

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-3047		Period: From 05/01/2023 To 04/30/2024		Worksheet S-2 Part I Date/Time Prepared: 9/9/2024 1:53 pm	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	
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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-3047

Period:
From 05/01/2023
To 04/30/2024

Worksheet S-3
Part I
Date/Time Prepared:
9/9/2024 1:53 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P	Title V
	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	40	14,640	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)		40	14,640	0.00	0	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)		40	14,640	0.00	0	14.00
15.00 CAH visits					0	15.00
15.10 REH hours and visits				0.00	0	15.10
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	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)		40				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	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-3047

Period:
From 05/01/2023
To 04/30/2024

Worksheet S-3
Part I
Date/Time Prepared:
9/9/2024 1:53 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	4,232	246	11,053		1.00
2.00	HMO and other (see instructions)	1,261	1,153			2.00
3.00	HMO IPF Subprovider	0	0			3.00
4.00	HMO IRF Subprovider	0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0	0	0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	4,232	246	11,053		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)	4,232	246	11,053	0.00	110.07
15.00	CAH visits	0	0	0		15.00
15.10	REH hours and visits	0	0	0		15.10
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF					17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE					21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00
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	110.07
28.00	Observation Bed Days		0	0		28.00
29.00	Ambulance Trips	0				29.00
30.00	Employee discount days (see instruction)			0		30.00
31.00	Employee discount days - IRF			0		31.00
32.00	Labor & delivery days (see instructions)	0	0	0		32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		32.01
33.00	LTCH non-covered days	0				33.00
33.01	LTCH site neutral days and discharges	0				33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0		34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-3047

Period:
From 05/01/2023
To 04/30/2024

Worksheet S-3
Part I
Date/Time Prepared:
9/9/2024 1:53 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
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	305	14	764	1.00
2.00	HMO and other (see instructions)			86	80		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	305	14	764	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	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

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-3047

Period:
From 05/01/2023
To 04/30/2024

Worksheet A
Date/Time Prepared:
9/9/2024 1:53 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (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		3,057,208	3,057,208	321,861	3,379,069	1.00
2.00	00200		103,318	103,318	25,841	129,159	2.00
3.00	00300		347,702	347,702	-347,702	0	3.00
4.00	00400	622,591	1,046,357	1,668,948	0	1,668,948	4.00
5.00	00500	1,671,177	1,293,722	2,964,899	0	2,964,899	5.00
7.00	00700	37,990	398,425	436,415	0	436,415	7.00
8.00	00800	0	48,215	48,215	0	48,215	8.00
9.00	00900	145,742	47,415	193,157	0	193,157	9.00
10.00	01000	449,767	265,960	715,727	0	715,727	10.00
13.00	01300	394,722	37,678	432,400	0	432,400	13.00
16.00	01600	93,563	18,331	111,894	0	111,894	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	3,095,872	426,598	3,522,470	0	3,522,470	30.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	68,561	68,561	-6,589	61,972	54.00
57.00	05700	0	0	0	5,430	5,430	57.00
58.00	05800	0	0	0	1,159	1,159	58.00
60.00	06000	0	40,032	40,032	0	40,032	60.00
65.00	06500	93,309	48,637	141,946	0	141,946	65.00
66.00	06600	630,779	80,978	711,757	-78,235	633,522	66.00
67.00	06700	542,819	45,123	587,942	58,215	646,157	67.00
68.00	06800	249,171	22,681	271,852	20,020	291,872	68.00
71.00	07100	46,409	161,730	208,139	0	208,139	71.00
73.00	07300	382,368	297,550	679,918	0	679,918	73.00
74.00	07400	0	232,169	232,169	0	232,169	74.00
76.00	03950	0	-91,984	-91,984	0	-91,984	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	0	0	0	0	0	91.00
91.01	04951	0	0	0	0	0	91.01
93.00	04950	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
117.00	06950	0	0	0	0	0	117.00
118.00		8,456,279	7,996,406	16,452,685	0	16,452,685	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00		8,456,279	7,996,406	16,452,685	0	16,452,685	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-3047

Period:
From 05/01/2023
To 04/30/2024

Worksheet A
Date/Time Prepared:
9/9/2024 1:53 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	96,984	3,476,053	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	14,838	143,997	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-3,901	1,665,047	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,269,814	4,234,713	5.00
7.00	00700	OPERATION OF PLANT	-9,690	426,725	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	48,215	8.00
9.00	00900	HOUSEKEEPING	0	193,157	9.00
10.00	01000	DIETARY	-5,866	709,861	10.00
13.00	01300	NURSING ADMINISTRATION	0	432,400	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-18	111,876	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	3,522,470	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	61,972	54.00
57.00	05700	CT SCAN	0	5,430	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,159	58.00
60.00	06000	LABORATORY	0	40,032	60.00
65.00	06500	RESPIRATORY THERAPY	-57	141,889	65.00
66.00	06600	PHYSICAL THERAPY	0	633,522	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	646,157	67.00
68.00	06800	SPEECH PATHOLOGY	0	291,872	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-1,218	206,921	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	679,918	73.00
74.00	07400	RENAL DIALYSIS	0	232,169	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	102,861	10,877	76.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,463,747	17,916,432	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	MARKETING	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	1,463,747	17,916,432	200.00

Provider CCN: 15-3047

Period:
From 05/01/2023
To 04/30/2024

Worksheet A-6
Date/Time Prepared:
9/9/2024 1:53 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - RCLS PCT THERAPY					
1.00	OCCUPATIONAL THERAPY	67.00	52,970	5,245	1.00
2.00	SPEECH PATHOLOGY	68.00	18,216	1,804	2.00
	TOTALS		71,186	7,049	
B - RCLS CT & MRI FROM RADIOLOGY					
1.00	CT SCAN	57.00	0	5,430	1.00
2.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	1,159	2.00
	TOTALS		0	6,589	
500.00	Grand Total: Increases		71,186	13,638	500.00

Provider CCN: 15-3047

Period:
From 05/01/2023
To 04/30/2024

Worksheet A-6
Date/Time Prepared:
9/9/2024 1:53 pm

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - RCLS PCT THERAPY						
1.00	PHYSICAL THERAPY	66.00	71,186	7,049	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		71,186	7,049		
B - RCLS CT & MRI FROM RADIOLOGY						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	6,589	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		0	6,589		
500.00	Grand Total: Decreases		71,186	13,638		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-3047

Period:
From 05/01/2023
To 04/30/2024

Worksheet A-7
Part I
Date/Time Prepared:
9/9/2024 1:53 pm

		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	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	19,911,038	1,215	0	1,215	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	95,810	-286,875	0	-286,875	0	5.00
6.00	Movable Equipment	2,791,778	-1,208,424	0	-1,208,424	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	22,798,626	-1,494,084	0	-1,494,084	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	22,798,626	-1,494,084	0	-1,494,084	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	19,912,253	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	-191,065	0				5.00
6.00	Movable Equipment	1,583,354	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	21,304,542	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	21,304,542	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-3047

Period:
From 05/01/2023
To 04/30/2024

Worksheet A-7
Part II
Date/Time Prepared:
9/9/2024 1:53 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	447,006	2,584,564	25,638	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	72,429	30,889	0	0	0	2.00
3.00	Total (sum of lines 1-2)	519,435	2,615,453	25,638	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	3,057,208				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	103,318				2.00
3.00	Total (sum of lines 1-2)	0	3,160,526				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-3047

Period:
From 05/01/2023
To 04/30/2024

Worksheet A-7
Part III
Date/Time Prepared:
9/9/2024 1:53 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	19,721,188	0	19,721,188	0.925680	37,968	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,583,354	0	1,583,354	0.074320	3,048	2.00
3.00	Total (sum of lines 1-2)	21,304,542	0	21,304,542	1.000000	41,016	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of col s. 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	283,893	0	321,861	543,990	2,584,564	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	22,793	0	25,841	87,267	30,889	2.00
3.00	Total (sum of lines 1-2)	306,686	0	347,702	631,257	2,615,453	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 col s. 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	25,638	37,968	283,893	0	3,476,053	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,048	22,793	0	143,997	2.00
3.00	Total (sum of lines 1-2)	25,638	41,016	306,686	0	3,620,050	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-3047

Period:
From 05/01/2023
To 04/30/2024

Worksheet A-8

Date/Time Prepared:
9/9/2024 1:53 pm

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)	A	-1,834		ADMINISTRATIVE & GENERAL	5.00		0	7.00
8.00 Television and radio service (chapter 21)	A	-6,846		OPERATION OF PLANT	7.00		0	8.00
9.00 Parking lot (chapter 21)			0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2		0				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	1,331,253					0	12.00
13.00 Laundry and linen service			0		0.00		0	13.00
14.00 Cafeteria-employees and guests	B	-5,866		DIETARY	10.00		0	14.00
15.00 Rental of quarters to employee and others			0		0.00		0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00		0	16.00
17.00 Sale of drugs to other than patients			0		0.00		0	17.00
18.00 Sale of medical records and abstracts	B	-18		MEDICAL RECORDS & LIBRARY	16.00		0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)			0		0.00		0	19.00
20.00 Vending machines			0		0.00		0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00		0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00		0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00		0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00		0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00			28.00
29.00 Physicians' assistant			0		0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00			30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00			30.99
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 INTEREST INCOME	B	-1,582		ADMINISTRATIVE & GENERAL	5.00		0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-3047

Period:
From 05/01/2023
To 04/30/2024

Worksheet A-8

Date/Time Prepared:
9/9/2024 1:53 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
33.02	MISC INCOME	B	-8,641	ADMINISTRATIVE & GENERAL	5.00	0 33.02
33.04	PRE-OPENING AMORTIZATION - CAP	A	81,895	CAP REL COSTS-BLDG & FIXT	1.00	9 33.04
33.05	PRE-OPENING AMORTIZATION - A&G	A	260,734	ADMINISTRATIVE & GENERAL	5.00	0 33.05
33.08	OTHER EXPENSE-ADVERTISING/MARKETING-OTHER	A	-7,007	ADMINISTRATIVE & GENERAL	5.00	0 33.08
33.14	EXPENSE-ADVERTISING/MARKETING-OTHER	A	-9,800	ADMINISTRATIVE & GENERAL	5.00	0 33.14
33.22	BAD DEBT EXPENSE-BAD DEBT--	A	-208,756	ADMINISTRATIVE & GENERAL	5.00	0 33.22
33.35	OTHER EXPENSE-CONTRIBUTIONS / SPONSO	A	-8,322	ADMINISTRATIVE & GENERAL	5.00	0 33.35
33.56	OTHER EXPENSE-FLOWERS & GIFTS--	A	-274	ADMINISTRATIVE & GENERAL	5.00	0 33.56
33.57	OTHER EXPENSE-FLOWERS & GIFTS--	A	-314	ADMINISTRATIVE & GENERAL	5.00	0 33.57
33.67	OTHER EXPENSE-PUBLIC INFORMATION--	A	-50	ADMINISTRATIVE & GENERAL	5.00	0 33.67
33.91	OTHER EXPENSE-GIVEAWAYS--	A	-1,930	ADMINISTRATIVE & GENERAL	5.00	0 33.91
33.93	OTHER EXPENSE-GIVEAWAYS--	A	-7,071	ADMINISTRATIVE & GENERAL	5.00	0 33.93
34.06	OTHER FEES-LATE FEES--	A	-57	RESPIRATORY THERAPY	65.00	0 34.06
34.10	OTHER FEES-LATE FEES--	A	-1,218	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0 34.10
34.13	OTHER FEES-LATE FEES--	A	-2,844	OPERATION OF PLANT	7.00	0 34.13
34.18	OTHER FEES-LATE FEES--	A	-932	ADMINISTRATIVE & GENERAL	5.00	0 34.18
34.21	OTHER FEES-LATE FEES--	A	-130	ADMINISTRATIVE & GENERAL	5.00	0 34.21
34.23	OTHER FEES-LATE FEES--	A	-15	ADMINISTRATIVE & GENERAL	5.00	0 34.23
34.46	TAXES-SALES TAX--	A	-424	ADMINISTRATIVE & GENERAL	5.00	0 34.46
34.54	MARKETING EXPENSE	A	-9,403	ADMINISTRATIVE & GENERAL	5.00	0 34.54
34.55	MARKETING BENEFITS	A	-1,014	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 34.55
34.56	TELEPHONE OPERATOR EXPENSE	A	-23,500	ADMINISTRATIVE & GENERAL	5.00	0 34.56
34.57	TELEPHONE BENEFIT EXPENSE	A	-2,887	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 34.57
34.59	UNALLOWABLE LOBBYING % OF ASSOC DUES	A	-2,261	ADMINISTRATIVE & GENERAL	5.00	0 34.59
34.63	PRIOR PD ACCR REVERSALS AND INVOICES	A	102,861	OTHER ANCILLARY SERVICE COST CENTERS	76.00	0 34.63
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1,463,747			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.

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-3047

Period:
From 05/01/2023
To 04/30/2024

Worksheet B
Part I
Date/Time Prepared:
9/9/2024 1:53 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	3,476,053	3,476,053			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	143,997		143,997		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,665,047	12,502	518	1,678,067	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	4,234,713	228,794	9,478	357,986	4,830,971 5.00
7.00 00700	OPERATION OF PLANT	426,725	1,033,242	42,802	8,138	1,510,907 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	48,215	0	0	0	48,215 8.00
9.00 00900	HOUSEKEEPING	193,157	76,350	3,163	31,220	303,890 9.00
10.00 01000	DIETARY	709,861	238,808	9,893	96,345	1,054,907 10.00
13.00 01300	NURSING ADMINISTRATION	432,400	119,659	4,957	84,554	641,570 13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	111,876	13,522	560	20,042	146,000 16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	3,522,470	1,226,508	50,808	663,170	5,462,956 30.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC	61,972	0	0	0	61,972 54.00
57.00 05700	CT SCAN	5,430	0	0	0	5,430 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	1,159	0	0	0	1,159 58.00
60.00 06000	LABORATORY	40,032	12,374	513	0	52,919 60.00
65.00 06500	RESPIRATORY THERAPY	141,889	0	0	19,988	161,877 65.00
66.00 06600	PHYSICAL THERAPY	633,522	300,360	12,443	119,872	1,066,197 66.00
67.00 06700	OCCUPATIONAL THERAPY	646,157	52,176	2,161	127,625	828,119 67.00
68.00 06800	SPEECH PATHOLOGY	291,872	21,368	885	57,278	371,403 68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	206,921	74,564	3,089	9,941	294,515 71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	679,918	65,698	2,722	81,908	830,246 73.00
74.00 07400	RENAL DIALYSIS	232,169	0	0	0	232,169 74.00
76.00 03950	OTHER ANCILLARY SERVICE COST CENTERS	10,877	0	0	0	10,877 76.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	0	0	0	0	0 91.00
91.01 04951	OUTPATIENT THERAPY	0	0	0	0	0 91.01
93.00 04950	OUTPATIENT WOUND CENTER	0	0	0	0	0 93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0 95.00
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0 101.00
SPECIAL PURPOSE COST CENTERS						
117.00 06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0 117.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	17,916,432	3,475,925	143,992	1,678,067	17,916,299 118.00
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
194.00 07950	MARKETING	0	128	5	0	133 194.00
194.01 07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.01
200.00	Cross Foot Adjustments					0 200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118 through 201)	17,916,432	3,476,053	143,997	1,678,067	17,916,432 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-3047

Period:
From 05/01/2023
To 04/30/2024

Worksheet B
Part I
Date/Time Prepared:
9/9/2024 1:53 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,830,971				5.00
7.00	00700	OPERATION OF PLANT	557,806	2,068,713			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,800	0	66,015		8.00
9.00	00900	HOUSEKEEPING	112,192	71,744	0	487,826	9.00
10.00	01000	DIETARY	389,457	224,403	0	54,818	1,723,585
13.00	01300	NURSING ADMINISTRATION	236,859	112,441	0	27,467	0
16.00	01600	MEDICAL RECORDS & LIBRARY	53,901	12,707	0	3,104	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,016,847	1,152,520	66,015	281,542	1,723,585
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,879	0	0	0	0
57.00	05700	CT SCAN	2,005	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	428	0	0	0	0
60.00	06000	LABORATORY	19,537	11,628	0	2,840	0
65.00	06500	RESPIRATORY THERAPY	59,763	0	0	0	0
66.00	06600	PHYSICAL THERAPY	393,625	282,242	0	68,947	0
67.00	06700	OCCUPATIONAL THERAPY	305,730	49,028	0	11,977	0
68.00	06800	SPEECH PATHOLOGY	137,117	20,079	0	4,905	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	108,731	70,066	0	17,116	0
73.00	07300	DRUGS CHARGED TO PATIENTS	306,515	61,735	0	15,081	0
74.00	07400	RENAL DIALYSIS	85,714	0	0	0	0
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	4,016	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0	0
91.01	04951	OUTPATIENT THERAPY	0	0	0	0	0
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,830,922	2,068,593	66,015	487,797	1,723,585
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	MARKETING	49	120	0	29	0
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	4,830,971	2,068,713	66,015	487,826	1,723,585

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-3047

Period:
From 05/01/2023
To 04/30/2024

Worksheet B
Part I
Date/Time Prepared:
9/9/2024 1:53 pm

Cost Center Description		NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		13.00	16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
13.00	01300	1,018,337					13.00
16.00	01600	0	215,712				16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,018,337	101,357	11,823,159	0	11,823,159	30.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	1,408	86,259	0	86,259	54.00
57.00	05700	0	123	7,558	0	7,558	57.00
58.00	05800	0	26	1,613	0	1,613	58.00
60.00	06000	0	10,733	97,657	0	97,657	60.00
65.00	06500	0	7,614	229,254	0	229,254	65.00
66.00	06600	0	24,484	1,835,495	0	1,835,495	66.00
67.00	06700	0	25,401	1,220,255	0	1,220,255	67.00
68.00	06800	0	8,735	542,239	0	542,239	68.00
71.00	07100	0	8,932	499,360	0	499,360	71.00
73.00	07300	0	26,117	1,239,694	0	1,239,694	73.00
74.00	07400	0	703	318,586	0	318,586	74.00
76.00	03950	0	79	14,972	0	14,972	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	0	0	0	0	0	91.00
91.01	04951	0	0	0	0	0	91.01
93.00	04950	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
117.00	06950	0	0	0	0	0	117.00
118.00		1,018,337	215,712	17,916,101	0	17,916,101	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	331	0	331	194.00
194.01	07951	0	0	0	0	0	194.01
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		1,018,337	215,712	17,916,432	0	17,916,432	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-3047	Period: From 05/01/2023 To 04/30/2024	Worksheet B Part II Date/Time Prepared: 9/9/2024 1:53 pm
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	12,502	518	13,020	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	228,794	9,478	238,272	5.00
7.00 00700	OPERATION OF PLANT	0	1,033,242	42,802	1,076,044	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	76,350	3,163	79,513	9.00
10.00 01000	DIETARY	0	238,808	9,893	248,701	10.00
13.00 01300	NURSING ADMINISTRATION	0	119,659	4,957	124,616	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	13,522	560	14,082	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	1,226,508	50,808	1,277,316	30.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00 06000	LABORATORY	0	12,374	513	12,887	60.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	300,360	12,443	312,803	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	52,176	2,161	54,337	67.00
68.00 06800	SPEECH PATHOLOGY	0	21,368	885	22,253	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	74,564	3,089	77,653	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	65,698	2,722	68,420	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	0	0	0	0	91.00
91.01 04951	OUTPATIENT THERAPY	0	0	0	0	91.01
93.00 04950	OUTPATIENT WOUND CENTER	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
117.00 06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	3,475,925	143,992	3,619,917	118.00
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	MARKETING	0	128	5	133	194.00
194.01 07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.01
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	3,476,053	143,997	3,620,050	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-3047	Period: From 05/01/2023 To 04/30/2024	Worksheet B Part II Date/Time Prepared: 9/9/2024 1:53 pm		
Cost Center	Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	241,049				5.00
7.00	00700	OPERATION OF PLANT	27,832	1,103,939			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	888	0	888		8.00
9.00	00900	HOUSEKEEPING	5,598	38,285	0	123,638	9.00
10.00	01000	DIETARY	19,432	119,749	0	13,893	10.00
13.00	01300	NURSING ADMINISTRATION	11,818	60,003	0	6,962	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,689	6,781	0	787	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	100,637	615,026	888	71,357	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,142	0	0	0	54.00
57.00	05700	CT SCAN	100	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	21	0	0	0	58.00
60.00	06000	LABORATORY	975	6,205	0	720	60.00
65.00	06500	RESPIRATORY THERAPY	2,982	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	19,640	150,614	0	17,474	66.00
67.00	06700	OCCUPATIONAL THERAPY	15,255	26,163	0	3,035	67.00
68.00	06800	SPEECH PATHOLOGY	6,842	10,715	0	1,243	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,425	37,390	0	4,338	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,294	32,944	0	3,822	73.00
74.00	07400	RENAL DIALYSIS	4,277	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	200	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	241,047	1,103,875	888	123,631	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	MARKETING	2	64	0	7	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	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)	241,049	1,103,939	888	123,638	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-3047	Period: From 05/01/2023 To 04/30/2024	Worksheet B Part II Date/Time Prepared: 9/9/2024 1:53 pm
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Cost Center Description		NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		13.00	16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
13.00	01300	204,055					13.00
16.00	01600	0	24,495				16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	204,055	11,510	2,688,459	0	2,688,459	30.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	160	1,302	0	1,302	54.00
57.00	05700	0	14	114	0	114	57.00
58.00	05800	0	3	24	0	24	58.00
60.00	06000	0	1,219	22,006	0	22,006	60.00
65.00	06500	0	865	4,002	0	4,002	65.00
66.00	06600	0	2,780	504,241	0	504,241	66.00
67.00	06700	0	2,884	102,664	0	102,664	67.00
68.00	06800	0	992	42,489	0	42,489	68.00
71.00	07100	0	1,014	125,897	0	125,897	71.00
73.00	07300	0	2,965	124,080	0	124,080	73.00
74.00	07400	0	80	4,357	0	4,357	74.00
76.00	03950	0	9	209	0	209	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	0	0	0	0	0	91.00
91.01	04951	0	0	0	0	0	91.01
93.00	04950	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
117.00	06950	0	0	0	0	0	117.00
118.00		204,055	24,495	3,619,844	0	3,619,844	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	206	0	206	194.00
194.01	07951	0	0	0	0	0	194.01
200.00				0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		204,055	24,495	3,620,050	0	3,620,050	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-3047

Period:
From 05/01/2023
To 04/30/2024

Worksheet B-1
Date/Time Prepared:
9/9/2024 1:53 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	54,497				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		54,497			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	196	196	7,833,688		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	3,587	3,587	1,671,177	-4,830,971	5.00
7.00 00700	OPERATION OF PLANT	16,199	16,199	37,990	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	1,197	1,197	145,742	0	9.00
10.00 01000	DIETARY	3,744	3,744	449,767	0	10.00
13.00 01300	NURSING ADMINISTRATION	1,876	1,876	394,722	0	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	212	212	93,563	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	19,229	19,229	3,095,872	0	30.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00 06000	LABORATORY	194	194	0	0	60.00
65.00 06500	RESPIRATORY THERAPY	0	0	93,309	0	65.00
66.00 06600	PHYSICAL THERAPY	4,709	4,709	559,593	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	818	818	595,789	0	67.00
68.00 06800	SPEECH PATHOLOGY	335	335	267,387	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,169	1,169	46,409	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,030	1,030	382,368	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	0	0	0	0	91.00
91.01 04951	OUTPATIENT THERAPY	0	0	0	0	91.01
93.00 04950	OUTPATIENT WOUND CENTER	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
117.00 06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	54,495	54,495	7,833,688	-4,830,971	118.00
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	MARKETING	2	2	0	0	194.00
194.01 07951	OTHER NONREIMBURSABLE COST CENTERS	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)	3,476,053	143,997	1,678,067	4,830,971	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	63.784300	2.642292	0.214212	0.369186	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			13,020	241,049	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.001662	0.018421	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: 15-3047

Period:
From 05/01/2023
To 04/30/2024

Worksheet B-1

Date/Time Prepared:
9/9/2024 1:53 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	NURSING ADMINISTRATION (NURSING SALARIES)	
		7.00	8.00	9.00	10.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700	34,515					7.00
8.00	00800	0	11,053				8.00
9.00	00900	1,197	0	33,318			9.00
10.00	01000	3,744	0	3,744	11,053		10.00
13.00	01300	1,876	0	1,876	0	3,095,872	13.00
16.00	01600	212	0	212	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	19,229	11,053	19,229	11,053	3,095,872	30.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	0	0	0	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	194	0	194	0	0	60.00
65.00	06500	0	0	0	0	0	65.00
66.00	06600	4,709	0	4,709	0	0	66.00
67.00	06700	818	0	818	0	0	67.00
68.00	06800	335	0	335	0	0	68.00
71.00	07100	1,169	0	1,169	0	0	71.00
73.00	07300	1,030	0	1,030	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03950	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	0	0	0	0	0	91.00
91.01	04951	0	0	0	0	0	91.01
93.00	04950	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
117.00	06950	0	0	0	0	0	117.00
118.00		34,513	11,053	33,316	11,053	3,095,872	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	0	0	0	0	192.00
194.00	07950	2	0	2	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00							201.00
202.00		2,068,713	66,015	487,826	1,723,585	1,018,337	202.00
203.00		59.936636	5.972587	14.641515	155.938207	0.328934	203.00
204.00		1,103,939	888	123,638	402,523	204,055	204.00
205.00		31.984326	0.080340	3.710847	36.417534	0.065912	205.00
206.00							206.00
207.00							207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-3047

Period:
From 05/01/2023
To 04/30/2024

Worksheet B-1
Date/Time Prepared:
9/9/2024 1:53 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		16.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
13.00	01300	NURSING ADMINISTRATION	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
		23,528,340	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
44.00	04400	SKILLED NURSING FACILITY	44.00
		11,055,000	
		0	
ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	76.00
		153,580	
		13,450	
		2,867	
		1,170,660	
		830,512	
		2,670,560	
		2,770,657	
		952,815	
		974,272	
		2,848,700	
		76,650	
		8,617	
OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	91.00
91.01	04951	OUTPATIENT THERAPY	91.01
93.00	04950	OUTPATIENT WOUND CENTER	93.00
		0	
		0	
		0	
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	95.00
101.00	10100	HOME HEALTH AGENCY	101.00
		0	
		0	
SPECIAL PURPOSE COST CENTERS			
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
		23,528,340	
NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	MARKETING	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	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)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	207.00
		215,712	
		0.009168	
		24,495	
		0.001041	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-3047

Period:
From 05/01/2023
To 04/30/2024

Worksheet C
Part I
Date/Time Prepared:
9/9/2024 1:53 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XVIII Hospital PPS			
				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	11,823,159		11,823,159	0	11,823,159	30.00
44.00	04400 SKILLED NURSING FACILITY	0		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400 RADIOLOGY-DIAGNOSTIC	86,259		86,259	0	86,259	54.00
57.00	05700 CT SCAN	7,558		7,558	0	7,558	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,613		1,613	0	1,613	58.00
60.00	06000 LABORATORY	97,657		97,657	0	97,657	60.00
65.00	06500 RESPIRATORY THERAPY	229,254	0	229,254	0	229,254	65.00
66.00	06600 PHYSICAL THERAPY	1,835,495	0	1,835,495	0	1,835,495	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,220,255	0	1,220,255	0	1,220,255	67.00
68.00	06800 SPEECH PATHOLOGY	542,239	0	542,239	0	542,239	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	499,360		499,360	0	499,360	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,239,694		1,239,694	0	1,239,694	73.00
74.00	07400 RENAL DIALYSIS	318,586		318,586	0	318,586	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	14,972		14,972	0	14,972	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0		0	0	0	91.00
91.01	04951 OUTPATIENT THERAPY	0		0	0	0	91.01
93.00	04950 OUTPATIENT WOUND CENTER	0		0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100 HOME HEALTH AGENCY	0		0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
117.00	06950 OTHER SPECIAL PURPOSE COST CENTERS	0		0		0	117.00
200.00	Subtotal (see instructions)	17,916,101	0	17,916,101	0	17,916,101	200.00
201.00	Less Observation Beds	0		0		0	201.00
202.00	Total (see instructions)	17,916,101	0	17,916,101	0	17,916,101	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-3047	Period: From 05/01/2023 To 04/30/2024	Worksheet C Part I Date/Time Prepared: 9/9/2024 1:53 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
9.00	10.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,055,000		11,055,000	30.00
44.00	04400	SKILLED NURSING FACILITY	0		0	44.00
ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	153,580	0	153,580	54.00
57.00	05700	CT SCAN	13,450	0	13,450	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,867	0	2,867	58.00
60.00	06000	LABORATORY	1,170,660	0	1,170,660	60.00
65.00	06500	RESPIRATORY THERAPY	830,512	0	830,512	65.00
66.00	06600	PHYSICAL THERAPY	2,670,560	0	2,670,560	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,770,657	0	2,770,657	67.00
68.00	06800	SPEECH PATHOLOGY	952,815	0	952,815	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	974,272	0	974,272	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,848,700	0	2,848,700	73.00
74.00	07400	RENAL DIALYSIS	76,650	0	76,650	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	8,617	0	8,617	76.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	117.00
200.00		Subtotal (see instructions)	23,528,340	0	23,528,340	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	23,528,340	0	23,528,340	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-3047	Period: From 05/01/2023 To 04/30/2024	Worksheet C Part I Date/Time Prepared: 9/9/2024 1:53 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
44.00	04400 SKILLED NURSING FACILITY			44.00
	ANCILLARY SERVICE COST CENTERS			
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.561655		54.00
57.00	05700 CT SCAN	0.561933		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.562609		58.00
60.00	06000 LABORATORY	0.083420		60.00
65.00	06500 RESPIRATORY THERAPY	0.276039		65.00
66.00	06600 PHYSICAL THERAPY	0.687307		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.440421		67.00
68.00	06800 SPEECH PATHOLOGY	0.569092		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.512547		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.435179		73.00
74.00	07400 RENAL DIALYSIS	4.156373		74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	1.737496		76.00
	OUTPATIENT SERVICE COST CENTERS			
91.00	09100 EMERGENCY	0.000000		91.00
91.01	04951 OUTPATIENT THERAPY	0.000000		91.01
93.00	04950 OUTPATIENT WOUND CENTER	0.000000		93.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
101.00	10100 HOME HEALTH AGENCY			101.00
	SPECIAL PURPOSE COST CENTERS			
117.00	06950 OTHER SPECIAL PURPOSE COST CENTERS			117.00
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: 15-3047	Period: From 05/01/2023 To 04/30/2024	Worksheet C Part I Date/Time Prepared: 9/9/2024 1:53 pm
		Title XIX	Hospital	PPS

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	11,823,159		11,823,159	0	11,823,159	30.00
44.00 04400 SKILLED NURSING FACILITY	0		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
54.00 05400 RADIOLOGY-DIAGNOSTIC	86,259		86,259	0	86,259	54.00
57.00 05700 CT SCAN	7,558		7,558	0	7,558	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1,613		1,613	0	1,613	58.00
60.00 06000 LABORATORY	97,657		97,657	0	97,657	60.00
65.00 06500 RESPIRATORY THERAPY	229,254	0	229,254	0	229,254	65.00
66.00 06600 PHYSICAL THERAPY	1,835,495	0	1,835,495	0	1,835,495	66.00
67.00 06700 OCCUPATIONAL THERAPY	1,220,255	0	1,220,255	0	1,220,255	67.00
68.00 06800 SPEECH PATHOLOGY	542,239	0	542,239	0	542,239	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	499,360		499,360	0	499,360	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1,239,694		1,239,694	0	1,239,694	73.00
74.00 07400 RENAL DIALYSIS	318,586		318,586	0	318,586	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	14,972		14,972	0	14,972	76.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0		0	0	0	91.00
91.01 04951 OUTPATIENT THERAPY	0		0	0	0	91.01
93.00 04950 OUTPATIENT WOUND CENTER	0		0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0		0	0	0	95.00
101.00 10100 HOME HEALTH AGENCY	0		0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
117.00 06950 OTHER SPECIAL PURPOSE COST CENTERS	0		0	0	0	117.00
200.00 Subtotal (see instructions)	17,916,101	0	17,916,101	0	17,916,101	200.00
201.00 Less Observation Beds	0		0	0	0	201.00
202.00 Total (see instructions)	17,916,101	0	17,916,101	0	17,916,101	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-3047	Period: From 05/01/2023 To 04/30/2024	Worksheet C Part I Date/Time Prepared: 9/9/2024 1:53 pm
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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
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,055,000		11,055,000			30.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	153,580	0	153,580	0.561655	0.000000	54.00
57.00	05700	CT SCAN	13,450	0	13,450	0.561933	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,867	0	2,867	0.562609	0.000000	58.00
60.00	06000	LABORATORY	1,170,660	0	1,170,660	0.083420	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	830,512	0	830,512	0.276039	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,670,560	0	2,670,560	0.687307	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,770,657	0	2,770,657	0.440421	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	952,815	0	952,815	0.569092	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	974,272	0	974,272	0.512547	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,848,700	0	2,848,700	0.435179	0.000000	73.00
74.00	07400	RENAL DIALYSIS	76,650	0	76,650	4.156373	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	8,617	0	8,617	1.737496	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	0	0.000000	0.000000	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0.000000	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
SPECIAL PURPOSE COST CENTERS								
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0			117.00
200.00		Subtotal (see instructions)	23,528,340	0	23,528,340			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	23,528,340	0	23,528,340			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-3047	Period: From 05/01/2023 To 04/30/2024	Worksheet C Part I Date/Time Prepared: 9/9/2024 1:53 pm
		Title XIX	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
44.00	04400 SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS				
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.561655		54.00
57.00	05700 CT SCAN	0.561933		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.562609		58.00
60.00	06000 LABORATORY	0.083420		60.00
65.00	06500 RESPIRATORY THERAPY	0.276039		65.00
66.00	06600 PHYSICAL THERAPY	0.687307		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.440421		67.00
68.00	06800 SPEECH PATHOLOGY	0.569092		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.512547		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.435179		73.00
74.00	07400 RENAL DIALYSIS	4.156373		74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	1.737496		76.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0.000000		91.00
91.01	04951 OUTPATIENT THERAPY	0.000000		91.01
93.00	04950 OUTPATIENT WOUND CENTER	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
117.00	06950 OTHER SPECIAL PURPOSE COST CENTERS			117.00
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: 15-3047

Period: From 05/01/2023 To 04/30/2024

Worksheet C Part II Date/Time Prepared: 9/9/2024 1:53 pm

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					
54.00	05400 RADIOLOGY-DIAGNOSTIC	86,259	153,580	0.561655	54.00
57.00	05700 CT SCAN	7,558	13,450	0.561933	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,613	2,867	0.562609	58.00
60.00	06000 LABORATORY	97,657	1,170,660	0.083420	60.00
65.00	06500 RESPIRATORY THERAPY	229,254	830,512	0.276039	65.00
66.00	06600 PHYSICAL THERAPY	1,835,495	2,670,560	0.687307	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,220,255	2,770,657	0.440421	67.00
68.00	06800 SPEECH PATHOLOGY	542,239	952,815	0.569092	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	499,360	974,272	0.512547	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,239,694	2,848,700	0.435179	73.00
74.00	07400 RENAL DIALYSIS	318,586	76,650	4.156373	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	14,972	8,617	1.737496	76.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0	0	0.000000	91.00
91.01	04951 OUTPATIENT THERAPY	0	0	0.000000	91.01
93.00	04950 OUTPATIENT WOUND CENTER	0	0	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	95.00
101.00	10100 HOME HEALTH AGENCY	0	0	0.000000	101.00
SPECIAL PURPOSE COST CENTERS					
117.00	06950 OTHER SPECIAL PURPOSE COST CENTERS	0	0	0.000000	117.00
200.00	Subtotal (sum of lines 50 thru 199)	6,092,942	12,473,340		200.00
201.00	Less Observation Beds	0	0		201.00
202.00	Total (line 200 minus line 201)	6,092,942	12,473,340		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-3047		Period: From 05/01/2023 To 04/30/2024		Worksheet D Part I Date/Time Prepared: 9/9/2024 1:53 pm	
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)	PPS
Title XVIII Hospital							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,688,459	0	2,688,459	11,053	243.23	30.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	2,688,459		2,688,459	11,053		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	4,232	1,029,349				
44.00	SKILLED NURSING FACILITY	0	0				
200.00	Total (lines 30 through 199)	4,232	1,029,349				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-3047	Period: From 05/01/2023 To 04/30/2024	Worksheet D Part II Date/Time Prepared: 9/9/2024 1:53 pm
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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								
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,302	153,580	0.008478	61,026	517	54.00
57.00	05700	CT SCAN	114	13,450	0.008476	5,823	49	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	24	2,867	0.008371	0	0	58.00
60.00	06000	LABORATORY	22,006	1,170,660	0.018798	432,440	8,129	60.00
65.00	06500	RESPIRATORY THERAPY	4,002	830,512	0.004819	307,650	1,483	65.00
66.00	06600	PHYSICAL THERAPY	504,241	2,670,560	0.188815	1,048,300	197,935	66.00
67.00	06700	OCCUPATIONAL THERAPY	102,664	2,770,657	0.037054	1,087,100	40,281	67.00
68.00	06800	SPEECH PATHOLOGY	42,489	952,815	0.044593	327,585	14,608	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	125,897	974,272	0.129222	421,745	54,499	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	124,080	2,848,700	0.043557	1,002,717	43,675	73.00
74.00	07400	RENAL DIALYSIS	4,357	76,650	0.056843	25,650	1,458	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	209	8,617	0.024254	4,308	104	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0.000000	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	0.000000	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0.000000	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	931,385	12,473,340		4,724,344	362,738	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-3047 Period: From 05/01/2023 To 04/30/2024 Worksheet D Part III Date/Time Prepared: 9/9/2024 1:53 pm

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	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00	
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	11,053	0.00	30.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0.00	44.00	
200.00		Total (lines 30 through 199)	0	0	11,053	0.00	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
44.00	04400	SKILLED NURSING FACILITY	0					44.00
200.00		Total (lines 30 through 199)	0					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3047

Period:
From 05/01/2023
To 04/30/2024

Worksheet D
Part IV
Date/Time Prepared:
9/9/2024 1:53 pm

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									
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00	
57.00	05700	CT SCAN	0	0	0	0	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00	
60.00	06000	LABORATORY	0	0	0	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00	
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00	
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	0	0	0	0	0	91.00	
91.01	04951	OUTPATIENT THERAPY	0	0	0	0	0	91.01	
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00	
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3047

Period:
From 05/01/2023
To 04/30/2024

Worksheet D
Part IV
Date/Time Prepared:
9/9/2024 1:53 pm

Cost Center Description		Title XVIII			Hospital	PPS		
		All Other Medical Education Cost	Total Cost (sum of col. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col. 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								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	153,580	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	13,450	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	2,867	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	1,170,660	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	830,512	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,670,560	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,770,657	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	952,815	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	974,272	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,848,700	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	76,650	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	8,617	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	0	0	0.000000	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	12,473,340		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-3047	Period: From 05/01/2023 To 04/30/2024	Worksheet D Part I Date/Time Prepared: 9/9/2024 1:53 pm
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Cost Center Description		Title XIX			Hospital	PPS	
		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)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	2,688,459	0	2,688,459	11,053	243.23	30.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	2,688,459		2,688,459	11,053		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	246	59,835				30.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
200.00	Total (lines 30 through 199)	246	59,835				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-3047	Period: From 05/01/2023 To 04/30/2024	Worksheet D Part II Date/Time Prepared: 9/9/2024 1:53 pm
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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								
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,302	153,580	0.008478	2,624	22	54.00
57.00	05700	CT SCAN	114	13,450	0.008476	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	24	2,867	0.008371	0	0	58.00
60.00	06000	LABORATORY	22,006	1,170,660	0.018798	32,356	608	60.00
65.00	06500	RESPIRATORY THERAPY	4,002	830,512	0.004819	27,141	131	65.00
66.00	06600	PHYSICAL THERAPY	504,241	2,670,560	0.188815	59,780	11,287	66.00
67.00	06700	OCCUPATIONAL THERAPY	102,664	2,770,657	0.037054	62,885	2,330	67.00
68.00	06800	SPEECH PATHOLOGY	42,489	952,815	0.044593	16,495	736	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	125,897	974,272	0.129222	42,016	5,429	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	124,080	2,848,700	0.043557	196,828	8,573	73.00
74.00	07400	RENAL DIALYSIS	4,357	76,650	0.056843	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	209	8,617	0.024254	4,308	104	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0.000000	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	0.000000	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0.000000	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	931,385	12,473,340		444,433	29,220	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-3047	Period: From 05/01/2023 To 04/30/2024	Worksheet D Part III Date/Time Prepared: 9/9/2024 1:53 pm
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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	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00	
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	11,053	0.00	246 30.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0.00	0 44.00	
200.00		Total (lines 30 through 199)	0	0	11,053	246	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
44.00	04400	SKILLED NURSING FACILITY	0					44.00
200.00		Total (lines 30 through 199)	0					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3047

Period:
From 05/01/2023
To 04/30/2024

Worksheet D
Part IV
Date/Time Prepared:
9/9/2024 1:53 pm

Cost Center Description		Title XIX			Hospital	PPS		
		All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	153,580	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	13,450	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	2,867	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	1,170,660	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	830,512	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,670,560	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,770,657	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	952,815	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	974,272	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,848,700	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	76,650	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	8,617	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	0	0	0.000000	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	12,473,340		200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-3047	Period: From 05/01/2023 To 04/30/2024	Worksheet D-1 Date/Time Prepared: 9/9/2024 1:53 pm
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)		11,053	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		11,053	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		11,053	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		4,232	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)		11,823,159	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)		11,823,159	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)		11,823,159	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)		1,069.68	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,526,886	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		4,526,886	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-3047	Period: From 05/01/2023 To 04/30/2024	Worksheet D-1 Date/Time Prepared: 9/9/2024 1:53 pm		
Cost Center Description			Title XVIII		Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)					42.00	
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT					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)					2,310,878	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					6,837,764	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)					1,029,349	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					362,738	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,392,087	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					5,445,677	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
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)					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
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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-3047		Period: From 05/01/2023 To 04/30/2024		Worksheet D-1 Date/Time Prepared: 9/9/2024 1:53 pm	
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	2,688,459	11,823,159	0.227389	0	0	90.00
91.00	Nursing Program cost	0	11,823,159	0.000000	0	0	91.00
92.00	Allied health cost	0	11,823,159	0.000000	0	0	92.00
93.00	All other Medical Education	0	11,823,159	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-3047		Period: From 05/01/2023 To 04/30/2024		Worksheet D-1 Date/Time Prepared: 9/9/2024 1:53 pm	
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	2,688,459	11,823,159	0.227389	0	0	90.00
91.00	Nursing Program cost	0	11,823,159	0.000000	0	0	91.00
92.00	Allied health cost	0	11,823,159	0.000000	0	0	92.00
93.00	All other Medical Education	0	11,823,159	0.000000	0	0	93.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-3047	Period: From 05/01/2023 To 04/30/2024	Worksheet E Part B Date/Time Prepared: 9/9/2024 1:53 pm
		Title XVIII	Hospital	PPS
				1.00
94.00	Total (sum of lines 91 and 93)			0 94.00
				1.00
200.00	MEDICARE PART B ANCILLARY COSTS Part B Combined Billed Days			0 200.00

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

Provider CCN: 15-3047

Period:
From 05/01/2023
To 04/30/2024

Worksheet G

Date/Time Prepared:
9/9/2024 1:53 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	6,031,170	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	4,087,747	0	0	0	4.00
5.00	Other receivable	24,624	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	130,684	0	0	0	6.00
7.00	Inventory	126,268	0	0	0	7.00
8.00	Prepaid expenses	386,636	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	10,787,129	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	19,912,253	0	0	0	15.00
16.00	Accumulated depreciation	-1,141,542	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	-191,065	0	0	0	19.00
20.00	Accumulated depreciation	-24,856	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	1,583,354	0	0	0	23.00
24.00	Accumulated depreciation	-976,338	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)	19,161,806	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	141,979,066	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	141,979,066	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	171,928,001	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	410,588	0	0	0	37.00
38.00	Salaries, wages, and fees payable	731,556	0	0	0	38.00
39.00	Payroll taxes payable	872,494	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	153,491,919	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	155,506,557	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	19,953,393	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	19,953,393	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	175,459,950	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-3,531,949	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)	-3,531,949	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	171,928,001	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-3047

Period:
From 05/01/2023
To 04/30/2024

Worksheet G-1

Date/Time Prepared:
9/9/2024 1:53 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-6,393,435		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		2,861,487				2.00
3.00	Total (sum of line 1 and line 2)		-3,531,948		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		-3,531,948		0		11.00
12.00	ROUNDING	1		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		1		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-3,531,949		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	ROUNDING		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-3047

Period:
From 05/01/2023
To 04/30/2024

Worksheet G-3

Date/Time Prepared:
9/9/2024 1:53 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	23,528,341	1.00
2.00	Less contractual allowances and discounts on patients' accounts	4,230,276	2.00
3.00	Net patient revenues (line 1 minus line 2)	19,298,065	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	16,452,685	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,845,380	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,582	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	5,866	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	18	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC INC	8,641	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	16,107	25.00
26.00	Total (line 5 plus line 25)	2,861,487	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,861,487	29.00