

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050 EXPIRES 09-30-2025

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet S Parts I-III Date/Time Prepared: 11/25/2024 11:36 am
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PART I - COST REPORT STATUS

Provider use only
 1. Electronically prepared cost report
 2. Manually prepared cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only
 5. Cost Report Status
 (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.

Date: 11/25/2024 Time: 11:36 am

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 ST. MARY MEDICAL CENTER, INC. (15-0034) for the cost reporting period beginning 07/01/2023 and ending 06/30/2024 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1	2		
1	Mary F. Sudicky	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Mary F. Sudicky		2
3	Signatory Title	CFO		3
4	Date	(Dated when report is electronic)		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	71,524	-39,181	0	0 1.00
2.00	SUBPROVIDER - IPF	0	0	0	0	0 2.00
3.00	SUBPROVIDER - IRF	0	-45,840	-11	0	0 3.00
5.00	SWING BED - SNF	0	0	0	0	0 5.00
6.00	SWING BED - NF	0	0	0	0	0 6.00
9.00	HOME HEALTH AGENCY I	0	0	-1	0	0 9.00
200.00	TOTAL	0	25,684	-39,193	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: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet S-2 Part I Date/Time Prepared: 11/25/2024 11:36 am
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1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1500 SOUTH LAKE PARK AVENUE			PO Box:		Date Certified		Payment System (P, T, O, or N)		1.00	
2.00	City: HOBART			State: IN		Zip Code: 46342		County: LAKE		2.00	
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		ST. MARY MEDICAL CENTER, INC.	150034	23844	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF		SMMC REHABILITATION UNIT	15T034	23844	5	01/01/2001	N	P	P	4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF										7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF		9.00								
10.00	Hospital-Based NF		10.00								
11.00	Hospital-Based OLTC		11.00								
12.00	Hospital-Based HHA		SMMC HOME HEALTH AGENCY	157313	23844		02/08/1996	N	P	N	12.00
13.00	Separately Certified ASC		13.00								
14.00	Hospital-Based Hospice		14.00								
15.00	Hospital-Based Health Clinic - RHC		15.00								
16.00	Hospital-Based Health Clinic - FQHC		16.00								
17.00	Hospital-Based (CMHC) I		17.00								
18.00	Renal Dialysis		18.00								
19.00	Other		19.00								
						From:	To:				
						1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)					07/01/2023	06/30/2024				20.00
21.00	Type of Control (see instructions)					2					21.00
						1.00	2.00	3.00			

Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N			22.00	
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y			22.01	
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02	
22.03	Did this hospital receive a geographic 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.					3	N			23.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0034			Period: From 07/01/2023 To 06/30/2024		Worksheet S-2 Part I Date/Time Prepared: 11/25/2024 11:36 am		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,064	136	33	33	4,695	126		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.	45	0	0	0	399			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	XVII	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	Y	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 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
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00

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		V	XVIII	XIX			
		1.00	2.00	3.00			
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00		
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	Y	Y		60.00		
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1	60.01		
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20	
						1.00	
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 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) Teaching Hospitals that Claim Residents in Nonprovider Settings				0.00	62.01	
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)				N	63.00	

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

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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.				Y	75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N N 0	76.00
			1.00			
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.				N	81.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.				N	87.00
			Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments		
			1.00	2.00		
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.				N	0 88.00
			Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge	
			1.00	2.00	3.00	
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.				0.00	0 89.00
			V	XIX		
			1.00	2.00		
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.				N	Y 90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.				N	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0034		Period: From 07/01/2023 To 06/30/2024		Worksheet S-2 Part I Date/Time Prepared: 11/25/2024 11:36 am	
		V		XIX			
		1.00		2.00			
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N			98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y			98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y			98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N			98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N			98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y			98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N			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	Occupational	Speech	Respiratory		
		1.00	2.00	3.00	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.						109.00
					1.00		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N		110.00
					1.00	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

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		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	1	0	0
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N	118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		N	N
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y	121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.		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	Y
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	15H054
		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: COMMUNITY FOUNDATION OF NW IN, INC.	Contractor's Name: WPS	Contractor's Number: 08001	
142.00	Street: 10010 DONALD S POWERS DRIVE STE 201	PO Box:		
143.00	City: MUNSTER	State: IN	Zip Code:	46321
			1.00	
144.00	Are provider based physicians' costs included in Worksheet A?		Y	144.00
			1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.		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: 15-0034		Period: From 07/01/2023 To 06/30/2024		Worksheet S-2 Part I Date/Time Prepared: 11/25/2024 11:36 am		
							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	
Multi campus								
165.00	Is this hospital part of a Multi campus 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
							1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						9.99	169.00
		Beginning	Ending					
		1.00	2.00					
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							170.00
		1.00	2.00					
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0034		Period: From 07/01/2023 To 06/30/2024		Worksheet S-2 Part II Date/Time Prepared: 11/25/2024 11:36 am	
		Y/N	Date				
		1.00	2.00				
PART II - HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE							
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y					7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	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					1.00
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	09/26/2024	Y	09/26/2024		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet S-2 Part II Date/Time Prepared: 11/25/2024 11:36 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
					1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
					1.00
					2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CATHERINE		WOERNER	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY FOUNDATION OF NW IN, INC.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	12197031267		CATHERINE. R. WOERNER@POWERSHEALTH.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 15-0034

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

Worksheet S-2
Part II
Date/Time Prepared:
11/25/2024 11:36 am

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT 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: 15-0034

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

Worksheet S-3
Part I
Date/Time Prepared:
11/25/2024 11:36 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P		
	Line No.				Visits	Trips	
	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	160	58,560	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)		160	58,560	0.00	0	7.00	
8.00 INTENSIVE CARE UNIT	31.00	20	7,320	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					0	13.00	
14.00 Total (see instructions)		180	65,880	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	41.00	20	7,320		0	17.00	
18.00 SUBPROVIDER						18.00	
19.00 SKILLED NURSING FACILITY						19.00	
20.00 NURSING FACILITY						20.00	
21.00 OTHER LONG TERM CARE						21.00	
22.00 HOME HEALTH AGENCY	101.00				0	22.00	
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00	
24.00 HOSPICE						24.00	
24.10 HOSPICE (non-distinct part)	30.00					24.10	
25.00 CMHC - CMHC						25.00	
26.00 RURAL HEALTH CLINIC						26.00	
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25	
27.00 Total (sum of lines 14-26)		200				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: 15-0034

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

Worksheet S-3
Part I
Date/Time Prepared:
11/25/2024 11:36 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	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)	11,364	807	32,076		1.00
2.00	HMO and other (see instructions)	13,587	4,897			2.00
3.00	HMO IPF Subprovider	0	0			3.00
4.00	HMO IRF Subprovider	1,088	399			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)	11,364	807	32,076		7.00
8.00	INTENSIVE CARE UNIT	1,295	211	5,193		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		46	1,419		13.00
14.00	Total (see instructions)	12,659	1,064	38,688	0.00	1,167.00
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	3,587	45	5,716	0.00	28.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY					19.00
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE					21.00
22.00	HOME HEALTH AGENCY	11,631	0	27,746	0.00	25.00
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
27.00	Total (sum of lines 14-26)				0.00	1,220.00
28.00	Observation Bed Days		0	6,029		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	126	254		32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		32.01
33.00	LTCH non-covered days	0				33.00
33.01	LTCH site neutral days and discharges	0				33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care					34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0034

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

Worksheet S-3
Part I
Date/Time Prepared:
11/25/2024 11:36 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
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	2,700	186	7,880	1.00
2.00	HMO and other (see instructions)			2,257	1,009		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				36		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	2,700	186	7,880	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	0.00	0	340	5	541	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0034

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

Worksheet S-3
Part II
Date/Time Prepared:
11/25/2024 11:36 am

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	92,690,341	0	92,690,341	2,535,321.88	36.56
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		3,128	0	3,128	64.00	48.88
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		5,386,036	10,245	5,396,281	118,381.19	45.58
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		8,202,220	0	8,202,220	125,644.17	65.28
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		789,750	0	789,750	4,981.11	158.55
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		12,308,718	0	12,308,718	316,625.48	38.87
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		24,232,210	0	24,232,210		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		1,186,919	0	1,186,919		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		642	0	642		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		3,398,942	0	3,398,942		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0034

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

Worksheet S-3
Part II
Date/Time Prepared:
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	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)	0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	630,894	0	630,894	16,920.16	37.29	26.00
27.00	Administrative & General	9,868,340	0	9,868,340	308,182.50	32.02	27.00
28.00	Administrative & General under contract (see inst.)	1,586,203	0	1,586,203	11,958.43	132.64	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	2,608,733	0	2,608,733	71,956.95	36.25	30.00
31.00	Laundry & Linen Service	109,073	0	109,073	6,576.61	16.58	31.00
32.00	Housekeeping	2,135,194	-10,245	2,124,949	114,179.46	18.61	32.00
33.00	Housekeeping under contract (see instructions)	0	0	0	0.00	0.00	33.00
34.00	Dietary	2,390,671	-1,034,310	1,356,361	66,139.84	20.51	34.00
35.00	Dietary under contract (see instructions)	0	0	0	0.00	0.00	35.00
36.00	Cafeteria	0	1,034,310	1,034,310	50,436.00	20.51	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	4,834,791	0	4,834,791	121,197.65	39.89	38.00
39.00	Central Services and Supply	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	0	0	0	0.00	0.00	41.00
42.00	Social Service	0	0	0	0.00	0.00	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0034

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

Worksheet S-3
Part III
Date/Time Prepared:
11/25/2024 11:36 am

	Worksheet A	Amount	Recl assi fi cation	Adjusted	Paid Hours	Average Hourly	
	Line Number	Reported	on of Salaries	Salaries	Related to	Wage (col. 4 ÷	
	1.00	2.00	(from	(col. 2 ± col.	Salaries in	col. 5)	
			Worksheet A-6)	3)	col. 4		
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	94,273,416	0	94,273,416	2,547,216.31	37.01	1.00
2.00	Excluded area salaries (see instructions)	5,386,036	10,245	5,396,281	118,381.19	45.58	2.00
3.00	Subtotal salaries (line 1 minus line 2)	88,887,380	-10,245	88,877,135	2,428,835.12	36.59	3.00
4.00	Subtotal other wages & related costs (see inst.)	21,300,688	0	21,300,688	447,250.76	47.63	4.00
5.00	Subtotal wage-related costs (see inst.)	27,631,152	0	27,631,152	0.00	31.09	5.00
6.00	Total (sum of lines 3 thru 5)	137,819,220	-10,245	137,808,975	2,876,085.88	47.92	6.00
7.00	Total overhead cost (see instructions)	24,163,899	-10,245	24,153,654	767,547.60	31.47	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet S-3 Part IV Date/Time Prepared: 11/25/2024 11:36 am
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	2,818,560	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	14,255,154	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	592,445	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	57,739	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	48,508	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	883,974	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	5,468,039	17.00
18.00	Medicare Taxes - Employers Portion Only	1,293,264	18.00
19.00	Unemployment Insurance	2,088	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	25,419,771	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet S-3 Part V Date/Time Prepared: 11/25/2024 11:36 am
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Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	8,202,220	25,419,771	1.00
2.00	Hospital	8,202,220	25,419,771	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I	0	0	17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 15-0034 Component CCN: 15-7313		Period: From 07/01/2023 To 06/30/2024		Worksheet S-4 Date/Time Prepared: 11/25/2024 11:36 am PPS	
				Home Health Agency I			
				1.00			
0.00	County			LAKE		0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	139	1	142	282	
2.00	Unduplicated Census Count (see instructions)	0.00	598.00	19.00	978.00	1,595.00	
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
				0	1.00	2.00	3.00
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00		0.00	0.00	0.00	
4.00	Director(s) and Assistant Director(s)			1.01	0.00	1.01	
5.00	Other Administrative Personnel			8.15	0.00	8.15	
6.00	Direct Nursing Service			7.64	0.14	7.78	
7.00	Nursing Supervisor			0.00	0.00	0.00	
8.00	Physical Therapy Service			4.24	0.00	4.24	
9.00	Physical Therapy Supervisor			1.01	0.00	1.01	
10.00	Occupational Therapy Service			1.77	0.00	1.77	
11.00	Occupational Therapy Supervisor			0.43	0.00	0.43	
12.00	Speech Pathology Service			0.08	0.00	0.08	
13.00	Speech Pathology Supervisor			0.45	0.00	0.45	
14.00	Medical Social Service			0.00	0.00	0.00	
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	
16.00	Home Health Aide			0.22	0.00	0.22	
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	
18.00	Other (specify)			0.00	0.00	0.00	
						CBSA Data	
						1.00	
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.					1	19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).					23844	20.00
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers			1-4)	
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	4,339	1,362	94	14	5,809	
22.00	Skilled Nursing Visit Charges	997,500	312,225	21,620	3,210	1,334,555	
23.00	Physical Therapy Visits	2,343	1,328	25	8	3,704	
24.00	Physical Therapy Visit Charges	634,415	358,964	6,703	2,185	1,002,267	
25.00	Occupational Therapy Visits	762	915	7	3	1,687	
26.00	Occupational Therapy Visit Charges	206,766	247,800	1,894	795	457,255	
27.00	Speech Pathology Visits	51	209	2	0	262	
28.00	Speech Pathology Visit Charges	13,944	56,724	556	0	71,224	
29.00	Medical Social Service Visits	0	0	0	0	0	
30.00	Medical Social Service Visit Charges	0	0	0	0	0	
31.00	Home Health Aide Visits	110	59	0	0	169	
32.00	Home Health Aide Visit Charges	19,290	10,420	0	0	29,710	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	7,605	3,873	128	25	11,631	
34.00	Other Charges	0	0	0	0	0	
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,871,915	986,133	30,773	6,190	2,895,011	
36.00	Total Number of Episodes (standard/non outlier)	818		92	2	912	
37.00	Total Number of Outlier Episodes		199		2	201	
38.00	Total Non-Routine Medical Supply Charges	33,118	8,380	724	39	42,261	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet S-10 Parts I & II Date/Time Prepared: 11/25/2024 11:36 am
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			1.00	
PART I - HOSPITAL AND HOSPITAL COMPLEX DATA				
Uncompensated and Indigent Care Cost-to-Charge Ratio				
1.00	Cost to charge ratio (see instructions)		0.185506	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		18,192,602	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		166,317,690	6.00
7.00	Medicaid cost (line 1 times line 6)		30,852,929	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)		12,660,327	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)		0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		12,660,327	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	7,875,470	1,289,583	9,165,053
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,460,947	489,018	1,949,965
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (see instructions)	1,460,947	489,018	1,949,965
			1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
25.01	Charges for insured patients' liability (see instructions)		982,899	25.01
26.00	Bad debt amount (see instructions)		9,684,878	26.00
27.00	Medicare reimbursable bad debts (see instructions)		470,572	27.00
27.01	Medicare allowable bad debts (see instructions)		723,956	27.01
28.00	Non-Medicare bad debt amount (see instructions)		8,960,922	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)		1,915,689	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)		3,865,654	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		16,525,981	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet S-10 Parts I & II Date/Time Prepared: 11/25/2024 11:36 am
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				1.00	
PART II - HOSPITAL DATA					
Uncompensated and Indigent Care Cost-to-Charge Ratio					
1.00	Cost to charge ratio (see instructions)			0.179901	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?				4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid				5.00
6.00	Medicaid charges				6.00
7.00	Medicaid cost (line 1 times line 6)				7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)				8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP				9.00
10.00	Stand-alone CHIP charges				10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)				11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)				12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)				13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)				14.00
15.00	State or local indigent care program cost (line 1 times line 14)				15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)				16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care				17.00
18.00	Government grants, appropriations or transfers for support of hospital operations				18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)				19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
Uncompensated care cost (see instructions for each line)					
20.00	Charity care charges and uninsured discounts (see instructions)	7,870,945	1,283,842	9,154,787	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,415,991	479,270	1,895,261	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (see instructions)	1,415,991	479,270	1,895,261	23.00
				1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
25.01	Charges for insured patients' liability (see instructions)			981,067	25.01
26.00	Bad debt amount (see instructions)			9,603,176	26.00
27.00	Medicare reimbursable bad debts (see instructions)			466,293	27.00
27.01	Medicare allowable bad debts (see instructions)			717,373	27.01
28.00	Non-Medicare bad debt amount (see instructions)			8,885,803	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)			1,849,645	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)			3,744,906	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			3,744,906	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 15-0034		Period: From 07/01/2023 To 06/30/2024		Worksheet A	
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (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		8,868,689	8,868,689	107,447	8,976,136	1.00
2.00	00200		8,607,050	8,607,050	14,805	8,621,855	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	630,894	13,762,913	14,393,807	0	14,393,807	4.00
5.01	00560	568,985	252,210	821,195	0	821,195	5.01
5.02	00570	3,101,746	457,763	3,559,509	0	3,559,509	5.02
5.03	00580	0	101	101	0	101	5.03
5.04	00590	6,197,609	62,557,987	68,755,596	-224,763	68,530,833	5.04
7.00	00700	2,608,733	9,050,834	11,659,567	-22,710	11,636,857	7.00
8.00	00800	109,073	970,340	1,079,413	-29	1,079,384	8.00
9.00	00900	2,135,194	1,085,082	3,220,276	-15,451	3,204,825	9.00
10.00	01000	2,390,671	2,486,931	4,877,602	-2,110,267	2,767,335	10.00
11.00	01100	0	0	0	2,110,267	2,110,267	11.00
13.00	01300	4,834,791	4,185,864	9,020,655	0	9,020,655	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
23.00	02300	294,233	66,544	360,777	0	360,777	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	15,752,062	4,046,350	19,798,412	693,866	20,492,278	30.00
31.00	03100	4,408,947	1,465,757	5,874,704	0	5,874,704	31.00
41.00	04100	2,208,908	1,027,100	3,236,008	0	3,236,008	41.00
43.00	04300	0	0	0	2,125,585	2,125,585	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	8,563,171	20,038,600	28,601,771	-188,395	28,413,376	50.00
51.00	05100	3,213,460	700,030	3,913,490	0	3,913,490	51.00
52.00	05200	3,308,319	1,177,217	4,485,536	-2,818,925	1,666,611	52.00
53.00	05300	0	6,745,028	6,745,028	0	6,745,028	53.00
54.00	05400	3,795,831	3,430,070	7,225,901	0	7,225,901	54.00
55.00	05500	655,913	627,599	1,283,512	0	1,283,512	55.00
56.00	05600	588,177	927,071	1,515,248	0	1,515,248	56.00
57.00	05700	1,442,463	1,733,939	3,176,402	0	3,176,402	57.00
58.00	05800	816,957	868,935	1,685,892	0	1,685,892	58.00
59.00	05900	1,975,767	2,522,707	4,498,474	-296,935	4,201,539	59.00
60.00	06000	4,640,646	6,474,607	11,115,253	0	11,115,253	60.00
63.00	06300	318,543	1,212,879	1,531,422	0	1,531,422	63.00
64.00	06400	457	69	526	-526	0	64.00
65.00	06500	2,155,749	729,744	2,885,493	0	2,885,493	65.00
66.00	06600	144,087	4,249,673	4,393,760	0	4,393,760	66.00
67.00	06700	59,995	1,403,165	1,463,160	0	1,463,160	67.00
68.00	06800	405,497	765,790	1,171,287	0	1,171,287	68.00
69.00	06900	1,191,498	611,046	1,802,544	0	1,802,544	69.00
70.00	07000	521,508	193,093	714,601	0	714,601	70.00
71.00	07100	0	14,125,969	14,125,969	228,938	14,354,907	71.00
72.00	07200	0	14,257,504	14,257,504	256,392	14,513,896	72.00
73.00	07300	2,823,082	6,846,845	9,669,927	0	9,669,927	73.00
74.00	07400	0	1,182,335	1,182,335	0	1,182,335	74.00
76.97	07697	556,700	136,856	693,556	0	693,556	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	1,747,309	613,794	2,361,103	0	2,361,103	90.00
91.00	09100	5,640,471	1,869,346	7,509,817	0	7,509,817	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	2,867,730	673,455	3,541,185	-3,420	3,537,765	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		92,675,176	213,008,881	305,684,057	-144,121	305,539,936	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	15,165	9,533	24,698	0	24,698	191.00
192.00	19200	0	4,643	4,643	0	4,643	192.00
194.00	07950	0	417,320	417,320	140,701	558,021	194.00
194.01	07952	0	382,206	382,206	3,420	385,626	194.01
200.00		92,690,341	213,822,583	306,512,924	0	306,512,924	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0034

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

Worksheet A
Date/Time Prepared:
11/25/2024 11:36 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	288,613	9,264,749	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,237,029	9,858,884	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,169,063	16,562,870	4.00
5.01	00560	PURCHASING RECEIVING AND STORES	0	821,195	5.01
5.02	00570	ADMINISTRATIVE	0	3,559,509	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	3,194,478	3,194,579	5.03
5.04	00590	OTHER ADMINISTRATIVE & GENERAL	-36,001,267	32,529,566	5.04
7.00	00700	OPERATION OF PLANT	-278,625	11,358,232	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,079,384	8.00
9.00	00900	HOUSEKEEPING	0	3,204,825	9.00
10.00	01000	DIETARY	-13,689	2,753,646	10.00
11.00	01100	CAFETERIA	-1,628,429	481,838	11.00
13.00	01300	NURSING ADMINISTRATION	-2,336,946	6,683,709	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,653,789	2,653,789	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
23.00	02300	PARAMEDICAL EDUCATION PROGRAM EMS	-58,630	302,147	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-105	20,492,173	30.00
31.00	03100	INTENSIVE CARE UNIT	-64,474	5,810,230	31.00
41.00	04100	SUBPROVIDER - IRF	0	3,236,008	41.00
43.00	04300	NURSERY	0	2,125,585	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-30,434	28,382,942	50.00
51.00	05100	RECOVERY ROOM	-8	3,913,482	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-378,333	1,288,278	52.00
53.00	05300	ANESTHESIOLOGY	-6,269,459	475,569	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-8,097	7,217,804	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	1,283,512	55.00
56.00	05600	RADIOISOTOPE	0	1,515,248	56.00
57.00	05700	CT SCAN	-20,450	3,155,952	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,685,892	58.00
59.00	05900	CARDIAC CATHETERIZATION	-7	4,201,532	59.00
60.00	06000	LABORATORY	-580,515	10,534,738	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	-148,833	1,382,589	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,885,493	65.00
66.00	06600	PHYSICAL THERAPY	0	4,393,760	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,463,160	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,171,287	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,802,544	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	714,601	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	14,354,907	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,513,896	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,669,927	73.00
74.00	07400	RENAL DIALYSIS	0	1,182,335	74.00
76.97	07697	CARDIAC REHABILITATION	-52,375	641,181	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-3,347	2,357,756	90.00
91.00	09100	EMERGENCY	-8	7,509,809	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	-14,400	3,523,365	101.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-38,345,459	267,194,477	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	24,698	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,643	192.00
194.00	07950	OTHER NON-REIMBURSABLE COST CENTER	0	558,021	194.00
194.01	07952	ADVERTISING	0	385,626	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-38,345,459	268,167,465	200.00

RECLASSIFICATIONS

Provider CCN: 15-0034

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

Worksheet A-6

Date/Time Prepared:
11/25/2024 11:36 am

		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
A - RECLASS PROPERTY INSURANCE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	209,164	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	14,879	2.00	
	0		0	224,043		
B - CAFETERIA EXPENSES RECLASS						
1.00	CAFETERIA	11.00	1,034,310	1,075,957	1.00	
	0		1,034,310	1,075,957		
C - RECLASS LDRP COSTS						
1.00	ADULTS & PEDIATRICS	30.00	511,375	181,965	1.00	
2.00	NURSERY	43.00	1,567,731	557,854	2.00	
	0		2,079,106	739,819		
D - INVENTORY ADJ EXPENSE						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	228,938	1.00	
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	256,392	2.00	
	TOTALS		0	485,330		
E - RENTAL EXPENSE - INFUSION						
1.00	OTHER NON-REIMBURSABLE COST CENTER	194.00	10,245	127,386	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
	TOTALS		10,245	127,386		
F - RENTAL EXPENSE - MTM						
1.00	OTHER NON-REIMBURSABLE COST CENTER	194.00	0	3,070	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
	TOTALS		0	3,070		
G - HOME HEALTH ADVERTISING						
1.00	ADVERTISING	194.01	0	3,420	1.00	
	TOTALS		0	3,420		
H - IV THERAPY						
1.00	ADULTS & PEDIATRICS	30.00	457	69	1.00	
	TOTALS		457	69		
500.00	Grand Total: Increases		3,124,118	2,659,094	500.00	

RECLASSIFICATIONS

Provider CCN: 15-0034

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

Worksheet A-6

Date/Time Prepared:
11/25/2024 11:36 am

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - RECLASS PROPERTY INSURANCE						
1.00	OTHER ADMINISTRATIVE & GENERAL	5.04	0	224,043	12	1.00
2.00		0.00	0	0	12	2.00
			0	224,043		
B - CAFETERIA EXPENSES RECLASS						
1.00	DIETARY	10.00	1,034,310	1,075,957	0	1.00
			1,034,310	1,075,957		
C - RECLASS LDRP COSTS						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	2,079,106	739,819	0	1.00
2.00		0.00	0	0	0	2.00
			2,079,106	739,819		
D - INVENTORY ADJ EXPENSE						
1.00	OPERATING ROOM	50.00	0	188,395	0	1.00
2.00	CARDIAC CATHETERIZATION	59.00	0	296,935	0	2.00
	TOTALS		0	485,330		
E - RENTAL EXPENSE - INFUSION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	100,313	9	1.00
2.00	OPERATION OF PLANT	7.00	0	21,867	0	2.00
3.00	HOUSEKEEPING	9.00	10,245	5,206	0	3.00
	TOTALS		10,245	127,386		
F - RENTAL EXPENSE - MTM						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,404	9	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	74	9	2.00
3.00	OTHER ADMINISTRATIVE & GENERAL	5.04	0	720	0	3.00
4.00	OPERATION OF PLANT	7.00	0	843	0	4.00
5.00	LAUNDRY & LINEN SERVICE	8.00	0	29	0	5.00
	TOTALS		0	3,070		
G - HOME HEALTH ADVERTISING						
1.00	HOME HEALTH AGENCY	101.00	0	3,420	0	1.00
	TOTALS		0	3,420		
H - IV THERAPY						
1.00	INTRAVENOUS THERAPY	64.00	457	69	0	1.00
	TOTALS		457	69		
500.00	Grand Total: Decreases		3,124,118	2,659,094		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0034

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

Worksheet A-7
Part I
Date/Time Prepared:
11/25/2024 11:36 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	18,663,251	0	0	0	0	1.00
2.00	Land Improvements	8,287,357	34,800	0	34,800	0	2.00
3.00	Buildings and Fixtures	136,101,884	270,744	0	270,744	0	3.00
4.00	Building Improvements	91,628,919	5,952,408	0	5,952,408	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	95,548,844	5,884,603	0	5,884,603	3,048,421	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	350,230,255	12,142,555	0	12,142,555	3,048,421	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	350,230,255	12,142,555	0	12,142,555	3,048,421	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	18,663,251	0				1.00
2.00	Land Improvements	8,322,157	0				2.00
3.00	Buildings and Fixtures	136,372,628	0				3.00
4.00	Building Improvements	97,581,327	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	98,385,026	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	359,324,389	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	359,324,389	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0034

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

Worksheet A-7
Part II
Date/Time Prepared:
11/25/2024 11:36 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	8,853,215	15,474	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,872,787	2,734,263	0	0	0	2.00
3.00	Total (sum of lines 1-2)	14,726,002	2,749,737	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	8,868,689				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	8,607,050				2.00
3.00	Total (sum of lines 1-2)	0	17,475,739				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CCN: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet A-7 Part III Date/Time Prepared: 11/25/2024 11:36 am
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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	260,939,362	0	260,939,362	0.726194	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	98,385,027	0	98,385,027	0.273806	0	2.00
3.00	Total (sum of lines 1-2)	359,324,389	0	359,324,389	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	9,040,111	15,474	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	7,109,742	2,734,263	2.00
3.00	Total (sum of lines 1-2)	0	0	0	16,149,853	2,749,737	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	209,164	0	0	9,264,749	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	14,879	0	0	9,858,884	2.00
3.00	Total (sum of lines 1-2)	0	224,043	0	0	19,123,633	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0034

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

Worksheet A-8

Date/Time Prepared:
11/25/2024 11:36 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
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)			0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00	0	7.00
8.00 Television and radio service (chapter 21)			0		0.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-9,315,884				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	-26,475,954				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests			0		0.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts			0		0.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			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	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00 OTHER REVENUE	B	-150		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00

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	
33.01 OTHER REVENUE	B	-24,369	OTHER ADMINISTRATIVE & GENERAL	5.04	0 33.01
33.02 OTHER REVENUE	B	-266,731	OPERATION OF PLANT	7.00	0 33.02
33.03 OTHER REVENUE	B	-13,689	DIETARY	10.00	0 33.03
33.04 OTHER REVENUE	B	-510	CAFETERIA	11.00	0 33.04
33.05 OTHER REVENUE	B	-30	NURSING ADMINISTRATION	13.00	0 33.05
33.06 OTHER REVENUE	B	-58,630	PARAMEDICAL EDUCATION PROGRAM EMS	23.00	0 33.06
33.07 OTHER REVENUE	B	-105	ADULTS & PEDIATRICS	30.00	0 33.07
33.08 OTHER REVENUE	B	-17	INTENSIVE CARE UNIT	31.00	0 33.08
33.09 OTHER REVENUE	B	-17	OPERATING ROOM	50.00	0 33.09
33.10 OTHER REVENUE	B	-8	RECOVERY ROOM	51.00	0 33.10
33.11 OTHER REVENUE	B	-1,557	RADIOLOGY-DIAGNOSTIC	54.00	0 33.11
33.12 OTHER REVENUE	B	-7	CARDIAC CATHETERIZATION	59.00	0 33.12
33.13 OTHER REVENUE	B	-223,074	LABORATORY	60.00	0 33.13
33.14 OTHER REVENUE	B	-8	EMERGENCY	91.00	0 33.14
33.15 OTHER REVENUE	B	-14,400	HOME HEALTH AGENCY	101.00	0 33.15
33.16 PRE-MERGER ASSETS DEPRECIATION	A	198,368	CAP REL COSTS-BLDG & FIXT	1.00	9 33.16
33.17 TAXABLE LABS	A	-357,441	LABORATORY	60.00	0 33.17
33.18 TAXABLE LABS	A	-148,833	BLOOD STORING, PROCESSING, & TRANS.	63.00	0 33.18
33.19 PATIENT TV PURCHASES	A	-11,894	OPERATION OF PLANT	7.00	0 33.19
33.20 CAFETERIA	B	-1,627,919	CAFETERIA	11.00	0 33.20
33.21 NON-PATIENT CARE COST	A	-2,600	OTHER ADMINISTRATIVE & GENERAL	5.04	0 33.21
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-38,345,459			50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
 (2) Basis for adjustment (see instructions).
 A. Costs - if cost, including applicable overhead, can be determined.
 B. Amount Received - if cost cannot be determined.
 (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
 Note: See instructions for column 5 referencing to Worksheet A-7.

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

Provider CCN: 15-0034

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

Worksheet A-8-1

Date/Time Prepared: 11/25/2024 11:36 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.04	OTHER ADMINISTRATIVE & GENERAL	0	18,583,726	1.00
2.00	5.04	OTHER ADMINISTRATIVE & GENERAL	0	37,460,128	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXTURES	90,245	0	3.00
3.01	2.00	CAP REL COSTS-MVBLE EQUIPMENT	1,237,029	0	3.01
3.02	5.04	OTHER ADMINISTRATIVE & GENERAL	8,838,141	0	3.02
3.03	4.00	EMPLOYEE BENEFITS DEPARTMENT	2,169,575	0	3.03
3.04	16.00	MEDICAL RECORDS & LIBRARY	2,653,789	0	3.04
3.05	5.04	OTHER ADMINISTRATIVE & GENERAL	89,808	0	3.05
3.06	5.03	CASHIERING/ACCOUNTS RECEIVABLE	3,194,478	0	3.06
3.07	5.04	OTHER ADMINISTRATIVE & GENERAL	11,558,385	0	3.07
3.08	5.04	OTHER ADMINISTRATIVE & GENERAL	0	588,636	3.08
3.09	5.04	OTHER ADMINISTRATIVE & GENERAL	47,248	0	3.09
3.10	13.00	NURSING ADMINISTRATION	112,930	0	3.10
3.11	5.04	OTHER ADMINISTRATIVE & GENERAL	164,908	0	3.11
4.00	0.00		0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.		30,156,536	56,632,490	5.00

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

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

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

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

6.00	B		0.00	CFNI	100.00	6.00
7.00	C		0.00	COMMUNITY CARE	33.00	7.00
8.00	G		0.00	CANCER FOUNDATN	0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify: NON-FINANCIAL					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: 15-0034

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

Worksheet A-8-1

Date/Time Prepared:
11/25/2024 11:36 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-18,583,726	0		1.00
2.00	-37,460,128	0		2.00
3.00	90,245	9		3.00
3.01	1,237,029	9		3.01
3.02	8,838,141	0		3.02
3.03	2,169,575	0		3.03
3.04	2,653,789	0		3.04
3.05	89,808	0		3.05
3.06	3,194,478	0		3.06
3.07	11,558,385	0		3.07
3.08	-588,636	0		3.08
3.09	47,248	0		3.09
3.10	112,930	0		3.10
3.11	164,908	0		3.11
4.00	0	0		4.00
5.00	-26,475,954			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		6.00
7.00	PHYSICIAN NTWRK		7.00
8.00	CANCER SUPPORT		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: 15-0034

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

Worksheet A-8-2

Date/Time Prepared:
11/25/2024 11:36 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	90.00	CLINIC	3,128	3,128	0	0	0	1.00
2.00	90.00	CLINIC	219	219	0	0	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	362	362	0	0	0	3.00
4.00	13.00	NURSING ADMINISTRATION	2,449,846	2,449,846	0	0	0	4.00
5.00	50.00	OPERATING ROOM	30,417	30,417	0	0	0	5.00
6.00	52.00	DELIVERY ROOM & LABOR ROOM	378,333	378,333	0	0	0	6.00
7.00	53.00	ANESTHESIOLOGY	6,269,459	6,269,459	0	0	0	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	6,540	6,540	0	0	0	8.00
9.00	57.00	CT SCAN	20,450	20,450	0	0	0	9.00
10.00	76.97	CARDIAC REHABILITATION	52,375	52,375	0	0	0	10.00
11.00	5.04	OTHER ADMINISTRATIVE & GENERAL	125,000	0	125,000	211,500	833	11.00
12.00	31.00	INTENSIVE CARE UNIT	200,000	0	200,000	211,500	1,333	12.00
200.00			9,536,129	9,211,129	325,000		2,166	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	90.00	CLINIC	0	0	0	0	0	1.00
2.00	90.00	CLINIC	0	0	0	0	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	3.00
4.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	6.00
7.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	8.00
9.00	57.00	CT SCAN	0	0	0	0	0	9.00
10.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	10.00
11.00	5.04	OTHER ADMINISTRATIVE & GENERAL	84,702	4,235	0	0	0	11.00
12.00	31.00	INTENSIVE CARE UNIT	135,543	6,777	0	0	0	12.00
200.00			220,245	11,012	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	90.00	CLINIC	0	0	0	3,128	1.00
2.00	90.00	CLINIC	0	0	0	219	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	362	3.00
4.00	13.00	NURSING ADMINISTRATION	0	0	0	2,449,846	4.00
5.00	50.00	OPERATING ROOM	0	0	0	30,417	5.00
6.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	378,333	6.00
7.00	53.00	ANESTHESIOLOGY	0	0	0	6,269,459	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	6,540	8.00
9.00	57.00	CT SCAN	0	0	0	20,450	9.00
10.00	76.97	CARDIAC REHABILITATION	0	0	0	52,375	10.00
11.00	5.04	OTHER ADMINISTRATIVE & GENERAL	0	84,702	40,298	40,298	11.00
12.00	31.00	INTENSIVE CARE UNIT	0	135,543	64,457	64,457	12.00
200.00			0	220,245	104,755	9,315,884	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0034

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

Worksheet B Part I Date/Time Prepared: 11/25/2024 11:36 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	PURCHASING RECEIVING AND STORES	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	9,264,749	9,264,749			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	9,858,884		9,858,884		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	16,562,870	38,491	0	16,601,361	4.00
5.01 00560	PURCHASING RECEIVING AND STORES	821,195	73,103	2,094	102,607	998,999 5.01
5.02 00570	ADMITTING	3,559,509	89,728	6,222	559,347	1,488 5.02
5.03 00580	CASHIERING/ACCOUNTS RECEIVABLE	3,194,579	11,334	0	0	0 5.03
5.04 00590	OTHER ADMINISTRATIVE & GENERAL	32,529,566	447,372	940,216	1,117,633	627 5.04
7.00 00700	OPERATION OF PLANT	11,358,232	1,285,413	368,454	470,441	1,097 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,079,384	15,631	0	19,669	0 8.00
9.00 00900	HOUSEKEEPING	3,204,825	63,773	40,028	383,198	3,055 9.00
10.00 01000	DIETARY	2,753,646	144,763	223,143	244,597	6,580 10.00
11.00 01100	CAFETERIA	481,838	48,671	95,633	186,520	2,820 11.00
13.00 01300	NURSING ADMINISTRATION	6,683,709	79,035	96,810	871,872	7,833 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0 14.00
15.00 01500	PHARMACY	0	0	0	0	0 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,653,789	33,874	0	0	0 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
23.00 02300	PARAMEDICAL EDUCATION PROGRAM EMS	302,147	7,118	3,985	53,060	705 23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	20,492,173	1,265,823	153,927	2,932,921	53,346 30.00
31.00 03100	INTENSIVE CARE UNIT	5,810,230	212,913	103,391	795,079	21,229 31.00
41.00 04100	SUBPROVIDER - I RF	3,236,008	178,205	8,892	398,339	4,308 41.00
43.00 04300	NURSERY	2,125,585	20,889	135,793	282,714	5,562 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	28,382,942	759,760	3,110,402	1,544,222	534,004 50.00
51.00 05100	RECOVERY ROOM	3,913,482	243,405	59,859	579,493	12,220 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,288,278	217,257	106,285	221,668	4,387 52.00
53.00 05300	ANESTHESIOLOGY	475,569	8,144	24,567	0	13,474 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	7,217,804	201,434	812,722	684,514	20,759 54.00
55.00 05500	RADIOLOGY - THERAPEUTIC	1,283,512	53,080	43,170	118,283	940 55.00
56.00 05600	RADIOISOTOPE	1,515,248	89,664	103,146	106,068	1,097 56.00
57.00 05700	CT SCAN	3,155,952	64,542	481,214	260,124	19,349 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	1,685,892	61,224	309,270	147,324	6,345 58.00
59.00 05900	CARDIAC CATHETERIZATION	4,201,532	138,287	676,957	356,296	32,274 59.00
60.00 06000	LABORATORY	10,534,738	181,171	205,390	836,862	152,909 60.00
63.00 06300	BLOOD STORING, PROCESSING, & TRANS.	1,382,589	14,300	50,054	57,444	2,193 63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	2,885,493	56,703	98,641	388,753	13,630 65.00
66.00 06600	PHYSICAL THERAPY	4,393,760	364,185	111,351	25,984	3,368 66.00
67.00 06700	OCCUPATIONAL THERAPY	1,463,160	32,736	4,848	10,819	235 67.00
68.00 06800	SPEECH PATHOLOGY	1,171,287	16,480	58,555	73,124	392 68.00
69.00 06900	ELECTROCARDIOLOGY	1,802,544	66,001	157,713	214,866	3,525 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	714,601	45,337	31,386	94,045	4,700 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,354,907	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	14,513,896	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	9,669,927	57,665	844,075	509,095	5,327 73.00
74.00 07400	RENAL DIALYSIS	1,182,335	5,178	0	0	0 74.00
76.97 07697	CARDIAC REHABILITATION	641,181	125,638	36,855	100,391	313 76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	2,357,756	219,245	167,062	315,097	11,750 90.00
91.00 09100	EMERGENCY	7,509,809	299,290	132,920	1,017,163	47,001 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	3,523,365	0	2,013	517,146	157 101.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	267,194,477	7,336,862	9,807,043	16,596,778	998,999 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,414	0	0	0 190.00
191.00 19100	RESEARCH	24,698	0	0	2,735	0 191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	4,643	1,902,253	0	0	0 192.00
194.00 07950	OTHER NON-REIMBURSABLE COST CENTER	558,021	0	51,841	1,848	0 194.00
194.01 07952	ADVERTISING	385,626	14,220	0	0	0 194.01
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118 through 201)	268,167,465	9,264,749	9,858,884	16,601,361	998,999 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0034

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

Worksheet B
Part I
Date/Time Prepared:
11/25/2024 11:36 am

Cost Center Description			ADMINISTRATIVE	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
			5.02	5.03	5A.03	5.04	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00570	ADMINISTRATIVE	4,216,294					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	3,205,913				5.03
5.04	00590	OTHER ADMINISTRATIVE & GENERAL	0	0	35,035,414	35,035,414		5.04
7.00	00700	OPERATION OF PLANT	0	0	13,483,637	2,026,334	15,509,971	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,114,684	167,516	33,122	8.00
9.00	00900	HOUSEKEEPING	0	0	3,694,879	555,270	135,138	9.00
10.00	01000	DIETARY	0	0	3,372,729	506,857	306,761	10.00
11.00	01100	CAFETERIA	0	0	815,482	122,551	103,137	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	7,739,259	1,163,064	167,479	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	2,687,663	403,905	71,781	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PARAMEDICAL EDUCATION PROGRAM EMS	0	0	367,015	55,155	15,083	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	296,570	225,499	25,420,259	3,820,182	2,682,340	30.00
31.00	03100	INTENSIVE CARE UNIT	54,961	41,790	7,039,593	1,057,917	451,173	31.00
41.00	04100	SUBPROVIDER - IIRF	31,767	24,155	3,881,674	583,342	377,625	41.00
43.00	04300	NURSERY	17,089	12,994	2,600,626	390,825	44,265	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	595,390	452,727	35,379,447	5,316,955	1,609,968	50.00
51.00	05100	RECOVERY ROOM	70,742	53,789	4,932,990	741,335	515,786	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,411	10,197	1,861,483	279,746	460,379	52.00
53.00	05300	ANESTHESIOLOGY	123,892	94,203	739,849	111,185	17,257	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	255,803	194,502	9,387,538	1,410,769	426,849	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	81,827	62,218	1,643,030	246,916	112,479	55.00
56.00	05600	RADIOISOTOPE	66,736	50,744	1,932,703	290,449	190,001	56.00
57.00	05700	CT SCAN	345,764	262,904	4,589,849	689,767	136,768	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	142,885	108,644	2,461,584	369,929	129,736	58.00
59.00	05900	CARDIAC CATHETERIZATION	340,476	258,884	6,004,706	902,393	293,036	59.00
60.00	06000	LABORATORY	478,287	363,670	12,753,027	1,916,538	383,910	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	15,566	11,836	1,533,982	230,528	30,302	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	47,907	36,427	3,527,554	530,124	120,156	65.00
66.00	06600	PHYSICAL THERAPY	67,617	51,413	5,017,678	754,062	771,726	66.00
67.00	06700	OCCUPATIONAL THERAPY	22,185	16,869	1,550,852	233,064	69,369	67.00
68.00	06800	SPEECH PATHOLOGY	11,312	8,601	1,339,751	201,339	34,922	68.00
69.00	06900	ELECTROCARDIOLOGY	143,851	109,378	2,497,878	375,384	139,860	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	36,229	27,547	953,845	143,345	96,071	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	116,912	88,895	14,560,714	2,188,199	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	111,184	84,539	14,709,619	2,210,576	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	239,274	181,934	11,507,297	1,729,328	122,195	73.00
74.00	07400	RENAL DIALYSIS	16,109	12,248	1,215,870	182,722	10,973	74.00
76.97	07697	CARDIAC REHABILITATION	8,466	6,437	919,281	138,150	266,233	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	33,876	25,758	3,130,544	470,461	464,592	90.00
91.00	09100	EMERGENCY	412,052	313,307	9,731,542	1,462,466	634,210	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	18,154	13,804	4,074,639	612,341	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,216,294	3,205,913	265,210,166	34,590,989	11,424,682	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	11,414	1,715	24,188	190.00
191.00	19100	RESEARCH	0	0	27,433	4,123	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,906,896	286,570	4,030,968	192.00
194.00	07950	OTHER NON-REIMBURSABLE COST CENTER	0	0	611,710	91,928	0	194.00
194.01	07952	ADVERTISING	0	0	399,846	60,089	30,133	194.01
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)	4,216,294	3,205,913	268,167,465	35,035,414	15,509,971	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet B Part I Date/Time Prepared: 11/25/2024 11:36 am
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Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00560	PURCHASING RECEIVING AND STORES					5.01
5.02	00570	ADMITTING					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00590	OTHER ADMINISTRATIVE & GENERAL					5.04
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,315,322				8.00
9.00	00900	HOUSEKEEPING	0	4,385,287			9.00
10.00	01000	DIETARY	0	87,685	4,274,032		10.00
11.00	01100	CAFETERIA	0	29,481	0	1,070,651	11.00
13.00	01300	NURSING ADMINISTRATION	0	47,872	0	68,998	9,186,672
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00	01500	PHARMACY	0	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	20,518	0	0	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
23.00	02300	PARAMEDICAL EDUCATION PROGRAM EMS	0	4,311	0	4,758	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	950,146	766,722	3,039,224	248,626	3,354,690
31.00	03100	INTENSIVE CARE UNIT	153,825	128,964	273,005	53,533	719,286
41.00	04100	SUBPROVIDER - I RF	169,318	107,941	477,509	33,309	443,361
43.00	04300	NURSERY	42,033	12,653	0	19,034	257,217
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	460,195	0	126,099	1,710,332
51.00	05100	RECOVERY ROOM	0	147,433	152,574	42,826	572,550
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	131,595	147,572	15,465	201,675
53.00	05300	ANESTHESIOLOGY	0	4,933	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	122,011	0	61,860	0
55.00	05500	RADIOLOGY - THERAPEUTIC	0	32,151	0	7,138	0
56.00	05600	RADIOISOTOPE	0	54,310	0	7,138	0
57.00	05700	CT SCAN	0	39,094	0	20,223	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	37,084	0	10,707	0
59.00	05900	CARDIAC CATHETERIZATION	0	83,762	0	24,982	342,338
60.00	06000	LABORATORY	0	109,737	0	90,411	0
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	8,662	0	4,758	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	34,346	0	30,930	0
66.00	06600	PHYSICAL THERAPY	0	220,591	0	1,190	0
67.00	06700	OCCUPATIONAL THERAPY	0	19,829	0	1,190	0
68.00	06800	SPEECH PATHOLOGY	0	9,982	0	5,948	0
69.00	06900	ELECTROCARDIOLOGY	0	39,978	0	17,844	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	27,461	0	9,517	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	34,928	0	34,499	0
74.00	07400	RENAL DIALYSIS	0	3,136	0	0	0
76.97	07697	CARDIAC REHABILITATION	0	76,100	0	8,327	106,177
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	132,799	0	27,361	361,942
91.00	09100	EMERGENCY	0	181,283	184,148	83,273	1,117,104
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	10,707	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,315,322	3,217,547	4,274,032	1,070,651	9,186,672
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,914	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,152,213	0	0	0
194.00	07950	OTHER NON-REIMBURSABLE COST CENTER	0	0	0	0	0
194.01	07952	ADVERTISING	0	8,613	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	1,315,322	4,385,287	4,274,032	1,070,651	9,186,672

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet B Part I Date/Time Prepared: 11/25/2024 11:36 am
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Cost Center Description			CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
			14.00	15.00	16.00	17.00	19.00	
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
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE & GENERAL						5.04
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	0					14.00
15.00	01500	PHARMACY	0	0				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	3,183,867			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PARAMEDICAL EDUCATION PROGRAM EMS	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	223,926	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	41,499	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	23,986	0	0	41.00
43.00	04300	NURSERY	0	0	12,903	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	449,886	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	53,414	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	10,126	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	93,545	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	193,145	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	61,784	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	50,390	0	0	56.00
57.00	05700	CT SCAN	0	0	261,071	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	107,886	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	257,078	0	0	59.00
60.00	06000	LABORATORY	0	0	361,133	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	11,753	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	36,173	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	51,055	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	16,751	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	8,541	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	108,615	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	27,355	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	88,275	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	83,950	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	180,665	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	12,163	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	6,392	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	25,578	0	0	90.00
91.00	09100	EMERGENCY	0	0	311,122	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	13,707	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	3,183,867	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NON-REIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07952	ADVERTISING	0	0	0	0	0	194.01
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)	0	0	3,183,867	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0034

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

Worksheet B
Part I
Date/Time Prepared:
11/25/2024 11:36 am

Cost Center Description			PARAMEDICAL EDUCATION PROGRAM EMS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			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
5.01	00560	PURCHASING RECEIVING AND STORES					5.01
5.02	00570	ADMITTING					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00590	OTHER ADMINISTRATIVE & GENERAL					5.04
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
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
23.00	02300	PARAMEDICAL EDUCATION PROGRAM EMS	446,322				23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	40,506,115	0	40,506,115	30.00
31.00	03100	INTENSIVE CARE UNIT	0	9,918,795	0	9,918,795	31.00
41.00	04100	SUBPROVIDER - IIRF	0	6,098,065	0	6,098,065	41.00
43.00	04300	NURSERY	0	3,379,556	0	3,379,556	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	11,030	45,063,912	0	45,063,912	50.00
51.00	05100	RECOVERY ROOM	0	7,158,908	0	7,158,908	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,108,041	0	3,108,041	52.00
53.00	05300	ANESTHESIOLOGY	0	966,769	0	966,769	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,602,172	0	11,602,172	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	2,103,498	0	2,103,498	55.00
56.00	05600	RADIOISOTOPE	0	2,524,991	0	2,524,991	56.00
57.00	05700	CT SCAN	0	5,736,772	0	5,736,772	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,116,926	0	3,116,926	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,207	7,913,502	0	7,913,502	59.00
60.00	06000	LABORATORY	0	15,614,756	0	15,614,756	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	1,819,985	0	1,819,985	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	5,870	4,285,153	0	4,285,153	65.00
66.00	06600	PHYSICAL THERAPY	0	6,816,302	0	6,816,302	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,891,055	0	1,891,055	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,600,483	0	1,600,483	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,179,559	0	3,179,559	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,257,594	0	1,257,594	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	16,837,188	0	16,837,188	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	17,004,145	0	17,004,145	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,608,912	0	13,608,912	73.00
74.00	07400	RENAL DIALYSIS	0	1,424,864	0	1,424,864	74.00
76.97	07697	CARDIAC REHABILITATION	0	1,520,660	0	1,520,660	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	4,613,277	0	4,613,277	90.00
91.00	09100	EMERGENCY	139,795	13,844,943	0	13,844,943	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	4,711,394	0	4,711,394	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	161,902	259,228,292	0	259,228,292	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	44,231	0	44,231	190.00
191.00	19100	RESEARCH	0	31,556	0	31,556	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,376,647	0	7,376,647	192.00
194.00	07950	OTHER NON-REIMBURSABLE COST CENTER	284,420	988,058	0	988,058	194.00
194.01	07952	ADVERTISING	0	498,681	0	498,681	194.01
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)	446,322	268,167,465	0	268,167,465	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0034

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

Worksheet B
Part II
Date/Time Prepared:
11/25/2024 11:36 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	38,491	0	38,491	4.00
5.01 00560	PURCHASING RECEIVING AND STORES	0	73,103	2,094	75,197	5.01
5.02 00570	ADMINISTRATIVE	0	89,728	6,222	95,950	5.02
5.03 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	11,334	0	11,334	5.03
5.04 00590	OTHER ADMINISTRATIVE & GENERAL	0	447,372	940,216	1,387,588	5.04
7.00 00700	OPERATION OF PLANT	0	1,285,413	368,454	1,653,867	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	15,631	0	15,631	8.00
9.00 00900	HOUSEKEEPING	0	63,773	40,028	103,801	9.00
10.00 01000	DIETARY	0	144,763	223,143	367,906	10.00
11.00 01100	CAFETERIA	0	48,671	95,633	144,304	11.00
13.00 01300	NURSING ADMINISTRATION	0	79,035	96,810	175,845	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00 01500	PHARMACY	0	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	33,874	0	33,874	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
23.00 02300	PARAMEDICAL EDUCATION PROGRAM EMS	0	7,118	3,985	11,103	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	1,265,823	153,927	1,419,750	30.00
31.00 03100	INTENSIVE CARE UNIT	0	212,913	103,391	316,304	31.00
41.00 04100	SUBPROVIDER - IRF	0	178,205	8,892	187,097	41.00
43.00 04300	NURSERY	0	20,889	135,793	156,682	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	759,760	3,110,402	3,870,162	50.00
51.00 05100	RECOVERY ROOM	0	243,405	59,859	303,264	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	217,257	106,285	323,542	52.00
53.00 05300	ANESTHESIOLOGY	0	8,144	24,567	32,711	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	201,434	812,722	1,014,156	54.00
55.00 05500	RADIOLOGY - THERAPEUTIC	0	53,080	43,170	96,250	55.00
56.00 05600	RADIOISOTOPE	0	89,664	103,146	192,810	56.00
57.00 05700	CT SCAN	0	64,542	481,214	545,756	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	61,224	309,270	370,494	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	138,287	676,957	815,244	59.00
60.00 06000	LABORATORY	0	181,171	205,390	386,561	60.00
63.00 06300	BLOOD STORING, PROCESSING, & TRANS.	0	14,300	50,054	64,354	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	56,703	98,641	155,344	65.00
66.00 06600	PHYSICAL THERAPY	0	364,185	111,351	475,536	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	32,736	4,848	37,584	67.00
68.00 06800	SPEECH PATHOLOGY	0	16,480	58,555	75,035	68.00
69.00 06900	ELECTROCARDIOLOGY	0	66,001	157,713	223,714	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	45,337	31,386	76,723	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	57,665	844,075	901,740	73.00
74.00 07400	RENAL DIALYSIS	0	5,178	0	5,178	74.00
76.97 07697	CARDIAC REHABILITATION	0	125,638	36,855	162,493	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	219,245	167,062	386,307	90.00
91.00 09100	EMERGENCY	0	299,290	132,920	432,210	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	0	2,013	2,013	101.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	7,336,862	9,807,043	17,143,905	38,481
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,414	0	11,414	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	1,902,253	0	1,902,253	192.00
194.00 07950	OTHER NON-REIMBURSABLE COST CENTER	0	0	51,841	51,841	194.00
194.01 07952	ADVERTISING	0	14,220	0	14,220	194.01
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	9,264,749	9,858,884	19,123,633	38,491

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0034		Period: From 07/01/2023 To 06/30/2024		Worksheet B Part II Date/Time Prepared: 11/25/2024 11:36 am	
Cost Center Description			PURCHASING RECEIVING AND STORES	ADMINITTING	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
			5.01	5.02	5.03	5.04	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES	75,435					5.01
5.02	00570	ADMINITTING	112	97,359				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	11,334			5.03
5.04	00590	OTHER ADMINISTRATIVE & GENERAL	47	0	0	1,390,226		5.04
7.00	00700	OPERATION OF PLANT	83	0	0	80,403	1,735,443	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	6,647	3,706	8.00
9.00	00900	HOUSEKEEPING	231	0	0	22,033	15,121	9.00
10.00	01000	DIETARY	497	0	0	20,112	34,324	10.00
11.00	01100	CAFETERIA	213	0	0	4,863	11,540	11.00
13.00	01300	NURSING ADMINISTRATION	592	0	0	46,149	18,740	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	16,027	8,032	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PARAMEDICAL EDUCATION PROGRAM EMS	53	0	0	2,189	1,688	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,028	6,881	786	151,581	300,133	30.00
31.00	03100	INTENSIVE CARE UNIT	1,603	1,275	146	41,977	50,483	31.00
41.00	04100	SUBPROVIDER - IRF	325	737	84	23,146	42,253	41.00
43.00	04300	NURSERY	420	396	45	15,508	4,953	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	40,324	13,347	1,733	211,026	180,143	50.00
51.00	05100	RECOVERY ROOM	923	1,641	188	29,415	57,712	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	331	311	36	11,100	51,513	52.00
53.00	05300	ANESTHESIOLOGY	1,017	2,875	329	4,412	1,931	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,567	5,935	678	55,978	47,761	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	71	1,899	217	9,797	12,586	55.00
56.00	05600	RADIOISOTOPE	83	1,548	177	11,525	21,260	56.00
57.00	05700	CT SCAN	1,461	8,022	917	27,369	15,303	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	479	3,315	379	14,678	14,516	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,437	7,900	903	35,806	32,788	59.00
60.00	06000	LABORATORY	11,546	11,097	1,268	76,046	42,956	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	166	361	41	9,147	3,391	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,029	1,112	127	21,035	13,445	65.00
66.00	06600	PHYSICAL THERAPY	254	1,569	179	29,920	86,350	66.00
67.00	06700	OCCUPATIONAL THERAPY	18	515	59	9,248	7,762	67.00
68.00	06800	SPEECH PATHOLOGY	30	262	30	7,989	3,908	68.00
69.00	06900	ELECTROCARDIOLOGY	266	3,338	381	14,895	15,649	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	355	841	96	5,688	10,750	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,713	310	86,826	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,580	295	87,713	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	402	5,552	634	68,618	13,673	73.00
74.00	07400	RENAL DIALYSIS	0	374	43	7,250	1,228	74.00
76.97	07697	CARDIAC REHABILITATION	24	196	22	5,482	29,789	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	887	786	90	18,667	51,984	90.00
91.00	09100	EMERGENCY	3,549	9,560	1,093	58,029	70,963	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	12	421	48	24,297	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	75,435	97,359	11,334	1,372,591	1,278,334	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	68	2,706	190.00
191.00	19100	RESEARCH	0	0	0	164	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	11,371	451,031	192.00
194.00	07950	OTHER NON-REIMBURSABLE COST CENTER	0	0	0	3,648	0	194.00
194.01	07952	ADVERTISING	0	0	0	2,384	3,372	194.01
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)	75,435	97,359	11,334	1,390,226	1,735,443	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet B Part II Date/Time Prepared: 11/25/2024 11:36 am
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Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00560	PURCHASING RECEIVING AND STORES					5.01
5.02	00570	ADMITTING					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00590	OTHER ADMINISTRATIVE & GENERAL					5.04
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	26,030				8.00
9.00	00900	HOUSEKEEPING	0	142,074			9.00
10.00	01000	DIETARY	0	2,841	426,247		10.00
11.00	01100	CAFETERIA	0	955	0	162,307	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,551	0	10,460	255,358
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	665	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
23.00	02300	PARAMEDICAL EDUCATION PROGRAM EMS	0	140	0	721	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	18,803	24,840	303,100	37,693	93,248
31.00	03100	INTENSIVE CARE UNIT	3,044	4,178	27,227	8,115	19,994
41.00	04100	SUBPROVIDER - I RF	3,351	3,497	47,622	5,050	12,324
43.00	04300	NURSERY	832	410	0	2,885	7,150
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	14,909	0	19,116	47,541
51.00	05100	RECOVERY ROOM	0	4,777	15,216	6,492	15,915
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,263	14,717	2,344	5,606
53.00	05300	ANESTHESIOLOGY	0	160	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,953	0	9,378	0
55.00	05500	RADIOLOGY - THERAPEUTIC	0	1,042	0	1,082	0
56.00	05600	RADIOISOTOPE	0	1,760	0	1,082	0
57.00	05700	CT SCAN	0	1,267	0	3,066	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,201	0	1,623	0
59.00	05900	CARDIAC CATHETERIZATION	0	2,714	0	3,787	9,516
60.00	06000	LABORATORY	0	3,555	0	13,706	0
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	281	0	721	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	1,113	0	4,689	0
66.00	06600	PHYSICAL THERAPY	0	7,147	0	180	0
67.00	06700	OCCUPATIONAL THERAPY	0	642	0	180	0
68.00	06800	SPEECH PATHOLOGY	0	323	0	902	0
69.00	06900	ELECTROCARDIOLOGY	0	1,295	0	2,705	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	890	0	1,443	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,132	0	5,230	0
74.00	07400	RENAL DIALYSIS	0	102	0	0	0
76.97	07697	CARDIAC REHABILITATION	0	2,465	0	1,262	2,951
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	4,302	0	4,148	10,061
91.00	09100	EMERGENCY	0	5,873	18,365	12,624	31,052
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	1,623	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,030	104,243	426,247	162,307	255,358
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	224	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	37,328	0	0	0
194.00	07950	OTHER NON-REIMBURSABLE COST CENTER	0	0	0	0	0
194.01	07952	ADVERTISING	0	279	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	26,030	142,074	426,247	162,307	255,358

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0034

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

Worksheet B
Part II
Date/Time Prepared:
11/25/2024 11:36 am

Cost Center Description			CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
			14.00	15.00	16.00	17.00	19.00	
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
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE & GENERAL						5.04
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	0					14.00
15.00	01500	PHARMACY	0	0				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	58,598			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PARAMEDICAL EDUCATION PROGRAM EMS	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	4,129	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	765	0		31.00
41.00	04100	SUBPROVIDER - IRF	0	0	442	0		41.00
43.00	04300	NURSERY	0	0	238	0		43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	8,190	0		50.00
51.00	05100	RECOVERY ROOM	0	0	985	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	187	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	1,725	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	3,561	0		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	1,139	0		55.00
56.00	05600	RADIOISOTOPE	0	0	929	0		56.00
57.00	05700	CT SCAN	0	0	4,813	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	1,989	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	4,740	0		59.00
60.00	06000	LABORATORY	0	0	6,658	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	217	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	667	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	941	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	309	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	157	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	2,003	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	504	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,628	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,548	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,331	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	224	0		74.00
76.97	07697	CARDIAC REHABILITATION	0	0	118	0		76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	472	0		90.00
91.00	09100	EMERGENCY	0	0	5,736	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	253	0		101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	58,598	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
191.00	19100	RESEARCH	0	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	OTHER NON-REIMBURSABLE COST CENTER	0	0	0	0		194.00
194.01	07952	ADVERTISING	0	0	0	0		194.01
200.00		Cross Foot Adjustments						0200.00
201.00		Negative Cost Centers	0	0	0	0		0201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	58,598	0	0	0202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet B Part II Date/Time Prepared: 11/25/2024 11:36 am
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Cost Center Description		PARAMEDICAL EDUCATION PROGRAM EMS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		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
5.01	00560	PURCHASING RECEIVING AND STORES				5.01
5.02	00570	ADMITTING				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.03
5.04	00590	OTHER ADMINISTRATIVE & GENERAL				5.04
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
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
23.00	02300	PARAMEDICAL EDUCATION PROGRAM EMS	16,017			23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		2,371,782	0	2,371,782
31.00	03100	INTENSIVE CARE UNIT		476,954	0	476,954
41.00	04100	SUBPROVIDER - IRF		326,851	0	326,851
43.00	04300	NURSERY		190,174	0	190,174
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		4,410,070	0	4,410,070
51.00	05100	RECOVERY ROOM		437,871	0	437,871
52.00	05200	DELIVERY ROOM & LABOR ROOM		414,464	0	414,464
53.00	05300	ANESTHESIOLOGY		45,160	0	45,160
54.00	05400	RADIOLOGY-DIAGNOSTIC		1,144,554	0	1,144,554
55.00	05500	RADIOLOGY - THERAPEUTIC		124,357	0	124,357
56.00	05600	RADIOISOTOPE		231,420	0	231,420
57.00	05700	CT SCAN		608,577	0	608,577
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		409,015	0	409,015
59.00	05900	CARDIAC CATHETERIZATION		916,661	0	916,661
60.00	06000	LABORATORY		555,333	0	555,333
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.		78,812	0	78,812
64.00	06400	INTRAVENOUS THERAPY		0	0	0
65.00	06500	RESPIRATORY THERAPY		199,462	0	199,462
66.00	06600	PHYSICAL THERAPY		602,136	0	602,136
67.00	06700	OCCUPATIONAL THERAPY		56,342	0	56,342
68.00	06800	SPEECH PATHOLOGY		88,805	0	88,805
69.00	06900	ELECTROCARDIOLOGY		264,744	0	264,744
70.00	07000	ELECTROENCEPHALOGRAPHY		97,508	0	97,508
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		91,477	0	91,477
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		92,136	0	92,136
73.00	07300	DRUGS CHARGED TO PATIENTS		1,001,492	0	1,001,492
74.00	07400	RENAL DIALYSIS		14,399	0	14,399
76.97	07697	CARDIAC REHABILITATION		205,035	0	205,035
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC		478,434	0	478,434
91.00	09100	EMERGENCY		651,412	0	651,412
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0	
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY		29,866	0	29,866
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	16,615,303	0	16,615,303
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		14,412	0	14,412
191.00	19100	RESEARCH		170	0	170
192.00	19200	PHYSICIANS' PRIVATE OFFICES		2,401,983	0	2,401,983
194.00	07950	OTHER NON-REIMBURSABLE COST CENTER		55,493	0	55,493
194.01	07952	ADVERTISING		20,255	0	20,255
200.00		Cross Foot Adjustments	16,017	16,017	0	16,017
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	16,017	19,123,633	0	19,123,633

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0034

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

Worksheet B-1

Date/Time Prepared:
11/25/2024 11:36 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	PURCHASING RECEIVING AND STORES (COSTED REQ)	ADMITTING (GROSS REVENUE)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	577,913				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		22,510,452			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,401	0	92,059,447		4.00
5.01 00560	PURCHASING RECEIVING AND STORES	4,560	4,782	568,985	12,753	5.01
5.02 00570	ADMITTING	5,597	14,207	3,101,746	19	1,397,412,540 5.02
5.03 00580	CASHIERING/ACCOUNTS RECEIVABLE	707	0	0	0	0 5.03
5.04 00590	OTHER ADMINISTRATIVE & GENERAL	27,906	2,146,764	6,197,609	8	0 5.04
7.00 00700	OPERATION OF PLANT	80,181	841,278	2,608,733	14	0 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	975	0	109,073	0	0 8.00
9.00 00900	HOUSEKEEPING	3,978	91,395	2,124,949	39	0 9.00
10.00 01000	DIETARY	9,030	509,494	1,356,361	84	0 10.00
11.00 01100	CAFETERIA	3,036	218,355	1,034,310	36	0 11.00
13.00 01300	NURSING ADMINISTRATION	4,930	221,042	4,834,791	100	0 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0 14.00
15.00 01500	PHARMACY	0	0	0	0	0 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,113	0	0	0	0 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
23.00 02300	PARAMEDICAL EDUCATION PROGRAM EMS	444	9,099	294,233	9	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	78,959	351,456	16,263,894	681	98,299,485 30.00
31.00 03100	INTENSIVE CARE UNIT	13,281	236,070	4,408,947	271	18,217,106 31.00
41.00 04100	SUBPROVIDER - I RF	11,116	20,302	2,208,908	55	10,529,473 41.00
43.00 04300	NURSERY	1,303	310,052	1,567,731	71	5,664,253 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	47,392	7,101,869	8,563,171	6,817	197,245,166 50.00
51.00 05100	RECOVERY ROOM	15,183	136,675	3,213,460	156	23,447,807 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	13,552	242,678	1,229,213	56	4,445,249 52.00
53.00 05300	ANESTHESIOLOGY	508	56,092	0	172	41,064,739 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	12,565	1,855,662	3,795,831	265	84,787,193 54.00
55.00 05500	RADIOLOGY - THERAPEUTIC	3,311	98,568	655,913	12	27,122,025 55.00
56.00 05600	RADIOISOTOPE	5,593	235,510	588,177	14	22,120,145 56.00
57.00 05700	CT SCAN	4,026	1,098,739	1,442,463	247	114,605,243 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	3,819	706,146	816,957	81	47,359,985 58.00
59.00 05900	CARDIAC CATHETERIZATION	8,626	1,545,674	1,975,767	412	112,852,566 59.00
60.00 06000	LABORATORY	11,301	468,960	4,640,646	1,952	158,530,781 60.00
63.00 06300	BLOOD STORING, PROCESSING, & TRANS.	892	114,287	318,543	28	5,159,565 63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	3,537	225,223	2,155,749	174	15,879,123 65.00
66.00 06600	PHYSICAL THERAPY	22,717	254,244	144,087	43	22,412,021 66.00
67.00 06700	OCCUPATIONAL THERAPY	2,042	11,069	59,995	3	7,353,322 67.00
68.00 06800	SPEECH PATHOLOGY	1,028	133,697	405,497	5	3,749,485 68.00
69.00 06900	ELECTROCARDIOLOGY	4,117	360,100	1,191,498	45	47,680,008 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	2,828	71,663	521,508	60	12,008,294 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	38,750,968 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	36,852,408 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	3,597	1,927,248	2,823,082	68	79,308,462 73.00
74.00 07400	RENAL DIALYSIS	323	0	0	0	5,339,350 74.00
76.97 07697	CARDIAC REHABILITATION	7,837	84,150	556,700	4	2,805,943 76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	13,676	381,448	1,747,309	150	11,228,264 90.00
91.00 09100	EMERGENCY	18,669	303,491	5,640,471	600	136,576,874 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	4,596	2,867,730	2	6,017,237 101.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	457,656	22,392,085	92,034,037	12,753	1,397,412,540 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	712	0	0	0	0 190.00
191.00 19100	RESEARCH	0	0	15,165	0	0 191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	118,658	0	0	0	0 192.00
194.00 07950	OTHER NON-REIMBURSABLE COST CENTER	0	118,367	10,245	0	0 194.00
194.01 07952	ADVERTISING	887	0	0	0	0 194.01
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	9,264,749	9,858,884	16,601,361	998,999	4,216,294 202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	16.031391	0.437969	0.180333	78.334431	0.003017 203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0034

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

Worksheet B-1

Date/Time Prepared:
11/25/2024 11:36 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	PURCHASING RECEIVING AND STORES (COSTED REQ)	ADMITTING (GROSS REVENUE)		
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00					4.00
204.00	Cost to be allocated (per Wkst. B, Part II)			38,491	75,435	97,359	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000418	5.915079	0.000070	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: 15-0034

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

Worksheet B-1

Date/Time Prepared:
11/25/2024 11:36 am

Cost Center Description		CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	
		5.03	5A.04	5.04	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00560						5.01
5.02	00570						5.02
5.03	00580	1,397,412,540					5.03
5.04	00590	0	-35,035,414	233,132,051			5.04
7.00	00700	0	0	13,483,637	456,561		7.00
8.00	00800	0	0	1,114,684	975	44,404	8.00
9.00	00900	0	0	3,694,879	3,978	0	9.00
10.00	01000	0	0	3,372,729	9,030	0	10.00
11.00	01100	0	0	815,482	3,036	0	11.00
13.00	01300	0	0	7,739,259	4,930	0	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	0	0	2,687,663	2,113	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
23.00	02300	0	0	367,015	444	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	98,299,485	0	25,420,259	78,959	32,076	30.00
31.00	03100	18,217,106	0	7,039,593	13,281	5,193	31.00
41.00	04100	10,529,473	0	3,881,674	11,116	5,716	41.00
43.00	04300	5,664,253	0	2,600,626	1,303	1,419	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	197,245,166	0	35,379,447	47,392	0	50.00
51.00	05100	23,447,807	0	4,932,990	15,183	0	51.00
52.00	05200	4,445,249	0	1,861,483	13,552	0	52.00
53.00	05300	41,064,739	0	739,849	508	0	53.00
54.00	05400	84,787,193	0	9,387,538	12,565	0	54.00
55.00	05500	27,122,025	0	1,643,030	3,311	0	55.00
56.00	05600	22,120,145	0	1,932,703	5,593	0	56.00
57.00	05700	114,605,243	0	4,589,849	4,026	0	57.00
58.00	05800	47,359,985	0	2,461,584	3,819	0	58.00
59.00	05900	112,852,566	0	6,004,706	8,626	0	59.00
60.00	06000	158,530,781	0	12,753,027	11,301	0	60.00
63.00	06300	5,159,565	0	1,533,982	892	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	15,879,123	0	3,527,554	3,537	0	65.00
66.00	06600	22,412,021	0	5,017,678	22,717	0	66.00
67.00	06700	7,353,322	0	1,550,852	2,042	0	67.00
68.00	06800	3,749,485	0	1,339,751	1,028	0	68.00
69.00	06900	47,680,008	0	2,497,878	4,117	0	69.00
70.00	07000	12,008,294	0	953,845	2,828	0	70.00
71.00	07100	38,750,968	0	14,560,714	0	0	71.00
72.00	07200	36,852,408	0	14,709,619	0	0	72.00
73.00	07300	79,308,462	0	11,507,297	3,597	0	73.00
74.00	07400	5,339,350	0	1,215,870	323	0	74.00
76.97	07697	2,805,943	0	919,281	7,837	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	11,228,264	0	3,130,544	13,676	0	90.00
91.00	09100	136,576,874	0	9,731,542	18,669	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	6,017,237	0	4,074,639	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		1,397,412,540	-35,035,414	230,174,752	336,304	44,404	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	11,414	712	0	190.00
191.00	19100	0	0	27,433	0	0	191.00
192.00	19200	0	0	1,906,896	118,658	0	192.00
194.00	07950	0	0	611,710	0	0	194.00
194.01	07952	0	0	399,846	887	0	194.01
200.00							200.00
201.00							201.00
202.00		3,205,913		35,035,414	15,509,971	1,315,322	202.00
203.00		0.002294		0.150281	33.971301	29.621701	203.00
204.00		11,334		1,390,226	1,735,443	26,030	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0034

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

Worksheet B-1

Date/Time Prepared:
11/25/2024 11:36 am

Cost Center Description		CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	
		5.03	5A.04	5.04	7.00	8.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000008		0.005963	3.801120	0.586208	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: 15-0034

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

Worksheet B-1

Date/Time Prepared:
11/25/2024 11:36 am

Cost Center Description		HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER OF FTES)	NURSING ADMINISTRATION (NURSING HOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00560						5.01
5.02	00570						5.02
5.03	00580						5.03
5.04	00590						5.04
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	451,608					9.00
10.00	01000	9,030	158,105				10.00
11.00	01100	3,036	0	900			11.00
13.00	01300	4,930	0	58	1,188,901		13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	2,113	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
23.00	02300	444	0	4	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	78,959	112,427	209	434,150	0	30.00
31.00	03100	13,281	10,099	45	93,087	0	31.00
41.00	04100	11,116	17,664	28	57,378	0	41.00
43.00	04300	1,303	0	16	33,288	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	47,392	0	106	221,344	0	50.00
51.00	05100	15,183	5,644	36	74,097	0	51.00
52.00	05200	13,552	5,459	13	26,100	0	52.00
53.00	05300	508	0	0	0	0	53.00
54.00	05400	12,565	0	52	0	0	54.00
55.00	05500	3,311	0	6	0	0	55.00
56.00	05600	5,593	0	6	5,593	0	56.00
57.00	05700	4,026	0	17	0	0	57.00
58.00	05800	3,819	0	9	0	0	58.00
59.00	05900	8,626	0	21	44,304	0	59.00
60.00	06000	11,301	0	76	0	0	60.00
63.00	06300	892	0	4	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	3,537	0	26	537	0	65.00
66.00	06600	22,717	0	1	0	0	66.00
67.00	06700	2,042	0	1	0	0	67.00
68.00	06800	1,028	0	5	0	0	68.00
69.00	06900	4,117	0	15	0	0	69.00
70.00	07000	2,828	0	8	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	3,597	0	29	0	0	73.00
74.00	07400	323	0	0	0	0	74.00
76.97	07697	7,837	0	7	13,741	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	13,676	0	23	46,841	0	90.00
91.00	09100	18,669	6,812	70	144,571	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	9	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		331,351	158,105	900	1,188,901	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	712	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	118,658	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07952	887	0	0	0	0	194.01
200.00							200.00
201.00							201.00
202.00		4,385,287	4,274,032	1,070,651	9,186,672	0	202.00
203.00		9.710384	27.032871	1,189.612222	7.727029	0.000000	203.00
204.00		142,074	426,247	162,307	255,358	0	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0034

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

Worksheet B-1

Date/Time Prepared:
11/25/2024 11:36 am

Cost Center Description		HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER OF FTES)	NURSING ADMINISTRATION (NURSING HO URS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		9.00	10.00	11.00	13.00	14.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	0.314596	2.695974	180.341111	0.214785	0.000000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0034

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

Worksheet B-1

Date/Time Prepared:
11/25/2024 11:36 am

Cost Center Description		PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	PARAMEDICAL EDUCATION PROGRAM EMS (ASSIGNED TIME)	
		15.00	16.00	17.00	19.00	23.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00560						5.01
5.02	00570						5.02
5.03	00580						5.03
5.04	00590						5.04
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500	0					15.00
16.00	01600	0	1,397,412,540				16.00
17.00	01700	0	0	0			17.00
19.00	01900	0	0	0	0		19.00
23.00	02300	0	0	0		9,428	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	98,299,485	0	0	0	30.00
31.00	03100	0	18,217,106	0	0	0	31.00
41.00	04100	0	10,529,473	0	0	0	41.00
43.00	04300	0	5,664,253	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	197,245,166	0	0	233	50.00
51.00	05100	0	23,447,807	0	0	0	51.00
52.00	05200	0	4,445,249	0	0	0	52.00
53.00	05300	0	41,064,739	0	0	0	53.00
54.00	05400	0	84,787,193	0	0	0	54.00
55.00	05500	0	27,122,025	0	0	0	55.00
56.00	05600	0	22,120,145	0	0	0	56.00
57.00	05700	0	114,605,243	0	0	0	57.00
58.00	05800	0	47,359,985	0	0	0	58.00
59.00	05900	0	112,852,566	0	0	110	59.00
60.00	06000	0	158,530,781	0	0	0	60.00
63.00	06300	0	5,159,565	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	15,879,123	0	0	124	65.00
66.00	06600	0	22,412,021	0	0	0	66.00
67.00	06700	0	7,353,322	0	0	0	67.00
68.00	06800	0	3,749,485	0	0	0	68.00
69.00	06900	0	47,680,008	0	0	0	69.00
70.00	07000	0	12,008,294	0	0	0	70.00
71.00	07100	0	38,750,968	0	0	0	71.00
72.00	07200	0	36,852,408	0	0	0	72.00
73.00	07300	0	79,308,462	0	0	0	73.00
74.00	07400	0	5,339,350	0	0	0	74.00
76.97	07697	0	2,805,943	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	11,228,264	0	0	0	90.00
91.00	09100	0	136,576,874	0	0	2,953	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	6,017,237	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		0	1,397,412,540	0	0	3,420	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	6,008	194.00
194.01	07952	0	0	0	0	0	194.01
200.00							200.00
201.00							201.00
202.00		0	3,183,867	0	0	446,322	202.00
203.00		0.000000	0.002278	0.000000	0.000000	47.340051	203.00
204.00		0	58,598	0	0	16,017	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0034

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

Worksheet B-1

Date/Time Prepared:
11/25/2024 11:36 am

Cost Center Description		PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	PARAMEDICAL EDUCATION PROGRAM EMS (ASSIGNED TIME)	
		15.00	16.00	17.00	19.00	23.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000042	0.000000	0.000000	1.698876	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						0 206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet C Part I Date/Time Prepared: 11/25/2024 11:36 am
		Title XVIII	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		40,506,115	0	40,506,115	30.00
31.00	03100 INTENSIVE CARE UNIT		9,918,795	64,457	9,983,252	31.00
41.00	04100 SUBPROVIDER - I RF		6,098,065	0	6,098,065	41.00
43.00	04300 NURSERY		3,379,556	0	3,379,556	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		45,063,912	0	45,063,912	50.00
51.00	05100 RECOVERY ROOM		7,158,908	0	7,158,908	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		3,108,041	0	3,108,041	52.00
53.00	05300 ANESTHESIOLOGY		966,769	0	966,769	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		11,602,172	0	11,602,172	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC		2,103,498	0	2,103,498	55.00
56.00	05600 RADIOISOTOPE		2,524,991	0	2,524,991	56.00
57.00	05700 CT SCAN		5,736,772	0	5,736,772	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		3,116,926	0	3,116,926	58.00
59.00	05900 CARDIAC CATHETERIZATION		7,913,502	0	7,913,502	59.00
60.00	06000 LABORATORY		15,614,756	0	15,614,756	60.00
63.00	06300 BLOOD STORAGE, PROCESSING, & TRANS.		1,819,985	0	1,819,985	63.00
64.00	06400 INTRAVENOUS THERAPY		0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	4,285,153	0	4,285,153	65.00
66.00	06600 PHYSICAL THERAPY	0	6,816,302	0	6,816,302	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,891,055	0	1,891,055	67.00
68.00	06800 SPEECH PATHOLOGY	0	1,600,483	0	1,600,483	68.00
69.00	06900 ELECTROCARDIOLOGY		3,179,559	0	3,179,559	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		1,257,594	0	1,257,594	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		16,837,188	0	16,837,188	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		17,004,145	0	17,004,145	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		13,608,912	0	13,608,912	73.00
74.00	07400 RENAL DIALYSIS		1,424,864	0	1,424,864	74.00
76.97	07697 CARDIAC REHABILITATION		1,520,660	0	1,520,660	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		4,613,277	0	4,613,277	90.00
91.00	09100 EMERGENCY		13,844,943	0	13,844,943	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		6,408,887	0	6,408,887	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY		4,711,394		4,711,394	101.00
200.00	Subtotal (see instructions)	0	265,637,179	64,457	265,701,636	200.00
201.00	Less Observation Beds		6,408,887		6,408,887	201.00
202.00	Total (see instructions)	0	259,228,292	64,457	259,292,749	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet C Part I Date/Time Prepared: 11/25/2024 11:36 am
		Title XVIII	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
	9.00	10.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	74,495,022		74,495,022	30.00
31.00	03100	INTENSIVE CARE UNIT	18,217,106		18,217,106	31.00
41.00	04100	SUBPROVIDER - IRF	10,529,473		10,529,473	41.00
43.00	04300	NURSERY	5,664,253		5,664,253	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	44,864,222	152,380,944	197,245,166	50.00
51.00	05100	RECOVERY ROOM	4,718,091	18,729,716	23,447,807	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,154,115	1,291,134	4,445,249	52.00
53.00	05300	ANESTHESIOLOGY	8,286,654	32,778,085	41,064,739	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,185,641	75,601,552	84,787,193	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	312,280	26,809,745	27,122,025	55.00
56.00	05600	RADIOISOTOPE	1,995,458	20,124,687	22,120,145	56.00
57.00	05700	CT SCAN	25,027,852	89,577,391	114,605,243	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	7,609,627	39,750,358	47,359,985	58.00
59.00	05900	CARDIAC CATHETERIZATION	27,424,779	85,427,787	112,852,566	59.00
60.00	06000	LABORATORY	43,371,228	115,159,553	158,530,781	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	3,487,257	1,672,308	5,159,565	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	13,336,032	2,543,091	15,879,123	65.00
66.00	06600	PHYSICAL THERAPY	4,921,697	17,490,324	22,412,021	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,153,094	3,200,228	7,353,322	67.00
68.00	06800	SPEECH PATHOLOGY	1,179,248	2,570,237	3,749,485	68.00
69.00	06900	ELECTROCARDIOLOGY	11,603,679	36,076,329	47,680,008	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	380,054	11,628,240	12,008,294	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16,503,739	22,247,229	38,750,968	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,933,916	23,918,492	36,852,408	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	51,418,931	27,889,531	79,308,462	73.00
74.00	07400	RENAL DIALYSIS	4,894,045	445,305	5,339,350	74.00
76.97	07697	CARDIAC REHABILITATION	343,294	2,462,649	2,805,943	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	340,031	10,888,233	11,228,264	90.00
91.00	09100	EMERGENCY	37,136,866	99,440,008	136,576,874	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,047,359	20,757,104	23,804,463	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	6,017,237	6,017,237	101.00
200.00		Subtotal (see instructions)	450,535,043	946,877,497	1,397,412,540	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	450,535,043	946,877,497	1,397,412,540	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet C Part I Date/Time Prepared: 11/25/2024 11:36 am
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.228466		50.00
51.00	05100 RECOVERY ROOM	0.305312		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.699183		52.00
53.00	05300 ANESTHESIOLOGY	0.023543		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.136839		54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.077557		55.00
56.00	05600 RADIOISOTOPE	0.114149		56.00
57.00	05700 CT SCAN	0.050057		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.065813		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.070122		59.00
60.00	06000 LABORATORY	0.098497		60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.352740		63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.269861		65.00
66.00	06600 PHYSICAL THERAPY	0.304136		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.257170		67.00
68.00	06800 SPEECH PATHOLOGY	0.426854		68.00
69.00	06900 ELECTROCARDIOLOGY	0.066685		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.104727		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.434497		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.461412		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.171595		73.00
74.00	07400 RENAL DIALYSIS	0.266861		74.00
76.97	07697 CARDIAC REHABILITATION	0.541943		76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.410863		90.00
91.00	09100 EMERGENCY	0.101371		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.269230		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100 HOME HEALTH AGENCY			101.00
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: 15-0034

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

Worksheet C
Part I
Date/Time Prepared:
11/25/2024 11:36 am

		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	40,506,115	40,506,115	0	40,506,115	30.00
31.00	03100 INTENSIVE CARE UNIT	9,918,795	9,918,795	64,457	9,983,252	31.00
41.00	04100 SUBPROVIDER - I RF	6,098,065	6,098,065	0	6,098,065	41.00
43.00	04300 NURSERY	3,379,556	3,379,556	0	3,379,556	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	45,063,912	45,063,912	0	45,063,912	50.00
51.00	05100 RECOVERY ROOM	7,158,908	7,158,908	0	7,158,908	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	3,108,041	3,108,041	0	3,108,041	52.00
53.00	05300 ANESTHESIOLOGY	966,769	966,769	0	966,769	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	11,602,172	11,602,172	0	11,602,172	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	2,103,498	2,103,498	0	2,103,498	55.00
56.00	05600 RADIOISOTOPE	2,524,991	2,524,991	0	2,524,991	56.00
57.00	05700 CT SCAN	5,736,772	5,736,772	0	5,736,772	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	3,116,926	3,116,926	0	3,116,926	58.00
59.00	05900 CARDIAC CATHETERIZATION	7,913,502	7,913,502	0	7,913,502	59.00
60.00	06000 LABORATORY	15,614,756	15,614,756	0	15,614,756	60.00
63.00	06300 BLOOD STORAGE, PROCESSING, & TRANS.	1,819,985	1,819,985	0	1,819,985	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	4,285,153	4,285,153	0	4,285,153	65.00
66.00	06600 PHYSICAL THERAPY	6,816,302	6,816,302	0	6,816,302	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,891,055	1,891,055	0	1,891,055	67.00
68.00	06800 SPEECH PATHOLOGY	1,600,483	1,600,483	0	1,600,483	68.00
69.00	06900 ELECTROCARDIOLOGY	3,179,559	3,179,559	0	3,179,559	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1,257,594	1,257,594	0	1,257,594	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	16,837,188	16,837,188	0	16,837,188	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	17,004,145	17,004,145	0	17,004,145	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	13,608,912	13,608,912	0	13,608,912	73.00
74.00	07400 RENAL DIALYSIS	1,424,864	1,424,864	0	1,424,864	74.00
76.97	07697 CARDIAC REHABILITATION	1,520,660	1,520,660	0	1,520,660	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	4,613,277	4,613,277	0	4,613,277	90.00
91.00	09100 EMERGENCY	13,844,943	13,844,943	0	13,844,943	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	6,408,887	6,408,887	0	6,408,887	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	4,711,394	4,711,394	0	4,711,394	101.00
200.00	Subtotal (see instructions)	265,637,179	265,637,179	64,457	265,701,636	200.00
201.00	Less Observation Beds	6,408,887	6,408,887	0	6,408,887	201.00
202.00	Total (see instructions)	259,228,292	259,228,292	64,457	259,292,749	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet C Part I Date/Time Prepared: 11/25/2024 11:36 am
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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	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	74,495,022		74,495,022		30.00
31.00	03100	INTENSIVE CARE UNIT	18,217,106		18,217,106		31.00
41.00	04100	SUBPROVIDER - IRF	10,529,473		10,529,473		41.00
43.00	04300	NURSERY	5,664,253		5,664,253		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	44,864,222	152,380,944	197,245,166	0.228466	50.00
51.00	05100	RECOVERY ROOM	4,718,091	18,729,716	23,447,807	0.305312	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,154,115	1,291,134	4,445,249	0.699183	52.00
53.00	05300	ANESTHESIOLOGY	8,286,654	32,778,085	41,064,739	0.23543	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,185,641	75,601,552	84,787,193	0.136839	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	312,280	26,809,745	27,122,025	0.077557	55.00
56.00	05600	RADIOISOTOPE	1,995,458	20,124,687	22,120,145	0.114149	56.00
57.00	05700	CT SCAN	25,027,852	89,577,391	114,605,243	0.050057	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	7,609,627	39,750,358	47,359,985	0.065813	58.00
59.00	05900	CARDIAC CATHETERIZATION	27,424,779	85,427,787	112,852,566	0.070122	59.00
60.00	06000	LABORATORY	43,371,228	115,159,553	158,530,781	0.098497	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	3,487,257	1,672,308	5,159,565	0.352740	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	13,336,032	2,543,091	15,879,123	0.269861	65.00
66.00	06600	PHYSICAL THERAPY	4,921,697	17,490,324	22,412,021	0.304136	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,153,094	3,200,228	7,353,322	0.257170	67.00
68.00	06800	SPEECH PATHOLOGY	1,179,248	2,570,237	3,749,485	0.426854	68.00
69.00	06900	ELECTROCARDIOLOGY	11,603,679	36,076,329	47,680,008	0.066685	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	380,054	11,628,240	12,008,294	0.104727	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16,503,739	22,247,229	38,750,968	0.434497	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,933,916	23,918,492	36,852,408	0.461412	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	51,418,931	27,889,531	79,308,462	0.171595	73.00
74.00	07400	RENAL DIALYSIS	4,894,045	445,305	5,339,350	0.266861	74.00
76.97	07697	CARDIAC REHABILITATION	343,294	2,462,649	2,805,943	0.541943	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	340,031	10,888,233	11,228,264	0.410863	90.00
91.00	09100	EMERGENCY	37,136,866	99,440,008	136,576,874	0.101371	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,047,359	20,757,104	23,804,463	0.269230	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	6,017,237	6,017,237		101.00
200.00		Subtotal (see instructions)	450,535,043	946,877,497	1,397,412,540		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	450,535,043	946,877,497	1,397,412,540		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet C Part I Date/Time Prepared: 11/25/2024 11:36 am
		Title XIX	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.228466		50.00
51.00	05100 RECOVERY ROOM	0.305312		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.699183		52.00
53.00	05300 ANESTHESIOLOGY	0.023543		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.136839		54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.077557		55.00
56.00	05600 RADIOISOTOPE	0.114149		56.00
57.00	05700 CT SCAN	0.050057		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.065813		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.070122		59.00
60.00	06000 LABORATORY	0.098497		60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.352740		63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.269861		65.00
66.00	06600 PHYSICAL THERAPY	0.304136		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.257170		67.00
68.00	06800 SPEECH PATHOLOGY	0.426854		68.00
69.00	06900 ELECTROCARDIOLOGY	0.066685		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.104727		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.434497		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.461412		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.171595		73.00
74.00	07400 RENAL DIALYSIS	0.266861		74.00
76.97	07697 CARDIAC REHABILITATION	0.541943		76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.410863		90.00
91.00	09100 EMERGENCY	0.101371		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.269230		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100 HOME HEALTH AGENCY			101.00
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: 15-0034

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

Worksheet C Part II Date/Time Prepared: 11/25/2024 11:36 am

Cost Center Description			Title XIX			Hospital	PPS	
			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	45,063,912	4,410,070	40,653,842	0	0	50.00
51.00	05100	RECOVERY ROOM	7,158,908	437,871	6,721,037	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,108,041	414,464	2,693,577	0	0	52.00
53.00	05300	ANESTHESIOLOGY	966,769	45,160	921,609	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,602,172	1,144,554	10,457,618	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	2,103,498	124,357	1,979,141	0	0	55.00
56.00	05600	RADIOISOTOPE	2,524,991	231,420	2,293,571	0	0	56.00
57.00	05700	CT SCAN	5,736,772	608,577	5,128,195	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,116,926	409,015	2,707,911	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	7,913,502	916,661	6,996,841	0	0	59.00
60.00	06000	LABORATORY	15,614,756	555,333	15,059,423	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	1,819,985	78,812	1,741,173	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	4,285,153	199,462	4,085,691	0	0	65.00
66.00	06600	PHYSICAL THERAPY	6,816,302	602,136	6,214,166	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,891,055	56,342	1,834,713	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,600,483	88,805	1,511,678	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,179,559	264,744	2,914,815	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,257,594	97,508	1,160,086	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16,837,188	91,477	16,745,711	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,004,145	92,136	16,912,009	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,608,912	1,001,492	12,607,420	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,424,864	14,399	1,410,465	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	1,520,660	205,035	1,315,625	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	4,613,277	478,434	4,134,843	0	0	90.00
91.00	09100	EMERGENCY	13,844,943	651,412	13,193,531	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,408,887	375,266	6,033,621	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	4,711,394	29,866	4,681,528	0	0	101.00
200.00		Subtotal (sum of lines 50 thru 199)	205,734,648	13,624,808	192,109,840	0	0	200.00
201.00		Less Observation Beds	6,408,887	375,266	6,033,621	0	0	201.00
202.00		Total (line 200 minus line 201)	199,325,761	13,249,542	186,076,219	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY		Provider CCN: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet C Part II Date/Time Prepared: 11/25/2024 11:36 am
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Cost Center Description		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		
Title XIX						
Hospital						
PPS						
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,063,912	197,245,166	0.228466	50.00
51.00	05100	RECOVERY ROOM	7,158,908	23,447,807	0.305312	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,108,041	4,445,249	0.699183	52.00
53.00	05300	ANESTHESIOLOGY	966,769	41,064,739	0.023543	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,602,172	84,787,193	0.136839	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	2,103,498	27,122,025	0.077557	55.00
56.00	05600	RADIOISOTOPE	2,524,991	22,120,145	0.114149	56.00
57.00	05700	CT SCAN	5,736,772	114,605,243	0.050057	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,116,926	47,359,985	0.065813	58.00
59.00	05900	CARDIAC CATHETERIZATION	7,913,502	112,852,566	0.070122	59.00
60.00	06000	LABORATORY	15,614,756	158,530,781	0.098497	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	1,819,985	5,159,565	0.352740	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	4,285,153	15,879,123	0.269861	65.00
66.00	06600	PHYSICAL THERAPY	6,816,302	22,412,021	0.304136	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,891,055	7,353,322	0.257170	67.00
68.00	06800	SPEECH PATHOLOGY	1,600,483	3,749,485	0.426854	68.00
69.00	06900	ELECTROCARDIOLOGY	3,179,559	47,680,008	0.066685	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,257,594	12,008,294	0.104727	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16,837,188	38,750,968	0.434497	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,004,145	36,852,408	0.461412	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,608,912	79,308,462	0.171595	73.00
74.00	07400	RENAL DIALYSIS	1,424,864	5,339,350	0.266861	74.00
76.97	07697	CARDIAC REHABILITATION	1,520,660	2,805,943	0.541943	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,613,277	11,228,264	0.410863	90.00
91.00	09100	EMERGENCY	13,844,943	136,576,874	0.101371	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,408,887	23,804,463	0.269230	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	4,711,394	6,017,237	0.782983	101.00
200.00		Subtotal (sum of lines 50 thru 199)	205,734,648	1,288,506,686		200.00
201.00		Less Observation Beds	6,408,887	0		201.00
202.00		Total (line 200 minus line 201)	199,325,761	1,288,506,686		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet D Part I Date/Time Prepared: 11/25/2024 11:36 am
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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		
Title XVIII Hospital PPS								
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	2,371,782	0	2,371,782	38,105	62.24	30.00	
31.00	INTENSIVE CARE UNIT	476,954		476,954	5,193	91.85	31.00	
41.00	SUBPROVIDER - IRF	326,851	0	326,851	5,716	57.18	41.00	
43.00	NURSERY	190,174		190,174	1,419	134.02	43.00	
200.00	Total (lines 30 through 199)	3,365,761		3,365,761	50,433		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	11,364	707,295					30.00
31.00	INTENSIVE CARE UNIT	1,295	118,946					31.00
41.00	SUBPROVIDER - IRF	3,587	205,105					41.00
43.00	NURSERY	0	0					43.00
200.00	Total (lines 30 through 199)	16,246	1,031,346					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet D Part II Date/Time Prepared: 11/25/2024 11:36 am
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Cost Center Description		Title XVIII			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	4,410,070	197,245,166	0.022358	13,327,381	297,974	50.00
51.00	05100	RECOVERY ROOM	437,871	23,447,807	0.018674	1,568,659	29,293	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	414,464	4,445,249	0.093238	5,402	504	52.00
53.00	05300	ANESTHESIOLOGY	45,160	41,064,739	0.001100	2,744,828	3,019	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,144,554	84,787,193	0.013499	3,071,311	41,460	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	124,357	27,122,025	0.004585	86,023	394	55.00
56.00	05600	RADIOISOTOPE	231,420	22,120,145	0.010462	673,659	7,048	56.00
57.00	05700	CT SCAN	608,577	114,605,243	0.005310	8,608,574	45,712	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	409,015	47,359,985	0.008636	2,597,997	22,436	58.00
59.00	05900	CARDIAC CATHETERIZATION	916,661	112,852,566	0.008123	10,312,244	83,766	59.00
60.00	06000	LABORATORY	555,333	158,530,781	0.003503	14,159,357	49,600	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	78,812	5,159,565	0.015275	1,023,870	15,640	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	199,462	15,879,123	0.012561	4,272,438	53,666	65.00
66.00	06600	PHYSICAL THERAPY	602,136	22,412,021	0.026867	960,302	25,800	66.00
67.00	06700	OCCUPATIONAL THERAPY	56,342	7,353,322	0.007662	518,787	3,975	67.00
68.00	06800	SPEECH PATHOLOGY	88,805	3,749,485	0.023685	278,680	6,601	68.00
69.00	06900	ELECTROCARDIOLOGY	264,744	47,680,008	0.005553	4,319,322	23,985	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	97,508	12,008,294	0.008120	130,389	1,059	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	91,477	38,750,968	0.002361	5,563,887	13,136	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	92,136	36,852,408	0.002500	6,123,553	15,309	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,001,492	79,308,462	0.012628	14,714,579	185,816	73.00
74.00	07400	RENAL DIALYSIS	14,399	5,339,350	0.002697	1,621,604	4,373	74.00
76.97	07697	CARDIAC REHABILITATION	205,035	2,805,943	0.073072	111,036	8,114	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	478,434	11,228,264	0.042610	52,683	2,245	90.00
91.00	09100	EMERGENCY	651,412	136,576,874	0.004770	13,459,392	64,201	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	375,266	23,804,463	0.015765	1,198,834	18,900	92.00
200.00		Total (lines 50 through 199)	13,594,942	1,282,489,449		111,504,791	1,024,026	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet D Part III Date/Time Prepared: 11/25/2024 11:36 am
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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	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00	
43.00	04300	NURSERY	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	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	38,105	0.00	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	5,193	0.00	31.00	
41.00	04100	SUBPROVIDER - IRF	0	0	5,716	0.00	41.00	
43.00	04300	NURSERY	0	0	1,419	0.00	43.00	
200.00		Total (lines 30 through 199)	0	0	50,433		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
41.00	04100	SUBPROVIDER - IRF	0					41.00
43.00	04300	NURSERY	0					43.00
200.00		Total (lines 30 through 199)	0					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0034

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

Worksheet D
Part IV
Date/Time Prepared:
11/25/2024 11:36 am

Cost Center Description			Title XVIII				Hospital		
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	PPS	
			1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	11,030	50.00	
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00	
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00	
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00	
57.00	05700	CT SCAN	0	0	0	0	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	5,207	59.00	
60.00	06000	LABORATORY	0	0	0	0	0	60.00	
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00	
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	5,870	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0	0	0	0	139,795	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00	
200.00		Total (lines 50 through 199)	0	0	0	0	161,902	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet D Part IV Date/Time Prepared: 11/25/2024 11:36 am
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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)	Title XVIII		Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)
				Hospital	PPS	
	4.00	5.00	6.00	Total Charges (from Wkst. C, Part I, col. 8)	7.00	8.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	11,030	11,030	197,245,166	0.000056	50.00
51.00 05100 RECOVERY ROOM	0	0	0	23,447,807	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	4,445,249	0.000000	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	41,064,739	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	84,787,193	0.000000	54.00
55.00 05500 RADIOLOGY - THERAPEUTIC	0	0	0	27,122,025	0.000000	55.00
56.00 05600 RADIOISOTOPE	0	0	0	22,120,145	0.000000	56.00
57.00 05700 CT SCAN	0	0	0	114,605,243	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	47,359,985	0.000000	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	5,207	5,207	112,852,566	0.000046	59.00
60.00 06000 LABORATORY	0	0	0	158,530,781	0.000000	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	5,159,565	0.000000	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00 06500 RESPIRATORY THERAPY	0	5,870	5,870	15,879,123	0.000370	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	22,412,021	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	7,353,322	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	3,749,485	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	47,680,008	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	12,008,294	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	38,750,968	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	36,852,408	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	79,308,462	0.000000	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	5,339,350	0.000000	74.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	2,805,943	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	11,228,264	0.000000	90.00
91.00 09100 EMERGENCY	0	139,795	139,795	136,576,874	0.001024	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	23,804,463	0.000000	92.00
200.00 Total (lines 50 through 199)	0	161,902	161,902	1,282,489,449		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0034

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

Worksheet D
Part IV
Date/Time Prepared:
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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	0.000056	13,327,381	746	36,663,127	2,053	50.00
51.00	05100 RECOVERY ROOM	0.000000	1,568,659	0	4,619,416	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	5,402	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	2,744,828	0	7,767,010	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	3,071,311	0	17,417,893	0	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.000000	86,023	0	7,627,634	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	673,659	0	6,217,389	0	56.00
57.00	05700 CT SCAN	0.000000	8,608,574	0	21,035,612	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	2,597,997	0	9,034,398	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000046	10,312,244	474	28,851,186	1,327	59.00
60.00	06000 LABORATORY	0.000000	14,159,357	0	10,117,438	0	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.000000	1,023,870	0	322,088	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000370	4,272,438	1,581	559,401	207	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	960,302	0	52,554	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	518,787	0	3,225	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	278,680	0	209,563	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	4,319,322	0	11,130,145	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	130,389	0	2,693,444	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	5,563,887	0	6,306,905	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	6,123,553	0	7,221,633	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	14,714,579	0	6,614,519	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	1,621,604	0	119,681	0	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	111,036	0	813,894	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	52,683	0	3,356,962	0	90.00
91.00	09100 EMERGENCY	0.001024	13,459,392	13,782	14,317,140	14,661	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,198,834	0	3,896,908	0	92.00
200.00	Total (lines 50 through 199)		111,504,791	16,583	206,969,165	18,248	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet D Part V Date/Time Prepared: 11/25/2024 11:36 am
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		Title XVIII		Hospital		PPS	
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		PPS Services (see inst.)
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.228466	36,663,127	40,970	0	8,376,278	50.00
51.00	05100 RECOVERY ROOM	0.305312	4,619,416	0	0	1,410,363	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.699183	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.023543	7,767,010	0	0	182,859	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.136839	17,417,893	0	0	2,383,447	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.077557	7,627,634	0	0	591,576	55.00
56.00	05600 RADIOISOTOPE	0.114149	6,217,389	0	0	709,709	56.00
57.00	05700 CT SCAN	0.050057	21,035,612	0	0	1,052,980	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.065813	9,034,398	0	0	594,581	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.070122	28,851,186	0	0	2,023,103	59.00
60.00	06000 LABORATORY	0.098497	10,117,438	0	0	996,537	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.352740	322,088	0	0	113,613	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.269861	559,401	0	0	150,961	65.00
66.00	06600 PHYSICAL THERAPY	0.304136	52,554	0	0	15,984	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.257170	3,225	0	0	829	67.00
68.00	06800 SPEECH PATHOLOGY	0.426854	209,563	0	0	89,453	68.00
69.00	06900 ELECTROCARDIOLOGY	0.066685	11,130,145	0	0	742,214	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.104727	2,693,444	0	0	282,076	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.434497	6,306,905	0	0	2,740,331	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.461412	7,221,633	0	0	3,332,148	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.171595	6,614,519	0	40,386	1,135,018	73.00
74.00	07400 RENAL DIALYSIS	0.266861	119,681	0	0	31,938	74.00
76.97	07697 CARDIAC REHABILITATION	0.541943	813,894	0	0	441,084	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.410863	3,356,962	0	0	1,379,251	90.00
91.00	09100 EMERGENCY	0.101371	14,317,140	0	0	1,451,343	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.269230	3,896,908	0	0	1,049,165	92.00
200.00	Subtotal (see instructions)		206,969,165	40,970	40,386	31,276,841	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 - line 201)		206,969,165	40,970	40,386	31,276,841	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet D Part V Date/Time Prepared: 11/25/2024 11:36 am
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	9,360	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00 05500 RADIOLOGY - THERAPEUTIC	0	0		55.00
56.00 05600 RADIOISOTOPE	0	0		56.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	6,930		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00 Subtotal (see instructions)	9,360	6,930		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	9,360	6,930		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 15-0034 Component CCN: 15-T034	Period: From 07/01/2023 To 06/30/2024	Worksheet D Part II Date/Time Prepared: 11/25/2024 11:36 am
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	4,410,070	197,245,166	0.022358	48,296	1,080	50.00
51.00	05100 RECOVERY ROOM	437,871	23,447,807	0.018674	2,821	53	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	414,464	4,445,249	0.093238	0	0	52.00
53.00	05300 ANESTHESIOLOGY	45,160	41,064,739	0.001100	6,378	7	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,144,554	84,787,193	0.013499	111,066	1,499	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	124,357	27,122,025	0.004585	0	0	55.00
56.00	05600 RADIOISOTOPE	231,420	22,120,145	0.010462	10,861	114	56.00
57.00	05700 CT SCAN	608,577	114,605,243	0.005310	162,264	862	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	409,015	47,359,985	0.008636	29,184	252	58.00
59.00	05900 CARDIAC CATHETERIZATION	916,661	112,852,566	0.008123	0	0	59.00
60.00	06000 LABORATORY	555,333	158,530,781	0.003503	777,991	2,725	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	78,812	5,159,565	0.015275	31,704	484	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	199,462	15,879,123	0.012561	416,178	5,228	65.00
66.00	06600 PHYSICAL THERAPY	602,136	22,412,021	0.026867	1,811,204	48,662	66.00
67.00	06700 OCCUPATIONAL THERAPY	56,342	7,353,322	0.007662	1,759,869	13,484	67.00
68.00	06800 SPEECH PATHOLOGY	88,805	3,749,485	0.023685	231,574	5,485	68.00
69.00	06900 ELECTROCARDIOLOGY	264,744	47,680,008	0.005553	39,757	221	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	97,508	12,008,294	0.008120	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	91,477	38,750,968	0.002361	323,397	764	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	92,136	36,852,408	0.002500	4,328	11	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,001,492	79,308,462	0.012628	1,676,034	21,165	73.00
74.00	07400 RENAL DIALYSIS	14,399	5,339,350	0.002697	148,553	401	74.00
76.97	07697 CARDIAC REHABILITATION	205,035	2,805,943	0.073072	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	478,434	11,228,264	0.042610	0	0	90.00
91.00	09100 EMERGENCY	651,412	136,576,874	0.004770	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	23,804,463	0.000000	0	0	92.00
200.00	Total (lines 50 through 199)	13,219,676	1,282,489,449		7,591,459	102,497	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0034 Component CCN: 15-T034	Period: From 07/01/2023 To 06/30/2024	Worksheet D Part IV Date/Time Prepared: 11/25/2024 11:36 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	11,030	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	5,207	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	5,870	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	139,795	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00	Total (lines 50 through 199)	0	0	0	0	161,902	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0034 Component CCN: 15-T034	Period: From 07/01/2023 To 06/30/2024	Worksheet D Part IV Date/Time Prepared: 11/25/2024 11:36 am
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Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 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	11,030	11,030	197,245,166	0.000056	50.00
51.00	05100 RECOVERY ROOM	0	0	0	23,447,807	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	4,445,249	0.000000	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	41,064,739	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	84,787,193	0.000000	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0	0	0	27,122,025	0.000000	55.00
56.00	05600 RADIOISOTOPE	0	0	0	22,120,145	0.000000	56.00
57.00	05700 CT SCAN	0	0	0	114,605,243	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	47,359,985	0.000000	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	5,207	5,207	112,852,566	0.000046	59.00
60.00	06000 LABORATORY	0	0	0	158,530,781	0.000000	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	5,159,565	0.000000	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500 RESPIRATORY THERAPY	0	5,870	5,870	15,879,123	0.000370	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	22,412,021	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	7,353,322	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	3,749,485	0.000000	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	47,680,008	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	12,008,294	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	38,750,968	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	36,852,408	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	79,308,462	0.000000	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	5,339,350	0.000000	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	2,805,943	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	11,228,264	0.000000	90.00
91.00	09100 EMERGENCY	0	139,795	139,795	136,576,874	0.001024	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	23,804,463	0.000000	92.00
200.00	Total (lines 50 through 199)	0	161,902	161,902	1,282,489,449		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0034 Component CCN: 15-T034	Period: From 07/01/2023 To 06/30/2024	Worksheet D Part IV Date/Time Prepared: 11/25/2024 11:36 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000056	48,296	3	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	2,821	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	6,378	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	111,066	0	338	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	10,861	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	162,264	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	29,184	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000046	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	777,991	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	31,704	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000370	416,178	154	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,811,204	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,759,869	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	231,574	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	39,757	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	323,397	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	4,328	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,676,034	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	148,553	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.001024	0	0	154	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		7,591,459	157	492	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0034 Component CCN: 15-T034	Period: From 07/01/2023 To 06/30/2024	Worksheet D Part V Date/Time Prepared: 11/25/2024 11:36 am
Title XVIII			Subprovider - IRF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.228466	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0.305312	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.699183	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.023543	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.136839	338	0	0	46	54.00
55.00 05500 RADIOLOGY - THERAPEUTIC	0.077557	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0.114149	0	0	0	0	56.00
57.00 05700 CT SCAN	0.050057	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.065813	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.070122	0	0	0	0	59.00
60.00 06000 LABORATORY	0.098497	0	0	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0.352740	0	0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0.269861	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.304136	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.257170	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.426854	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.066685	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.104727	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.434497	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.461412	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.171595	0	0	364	0	73.00
74.00 07400 RENAL DIALYSIS	0.266861	0	0	0	0	74.00
76.97 07697 CARDIAC REHABILITATION	0.541943	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.410863	0	0	0	0	90.00
91.00 09100 EMERGENCY	0.101371	154	0	0	16	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.269230	0	0	0	0	92.00
200.00 Subtotal (see instructions)		492	0	364	62	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00 Net Charges (line 200 - line 201)		492	0	364	62	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0034 Component CCN: 15-T034	Period: From 07/01/2023 To 06/30/2024	Worksheet D Part V Date/Time Prepared: 11/25/2024 11:36 am
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00 05500 RADIOLOGY - THERAPEUTIC	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	56.00
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	62	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
76.97 07697 CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS			
90.00 09000 CLINIC	0	0	90.00
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00 Subtotal (see instructions)	0	62	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 - line 201)	0	62	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet D Part I Date/Time Prepared: 11/25/2024 11:36 am
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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	
Title XIX Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,371,782	0	2,371,782	38,105	62.24	30.00
31.00	INTENSIVE CARE UNIT	476,954		476,954	5,193	91.85	31.00
41.00	SUBPROVIDER - IRF	326,851	0	326,851	5,716	57.18	41.00
43.00	NURSERY	190,174		190,174	1,419	134.02	43.00
200.00	Total (lines 30 through 199)	3,365,761		3,365,761	50,433		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	807	50,228				
31.00	INTENSIVE CARE UNIT	211	19,380				
41.00	SUBPROVIDER - IRF	45	2,573				
43.00	NURSERY	46	6,165				
200.00	Total (lines 30 through 199)	1,109	78,346				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet D Part II Date/Time Prepared: 11/25/2024 11:36 am
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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	4,410,070	197,245,166	0.022358	582,502	13,024	50.00
51.00	05100	RECOVERY ROOM	437,871	23,447,807	0.018674	37,650	703	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	414,464	4,445,249	0.093238	16,476	1,536	52.00
53.00	05300	ANESTHESIOLOGY	45,160	41,064,739	0.001100	83,378	92	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,144,554	84,787,193	0.013499	149,430	2,017	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	124,357	27,122,025	0.004585	0	0	55.00
56.00	05600	RADIOISOTOPE	231,420	22,120,145	0.010462	40,240	421	56.00
57.00	05700	CT SCAN	608,577	114,605,243	0.005310	524,984	2,788	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	409,015	47,359,985	0.008636	126,119	1,089	58.00
59.00	05900	CARDIAC CATHETERIZATION	916,661	112,852,566	0.008123	39,371	320	59.00
60.00	06000	LABORATORY	555,333	158,530,781	0.003503	937,463	3,284	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	78,812	5,159,565	0.015275	26,412	403	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	199,462	15,879,123	0.012561	225,634	2,834	65.00
66.00	06600	PHYSICAL THERAPY	602,136	22,412,021	0.026867	36,161	972	66.00
67.00	06700	OCCUPATIONAL THERAPY	56,342	7,353,322	0.007662	24,249	186	67.00
68.00	06800	SPEECH PATHOLOGY	88,805	3,749,485	0.023685	21,865	518	68.00
69.00	06900	ELECTROCARDIOLOGY	264,744	47,680,008	0.005553	216,584	1,203	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	97,508	12,008,294	0.008120	53,995	438	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	91,477	38,750,968	0.002361	176,190	416	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	92,136	36,852,408	0.002500	67,635	169	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,001,492	79,308,462	0.012628	1,120,618	14,151	73.00
74.00	07400	RENAL DIALYSIS	14,399	5,339,350	0.002697	145,049	391	74.00
76.97	07697	CARDIAC REHABILITATION	205,035	2,805,943	0.073072	1,935	141	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	478,434	11,228,264	0.042610	0	0	90.00
91.00	09100	EMERGENCY	651,412	136,576,874	0.004770	524,522	2,502	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	375,266	23,804,463	0.015765	61,133	964	92.00
200.00		Total (lines 50 through 199)	13,594,942	1,282,489,449		5,239,595	50,562	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet D Part III Date/Time Prepared: 11/25/2024 11:36 am
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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	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00	
43.00	04300	NURSERY	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	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	38,105	0.00	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	5,193	0.00	31.00	
41.00	04100	SUBPROVIDER - IRF	0	0	5,716	0.00	41.00	
43.00	04300	NURSERY	0	0	1,419	0.00	43.00	
200.00		Total (lines 30 through 199)	0	0	50,433	1,109	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
41.00	04100	SUBPROVIDER - IRF	0					41.00
43.00	04300	NURSERY	0					43.00
200.00		Total (lines 30 through 199)	0					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0034

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

Worksheet D
Part IV
Date/Time Prepared:
11/25/2024 11:36 am

Cost Center Description		Title XIX			Hospital		Allied Health Adjustments	Allied Health Adjustments	
		Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	PPS			
		1.00	2A	2.00	3A	3.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	11,030	50.00	
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00	
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00	
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00	
57.00	05700	CT SCAN	0	0	0	0	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	5,207	59.00	
60.00	06000	LABORATORY	0	0	0	0	0	60.00	
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00	
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	5,870	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0	0	0	0	139,795	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00	
200.00		Total (lines 50 through 199)	0	0	0	0	161,902	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0034

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

Worksheet D
Part IV
Date/Time Prepared:
11/25/2024 11:36 am

Cost Center Description		All Other Medical Education Cost	Title XIX		Hospital	PPS		
			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	11,030	11,030	197,245,166	0.000056	50.00
51.00	05100	RECOVERY ROOM	0	0	0	23,447,807	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	4,445,249	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	41,064,739	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	84,787,193	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	27,122,025	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	22,120,145	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	114,605,243	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	47,359,985	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	5,207	5,207	112,852,566	0.000046	59.00
60.00	06000	LABORATORY	0	0	0	158,530,781	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	5,159,565	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	5,870	5,870	15,879,123	0.000370	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	22,412,021	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	7,353,322	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,749,485	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	47,680,008	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	12,008,294	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	38,750,968	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	36,852,408	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	79,308,462	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	5,339,350	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	2,805,943	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	11,228,264	0.000000	90.00
91.00	09100	EMERGENCY	0	139,795	139,795	136,576,874	0.001024	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	23,804,463	0.000000	92.00
200.00		Total (lines 50 through 199)	0	161,902	161,902	1,282,489,449		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0034

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

Worksheet D
Part IV
Date/Time Prepared:
11/25/2024 11:36 am

Cost Center Description		Title XIX			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	0.000056	582,502	33	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	37,650	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	16,476	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	83,378	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	149,430	0	0	0	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	40,240	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	524,984	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	126,119	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000046	39,371	2	0	0	59.00
60.00	06000 LABORATORY	0.000000	937,463	0	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.000000	26,412	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000370	225,634	83	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	36,161	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	24,249	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	21,865	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	216,584	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	53,995	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	176,190	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	67,635	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	1,120,618	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	145,049	0	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	1,935	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.001024	524,522	537	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	61,133	0	0	0	92.00
200.00	Total (lines 50 through 199)		5,239,595	655	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 15-0034 Component CCN: 15-T034	Period: From 07/01/2023 To 06/30/2024	Worksheet D Part II Date/Time Prepared: 11/25/2024 11:36 am
	Title XIX	Subprovider - IRF	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	4,410,070	197,245,166	0.022358	0	0	50.00
51.00	05100 RECOVERY ROOM	437,871	23,447,807	0.018674	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	414,464	4,445,249	0.093238	0	0	52.00
53.00	05300 ANESTHESIOLOGY	45,160	41,064,739	0.001100	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,144,554	84,787,193	0.013499	967	13	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	124,357	27,122,025	0.004585	0	0	55.00
56.00	05600 RADIOISOTOPE	231,420	22,120,145	0.010462	0	0	56.00
57.00	05700 CT SCAN	608,577	114,605,243	0.005310	6,819	36	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	409,015	47,359,985	0.008636	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	916,661	112,852,566	0.008123	0	0	59.00
60.00	06000 LABORATORY	555,333	158,530,781	0.003503	10,962	38	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	78,812	5,159,565	0.015275	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	199,462	15,879,123	0.012561	3,047	38	65.00
66.00	06600 PHYSICAL THERAPY	602,136	22,412,021	0.026867	21,840	587	66.00
67.00	06700 OCCUPATIONAL THERAPY	56,342	7,353,322	0.007662	23,900	183	67.00
68.00	06800 SPEECH PATHOLOGY	88,805	3,749,485	0.023685	4,237	100	68.00
69.00	06900 ELECTROCARDIOLOGY	264,744	47,680,008	0.005553	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	97,508	12,008,294	0.008120	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	91,477	38,750,968	0.002361	3,287	8	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	92,136	36,852,408	0.002500	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,001,492	79,308,462	0.012628	21,378	270	73.00
74.00	07400 RENAL DIALYSIS	14,399	5,339,350	0.002697	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	205,035	2,805,943	0.073072	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	478,434	11,228,264	0.042610	0	0	90.00
91.00	09100 EMERGENCY	651,412	136,576,874	0.004770	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	23,804,463	0.000000	0	0	92.00
200.00	Total (lines 50 through 199)	13,219,676	1,282,489,449		96,437	1,273	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0034 Component CCN: 15-T034	Period: From 07/01/2023 To 06/30/2024	Worksheet D Part IV Date/Time Prepared: 11/25/2024 11:36 am
Title XIX		Subprovider - IRF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	11,030	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	5,207	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	5,870	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	139,795	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00	Total (lines 50 through 199)	0	0	0	0	161,902	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0034 Component CCN: 15-T034	Period: From 07/01/2023 To 06/30/2024	Worksheet D Part IV Date/Time Prepared: 11/25/2024 11:36 am
	Title XIX	Subprovider - IRF	PPS

Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col.s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col.s. 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	11,030	11,030	197,245,166	0.000056	50.00
51.00	05100 RECOVERY ROOM	0	0	0	23,447,807	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	4,445,249	0.000000	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	41,064,739	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	84,787,193	0.000000	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0	0	0	27,122,025	0.000000	55.00
56.00	05600 RADIOISOTOPE	0	0	0	22,120,145	0.000000	56.00
57.00	05700 CT SCAN	0	0	0	114,605,243	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	47,359,985	0.000000	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	5,207	5,207	112,852,566	0.000046	59.00
60.00	06000 LABORATORY	0	0	0	158,530,781	0.000000	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	5,159,565	0.000000	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500 RESPIRATORY THERAPY	0	5,870	5,870	15,879,123	0.000370	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	22,412,021	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	7,353,322	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	3,749,485	0.000000	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	47,680,008	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	12,008,294	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	38,750,968	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	36,852,408	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	79,308,462	0.000000	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	5,339,350	0.000000	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	2,805,943	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	11,228,264	0.000000	90.00
91.00	09100 EMERGENCY	0	139,795	139,795	136,576,874	0.001024	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	23,804,463	0.000000	92.00
200.00	Total (lines 50 through 199)	0	161,902	161,902	1,282,489,449		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0034 Component CCN: 15-T034	Period: From 07/01/2023 To 06/30/2024	Worksheet D Part IV Date/Time Prepared: 11/25/2024 11:36 am
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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	0.000056	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	967	0	0	0	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	6,819	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000046	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	10,962	0	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000370	3,047	1	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	21,840	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	23,900	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	4,237	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	3,287	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	21,378	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.001024	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00	Total (lines 50 through 199)		96,437	1	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet D-1 Date/Time Prepared: 11/25/2024 11:36 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		38,105	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		38,105	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)		32,076	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)		11,364	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)		40,506,115	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)		40,506,115	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)		40,506,115	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)		1,063.01	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		12,080,046	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)		12,080,046	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0034		Period: From 07/01/2023 To 06/30/2024		Worksheet D-1	
		Title XVIII		Hospital		PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	9,983,252	5,193	1,922.44	1,295	2,489,560	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)					19,145,581	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)					33,715,187	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)					826,241	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,040,609	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,866,850	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					31,848,337	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)					6,029	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,063.01	88.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0034		Period: From 07/01/2023 To 06/30/2024		Worksheet D-1 Date/Time Prepared: 11/25/2024 11:36 am	
Cost Center Description		Title XVIII		Hospital		PPS	
Cost Center Description		Cost		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	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					6,408,887	89.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,371,782	40,506,115	0.058554	6,408,887	375,266	90.00
91.00	Nursing Program cost	0	40,506,115	0.000000	6,408,887	0	91.00
92.00	Allied health cost	0	40,506,115	0.000000	6,408,887	0	92.00
93.00	All other Medical Education	0	40,506,115	0.000000	6,408,887	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0034 Component CCN: 15-T034	Period: From 07/01/2023 To 06/30/2024	Worksheet D-1 Date/Time Prepared: 11/25/2024 11:36 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,716	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,716	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		5,716	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		3,587	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)		6,098,065	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)		6,098,065	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)		6,098,065	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)		1,066.84	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,826,755	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		3,826,755	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0034 Component CCN: 15-T034		Period: From 07/01/2023 To 06/30/2024		Worksheet D-1 Date/Time Prepared: 11/25/2024 11:36 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,813,340	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)					5,640,095	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)					205,105	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					102,654	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					307,759	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					5,332,336	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
55.01	Permanent adjustment amount per discharge					0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)					0.00	55.02
55.03	CAR T-cell amount paid as an interim payment						55.03
56.00	Target amount ((line 54 x sum of lines 55, 55.01, and 55.02) plus line 55.03)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0034 Component CCN: 15-T034		Period: From 07/01/2023 To 06/30/2024		Worksheet D-1 Date/Time Prepared: 11/25/2024 11:36 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description						1.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 + line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	326,851	6,098,065	0.053599	0	0	90.00
91.00	Nursing Program cost	0	6,098,065	0.000000	0	0	91.00
92.00	Allied health cost	0	6,098,065	0.000000	0	0	92.00
93.00	All other Medical Education	0	6,098,065	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet D-1 Date/Time Prepared: 11/25/2024 11:36 am
Cost Center Description		Title XIX	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		38,105	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		38,105	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)		32,076	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)		807	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		1,419	15.00
16.00	Nursery days (title V or XIX only)		46	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)		40,506,115	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)		40,506,115	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)		40,506,115	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)		1,063,01	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		857,849	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)		857,849	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0034		Period: From 07/01/2023 To 06/30/2024		Worksheet D-1	
Title XIX		Hospital		PPS		Date/Time Prepared: 11/25/2024 11:36 am	
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)		
42.00 NURSERY (title V & XIX only)	3,379,556	1,419	2,381.65	46	109,556		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	9,983,252	5,193	1,922.44	211	405,635		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)					839,091		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)					2,212,131		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)					75,773		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					51,217		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					126,990		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,085,141		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)					6,029		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,063.01		88.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0034		Period: From 07/01/2023 To 06/30/2024		Worksheet D-1 Date/Time Prepared: 11/25/2024 11:36 am	
Cost Center Description		Title XIX		Hospital		PPS	
89.00 Observation bed cost (line 87 x line 88) (see instructions)						1.00 6,408,887 89.00	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,371,782	40,506,115	0.058554	6,408,887	375,266	90.00
91.00	Nursing Program cost	0	40,506,115	0.000000	6,408,887	0	91.00
92.00	Allied health cost	0	40,506,115	0.000000	6,408,887	0	92.00
93.00	All other Medical Education	0	40,506,115	0.000000	6,408,887	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0034 Component CCN: 15-T034	Period: From 07/01/2023 To 06/30/2024	Worksheet D-1 Date/Time Prepared: 11/25/2024 11:36 am
		Title XIX	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,716	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,716	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		5,716	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)		45	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		1,419	15.00
16.00	Nursery days (title V or XIX only)		46	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)		6,098,065	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)		6,098,065	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)		6,098,065	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)		1,066.84	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		48,008	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)		48,008	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet D-1	
				Component CCN: 15-T034		Date/Time Prepared: 11/25/2024 11:36 am	
				Title XIX	Subprovider - IRF	PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00	
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00	
44.00 CORONARY CARE UNIT						44.00	
45.00 BURN INTENSIVE CARE UNIT						45.00	
46.00 SURGICAL INTENSIVE CARE UNIT						46.00	
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00	
Cost Center Description						1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					22,068	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)					70,076	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)					2,573	50.00	
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,274	51.00	
52.00 Total Program excludable cost (sum of lines 50 and 51)					3,847	52.00	
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					66,229	53.00	
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0	54.00	
55.00 Target amount per discharge					0.00	55.00	
55.01 Permanent adjustment amount per discharge					0.00	55.01	
55.02 Adjustment amount per discharge (contractor use only)					0.00	55.02	
55.03 CAR T-cell amount paid as an interim payment						55.03	
56.00 Target amount ((line 54 x sum of lines 55, 55.01, and 55.02) plus line 55.03)					0	56.00	
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00	
58.00 Bonus payment (see instructions)					0	58.00	
59.00 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00	59.00	
60.00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00	60.00	
61.00 Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0	61.00	
62.00 Relief payment (see instructions)					0	62.00	
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00	
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00	
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00	
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					0	66.00	
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00	
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00	
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00	
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00	
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00	
72.00 Program routine service cost (line 9 x line 71)						72.00	
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00	
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00	
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00	
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00	
77.00 Program capital-related costs (line 9 x line 76)						77.00	
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00	
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00	
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00	
81.00 Inpatient routine service cost per diem limitation						81.00	
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00	
83.00 Reasonable inpatient routine service costs (see instructions)						83.00	
84.00 Program inpatient ancillary services (see instructions)						84.00	
85.00 Utilization review - physician compensation (see instructions)						85.00	
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00	
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0	87.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0034 Component CCN: 15-T034	Period: From 07/01/2023 To 06/30/2024	Worksheet D-1 Date/Time Prepared: 11/25/2024 11:36 am
		Title XIX	Subprovider - IRF	PPS

Cost Center Description						1.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 + line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	326,851	6,098,065	0.053599	0	0	90.00
91.00	Nursing Program cost	0	6,098,065	0.000000	0	0	91.00
92.00	Allied health cost	0	6,098,065	0.000000	0	0	92.00
93.00	All other Medical Education	0	6,098,065	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet D-3 Date/Time Prepared: 11/25/2024 11:36 am	
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		25,115,939	30.00
31.00	03100	INTENSIVE CARE UNIT		5,691,474	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.228466	13,327,381	50.00
51.00	05100	RECOVERY ROOM	0.305312	1,568,659	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.699183	5,402	52.00
53.00	05300	ANESTHESIOLOGY	0.023543	2,744,828	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136839	3,071,311	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.077557	86,023	55.00
56.00	05600	RADIOISOTOPE	0.114149	673,659	56.00
57.00	05700	CT SCAN	0.050057	8,608,574	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.065813	2,597,997	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.070122	10,312,244	59.00
60.00	06000	LABORATORY	0.098497	14,159,357	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.352740	1,023,870	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.269861	4,272,438	65.00
66.00	06600	PHYSICAL THERAPY	0.304136	960,302	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.257170	518,787	67.00
68.00	06800	SPEECH PATHOLOGY	0.426854	278,680	68.00
69.00	06900	ELECTROCARDIOLOGY	0.066685	4,319,322	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.104727	130,389	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.434497	5,563,887	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.461412	6,123,553	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.171595	14,714,579	73.00
74.00	07400	RENAL DIALYSIS	0.266861	1,621,604	74.00
76.97	07697	CARDIAC REHABILITATION	0.541943	111,036	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.410863	52,683	90.00
91.00	09100	EMERGENCY	0.101371	13,459,392	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.269230	1,198,834	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		111,504,791	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)		111,504,791	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0034 Component CCN: 15-T034	Period: From 07/01/2023 To 06/30/2024	Worksheet D-3 Date/Time Prepared: 11/25/2024 11:36 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF		6,653,094	41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.228466	48,296	11,034 50.00
51.00	05100 RECOVERY ROOM	0.305312	2,821	861 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.699183	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0.023543	6,378	150 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.136839	111,066	15,198 54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.077557	0	0 55.00
56.00	05600 RADIOISOTOPE	0.114149	10,861	1,240 56.00
57.00	05700 CT SCAN	0.050057	162,264	8,122 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.065813	29,184	1,921 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.070122	0	0 59.00
60.00	06000 LABORATORY	0.098497	777,991	76,630 60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.352740	31,704	11,183 63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0 64.00
65.00	06500 RESPIRATORY THERAPY	0.269861	416,178	112,310 65.00
66.00	06600 PHYSICAL THERAPY	0.304136	1,811,204	550,852 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.257170	1,759,869	452,586 67.00
68.00	06800 SPEECH PATHOLOGY	0.426854	231,574	98,848 68.00
69.00	06900 ELECTROCARDIOLOGY	0.066685	39,757	2,651 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.104727	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.434497	323,397	140,515 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.461412	4,328	1,997 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.171595	1,676,034	287,599 73.00
74.00	07400 RENAL DIALYSIS	0.266861	148,553	39,643 74.00
76.97	07697 CARDIAC REHABILITATION	0.541943	0	0 76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.410863	0	0 90.00
91.00	09100 EMERGENCY	0.101371	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.269230	0	0 92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		7,591,459	1,813,340 200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00	Net charges (line 200 minus line 201)		7,591,459	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet D-3 Date/Time Prepared: 11/25/2024 11:36 am
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Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		1,736,497		30.00
31.00	03100 INTENSIVE CARE UNIT		406,650		31.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY		109,820		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.228466	582,502	133,082	50.00
51.00	05100 RECOVERY ROOM	0.305312	37,650	11,495	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.699183	16,476	11,520	52.00
53.00	05300 ANESTHESIOLOGY	0.023543	83,378	1,963	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.136839	149,430	20,448	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.077557	0	0	55.00
56.00	05600 RADIOISOTOPE	0.114149	40,240	4,593	56.00
57.00	05700 CT SCAN	0.050057	524,984	26,279	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.065813	126,119	8,300	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.070122	39,371	2,761	59.00
60.00	06000 LABORATORY	0.098497	937,463	92,337	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.352740	26,412	9,317	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.269861	225,634	60,890	65.00
66.00	06600 PHYSICAL THERAPY	0.304136	36,161	10,998	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.257170	24,249	6,236	67.00
68.00	06800 SPEECH PATHOLOGY	0.426854	21,865	9,333	68.00
69.00	06900 ELECTROCARDIOLOGY	0.066685	216,584	14,443	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.104727	53,995	5,655	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.434497	176,190	76,554	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.461412	67,635	31,208	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.171595	1,120,618	192,292	73.00
74.00	07400 RENAL DIALYSIS	0.266861	145,049	38,708	74.00
76.97	07697 CARDIAC REHABILITATION	0.541943	1,935	1,049	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.410863	0	0	90.00
91.00	09100 EMERGENCY	0.101371	524,522	53,171	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.269230	61,133	16,459	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		5,239,595	839,091	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		5,239,595		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0034 Component CCN: 15-T034	Period: From 07/01/2023 To 06/30/2024	Worksheet D-3 Date/Time Prepared: 11/25/2024 11:36 am
		Title XIX	Subprovider - IRF	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF		79,370	41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.228466	0	50.00
51.00	05100 RECOVERY ROOM	0.305312	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.699183	0	52.00
53.00	05300 ANESTHESIOLOGY	0.023543	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.136839	967	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.077557	0	55.00
56.00	05600 RADIOISOTOPE	0.114149	0	56.00
57.00	05700 CT SCAN	0.050057	6,819	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.065813	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.070122	0	59.00
60.00	06000 LABORATORY	0.098497	10,962	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.352740	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.269861	3,047	65.00
66.00	06600 PHYSICAL THERAPY	0.304136	21,840	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.257170	23,900	67.00
68.00	06800 SPEECH PATHOLOGY	0.426854	4,237	68.00
69.00	06900 ELECTROCARDIOLOGY	0.066685	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.104727	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.434497	3,287	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.461412	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.171595	21,378	73.00
74.00	07400 RENAL DIALYSIS	0.266861	0	74.00
76.97	07697 CARDIAC REHABILITATION	0.541943	0	76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.410863	0	90.00
91.00	09100 EMERGENCY	0.101371	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.269230	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		96,437	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00	Net charges (line 200 minus line 201)		96,437	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet E Part A Date/Time Prepared: 11/25/2024 11:36 am
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		7,413,464	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		22,763,698	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		27,091	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		67,623	2.04
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		163.53	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
5.01	FTE cap adjustment for qualifying hospitals under §131 of the CAA 2021 (see instructions)		0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)		0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)		0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)		0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.38	30.00
31.00	Percentage of Medicaid patient days (see instructions)		15.63	31.00
32.00	Sum of lines 30 and 31		19.01	32.00
33.00	Allowable disproportionate share percentage (see instructions)		5.11	33.00
34.00	Disproportionate share adjustment (see instructions)		385,513	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet E Part A Date/Time Prepared: 11/25/2024 11:36 am
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Payment Adjustment				
35.00	Total uncompensated care amount (see instructions)	6,874,403,459	5,938,006,757	35.00
35.01	Factor 3 (see instructions)	0.000148207	0.000134948	35.01
35.02	Hospital UCP, including supplemental UCP (see instructions)	1,018,837	801,323	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	256,803	599,898	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	856,701		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges (see instructions)		0	40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges (see instructions)		0	41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)		0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	46.00
47.00	Subtotal (see instructions)	31,514,090		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	48.00
				Amount
				1.00
49.00	Total payment for inpatient operating costs (see instructions)		31,514,090	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,423,416	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		15,989	53.00
54.00	Special add-on payments for new technologies		22,012	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
55.01	Cellular therapy acquisition cost (see instructions)		0	55.01
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		16,583	58.00
59.00	Total (sum of amounts on lines 49 through 58)		33,992,090	59.00
60.00	Primary payer payments		9,460	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		33,982,630	61.00
62.00	Deductibles billed to program beneficiaries		3,075,168	62.00
63.00	Coinurance billed to program beneficiaries		83,256	63.00
64.00	Allowable bad debts (see instructions)		259,024	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		168,366	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		21,412	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		30,992,572	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)		0	70.75
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		20,015	70.93
70.94	HRR adjustment amount (see instructions)		-272,194	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet E Part A Date/Time Prepared: 11/25/2024 11:36 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0		0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0		0	70.97
70.98	Low Volume Payment-3	0		0	70.98
70.99	HAC adjustment amount (see instructions)			0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			30,740,393	71.00
71.01	Sequestration adjustment (see instructions)			614,808	71.01
71.02	Demonstration payment adjustment amount after sequestration			0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			0	71.03
72.00	Interim payments			30,054,061	72.00
72.01	Interim payments-PARHM				72.01
73.00	Tentative settlement (for contractor use only)			0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)				73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)			71,524	74.00
74.01	Balance due provider/program-PARHM (see instructions)				74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			803,902	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. 1, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. 11, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet E Part B Date/Time Prepared: 11/25/2024 11:36 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		16,290	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		31,258,593	2.00
3.00	OPPS or REH payments		31,408,012	3.00
4.00	Outlier payment (see instructions)		3,202	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		18,248	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		16,290	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		81,356	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)		81,356	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)		81,356	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		65,066	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)		16,290	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)		31,429,462	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)		5,646,817	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)		25,798,935	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)		25,798,935	30.00
31.00	Primary payer payments		10,844	31.00
32.00	Subtotal (line 30 minus line 31)		25,788,091	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)		458,349	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		297,927	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		270,097	36.00
37.00	Subtotal (see instructions)		26,086,018	37.00
38.00	MSP-LCC reconciliation amount from PS&R		48	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.75	N95 respirator payment adjustment amount (see instructions)		0	39.75
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		26,085,970	40.00
40.01	Sequestration adjustment (see instructions)		521,719	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		25,603,432	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)		-39,181	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		35,000	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: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet E Part B Date/Time Prepared: 11/25/2024 11:36 am
		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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0034 Component CCN: 15-T034	Period: From 07/01/2023 To 06/30/2024	Worksheet E Part B Date/Time Prepared: 11/25/2024 11:36 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		62	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		62	2.00
3.00	OPPS or REH payments		124	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)		62	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		364	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)		364	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		364	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		302	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)		62	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)		124	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)		17	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)		169	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)		169	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		169	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)		169	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)		169	40.00
40.01	Sequestration adjustment (see instructions)		3	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		177	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)		-11	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0034 Component CCN: 15-T034	Period: From 07/01/2023 To 06/30/2024	Worksheet E Part B Date/Time Prepared: 11/25/2024 11:36 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00
				1.00
MEDI CARE PART B ANCI LLARY COSTS				
200.00	Part B Combined Billed Days			200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0034

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

Worksheet E-1
Part I
Date/Time Prepared:
11/25/2024 11:36 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		30,054,061		25,603,432	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		30,054,061		25,603,432	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		71,524		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		39,181	6.02	
7.00	Total Medicare program liability (see instructions)		30,125,585		25,564,251	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 15-0034 Component CCN: 15-T034	Period: From 07/01/2023 To 06/30/2024	Worksheet E-1 Part I Date/Time Prepared: 11/25/2024 11:36 am	
		Title XVIII	Subprovider - IRF	PPS	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider				177 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		7,426,132		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)				0 3.00
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0 3.01
3.02			0		0 3.02
3.03			0		0 3.03
3.04			0		0 3.04
3.05			0		0 3.05
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0 3.50
3.51			0		0 3.51
3.52			0		0 3.52
3.53			0		0 3.53
3.54			0		0 3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0 3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		7,426,132		177 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)				0 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)				0 6.00
6.01	SETTLEMENT TO PROVIDER		0		0 6.01
6.02	SETTLEMENT TO PROGRAM		45,840		11 6.02
7.00	Total Medicare program liability (see instructions)		7,380,292		166 7.00
				Contractor Number	NPR Date (Mo/Day/Yr)
			0	1.00	2.00
8.00	Name of Contractor				0 8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet E-1 Part II Date/Time Prepared: 11/25/2024 11:36 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days (see instructions)			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days (see instructions)			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0034 Component CCN: 15-T034	Period: From 07/01/2023 To 06/30/2024	Worksheet E-3 Part III Date/Time Prepared: 11/25/2024 11:36 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)		7,389,014	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)		0.0103	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)		200,981	3.00
4.00	Outlier Payments		34,455	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)		0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	5.01
6.00	New Teaching program adjustment. (see instructions)		0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)		0.00	9.00
10.00	Average Daily Census (see instructions)		15.617486	10.00
11.00	Teaching Adjustment Factor (see instructions)		0.000000	11.00
12.00	Teaching Adjustment (see instructions)		0	12.00
13.00	Total PPS Payment (see instructions)		7,624,450	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)		0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		0	15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)		0	16.00
17.00	Subtotal (see instructions)		7,624,450	17.00
18.00	Primary payer payments		0	18.00
19.00	Subtotal (line 17 less line 18).		7,624,450	19.00
20.00	Deductibles		38,816	20.00
21.00	Subtotal (line 19 minus line 20)		7,585,634	21.00
22.00	Coinsurance		59,160	22.00
23.00	Subtotal (line 21 minus line 22)		7,526,474	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		6,583	24.00
25.00	Adjusted reimbursable bad debts (see instructions)		4,279	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		117	26.00
27.00	Subtotal (sum of lines 23 and 25)		7,530,753	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	28.00
29.00	Other pass through costs (see instructions)		157	29.00
30.00	Outlier payments reconciliation		0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	31.50
31.98	Recovery of accelerated depreciation.		0	31.98
31.99	Demonstration payment adjustment amount before sequestration		0	31.99
32.00	Total amount payable to the provider (see instructions)		7,530,910	32.00
32.01	Sequestration adjustment (see instructions)		150,618	32.01
32.02	Demonstration payment adjustment amount after sequestration		0	32.02
33.00	Interim payments		7,426,132	33.00
34.00	Tentative settlement (for contractor use only)		0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)		-45,840	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4		34,455	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00
FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)				
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.		0.000000	99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)		0.000000	99.01

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT		Provider CCN: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet E-5 Date/Time Prepared: 11/25/2024 11:36 am
Title XVIII			PPS	
			1.00	
TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2		0	2.00
3.00	Operating outlier reconciliation adjustment amount (see instructions)		0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instructions)		0	4.00
5.00	The rate used to calculate the time value of money (see instructions)		0.00	5.00
6.00	Time value of money for operating expenses (see instructions)		0	6.00
7.00	Time value of money for capital related expenses (see instructions)		0	7.00

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

Provider CCN: 15-0034

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

Worksheet G

Date/Time Prepared:
11/25/2024 11:36 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	2,375	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	39,070,035	0	0	0	4.00
5.00	Other receivable	862,793	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	6,260,181	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	2,076,998	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)	48,272,382	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	153,072,883	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	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)	153,072,883	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	10,366,939	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	10,366,939	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	211,712,204	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,804,770	0	0	0	37.00
38.00	Salaries, wages, and fees payable	7,061,433	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	3,785,666	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	12,651,869	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	3,837,867	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	3,837,867	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	16,489,736	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	195,222,468	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)	195,222,468	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	211,712,204	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0034

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

Worksheet G-1

Date/Time Prepared:
11/25/2024 11:36 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		189,563,029		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		36,422,246			2.00
3.00	Total (sum of line 1 and line 2)		225,985,275		0	3.00
4.00	RESTRICTED CONTRIBUTIONS	81,329		0		4.00
5.00	NET ASSETS RELEASED-CAPITAL	24,322		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		105,651		0	10.00
11.00	Subtotal (line 3 plus line 10)		226,090,926		0	11.00
12.00	TRANSFERRED TO/FROM AFFILIATES	30,811,573		0		12.00
13.00	FUND TRANSFER	324		0		13.00
14.00	NET ASSETS RELEASED-OPERATING	32,240		0		14.00
15.00	NET ASSETS RELEASED-CAPITAL	24,321		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		30,868,458		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		195,222,468		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	RESTRICTED CONTRIBUTIONS		0			4.00
5.00	NET ASSETS RELEASED-CAPITAL		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	TRANSFERRED TO/FROM AFFILIATES		0			12.00
13.00	FUND TRANSFER		0			13.00
14.00	NET ASSETS RELEASED-OPERATING		0			14.00
15.00	NET ASSETS RELEASED-CAPITAL		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: 15-0034

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/25/2024 11:36 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	78,018,420		78,018,420	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	10,355,680		10,355,680	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	88,374,100		88,374,100	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	18,621,889		18,621,889	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)	18,621,889		18,621,889	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	106,995,989		106,995,989	17.00
18.00	Ancillary services	343,539,054		343,539,054	18.00
19.00	Outpatient services	0	940,895,235	940,895,235	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		6,017,390	6,017,390	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	TAXABLE LAB	0	4,162,018	4,162,018	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	450,535,043	951,074,643	1,401,609,686	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		306,512,924		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)		306,512,924		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet G-3 Date/Time Prepared: 11/25/2024 11:36 am
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		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,401,609,686	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,062,605,341	2.00
3.00	Net patient revenues (line 1 minus line 2)	339,004,345	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	306,512,924	4.00
5.00	Net income from service to patients (line 3 minus line 4)	32,491,421	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	1,035	6.00
7.00	Income from investments	219,238	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	1,474,510	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	17,314	21.00
22.00	Rental of hospital space	1,321,482	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	315,057	24.00
24.01	TEMP ASSETS RELEASED FROM RESTRICTION	32,240	24.01
24.02	UBI INCOME	223,074	24.02
24.03	CLASSES	59,931	24.03
24.04	GAIN ON SALE OF ASSETS	34,188	24.04
24.05	GRANT INCOME	232,756	24.05
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	3,930,825	25.00
26.00	Total (line 5 plus line 25)	36,422,246	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	36,422,246	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-0034

Period: From 07/01/2023

Worksheet H

HHA CCN: 15-7313

To 06/30/2024

Date/Time Prepared: 11/25/2024 11:36 am

Home Health Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col.s. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00			0		0	0	1.00
2.00			0		0	0	2.00
3.00	0	0	0	0	0	0	3.00
4.00	0	0	0	0	0	0	4.00
5.00	711,835	71,411	0	11,964	124,123	919,333	5.00
HHA REIMBURSABLE SERVICES							
6.00	1,015,145	101,839	76,707	24,562	0	1,218,253	6.00
7.00	861,187	86,394	32,870	0	0	980,451	7.00
8.00	221,098	22,180	17,960	0	0	261,238	8.00
9.00	50,847	5,101	318	0	0	56,266	9.00
10.00	0	0	0	0	0	0	10.00
11.00	7,618	764	1,617	0	0	9,999	11.00
12.00	0	0	0	0	95,645	95,645	12.00
13.00	0	0	0	0	0	0	13.00
14.00	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	0	0	0	0	0	0	15.00
16.00	0	0	0	0	0	0	16.00
17.00	0	0	0	0	0	0	17.00
18.00	0	0	0	0	0	0	18.00
19.00	0	0	0	0	0	0	19.00
20.00	0	0	0	0	0	0	20.00
21.00	0	0	0	0	0	0	21.00
22.00	0	0	0	0	0	0	22.00
23.00	0	0	0	0	0	0	23.00
23.50	0	0	0	0	0	0	23.50
24.00	2,867,730	287,689	129,472	36,526	219,768	3,541,185	24.00
	Reclassified	Reclassified	Adjustments	Net Expenses			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00	0	0	0	0			1.00
2.00	0	0	0	0			2.00
3.00	0	0	0	0			3.00
4.00	0	0	0	0			4.00
5.00	-3,420	915,913	-14,400	901,513			5.00
HHA REIMBURSABLE SERVICES							
6.00	0	1,218,253	0	1,218,253			6.00
7.00	-68,317	912,134	0	912,134			7.00
8.00	58,693	319,931	0	319,931			8.00
9.00	9,624	65,890	0	65,890			9.00
10.00	0	0	0	0			10.00
11.00	0	9,999	0	9,999			11.00
12.00	0	95,645	0	95,645			12.00
13.00	0	0	0	0			13.00
14.00	0	0	0	0			14.00
HHA NONREIMBURSABLE SERVICES							
15.00	0	0	0	0			15.00
16.00	0	0	0	0			16.00
17.00	0	0	0	0			17.00
18.00	0	0	0	0			18.00
19.00	0	0	0	0			19.00
20.00	0	0	0	0			20.00
21.00	0	0	0	0			21.00
22.00	0	0	0	0			22.00
23.00	0	0	0	0			23.00
23.50	0	0	0	0			23.50
24.00	-3,420	3,537,765	-14,400	3,523,365			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 15-0034	Period: From 07/01/2023	Worksheet H-1
		HHA CCN: 15-7313	To 06/30/2024	Part I
				Date/Time Prepared: 11/25/2024 11:36 am
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	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)		
		Bldgs & Fixtures	Movable Equipment					
		1.00	2.00					3.00
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00	
2.00	Capital Related - Movable Equipment	0	0			0	2.00	
3.00	Plant Operation & Maintenance	0	0	0		0	3.00	
4.00	Transportation	0	0	0	0	0	4.00	
5.00	Administrative and General	901,513	0	0	0	901,513	5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	1,218,253	0	0	0	1,218,253	6.00	
7.00	Physical Therapy	912,134	0	0	0	912,134	7.00	
8.00	Occupational Therapy	319,931	0	0	0	319,931	8.00	
9.00	Speech Pathology	65,890	0	0	0	65,890	9.00	
10.00	Medical Social Services	0	0	0	0	0	10.00	
11.00	Home Health Aide	9,999	0	0	0	9,999	11.00	
12.00	Supplies (see instructions)	95,645	0	0	0	95,645	12.00	
13.00	Drugs	0	0	0	0	0	13.00	
14.00	DME	0	0	0	0	0	14.00	
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	23.00	
23.50	Telemedicine	0	0	0	0	0	23.50	
24.00	Total (sum of lines 1-23)	3,523,365	0	0	0	3,523,365	24.00	
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures						1.00	
2.00	Capital Related - Movable Equipment						2.00	
3.00	Plant Operation & Maintenance						3.00	
4.00	Transportation						4.00	
5.00	Administrative and General	901,513					5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	418,891	1,637,144				6.00	
7.00	Physical Therapy	313,634	1,225,768				7.00	
8.00	Occupational Therapy	110,007	429,938				8.00	
9.00	Speech Pathology	22,656	88,546				9.00	
10.00	Medical Social Services	0	0				10.00	
11.00	Home Health Aide	3,438	13,437				11.00	
12.00	Supplies (see instructions)	32,887	128,532				12.00	
13.00	Drugs	0	0				13.00	
14.00	DME	0	0				14.00	
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0				15.00	
16.00	Respiratory Therapy	0	0				16.00	
17.00	Private Duty Nursing	0	0				17.00	
18.00	Clinic	0	0				18.00	
19.00	Health Promotion Activities	0	0				19.00	
20.00	Day Care Program	0	0				20.00	
21.00	Home Delivered Meals Program	0	0				21.00	
22.00	Homemaker Service	0	0				22.00	
23.00	All Others (specify)	0	0				23.00	
23.50	Telemedicine	0	0				23.50	
24.00	Total (sum of lines 1-23)		3,523,365				24.00	

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 15-0034
HHA CCN: 15-7313

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

Worksheet H-1
Part II
Date/Time Prepared:
11/25/2024 11:36 am
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	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	100			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	100	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	100	0	100	0	-901,513	2,621,852
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	1,218,253	6.00
7.00	Physical Therapy	0	0	0	0	912,134	7.00
8.00	Occupational Therapy	0	0	0	0	319,931	8.00
9.00	Speech Pathology	0	0	0	0	65,890	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	9,999	11.00
12.00	Supplies (see instructions)	0	0	0	0	95,645	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	100	0	100	0	-901,513	2,621,852
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0	901,513	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000	0.343846	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0034

Period: From 07/01/2023

Worksheet H-2

HHA CCN: 15-7313

To 06/30/2024

Part I Date/Time Prepared: 11/25/2024 11:36 am

Home Health Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	PURCHASING RECEIVING AND STORES	ADMITTING	
		BLDG & FIXT	MVBLE EQUIP				
		1.00	2.00				
1.00 Administrative and General	0	0	2,013	128,367	157	18,154	1.00
2.00 Skilled Nursing Care	1,637,144	0	0	183,065	0	0	2.00
3.00 Physical Therapy	1,225,768	0	0	155,300	0	0	3.00
4.00 Occupational Therapy	429,938	0	0	39,871	0	0	4.00
5.00 Speech Pathology	88,546	0	0	9,169	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	13,437	0	0	1,374	0	0	7.00
8.00 Supplies (see instructions)	128,532	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19) (2)	3,523,365	0	2,013	517,146	157	18,154	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
	5.03	5A.03	5.04	7.00	8.00	9.00	
	1.00 Administrative and General	13,804	162,495	24,420	0	0	0
2.00 Skilled Nursing Care	0	1,820,209	273,543	0	0	0	2.00
3.00 Physical Therapy	0	1,381,068	207,548	0	0	0	3.00
4.00 Occupational Therapy	0	469,809	70,603	0	0	0	4.00
5.00 Speech Pathology	0	97,715	14,685	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	14,811	2,226	0	0	0	7.00
8.00 Supplies (see instructions)	0	128,532	19,316	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19) (2)	13,804	4,074,639	612,341	0	0	0	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		0.000000					21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0034

Period: From 07/01/2023

Worksheet H-2 Part I

HHA CCN: 15-7313

To 06/30/2024

Date/Time Prepared: 11/25/2024 11:36 am

Home Health Agency I

PPS

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		10.00	11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	10,707	0	0	0	13,707	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	10,707	0	0	0	13,707	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	PARAMEDICAL EDUCATION PROGRAM EMS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		17.00	19.00	23.00	24.00	25.00	26.00	
1.00	Administrative and General	0	0	0	211,329	0	211,329	1.00
2.00	Skilled Nursing Care	0	0	0	2,093,752	0	2,093,752	2.00
3.00	Physical Therapy	0	0	0	1,588,616	0	1,588,616	3.00
4.00	Occupational Therapy	0	0	0	540,412	0	540,412	4.00
5.00	Speech Pathology	0	0	0	112,400	0	112,400	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	17,037	0	17,037	7.00
8.00	Supplies (see instructions)	0	0	0	147,848	0	147,848	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	4,711,394	0	4,711,394	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0034

Period: From 07/01/2023

Worksheet H-2

HHA CCN: 15-7313

To 06/30/2024

Part I
Date/Time Prepared:
11/25/2024 11:36 am

Home Health
Agency I

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Cost Center Description		Allocated HHA A&G (see Part II)	Total HHA Costs		
		27.00	28.00		
1.00	Administrative and General				1.00
2.00	Skilled Nursing Care	98,327	2,192,079		2.00
3.00	Physical Therapy	74,603	1,663,219		3.00
4.00	Occupational Therapy	25,378	565,790		4.00
5.00	Speech Pathology	5,278	117,678		5.00
6.00	Medical Social Services	0	0		6.00
7.00	Home Health Aide	800	17,837		7.00
8.00	Supplies (see instructions)	6,943	154,791		8.00
9.00	Drugs	0	0		9.00
10.00	DME	0	0		10.00
11.00	Home Dialysis Aide Services	0	0		11.00
12.00	Respiratory Therapy	0	0		12.00
13.00	Private Duty Nursing	0	0		13.00
14.00	Clinic	0	0		14.00
15.00	Health Promotion Activities	0	0		15.00
16.00	Day Care Program	0	0		16.00
17.00	Home Delivered Meals Program	0	0		17.00
18.00	Homemaker Service	0	0		18.00
19.00	All Others (specify)	0	0		19.00
19.50	Telemedicine	0	0		19.50
20.00	Total (sum of lines 1-19) (2)	211,329	4,711,394		20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.046961			21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0034
HHA CCN: 15-7313

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

Worksheet H-2 Part II
Date/Time Prepared: 11/25/2024 11:36 am
PPS

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	PURCHASING RECEIVING AND STORES (COSTED REQ)	ADMITTING (GROSS REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00					
1.00 Administrative and General	0	4,596	711,835	2	6,017,237	6,017,237	1.00
2.00 Skilled Nursing Care	0	0	1,015,145	0	0	0	2.00
3.00 Physical Therapy	0	0	861,187	0	0	0	3.00
4.00 Occupational Therapy	0	0	221,098	0	0	0	4.00
5.00 Speech Pathology	0	0	50,847	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	7,618	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	0	4,596	2,867,730	2	6,017,237	6,017,237	20.00
21.00 Total cost to be allocated	0	2,013	517,146	157	18,154	13,804	21.00
22.00 Unit cost multiplier	0.000000	0.437990	0.180333	78.500000	0.003017	0.002294	22.00
Cost Center Description	Reconciliation	OTHER ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
	5A.04	5.04	7.00	8.00	9.00	10.00	
1.00 Administrative and General	0	162,495	0	0	0	0	1.00
2.00 Skilled Nursing Care	0	1,820,209	0	0	0	0	2.00
3.00 Physical Therapy	0	1,381,068	0	0	0	0	3.00
4.00 Occupational Therapy	0	469,809	0	0	0	0	4.00
5.00 Speech Pathology	0	97,715	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	14,811	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	128,532	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	0	4,074,639	0	0	0	0	20.00
21.00 Total cost to be allocated	0	612,341	0	0	0	0	21.00
22.00 Unit cost multiplier	0.000000	0.150281	0.000000	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0034

Period: From 07/01/2023

Worksheet H-2

HHA CCN: 15-7313

To 06/30/2024

Part II Date/Time Prepared: 11/25/2024 11:36 am

Home Health Agency I

PPS

Cost Center Description		CAFETERIA (NUMBER OF FTES)	NURSING ADMINISTRATION (NURSING HOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	17.00	
1.00	Administrative and General	9	0	0	0	6,017,237	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	9	0	0	0	6,017,237	0	20.00
21.00	Total cost to be allocated	10,707	0	0	0	13,707	0	21.00
22.00	Unit cost multiplier	1,189.666667	0.000000	0.000000	0.000000	0.002278	0.000000	22.00
Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	PARAMEDICAL EDUCATION PROGRAM EMS (ASSIGNED TIME)					
		19.00	23.00					
1.00	Administrative and General	0	0					1.00
2.00	Skilled Nursing Care	0	0					2.00
3.00	Physical Therapy	0	0					3.00
4.00	Occupational Therapy	0	0					4.00
5.00	Speech Pathology	0	0					5.00
6.00	Medical Social Services	0	0					6.00
7.00	Home Health Aide	0	0					7.00
8.00	Supplies (see instructions)	0	0					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
19.50	Telemedicine	0	0					19.50
20.00	Total (sum of lines 1-19)	0	0					20.00
21.00	Total cost to be allocated	0	0					21.00
22.00	Unit cost multiplier	0.000000	0.000000					22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet H-3 Part I Date/Time Prepared: 11/25/2024 11:36 am
		HHA CCN: 15-7313	Title XVIII	Home Health Agency I PPS

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

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	2,192,079		2,192,079	14,738	148.74	1.00
2.00	Physical Therapy	3.00	1,663,219	0	1,663,219	8,464	196.51	2.00
3.00	Occupational Therapy	4.00	565,790	0	565,790	3,574	158.31	3.00
4.00	Speech Pathology	5.00	117,678	0	117,678	586	200.82	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	17,837		17,837	384	46.45	6.00
7.00	Total (sum of lines 1-6)		4,556,603	0	4,556,603	27,746		7.00

Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits		Ratio (col. 3 ÷ col. 4)
				Not Subject to Deductibles & Coinsurance	Subject to Deductibles	
	0	1.00	2.00	3.00	4.00	5.00

Limitation Cost Computation							
8.00	Skilled Nursing Care		23844	0	5,809		8.00
9.00	Physical Therapy		23844	0	3,704		9.00
10.00	Occupational Therapy		23844	0	1,687		10.00
11.00	Speech Pathology		23844	0	262		11.00
12.00	Medical Social Services		23844	0	0		12.00
13.00	Home Health Aide		23844	0	169		13.00
14.00	Total (sum of lines 8-13)			0	11,631		14.00

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

Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	154,791	0	154,791	83,179	1.860938	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

Cost Center Description	Part A	Program Visits		Cost of Services	Part B	
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
	6.00	7.00	8.00	9.00	10.00	11.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	5,809		0	864,031	1.00
2.00	Physical Therapy	0	3,704		0	727,873	2.00
3.00	Occupational Therapy	0	1,687		0	267,069	3.00
4.00	Speech Pathology	0	262		0	52,615	4.00
5.00	Medical Social Services	0	0		0	0	5.00
6.00	Home Health Aide	0	169		0	7,850	6.00
7.00	Total (sum of lines 1-6)	0	11,631		0	1,919,438	7.00

Cost Center Description	6.00	7.00	8.00	9.00	10.00	11.00
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Limitation Cost Computation							
8.00	Skilled Nursing Care						8.00
9.00	Physical Therapy						9.00
10.00	Occupational Therapy						10.00
11.00	Speech Pathology						11.00
12.00	Medical Social Services						12.00
13.00	Home Health Aide						13.00
14.00	Total (sum of lines 8-13)						14.00

APPORTIONMENT OF PATIENT SERVICE COSTS			Provider CCN: 15-0034 HHA CCN: 15-7313		Period: From 07/01/2023 To 06/30/2024		Worksheet H-3 Part I Date/Time Prepared: 11/25/2024 11:36 am	
			Title XVIII		Home Health Agency I		PPS	
Cost Center Description	Program Covered Charges			Cost of Services				
	Part A	Part B			Part A	Part B		
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	6.00	7.00	8.00	9.00	10.00	11.00		
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	0	42,261	0	0	78,645	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00
Cost Center Description		Total Program Cost (sum of col.s. 9-10)						
		12.00						
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	864,031						1.00
2.00	Physical Therapy	727,873						2.00
3.00	Occupational Therapy	267,069						3.00
4.00	Speech Pathology	52,615						4.00
5.00	Medical Social Services	0						5.00
6.00	Home Health Aide	7,850						6.00
7.00	Total (sum of lines 1-6)	1,919,438						7.00
Cost Center Description								
		12.00						
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0034
HHA CCN: 15-7313

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

Worksheet H-3
Part II
Date/Time Prepared:
11/25/2024 11:36 am
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Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.304136	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.257170	0	0	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.426854	0	0	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.434497	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.171595	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0034 HHA CCN: 15-7313	Period: From 07/01/2023 To 06/30/2024	Worksheet H-4 Part I-11 Date/Time Prepared: 11/25/2024 11:36 am
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	755	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	-755
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	1,759,641
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	448,181
13.00	Total PPS Reimbursement - LUPA Episodes		0	22,853
14.00	Total PPS Reimbursement - PEP Episodes		0	2,879
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	133,406
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	545
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	2,366,750
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	2,366,750
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	2,366,750
27.00	Allowable bad debts (from your records)		0	0
27.01	Adjusted reimbursable bad debts (see instructions)		0	0
28.00	Allowable bad debts for dual eligible (see instructions)		0	0
29.00	Total costs - current cost reporting period (see instructions)		0	2,366,750
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
30.99	Demonstration payment adjustment amount before sequestration		0	0
31.00	Subtotal (see instructions)		0	2,366,750
31.01	Sequestration adjustment (see instructions)		0	47,330
31.02	Demonstration payment adjustment after sequestration		0	0
31.75	Sequestration adjustment for non-claims based amounts (see instructions)		0	0
32.00	Interim payments (see instructions)		0	2,319,421
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 31.75, 32, and 33)		0	-1
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 15-0034
HHA CCN: 15-7313

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

Worksheet H-5
Date/Time Prepared:
11/25/2024 11:36 am
PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		2,319,421	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			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		2,319,421	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		1	6.02
7.00	Total Medicare program liability (see instructions)		0		2,319,420	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
				0	1.00	2.00
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0034	Period: From 07/01/2023 To 06/30/2024	Worksheet L Parts I-III Date/Time Prepared: 11/25/2024 11:36 am
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		2,327,795	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		4,139	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		102.52	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		3.38	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		15.63	8.00
9.00	Sum of lines 7 and 8		19.01	9.00
10.00	Allowable disproportionate share percentage (see instructions)		3.93	10.00
11.00	Disproportionate share adjustment (see instructions)		91,482	11.00
12.00	Total prospective capital payments (see instructions)		2,423,416	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00