.31
33.32	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.32
33.33	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.33
33.34	MALPRACTICE TAIL LIABILITY	A	4,670	ADMINISTRATIVE & GENERAL	5.00	0	33.34

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-2013

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

Worksheet A-8

Date/Time Prepared:
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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 #		
33.35	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.35
33.36	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.36
33.37	PHYSICIAN BILLING COLLECTION FEES	A	-9,835	ADMINISTRATIVE & GENERAL	5.00	0	33.37
33.38	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.38
33.39	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.39
33.40	MISCELLANEOUS EXPENSE	A	16,603	ADMINISTRATIVE & GENERAL	5.00	0	33.40
33.41	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.41
33.42	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.42
33.43	DISTRICT OFFICE SALES AND MARKETING	A	-6,583	ADMINISTRATIVE & GENERAL	5.00	0	33.43
33.44	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.44
33.45	BUSINESS INTERRUPTIONS INS PREMIUM	A	-12,753	CAP REL COSTS-BLDG & FIXT	1.00	12	33.45
34.00	MEDICARE VS BOOK BLDG	A	-89,704	CAP REL COSTS-BLDG & FIXT	1.00	9	34.00
34.01	MEDICARE VS BOOK MOV EQUIP	A	20,684	CAP REL COSTS-MVBLE EQUIP	2.00	9	34.01
34.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.02
34.03	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.03
34.04	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.04
34.05	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.05
34.06	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.06
34.07	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.07
34.08	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.08
34.09	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.09
34.10	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.10
34.11	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.11
34.12	NON ALLOWABLE LOBBYING FEES	A	-2,177	ADMINISTRATIVE & GENERAL	5.00	0	34.12
34.13	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.13
34.14	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.14
34.15	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.15
34.16	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.16
34.17	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.17
34.18	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.18
34.19	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.19
34.20	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.20
34.21	PATIENT PHONE - DEPREC EQUIP	A	-4,219	CAP REL COSTS-MVBLE EQUIP	2.00	9	34.21
34.22	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.22
34.23	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.23
34.24	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.24

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-2013

Period:
From 09/01/2023
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Worksheet A-8

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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
34.25	OTHER ADJUSTMENTS (SPECIFY (3)		0		0.00	0	34.25	
34.26	OTHER ADJUSTMENTS (SPECIFY (3)		0		0.00	0	34.26	
34.27	OTHER ADJUSTMENTS (SPECIFY (3)		0		0.00	0	34.27	
34.28	OTHER ADJUSTMENTS (SPECIFY (3)		0		0.00	0	34.28	
34.40	NONALLOWABLE VEBA EXPENSE	A	-358,295	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.40	
34.41	ALLOWABLE VEBA CLAIMS	A	512,595	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.41	
35.00	OTHER ADJUSTMENTS (SPECIFY (3)		0		0.00	0	35.00	
35.01	OTHER ADJUSTMENTS (SPECIFY (3)		0		0.00	0	35.01	
35.02	OTHER ADJUSTMENTS (SPECIFY (3)		0		0.00	0	35.02	
35.03	OTHER ADJUSTMENTS (SPECIFY (3)		0		0.00	0	35.03	
35.04	OTHER ADJUSTMENTS (SPECIFY (3)		0		0.00	0	35.04	
35.05	OTHER ADJUSTMENTS (SPECIFY (3)		0		0.00	0	35.05	
35.06	OTHER ADJUSTMENTS (SPECIFY (3)		0		0.00	0	35.06	
35.07	OTHER ADJUSTMENTS (SPECIFY (3)		0		0.00	0	35.07	
35.08	OTHER ADJUSTMENTS (SPECIFY (3)		0		0.00	0	35.08	
35.09	OTHER ADJUSTMENTS (SPECIFY (3)		0		0.00	0	35.09	
35.10	OTHER ADJUSTMENTS (SPECIFY (3)		0		0.00	0	35.10	
35.11	PHYSICIAN FEE ADJUSTMENT		A	-1	ADULTS & PEDIATRICS	30.00	0	35.11
35.12	OTHER ADJUSTMENTS (SPECIFY (3)			0		0.00	0	35.12
35.13	OTHER ADJUSTMENTS (SPECIFY (3)			0		0.00	0	35.13
35.14	OTHER ADJUSTMENTS (SPECIFY (3)			0		0.00	0	35.14
35.15	OTHER ADJUSTMENTS (SPECIFY (3)			0		0.00	0	35.15
35.16	OTHER ADJUSTMENTS (SPECIFY (3)		0		0.00	0	35.16	
35.17	OTHER ADJUSTMENTS (SPECIFY (3)		0		0.00	0	35.17	
35.18	OTHER ADJUSTMENTS (SPECIFY (3)		0		0.00	0	35.18	
35.19	OTHER ADJUSTMENTS (SPECIFY (3)		0		0.00	0	35.19	
35.20	OTHER ADJUSTMENTS (SPECIFY (3)		0		0.00	0	35.20	
35.21	OTHER ADJUSTMENTS (SPECIFY (3)		0		0.00	0	35.21	
35.22	OTHER ADJUSTMENTS (SPECIFY (3)		0		0.00	0	35.22	
35.23	OTHER ADJUSTMENTS (SPECIFY (3)		0		0.00	0	35.23	
35.24	OTHER ADJUSTMENTS (SPECIFY (3)		0		0.00	0	35.24	
35.25	OTHER ADJUSTMENTS (SPECIFY (3)		0		0.00	0	35.25	
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,287,708				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.

ADJUSTMENTS TO EXPENSES			Provider CCN: 15-2013		Period: From 09/01/2023 To 08/31/2024		Worksheet A-8 Date/Time Prepared: 11/20/2024 3:28 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		

B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscrip

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

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

Provider CCN: 15-2013

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

Worksheet A-8-1

Date/Time Prepared:
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	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	5.00	ADMINISTRATIVE & GENERAL	Home Office Costs - Actual	277,254	572,487	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	Home Office Costs - Estimate	553,602	879,519	2.00
3.00	0.00			0	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	Liability Insurance	0	90,185	4.00
4.03	66.00	PHYSICAL THERAPY	Therapy Services	449,715	449,715	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	AfterCare Services	0	1,867	4.04
5.00	0			1,280,571	1,993,773	5.00

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

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

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

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

6.00	B		100.00	KHOLLC	0.00	6.00
7.00	A	KHOLLC	100.00	Cornerstone	100.00	7.00
8.00	A	Apollo	100.00	Lifepoint Health	100.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 15-2013

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

Worksheet A-8-1

Date/Time Prepared:
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	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-295,233	0		1.00
2.00	-325,917	0		2.00
3.00	0	0		3.00
4.00	-90,185	0		4.00
4.03	0	0		4.03
4.04	-1,867	0		4.04
5.00	-713,202			5.00

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

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

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

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

6.00	Home Office Cost		6.00
7.00	Liability Insurance		7.00
8.00	TSA/Rehab/Psych/Aftercare		8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-2013

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

Worksheet A-8-2

Date/Time Prepared:
11/20/2024 3:28 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	DR. A	183,022	183,022	0	211,500	0	1.00
2.00	74.00	DR. B	97,800	97,800	0	211,500	0	2.00
3.00	74.00	DR. C	110,500	110,500	0	211,500	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		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			391,322	391,322	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	30.00	DR. A	0	0	0	0	0	1.00
2.00	74.00	DR. B	0	0	0	0	0	2.00
3.00	74.00	DR. C	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		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	30.00	DR. A	0	0	0	183,022		1.00
2.00	74.00	DR. B	0	0	0	97,800		2.00
3.00	74.00	DR. C	0	0	0	110,500		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		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	391,322		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-2013

Period:
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To 08/31/2024Worksheet B
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,747,071	1,747,071			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	449,617		449,617		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,195,588	0	0	1,195,588	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,119,386	414,731	106,733	130,391	5.00
7.00	00700	OPERATION OF PLANT	653,377	81,469	20,966	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	54,183	37,373	9,618	0	8.00
9.00	00900	HOUSEKEEPING	311,596	11,544	2,971	42	9.00
10.00	01000	DIETARY	561,711	170,457	43,868	71,628	10.00
11.00	01100	CAFETERIA	0	22,291	5,737	0	11.00
13.00	01300	NURSING ADMINISTRATION	803,135	84,123	21,649	133,695	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	32,736	24,989	6,431	5,310	14.00
15.00	01500	PHARMACY	492,702	20,566	5,293	74,859	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	318,373	16,586	4,268	42,476	16.00
17.00	01700	SOCIAL SERVICE	270,021	4,423	1,138	41,509	17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,911,370	785,364	202,119	440,891	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	325,045	0	0	23,339	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	212,518	26,228	6,750	22,886	54.00
60.00	06000	LABORATORY	174,828	4,556	1,172	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,144,416	7,519	1,935	169,246	65.00
66.00	06600	PHYSICAL THERAPY	466,153	16,984	4,371	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	472,795	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	313,774	17,868	4,598	39,118	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,030,395	1,747,071	449,617	1,195,390	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
194.00	07950	NONALLOWABLE CASE MANAGER	1,323	0	0	198	194.00
194.01	07951	IDLE SPACE	0	0	0	0	194.01
194.02	07952	REGION	0	0	0	0	194.02
194.03	07953	REGIONAL SALES	0	0	0	0	194.03
194.04	07954	VERILY LEASE	0	0	0	0	194.04
194.05	07955	BHN	0	0	0	0	194.05
194.06	07956	PHYSICIANS DINING ROOM	0	0	0	0	194.06
194.07	07957	HR MANAGED CARE	0	0	0	0	194.07
194.08	07959	SALES & MARKETING	0	0	0	0	194.08
194.09	07958	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.09
194.10	07962	NONREIMBURSABLE PROJECTS	1,107	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	194.11
194.12	07960	VISITOR MEALS	0	0	0	0	194.12
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	16,032,825	1,747,071	449,617	1,195,588	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,771,241					5.00
7.00	00700	OPERATION OF PLANT	157,953	913,765				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	21,144	27,301	149,619			8.00
9.00	00900	HOUSEKEEPING	68,161	8,433	0	402,747		9.00
10.00	01000	DIETARY	177,149	124,519	0	57,116	1,206,448	10.00
11.00	01100	CAFETERIA	5,857	16,284	0	7,469	767,756	11.00
13.00	01300	NURSING ADMINISTRATION	217,888	61,452	0	28,188	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14,517	18,255	0	8,373	0	14.00
15.00	01500	PHARMACY	124,016	15,024	0	6,891	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	79,770	12,116	0	5,557	0	16.00
17.00	01700	SOCIAL SERVICE	66,267	3,231	0	1,482	0	17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,115,929	573,710	149,619	263,160	438,692	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	72,807	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	56,088	19,159	0	8,788	0	54.00
60.00	06000	LABORATORY	37,733	3,328	0	1,526	0	60.00
65.00	06500	RESPIRATORY THERAPY	276,511	5,493	0	2,519	0	65.00
66.00	06600	PHYSICAL THERAPY	101,882	12,407	0	5,691	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	98,807	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	78,444	13,053	0	5,987	0	74.00
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
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,770,923	913,765	149,619	402,747	1,206,448	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
194.00	07950	NONALLOWABLE CASE MANAGER	318	0	0	0	0	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	REGION	0	0	0	0	0	194.02
194.03	07953	REGIONAL SALES	0	0	0	0	0	194.03
194.04	07954	VERILY LEASE	0	0	0	0	0	194.04
194.05	07955	BHN	0	0	0	0	0	194.05
194.06	07956	PHYSICIANS DINING ROOM	0	0	0	0	0	194.06
194.07	07957	HR MANAGED CARE	0	0	0	0	0	194.07
194.08	07959	SALES & MARKETING	0	0	0	0	0	194.08
194.09	07958	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.09
194.10	07962	NONREIMBURSABLE PROJECTS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
194.12	07960	VISITOR MEALS	0	0	0	0	0	194.12
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,771,241	913,765	149,619	402,747	1,206,448	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-2013

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Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	825,394					11.00
13.00	01300	NURSING ADMINISTRATION	77,381	1,427,511				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,897	0	123,508			14.00
15.00	01500	PHARMACY	51,587	0	5,941	796,879		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	51,587	0	0	0	530,733	16.00
17.00	01700	SOCIAL SERVICE	12,897	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	399,799	1,382,901	79,966	11,449	277,219	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	12,897	44,610	671	0	10,001	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,794	0	384	0	8,991	54.00
60.00	06000	LABORATORY	0	0	1,356	0	26,617	60.00
65.00	06500	RESPIRATORY THERAPY	141,865	0	27,062	0	86,777	65.00
66.00	06600	PHYSICAL THERAPY	0	0	3,038	0	7,879	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	785,430	101,571	73.00
74.00	07400	RENAL DIALYSIS	38,690	0	5,090	0	11,678	74.00
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
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	825,394	1,427,511	123,508	796,879	530,733	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
194.00	07950	NONALLOWABLE CASE MANAGER	0	0	0	0	0	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	REGION	0	0	0	0	0	194.02
194.03	07953	REGIONAL SALES	0	0	0	0	0	194.03
194.04	07954	VERILY LEASE	0	0	0	0	0	194.04
194.05	07955	BHN	0	0	0	0	0	194.05
194.06	07956	PHYSICIANS DINING ROOM	0	0	0	0	0	194.06
194.07	07957	HR MANAGED CARE	0	0	0	0	0	194.07
194.08	07959	SALES & MARKETING	0	0	0	0	0	194.08
194.09	07958	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.09
194.10	07962	NONREIMBURSABLE PROJECTS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
194.12	07960	VISITOR MEALS	0	0	0	0	0	194.12
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)	825,394	1,427,511	123,508	796,879	530,733	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-2013

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Cost Center Description			SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	400,968					17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	400,968	0	10,433,156	0	10,433,156	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	489,370	0	489,370	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	387,586	0	387,586	54.00
60.00	06000	LABORATORY	0	0	251,116	0	251,116	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,863,343	0	1,863,343	65.00
66.00	06600	PHYSICAL THERAPY	0	0	618,405	0	618,405	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,458,603	0	1,458,603	73.00
74.00	07400	RENAL DIALYSIS	0	0	528,300	0	528,300	74.00
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
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	400,968	0	16,029,879	0	16,029,879	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
194.00	07950	NONALLOWABLE CASE MANAGER	0	0	1,839	0	1,839	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	REGION	0	0	0	0	0	194.02
194.03	07953	REGIONAL SALES	0	0	0	0	0	194.03
194.04	07954	VERILY LEASE	0	0	0	0	0	194.04
194.05	07955	BHN	0	0	0	0	0	194.05
194.06	07956	PHYSICIANS DINING ROOM	0	0	0	0	0	194.06
194.07	07957	HR MANAGED CARE	0	0	0	0	0	194.07
194.08	07959	SALES & MARKETING	0	0	0	0	0	194.08
194.09	07958	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.09
194.10	07962	NONREIMBURSABLE PROJECTS	0	0	1,107	0	1,107	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
194.12	07960	VISITOR MEALS	0	0	0	0	0	194.12
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)	400,968	0	16,032,825	0	16,032,825	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-2013

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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	31,432	414,731	106,733	552,896	0 5.00
7.00	00700	OPERATION OF PLANT	0	81,469	20,966	102,435	0 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	37,373	9,618	46,991	0 8.00
9.00	00900	HOUSEKEEPING	0	11,544	2,971	14,515	0 9.00
10.00	01000	DIETARY	0	170,457	43,868	214,325	0 10.00
11.00	01100	CAFETERIA	0	22,291	5,737	28,028	0 11.00
13.00	01300	NURSING ADMINISTRATION	0	84,123	21,649	105,772	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	24,989	6,431	31,420	0 14.00
15.00	01500	PHARMACY	0	20,566	5,293	25,859	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	16,586	4,268	20,854	0 16.00
17.00	01700	SOCIAL SERVICE	0	4,423	1,138	5,561	0 17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	785,364	202,119	987,483	0 30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0 31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	26,228	6,750	32,978	0 54.00
60.00	06000	LABORATORY	0	4,556	1,172	5,728	0 60.00
65.00	06500	RESPIRATORY THERAPY	0	7,519	1,935	9,454	0 65.00
66.00	06600	PHYSICAL THERAPY	0	16,984	4,371	21,355	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00	07400	RENAL DIALYSIS	0	17,868	4,598	22,466	0 74.00
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
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0 95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0 98.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,432	1,747,071	449,617	2,228,120	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
194.00	07950	NONALLOWABLE CASE MANAGER	0	0	0	0	0 194.00
194.01	07951	IDLE SPACE	0	0	0	0	0 194.01
194.02	07952	REGION	0	0	0	0	0 194.02
194.03	07953	REGIONAL SALES	0	0	0	0	0 194.03
194.04	07954	VERILY LEASE	0	0	0	0	0 194.04
194.05	07955	BHN	0	0	0	0	0 194.05
194.06	07956	PHYSICIANS DINING ROOM	0	0	0	0	0 194.06
194.07	07957	HR MANAGED CARE	0	0	0	0	0 194.07
194.08	07959	SALES & MARKETING	0	0	0	0	0 194.08
194.09	07958	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.09
194.10	07962	NONREIMBURSABLE PROJECTS	0	0	0	0	0 194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0 194.11
194.12	07960	VISITOR MEALS	0	0	0	0	0 194.12
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)	31,432	1,747,071	449,617	2,228,120	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS				Provider CCN: 15-2013		Period: From 09/01/2023 To 08/31/2024		Worksheet B Part II Date/Time Prepared: 11/20/2024 3:28 pm	
Cost Center Description				ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
				5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS									
1.00	00100	CAP REL COSTS-BLDG & FIXT							1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP							2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT							4.00
5.00	00500	ADMINISTRATIVE & GENERAL	552,896						5.00
7.00	00700	OPERATION OF PLANT	31,514		133,949				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,218		4,002	55,211			8.00
9.00	00900	HOUSEKEEPING	13,599		1,236	0	29,350		9.00
10.00	01000	DIETARY	35,343		18,253	0	4,162	272,083	10.00
11.00	01100	CAFETERIA	1,169		2,387	0	544	173,147	11.00
13.00	01300	NURSING ADMINISTRATION	43,471		9,008	0	2,054	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,896		2,676	0	610	0	14.00
15.00	01500	PHARMACY	24,743		2,202	0	502	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,915		1,776	0	405	0	16.00
17.00	01700	SOCIAL SERVICE	13,221		474	0	108	0	17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0		0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	222,642		84,101	55,211	19,179	98,936	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	14,526		0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,190		2,809	0	640	0	54.00
60.00	06000	LABORATORY	7,528		488	0	111	0	60.00
65.00	06500	RESPIRATORY THERAPY	55,167		805	0	184	0	65.00
66.00	06600	PHYSICAL THERAPY	20,327		1,819	0	415	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0		0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0		0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,713		0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	15,651		1,913	0	436	0	74.00
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
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0		0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS									
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	552,833		133,949	55,211	29,350	272,083	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
194.00	07950	NONALLOWABLE CASE MANAGER	63		0	0	0	0	194.00
194.01	07951	IDLE SPACE	0		0	0	0	0	194.01
194.02	07952	REGION	0		0	0	0	0	194.02
194.03	07953	REGIONAL SALES	0		0	0	0	0	194.03
194.04	07954	VERILY LEASE	0		0	0	0	0	194.04
194.05	07955	BHN	0		0	0	0	0	194.05
194.06	07956	PHYSICIANS DINING ROOM	0		0	0	0	0	194.06
194.07	07957	HR MANAGED CARE	0		0	0	0	0	194.07
194.08	07959	SALES & MARKETING	0		0	0	0	0	194.08
194.09	07958	OTHER NONREIMBURSABLE COST CENTERS	0		0	0	0	0	194.09
194.10	07962	NONREIMBURSABLE PROJECTS	0		0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0		0	0	0	0	194.11
194.12	07960	VISITOR MEALS	0		0	0	0	0	194.12
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)	552,896		133,949	55,211	29,350	272,083	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-2013

Period:
From 09/01/2023
To 08/31/2024Worksheet B
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	205,275					11.00
13.00	01300	NURSING ADMINISTRATION	19,245	179,550				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,207	0	40,809			14.00
15.00	01500	PHARMACY	12,830	0	1,963	68,099		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,830	0	0	0	51,780	16.00
17.00	01700	SOCIAL SERVICE	3,207	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	99,430	173,939	26,421	978	27,039	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,207	5,611	222	0	976	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,415	0	127	0	877	54.00
60.00	06000	LABORATORY	0	0	448	0	2,598	60.00
65.00	06500	RESPIRATORY THERAPY	35,282	0	8,942	0	8,469	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,004	0	769	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	67,121	9,912	73.00
74.00	07400	RENAL DIALYSIS	9,622	0	1,682	0	1,140	74.00
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
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	205,275	179,550	40,809	68,099	51,780	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
194.00	07950	NONALLOWABLE CASE MANAGER	0	0	0	0	0	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	REGION	0	0	0	0	0	194.02
194.03	07953	REGIONAL SALES	0	0	0	0	0	194.03
194.04	07954	VERILY LEASE	0	0	0	0	0	194.04
194.05	07955	BHN	0	0	0	0	0	194.05
194.06	07956	PHYSICIANS DINING ROOM	0	0	0	0	0	194.06
194.07	07957	HR MANAGED CARE	0	0	0	0	0	194.07
194.08	07959	SALES & MARKETING	0	0	0	0	0	194.08
194.09	07958	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.09
194.10	07962	NONREIMBURSABLE PROJECTS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
194.12	07960	VISITOR MEALS	0	0	0	0	0	194.12
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)	205,275	179,550	40,809	68,099	51,780	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-2013

Period:
From 09/01/2023
To 08/31/2024Worksheet B
Part II
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Cost Center Description			SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	22,571					17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	22,571		1,817,930	0	1,817,930	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0		24,542	0	24,542	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		55,036	0	55,036	54.00
60.00	06000	LABORATORY	0		16,901	0	16,901	60.00
65.00	06500	RESPIRATORY THERAPY	0		118,303	0	118,303	65.00
66.00	06600	PHYSICAL THERAPY	0		45,689	0	45,689	66.00
67.00	06700	OCCUPATIONAL THERAPY	0		0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0		0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		96,746	0	96,746	73.00
74.00	07400	RENAL DIALYSIS	0		52,910	0	52,910	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	0		0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,571	0	2,228,057	0	2,228,057	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
194.00	07950	NONALLOWABLE CASE MANAGER	0		63	0	63	194.00
194.01	07951	IDLE SPACE	0		0	0	0	194.01
194.02	07952	REGION	0		0	0	0	194.02
194.03	07953	REGIONAL SALES	0		0	0	0	194.03
194.04	07954	VERILY LEASE	0		0	0	0	194.04
194.05	07955	BHN	0		0	0	0	194.05
194.06	07956	PHYSICIANS DINING ROOM	0		0	0	0	194.06
194.07	07957	HR MANAGED CARE	0		0	0	0	194.07
194.08	07959	SALES & MARKETING	0		0	0	0	194.08
194.09	07958	OTHER NONREIMBURSABLE COST CENTERS	0		0	0	0	194.09
194.10	07962	NONREIMBURSABLE PROJECTS	0		0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0		0	0	0	194.11
194.12	07960	VISITOR MEALS	0		0	0	0	194.12
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)	22,571	0	2,228,120	0	2,228,120	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-2013

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

Worksheet B-1

Date/Time Prepared:
11/20/2024 3:28 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET #1)	MVBLE EQUIP (SQUARE FEET #2)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	39,501					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		39,501				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	7,178,090			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,377	9,377	782,842	-2,771,241	13,260,477	5.00
7.00	00700	OPERATION OF PLANT	1,842	1,842	0	0	755,812	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	845	845	0	0	101,174	8.00
9.00	00900	HOUSEKEEPING	261	261	250	0	326,153	9.00
10.00	01000	DIETARY	3,854	3,854	430,040	0	847,664	10.00
11.00	01100	CAFETERIA	504	504	0	0	28,028	11.00
13.00	01300	NURSING ADMINISTRATION	1,902	1,902	802,678	0	1,042,602	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	565	565	31,878	0	69,466	14.00
15.00	01500	PHARMACY	465	465	449,438	0	593,420	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	375	375	255,016	0	381,703	16.00
17.00	01700	SOCIAL SERVICE	100	100	249,211	0	317,091	17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	17,757	17,757	2,647,044	0	5,339,744	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	140,124	0	348,384	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	593	593	137,404	0	268,382	54.00
60.00	06000	LABORATORY	103	103	0	0	180,556	60.00
65.00	06500	RESPIRATORY THERAPY	170	170	1,016,121	0	1,323,116	65.00
66.00	06600	PHYSICAL THERAPY	384	384	0	0	487,508	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	472,795	73.00
74.00	07400	RENAL DIALYSIS	404	404	234,858	0	375,358	74.00
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
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	39,501	39,501	7,176,904	-2,771,241	13,258,956	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
194.00	07950	NONALLOWABLE CASE MANAGER	0	0	1,186	0	1,521	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	REGION	0	0	0	0	0	194.02
194.03	07953	REGIONAL SALES	0	0	0	0	0	194.03
194.04	07954	VERILY LEASE	0	0	0	0	0	194.04
194.05	07955	BHN	0	0	0	0	0	194.05
194.06	07956	PHYSICIANS DINING ROOM	0	0	0	0	0	194.06
194.07	07957	HR MANAGED CARE	0	0	0	0	0	194.07
194.08	07959	SALES & MARKETING	0	0	0	0	0	194.08
194.09	07958	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.09
194.10	07962	NONREIMBURSABLE PROJECTS	0	0	0	-1,107	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
194.12	07960	VISITOR MEALS	0	0	0	0	0	194.12
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)	1,747,071	449,617	1,195,588		2,771,241	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	44.228526	11.382421	0.166561		0.208985	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		552,896	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.041695	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: 15-2013

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

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Cost Center Description		OPERATION OF PLANT (SQUARE FEET #3)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET #4)	DIETARY (MEALS SERVED)	CAFETERIA (CAFETERIA FTES)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	28,282				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	845	7,159			8.00
9.00	00900	HOUSEKEEPING	261	0	27,176		9.00
10.00	01000	DIETARY	3,854	0	3,854	27,270	10.00
11.00	01100	CAFETERIA	504	0	504	17,354	64 11.00
13.00	01300	NURSING ADMINISTRATION	1,902	0	1,902	0	6 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	565	0	565	0	1 14.00
15.00	01500	PHARMACY	465	0	465	0	4 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	375	0	375	0	4 16.00
17.00	01700	SOCIAL SERVICE	100	0	100	0	1 17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	17,757	7,159	17,757	9,916	31 30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0 31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	1 50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	593	0	593	0	2 54.00
60.00	06000	LABORATORY	103	0	103	0	0 60.00
65.00	06500	RESPIRATORY THERAPY	170	0	170	0	11 65.00
66.00	06600	PHYSICAL THERAPY	384	0	384	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00	07400	RENAL DIALYSIS	404	0	404	0	3 74.00
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
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0 95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0 98.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,282	7,159	27,176	27,270	64 118.00
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
194.00	07950	NONALLOWABLE CASE MANAGER	0	0	0	0	0 194.00
194.01	07951	IDLE SPACE	0	0	0	0	0 194.01
194.02	07952	REGION	0	0	0	0	0 194.02
194.03	07953	REGIONAL SALES	0	0	0	0	0 194.03
194.04	07954	VERILY LEASE	0	0	0	0	0 194.04
194.05	07955	BHN	0	0	0	0	0 194.05
194.06	07956	PHYSICIANS DINING ROOM	0	0	0	0	0 194.06
194.07	07957	HR MANAGED CARE	0	0	0	0	0 194.07
194.08	07959	SALES & MARKETING	0	0	0	0	0 194.08
194.09	07958	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.09
194.10	07962	NONREIMBURSABLE PROJECTS	0	0	0	0	0 194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0 194.11
194.12	07960	VISITOR MEALS	0	0	0	0	0 194.12
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)	913,765	149,619	402,747	1,206,448	825,394 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	32.309066	20.899427	14.819951	44.240851	12,896.781250 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	133,949	55,211	29,350	272,083	205,275 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.736193	7.712111	1.079997	9.977374	3,207.421875 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: 15-2013

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

Worksheet B-1

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Cost Center Description		NURSING ADMINISTRATIO N (NURSING FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION	32				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	558,806			14.00
15.00	01500	PHARMACY	0	26,878	479,687		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	51,333,458	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	31	361,809	6,892	26,813,326	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1	3,037	0	967,261	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,737	0	869,643	54.00
60.00	06000	LABORATORY	0	6,133	0	2,574,404	60.00
65.00	06500	RESPIRATORY THERAPY	0	122,439	0	8,393,125	65.00
66.00	06600	PHYSICAL THERAPY	0	13,744	0	762,105	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	472,795	9,824,055	73.00
74.00	07400	RENAL DIALYSIS	0	23,029	0	1,129,539	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32	558,806	479,687	51,333,458	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
194.00	07950	NONALLOWABLE CASE MANAGER	0	0	0	0	194.00
194.01	07951	IDLE SPACE	0	0	0	0	194.01
194.02	07952	REGION	0	0	0	0	194.02
194.03	07953	REGIONAL SALES	0	0	0	0	194.03
194.04	07954	VERILY LEASE	0	0	0	0	194.04
194.05	07955	BHN	0	0	0	0	194.05
194.06	07956	PHYSICIANS DINING ROOM	0	0	0	0	194.06
194.07	07957	HR MANAGED CARE	0	0	0	0	194.07
194.08	07959	SALES & MARKETING	0	0	0	0	194.08
194.09	07958	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.09
194.10	07962	NONREIMBURSABLE PROJECTS	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	194.11
194.12	07960	VISITOR MEALS	0	0	0	0	194.12
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)	1,427,511	123,508	796,879	530,733	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	44,609.718750	0.221021	1.661248	0.010339	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	179,550	40,809	68,099	51,780	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5,610.937500	0.073029	0.141965	0.001009	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: 15-2013

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

Worksheet B-1

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Cost Center Description		PARAMED ED PRGM (ASSIGNED TIME)	
		23.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
44.00	04400	SKILLED NURSING FACILITY	44.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	98.00
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	NONALLOWABLE CASE MANAGER	194.00
194.01	07951	IDLE SPACE	194.01
194.02	07952	REGION	194.02
194.03	07953	REGIONAL SALES	194.03
194.04	07954	VERILY LEASE	194.04
194.05	07955	BHN	194.05
194.06	07956	PHYSICIANS DINING ROOM	194.06
194.07	07957	HR MANAGED CARE	194.07
194.08	07959	SALES & MARKETING	194.08
194.09	07958	OTHER NONREIMBURSABLE COST CENTERS	194.09
194.10	07962	NONREIMBURSABLE PROJECTS	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	194.11
194.12	07960	VISITOR MEALS	194.12
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)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	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: 15-2013	Period: From 09/01/2023 To 08/31/2024	Worksheet C Part I Date/Time Prepared: 11/20/2024 3:28 pm		
				Title XVIII	Hospital	PPS		
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE	Total Costs	
						Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,433,156		10,433,156	0	10,433,156	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	489,370		489,370	0	489,370	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	387,586		387,586	0	387,586	54.00
60.00	06000	LABORATORY	251,116		251,116	0	251,116	60.00
65.00	06500	RESPIRATORY THERAPY	1,863,343	0	1,863,343	0	1,863,343	65.00
66.00	06600	PHYSICAL THERAPY	618,405	0	618,405	0	618,405	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,458,603		1,458,603	0	1,458,603	73.00
74.00	07400	RENAL DIALYSIS	528,300		528,300	0	528,300	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	0		0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
200.00		Subtotal (see instructions)	16,029,879	0	16,029,879	0	16,029,879	200.00
201.00		Less Observation Beds	0		0			201.00
202.00		Total (see instructions)	16,029,879	0	16,029,879	0	16,029,879	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-2013

Period:
From 09/01/2023
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Part I
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			Title XVIII		Hospital	PPS		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	26,813,326		26,813,326			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	967,261	0	967,261	0.505934	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	863,396	6,247	869,643	0.445684	0.000000	54.00
60.00	06000	LABORATORY	2,534,961	39,443	2,574,404	0.097543	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	8,389,041	4,084	8,393,125	0.222008	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	750,141	11,964	762,105	0.811443	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,824,055	0	9,824,055	0.148473	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,060,859	68,680	1,129,539	0.467713	0.000000	74.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
200.00		Subtotal (see instructions)	51,203,040	130,418	51,333,458			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	51,203,040	130,418	51,333,458			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-2013

Period:
From 09/01/2023
To 08/31/2024Worksheet C
Part I
Date/Time Prepared:
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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
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.505934		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.445684		54.00
60.00	06000	LABORATORY	0.097543		60.00
65.00	06500	RESPIRATORY THERAPY	0.222008		65.00
66.00	06600	PHYSICAL THERAPY	0.811443		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.148473		73.00
74.00	07400	RENAL DIALYSIS	0.467713		74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES					Provider CCN: 15-2013	Period: From 09/01/2023 To 08/31/2024	Worksheet C Part I Date/Time Prepared: 11/20/2024 3:28 pm	
					Title XIX	Hospital	PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,433,156		10,433,156	0	10,433,156	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	489,370		489,370	0	489,370	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	387,586		387,586	0	387,586	54.00
60.00	06000	LABORATORY	251,116		251,116	0	251,116	60.00
65.00	06500	RESPIRATORY THERAPY	1,863,343	0	1,863,343	0	1,863,343	65.00
66.00	06600	PHYSICAL THERAPY	618,405	0	618,405	0	618,405	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,458,603		1,458,603	0	1,458,603	73.00
74.00	07400	RENAL DIALYSIS	528,300		528,300	0	528,300	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	0		0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
200.00		Subtotal (see instructions)	16,029,879	0	16,029,879	0	16,029,879	200.00
201.00		Less Observation Beds	0		0			201.00
202.00		Total (see instructions)	16,029,879	0	16,029,879	0	16,029,879	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-2013

Period:
From 09/01/2023
To 08/31/2024Worksheet C
Part I
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			Title XIX		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	26,813,326		26,813,326			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	967,261	0	967,261	0.505934	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	863,396	6,247	869,643	0.445684	0.000000	54.00
60.00	06000	LABORATORY	2,534,961	39,443	2,574,404	0.097543	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	8,389,041	4,084	8,393,125	0.222008	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	750,141	11,964	762,105	0.811443	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,824,055	0	9,824,055	0.148473	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,060,859	68,680	1,129,539	0.467713	0.000000	74.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
200.00		Subtotal (see instructions)	51,203,040	130,418	51,333,458			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	51,203,040	130,418	51,333,458			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-2013

Period:
From 09/01/2023
To 08/31/2024Worksheet C
Part I
Date/Time Prepared:
11/20/2024 3:28 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
44.00	04400	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.505934			50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.445684			54.00
60.00	06000	LABORATORY	0.097543			60.00
65.00	06500	RESPIRATORY THERAPY	0.222008			65.00
66.00	06600	PHYSICAL THERAPY	0.811443			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.148473			73.00
74.00	07400	RENAL DIALYSIS	0.467713			74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000			98.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 15-2013

Period:
From 09/01/2023
To 08/31/2024Worksheet C
Part II
Date/Time Prepared:
11/20/2024 3:28 pm

			Title XIX		Hospital	PPS	
Cost Center Description			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount
			1.00	2.00	3.00	4.00	5.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	489,370	24,542	464,828	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	387,586	55,036	332,550	0	0
60.00	06000	LABORATORY	251,116	16,901	234,215	0	0
65.00	06500	RESPIRATORY THERAPY	1,863,343	118,303	1,745,040	0	0
66.00	06600	PHYSICAL THERAPY	618,405	45,689	572,716	0	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,458,603	96,746	1,361,857	0	0
74.00	07400	RENAL DIALYSIS	528,300	52,910	475,390	0	0
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	0
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
200.00		Subtotal (sum of lines 50 thru 199)	5,596,723	410,127	5,186,596	0	0
201.00		Less Observation Beds	0	0	0	0	0
202.00		Total (line 200 minus line 201)	5,596,723	410,127	5,186,596	0	0

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 15-2013

Period:
From 09/01/2023
To 08/31/2024Worksheet C
Part II
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11/20/2024 3:28 pm

Cost Center Description			Title XIX		Hospital	PPS
			Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	489,370	967,261	0.505934	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	387,586	869,643	0.445684	54.00
60.00	06000	LABORATORY	251,116	2,574,404	0.097543	60.00
65.00	06500	RESPIRATORY THERAPY	1,863,343	8,393,125	0.222008	65.00
66.00	06600	PHYSICAL THERAPY	618,405	762,105	0.811443	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,458,603	9,824,055	0.148473	73.00
74.00	07400	RENAL DIALYSIS	528,300	1,129,539	0.467713	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0.000000	91.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	98.00
200.00		Subtotal (sum of lines 50 thru 199)	5,596,723	24,520,132		200.00
201.00		Less Observation Beds	0	0		201.00
202.00		Total (line 200 minus line 201)	5,596,723	24,520,132		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS				Provider CCN: 15-2013		Period: From 09/01/2023 To 08/31/2024		Worksheet D Part I Date/Time Prepared: 11/20/2024 3:28 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	1,817,930	0	1,817,930	7,159	253.94	30.00		
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00		
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00		
200.00	Total (lines 30 through 199)	1,817,930		1,817,930	7,159		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	1,889	479,693					30.00	
31.00	INTENSIVE CARE UNIT	0	0					31.00	
44.00	SKILLED NURSING FACILITY	0	0					44.00	
200.00	Total (lines 30 through 199)	1,889	479,693					200.00	

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 15-2013		Period: From 09/01/2023 To 08/31/2024		Worksheet D Part II Date/Time Prepared: 11/20/2024 3:28 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description				Capital Related Cost (from Wkst. C, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
				1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		24,542	967,261	0.025373	247,237	6,273	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		55,036	869,643	0.063286	255,897	16,195	54.00
60.00	06000	LABORATORY		16,901	2,574,404	0.006565	692,395	4,546	60.00
65.00	06500	RESPIRATORY THERAPY		118,303	8,393,125	0.014095	2,824,541	39,812	65.00
66.00	06600	PHYSICAL THERAPY		45,689	762,105	0.059951	226,987	13,608	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0.000000	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0.000000	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		96,746	9,824,055	0.009848	2,332,842	22,974	73.00
74.00	07400	RENAL DIALYSIS		52,910	1,129,539	0.046842	317,374	14,866	74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY		0	0	0.000000	0	0	91.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES		0	0	0.000000	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS		0	0	0.000000	0	0	98.00
200.00		Total (lines 50 through 199)		410,127	24,520,132		6,897,273	118,274	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 15-2013		Period: From 09/01/2023 To 08/31/2024		Worksheet D Part III Date/Time Prepared: 11/20/2024 3:28 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		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00		
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	7,159	0.00	1,889	30.00		
31.00	03100	INTENSIVE CARE UNIT		0	0	0.00	0	31.00		
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00		
200.00		Total (lines 30 through 199)		0	7,159		1,889	200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)							
			9.00							
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0						30.00	
31.00	03100	INTENSIVE CARE UNIT	0						31.00	
44.00	04400	SKILLED NURSING FACILITY	0						44.00	
200.00		Total (lines 30 through 199)	0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 15-2013

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

Worksheet D
Part IV
Date/Time Prepared:
11/20/2024 3:28 pm

Cost Center Description			Title XVIII		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
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
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
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: 15-2013

Period:
From 09/01/2023
To 08/31/2024Worksheet D
Part IV
Date/Time Prepared:
11/20/2024 3:28 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	967,261	0.000000	50.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	869,643	0.000000	54.00	
60.00	06000	LABORATORY	0	0	0	2,574,404	0.000000	60.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,393,125	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	762,105	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,824,055	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	1,129,539	0.000000	74.00	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00	
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES						95.00	
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0.000000	98.00	
200.00		Total (lines 50 through 199)	0	0	0	24,520,132		200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-2013

Period:
From 09/01/2023
To 08/31/2024Worksheet D
Part IV
Date/Time Prepared:
11/20/2024 3:28 pm

Cost Center Description			Title XVIII		Hospital		PPS
			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	247,237	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	255,897	0	4,952	0
60.00	06000	LABORATORY	0.000000	692,395	0	5,266	0
65.00	06500	RESPIRATORY THERAPY	0.000000	2,824,541	0	668	0
66.00	06600	PHYSICAL THERAPY	0.000000	226,987	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,332,842	0	0	0
74.00	07400	RENAL DIALYSIS	0.000000	317,374	0	50,500	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	0	0	0	0
91.00	09100	EMERGENCY	0.000000	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.000000	0	0	0	0
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0
200.00		Total (lines 50 through 199)		6,897,273	0	61,386	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST					Provider CCN:15-2013		Period: From 09/01/2023 To 08/31/2024		Worksheet D Part V Date/Time Prepared: 11/20/2024 3:28 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	0.505934	0	0	0	0	0	50.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.445684	4,952	0	0	0	2,207	54.00	
60.00	06000	LABORATORY	0.097543	5,266	0	0	0	514	60.00	
65.00	06500	RESPIRATORY THERAPY	0.222008	668	0	0	0	148	65.00	
66.00	06600	PHYSICAL THERAPY	0.811443	0	0	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	0	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	0	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.148473	0	0	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0.467713	50,500	0	0	0	23,620	74.00	
OUTPATIENT SERVICE COST CENTERS										
90.00	09000	CLINIC	0.000000	0	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0.000000	0	0	0	0	0	91.00	
OTHER REIMBURSABLE COST CENTERS										
95.00	09500	AMBULANCE SERVICES	0.000000		0				95.00	
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	0	98.00	
200.00		Subtotal (see instructions)		61,386	0	0	0	26,489	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0		201.00	
202.00		Net Charges (line 200 - line 201)		61,386	0	0	0	26,489	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-2013

Period:
From 09/01/2023
To 08/31/2024Worksheet D
Part V
Date/Time Prepared:
11/20/2024 3:28 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS				Provider CCN: 15-2013		Period: From 09/01/2023 To 08/31/2024		Worksheet D Part I Date/Time Prepared: 11/20/2024 3:28 pm	
				Title XIX		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	1,817,930	0	1,817,930	7,159	253.94	30.00		
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00		
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00		
200.00	Total (lines 30 through 199)	1,817,930		1,817,930	7,159		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	43	10,919						30.00
31.00	INTENSIVE CARE UNIT	0	0						31.00
44.00	SKILLED NURSING FACILITY	0	0						44.00
200.00	Total (lines 30 through 199)	43	10,919						200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-2013

Period:
From 09/01/2023
To 08/31/2024Worksheet D
Part II
Date/Time Prepared:
11/20/2024 3:28 pm

Cost Center Description		Title XIX		Hospital		PPS	
		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	24,542	967,261	0.025373	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	55,036	869,643	0.063286	0	0	54.00
60.00	06000 LABORATORY	16,901	2,574,404	0.006565	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	118,303	8,393,125	0.014095	0	0	65.00
66.00	06600 PHYSICAL THERAPY	45,689	762,105	0.059951	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	96,746	9,824,055	0.009848	0	0	73.00
74.00	07400 RENAL DIALYSIS	52,910	1,129,539	0.046842	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0	0	0.000000	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00	Total (lines 50 through 199)	410,127	24,520,132		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 15-2013		Period: From 09/01/2023 To 08/31/2024		Worksheet D Part III Date/Time Prepared: 11/20/2024 3:28 pm	
					Title XIX		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		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00		
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	7,159	0.00	43	30.00		
31.00	03100	INTENSIVE CARE UNIT		0	0	0.00	0	31.00		
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00		
200.00		Total (lines 30 through 199)		0	7,159		43	200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)							
			9.00							
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0						30.00	
31.00	03100	INTENSIVE CARE UNIT	0						31.00	
44.00	04400	SKILLED NURSING FACILITY	0						44.00	
200.00		Total (lines 30 through 199)	0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 15-2013

Period:
From 09/01/2023
To 08/31/2024Worksheet D
Part IV
Date/Time Prepared:
11/20/2024 3:28 pm

				Title XIX		Hospital	PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
	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
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
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: 15-2013

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

Worksheet D
Part IV
Date/Time Prepared:
11/20/2024 3:28 pm

				Title XIX		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	967,261	0.000000	50.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	869,643	0.000000	54.00	
60.00	06000	LABORATORY	0	0	0	2,574,404	0.000000	60.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,393,125	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	762,105	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,824,055	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	1,129,539	0.000000	74.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00	
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00	
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0.000000	98.00	
200.00		Total (lines 50 through 199)	0	0	0	24,520,132		200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 15-2013

Period:
From 09/01/2023
To 08/31/2024Worksheet D
Part IV
Date/Time Prepared:
11/20/2024 3:28 pm

			Title XIX		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	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-2013	Period: From 09/01/2023 To 08/31/2024	Worksheet D-1 Date/Time Prepared: 11/20/2024 3:28 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)			7,159	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			7,159	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			7,159	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)			1,889	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)			10,433,156	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)			10,433,156	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)			10,433,156	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)			1,457.35	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			2,752,934	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)			2,752,934	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-2013

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

Worksheet D-1

Date/Time Prepared:
11/20/2024 3:28 pm

		Title XVIII		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)					42.00
	Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT	0	0	0.00	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)				1,612,735	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)				4,365,669	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)				479,693	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				118,274	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				597,967	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				3,767,702	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)				0	87.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-2013	Period: From 09/01/2023 To 08/31/2024	Worksheet D-1 Date/Time Prepared: 11/20/2024 3:28 pm	
				Title XVIII	Hospital	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	1,817,930	10,433,156	0.174245	0	0	90.00
91.00	Nursing Program cost	0	10,433,156	0.000000	0	0	91.00
92.00	Allied health cost	0	10,433,156	0.000000	0	0	92.00
93.00	All other Medical Education	0	10,433,156	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-2013	Period: From 09/01/2023 To 08/31/2024	Worksheet D-1 Date/Time Prepared: 11/20/2024 3:28 pm	
		Title XIX	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)			7,159	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			7,159	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			7,159	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)			43	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)			10,433,156	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)			10,433,156	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)			10,433,156	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)			1,457.35	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			62,666	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)			62,666	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-2013

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

Worksheet D-1

Date/Time Prepared:
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Cost Center Description		Title XIX		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)						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)					0	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					62,666	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)					10,919	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)					10,919	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					51,747	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)					0	87.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN:15-2013		Period: From 09/01/2023 To 08/31/2024		Worksheet D-1 Date/Time Prepared: 11/20/2024 3:28 pm	
				Title XIX		Hospital		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	1,817,930	10,433,156	0.174245	0	0	0	90.00	
91.00	Nursing Program cost	0	10,433,156	0.000000	0	0	0	91.00	
92.00	Allied health cost	0	10,433,156	0.000000	0	0	0	92.00	
93.00	All other Medical Education	0	10,433,156	0.000000	0	0	0	93.00	

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 15-2013

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

Worksheet D-2

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Cost Center Description	Percent of Assigned Time	Expense Allocation	Total Inpatient Day All Patients	Average Cost Per Day	Health Care Program Inpatient Days	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
PART I - NOT IN APPROVED TEACHING PROGRAM						
1.00	Total cost of services rendered	0.00	0			1.00
Hospital Inpatient Routine Services:						
2.00	ADULTS & PEDIATRICS	0.00	0	7,159	0.00	2.00
3.00	INTENSIVE CARE UNIT	0.00	0	0	0.00	3.00
4.00	CORONARY CARE UNIT					4.00
5.00	BURN INTENSIVE CARE UNIT					5.00
6.00	SURGICAL INTENSIVE CARE UNIT					6.00
7.00	OTHER SPECIAL CARE (SPECIFY)					7.00
8.00	NURSERY					8.00
9.00	Subtotal (sum of lines 2 through 8)	0.00	0			9.00
10.00	SUBPROVIDER - IPF					10.00
11.00	SUBPROVIDER - IRF					11.00
12.00	SUBPROVIDER					12.00
13.00	SKILLED NURSING FACILITY	0.00	0	0	0.00	13.00
14.00	NURSING FACILITY					14.00
15.00	OTHER LONG TERM CARE					15.00
16.00	HOME HEALTH AGENCY					16.00
17.00	CMHC					17.00
18.00	AMBULATORY SURGICAL CENTER (D.P.)					18.00
19.00	HOSPICE					19.00
20.00	Subtotal (sum of lines 9 through 19)	0.00	0			20.00
Cost Center Description Total Charges (from Worksheet C. Part I, column 8, lines 88 through 93) Ratio of Cost to Charges (col. 2 ÷ col. 3) Titles V and XIX Outpatient and Title XVIII Part B Charges Title V						
	1.00	2.00	3.00	4.00	5.00	
Hospital Outpatient Services:						
21.00	RURAL HEALTH CLINIC					21.00
22.00	FEDERALLY QUALIFIED HEALTH CENTER					22.00
23.00	CLINIC	0.00	0	0	0.000000	23.00
24.00	EMERGENCY	0.00	0	0	0.000000	24.00
25.00	OBSERVATION BEDS (NON-DISTINCT PART)					25.00
26.00	OTHER OUTPATIENT SERVICE COST CENTER					26.00
27.00	Subtotal (sum of lines 21 through 26)	0.00	0			27.00
28.00	Total (sum of lines 20 and 27)	0.00	0			28.00
Cost Center Description Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22 Swing bed Amount Net cost (column 1 plus column 2) Total Inpatient Days - All Patients Average Cost Per Day (col. 3 ÷ col. 4)						
	1.00	2.00	3.00	4.00	5.00	
PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)						
Hospital Inpatient Routine Services:						
29.00	ADULTS & PEDIATRICS	0	0	0	0.00	29.00
30.00	Swing Bed - SNF		0	0	0.00	30.00
31.00	Swing Bed - NF		0			31.00
32.00	INTENSIVE CARE UNIT	0		0	0.00	32.00
33.00	CORONARY CARE UNIT					33.00
34.00	BURN INTENSIVE CARE UNIT					34.00
35.00	SURGICAL INTENSIVE CARE UNIT					35.00
36.00	OTHER SPECIAL CARE (SPECIFY)					36.00
37.00	Subtotal (sum of lines 29, and 32 through 36)	0		0		37.00
38.00	SUBPROVIDER - IPF					38.00
39.00	SUBPROVIDER - IRF					39.00
40.00	SUBPROVIDER					40.00
41.00	SKILLED NURSING FACILITY	0		0	0.00	41.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 15-2013

Period:
From 09/01/2023
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Cost Center Description		Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22	Swing bed Amount	Net cost (column 1 plus column 2)	Total Inpatient Days - All Patients	Average Cost Per Day (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	Total (sum of lines 37 through 41)	0		0			42.00
Cost Center Description		Not In Approved Teaching Program			In Approved Teaching Program		
		(from Part I:)		Amount	(from Part II, col. 7, -)		
		1.00		2.00	3.00		
PART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED)							
Hospital							
43.00	Inpatient	col. 9, line 9.00		0	line 37.00		43.00
44.00	Outpatient	col. 9, line 27.00		0			44.00
45.00	Total Hospital (sum of lines 43 and 44)			0			45.00
46.00	SUBPROVIDER - IPF						46.00
47.00	SUBPROVIDER - IRF						47.00
48.00	SUBPROVIDER						48.00
49.00	SKILLED NURSING FACILITY	col. 9, line 13.00		0	col. 9, line 41.00		49.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 15-2013

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

Worksheet D-2

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Cost Center Description		Health Care Program Inpatient Days		Title V (col. 4 x col. 5)	Title XVIII (col. 4 x col. 6)	Title XIX (col. 4 x col. 7)	
		Title XVIII, Part B Only less Part A Coverage but no Part B Coverage	Title XIX				
		6.00	7.00				
PART I - NOT IN APPROVED TEACHING PROGRAM							
1.00	Total cost of services rendered						1.00
Hospital Inpatient Routine Services:							
2.00	ADULTS & PEDIATRICS	1,889	43	0	0	0	2.00
3.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	CORONARY CARE UNIT						4.00
5.00	BURN INTENSIVE CARE UNIT						5.00
6.00	SURGICAL INTENSIVE CARE UNIT						6.00
7.00	OTHER SPECIAL CARE (SPECIFY)						7.00
8.00	NURSERY						8.00
9.00	Subtotal (sum of lines 2 through 8)			0	0	0	9.00
10.00	SUBPROVIDER - IPF						10.00
11.00	SUBPROVIDER - IRF						11.00
12.00	SUBPROVIDER						12.00
13.00	SKILLED NURSING FACILITY	0	0	0	0	0	13.00
14.00	NURSING FACILITY						14.00
15.00	OTHER LONG TERM CARE						15.00
16.00	HOME HEALTH AGENCY						16.00
17.00	CMHC						17.00
18.00	AMBULATORY SURGICAL CENTER (D.P.)						18.00
19.00	HOSPICE						19.00
20.00	Subtotal (sum of lines 9 through 19)						20.00
Cost Center Description		Titles V and XIX Outpatient and Title XVIII Part B Charges		Titles V and XIX Outpatient and Title XVIII Part B Cost			
		Title XVIII Part B	Title XIX	Title V	Title XVIII Part B	Title XIX	
		6.00	7.00	8.00	9.00	10.00	
Hospital Outpatient Services:							
21.00	RURAL HEALTH CLINIC						21.00
22.00	FEDERALLY QUALIFIED HEALTH CENTER						22.00
23.00	CLINIC	0	0	0	0	0	23.00
24.00	EMERGENCY	0	0	0	0	0	24.00
25.00	OBSERVATION BEDS (NON-DISTINCT PART)						25.00
26.00	OTHER OUTPATIENT SERVICE COST CENTER						26.00
27.00	Subtotal (sum of lines 21 through 26)			0	0	0	27.00
28.00	Total (sum of lines 20 and 27)						28.00
Cost Center Description		Title XVIII Part B Inpatient Days	Expenses Applicable to Title XVIII (col. 5 x col. 6)	PSA Adj. Interns & Residents			
		6.00	7.00	11.00			
		PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)					
Hospital Inpatient Routine Services:							
29.00	ADULTS & PEDIATRICS		0				29.00
30.00	Swing Bed - SNF		0				30.00
31.00	Swing Bed - NF						31.00
32.00	INTENSIVE CARE UNIT		0				32.00
33.00	CORONARY CARE UNIT						33.00
34.00	BURN INTENSIVE CARE UNIT						34.00
35.00	SURGICAL INTENSIVE CARE UNIT						35.00
36.00	OTHER SPECIAL CARE (SPECIFY)						36.00
37.00	Subtotal (sum of lines 29, and 32 through 36)		0				37.00
38.00	SUBPROVIDER - IPF						38.00
39.00	SUBPROVIDER - IRF						39.00
40.00	SUBPROVIDER						40.00
41.00	SKILLED NURSING FACILITY		0				41.00
42.00	Total (sum of lines 37 through 41)		0				42.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS	Provider CCN: 15-2013	Period: From 09/01/2023 To 08/31/2024	Worksheet D-2 Date/Time Prepared: 11/20/2024 3:28 pm
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Cost Center Description		In Approved Teaching Program	Total Title XVIII Costs		
		Amount	(to Wkst. E, Part B -)	(col. 2 + col. 4)	
		4.00	5.00	6.00	
PART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED)					
Hospital					
43.00	Inpatient	0		0	43.00
44.00	Outpatient				44.00
45.00	Total Hospital (sum of lines 43 and 44)	0	line 22	0	45.00
46.00	SUBPROVIDER - IPF				46.00
47.00	SUBPROVIDER - IRF				47.00
48.00	SUBPROVIDER				48.00
49.00	SKILLED NURSING FACILITY	0	line 22	0	49.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 15-2013	Period: From 09/01/2023 To 08/31/2024	Worksheet D-3 Date/Time Prepared: 11/20/2024 3:28 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		7,064,564		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.505934	247,237	125,086	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.445684	255,897	114,049	54.00
60.00	06000	LABORATORY	0.097543	692,395	67,538	60.00
65.00	06500	RESPIRATORY THERAPY	0.222008	2,824,541	627,071	65.00
66.00	06600	PHYSICAL THERAPY	0.811443	226,987	184,187	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.148473	2,332,842	346,364	73.00
74.00	07400	RENAL DIALYSIS	0.467713	317,374	148,440	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES				95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		6,897,273	1,612,735	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		6,897,273		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-2013	Period: From 09/01/2023 To 08/31/2024	Worksheet E Part B Date/Time Prepared: 11/20/2024 3:28 pm	
		Title XVIII	Hospital	PPS	
				1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)			0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			26,489	2.00
3.00	OPPS or REH payments			16,888	3.00
4.00	Outlier payment (see instructions)			0	4.00
4.01	Outlier reconciliation amount (see instructions)			0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000	5.00
6.00	Line 2 times line 5			0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.00
8.00	Transitional corridor payment (see instructions)			0	8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200			0	9.00
10.00	Organ acquisitions			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0	14.00
Customary charges					
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a 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)			0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0	20.00
21.00	Lesser of cost or charges (see instructions)			0	21.00
22.00	Interns and residents (see instructions)			0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			16,888	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)			3,378	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)			13,510	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)			13,510	30.00
31.00	Primary payer payments			0	31.00
32.00	Subtotal (line 30 minus line 31)			13,510	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)					
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
34.00	Allowable bad debts (see instructions)			0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	36.00
37.00	Subtotal (see instructions)			13,510	37.00
38.00	MSP-LCC reconciliation amount from PS&R			0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
39.75	N95 respirator payment adjustment amount (see instructions)			0	39.75
39.97	Demonstration payment adjustment amount before sequestration			0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	39.99
40.00	Subtotal (see instructions)			13,510	40.00
40.01	Sequestration adjustment (see instructions)			270	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			13,240	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)			0	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:15-2013	Period: From 09/01/2023 To 08/31/2024	Worksheet E Part B Date/Time Prepared: 11/20/2024 3:28 pm	
		Title XVIII	Hospital	PPS	
				1.00	
94.00	Total (sum of lines 91 and 93)			0	94.00
				1.00	
200.00	MEDICARE PART B ANCILLARY COSTS Part B Combined Billed Days			0	200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-2013

Period:
From 09/01/2023
To 08/31/2024Worksheet E-1
Part I
Date/Time Prepared:
11/20/2024 3:28 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		4,761,720		13,240	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		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	06/14/2024	878,525		0	3.50
3.51		06/19/2024	108,199		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)		-986,724		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)		3,774,996		13,240	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	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		2,881		0	6.02
7.00	Total Medicare program liability (see instructions)		3,772,115		13,240	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		Provider CCN: 15-2013	Period: From 09/01/2023 To 08/31/2024	Worksheet E-3 Part IV Date/Time Prepared: 11/20/2024 3:28 pm
		Title XVIII	Hospital	PPS
			1.00	
PART IV - MEDICARE PART A SERVICES - LTCH PPS				
1.00	Net Federal PPS Payments (see instructions)		3,644,071	1.00
1.01	Full standard payment amount		2,722,857	1.01
1.02	Short stay outlier standard payment amount		921,214	1.02
1.03	Site neutral payment amount - Cost		0	1.03
1.04	Site neutral payment amount - IPPS comparable		0	1.04
2.00	Outlier Payments		376,865	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)		4,020,936	3.00
4.00	Nursing and Allied Health Managed Care payments (see instructions)		0	4.00
5.00	Organ acquisition (DO NOT USE THIS LINE)		0	5.00
6.00	Cost of physicians' services in a teaching hospital (see instructions)		0	6.00
7.00	Subtotal (see instructions)		4,020,936	7.00
8.00	Primary payer payments		0	8.00
9.00	Subtotal (line 7 less line 8).		4,020,936	9.00
10.00	Deductibles		12,992	10.00
11.00	Subtotal (line 9 minus line 10)		4,007,944	11.00
12.00	Coinsurance		234,152	12.00
13.00	Subtotal (line 11 minus line 12)		3,773,792	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		115,854	14.00
15.00	Adjusted reimbursable bad debts (see instructions)		75,305	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		100,397	16.00
17.00	Subtotal (sum of lines 13 and 15)		3,849,097	17.00
18.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	18.00
19.00	Other pass through costs (see instructions)		0	19.00
20.00	Outlier payments reconciliation		0	20.00
21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	21.00
21.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	21.50
21.98	Recovery of accelerated depreciation.		0	21.98
21.99	Demonstration payment adjustment amount before sequestration		0	21.99
22.00	Total amount payable to the provider (see instructions)		3,849,097	22.00
22.01	Sequestration adjustment (see instructions)		76,982	22.01
22.02	Demonstration payment adjustment amount after sequestration		0	22.02
23.00	Interim payments		3,774,996	23.00
24.00	Tentative settlement (for contractor use only)		0	24.00
25.00	Balance due provider/program (line 22 minus lines 22.01, 22.02, 23 and 24)		-2,881	25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	26.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions)		376,865	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 (see instructions)		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-2013	Period: From 09/01/2023 To 08/31/2024	Worksheet E-3 Part VII Date/Time Prepared: 11/20/2024 3:28 pm	
		Title XIX	Hospital	PPS	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant programs only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	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)		0	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)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		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)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS		0	0	37.00
37.01	OTHER ADJUSTMENTS		0	0	37.01
38.00	Subtotal (line 36 ± line 37)		0	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)		0	0	40.00
41.00	Interim payments		0		41.00
42.00	Balance due provider/program (line 40 minus line 41)		0		42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 15-2013

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

Worksheet G

Date/Time Prepared:
11/20/2024 3:28 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	0	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	6,232,737	0	0	0	4.00
5.00	Other receivable	-3,502	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,031,491	0	0	0	6.00
7.00	Inventory	223,870	0	0	0	7.00
8.00	Prepaid expenses	134,585	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	4,556,199	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	6,531	0	0	0	15.00
16.00	Accumulated depreciation	-4,354	0	0	0	16.00
17.00	Leasehold improvements	589,072	0	0	0	17.00
18.00	Accumulated depreciation	-259,036	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	1,165,843	0	0	0	23.00
24.00	Accumulated depreciation	-583,529	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	914,527	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	17,208	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	2,577,187	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,594,395	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	8,065,121	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,576,040	0	0	0	37.00
38.00	Salaries, wages, and fees payable	320,722	0	0	0	38.00
39.00	Payroll taxes payable	91,136	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,951,413	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,939,311	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	9,606,499	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	9,606,499	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	14,545,810	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-6,480,689	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-6,480,689	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	8,065,121	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-2013

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

Worksheet G-1

Date/Time Prepared:
11/20/2024 3:28 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		-3,195,136		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-3,285,548				2.00
3.00	Total (sum of line 1 and line 2)		-6,480,684		0		3.00
4.00	Additions (credit adjustments)	0		0		0	4.00
5.00	INTERCOMPANY TRANSFERS\ROUNDING	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)		-6,480,684		0		11.00
12.00	Deductions (debit adjustments)	0		0		0	12.00
13.00	INTERCOMPANY TRANSFERS\ROUNDING	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)		-6,480,684		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)		0				4.00
5.00	INTERCOMPANY TRANSFERS\ROUNDING		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)		0				12.00
13.00	INTERCOMPANY TRANSFERS\ROUNDING		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: 15-2013

Period:
From 09/01/2023
To 08/31/2024Worksheet G-2
Parts I & II
Date/Time Prepared:
11/20/2024 3:28 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	26,813,326		26,813,326	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	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)	26,813,326		26,813,326	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	26,813,326		26,813,326	17.00
18.00	Ancillary services	24,389,714	130,418	24,520,132	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	51,203,040	130,418	51,333,458	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		17,320,533		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		17,320,533		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-2013

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

Worksheet G-3

Date/Time Prepared:
11/20/2024 3:28 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	51,333,458	1.00
2.00	Less contractual allowances and discounts on patients' accounts	37,423,474	2.00
3.00	Net patient revenues (line 1 minus line 2)	13,909,984	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	17,320,533	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,410,549	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	173	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	20,134	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	552	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	104,142	24.00
24.50	COVID-19 PHE Funding	0	24.50
24.51	FEMA OTHER INCOME	0	24.51
25.00	Total other income (sum of lines 6-24)	125,001	25.00
26.00	Total (line 5 plus line 25)	-3,285,548	26.00
27.00	OTHER EXPENSES	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-3,285,548	29.00