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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0047	Period: From 06/01/2023 To 05/31/2024	Worksheet S Parts I-III Date/Time Prepared: 10/31/2024 9:22 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 10/31/2024 Time: 9:22 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by LUTHERAN DOWNTOWN HOSPITAL (15-0047) for the cost reporting period beginning 06/01/2023 and ending 05/31/2024 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1				I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name				2
3	Signatory Title	VICE PRESIDENT-REVENUE MANAGEMENT			3
4	Date				4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	482,800	22,391	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	482,800	22,391	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet S-2 Part I | Date/Time Prepared: 10/31/2024 9:22 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 702 VAN BUREN ST	PO Box:			1.00
2.00	City: FORT WAYNE	State: IN	Zip Code: 46802	County: ALLEN	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	LUTHERAN DOWNTOWN HOSPITAL	150047	23060	1	07/01/1996	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	06/01/2023	05/31/2024	20.00
21.00	Type of Control (see instructions)	4		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N		22.00
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y		22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet S-2 Part I | Date/Time Prepared: 10/31/2024 9:22 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	243	29	0	0	1,119	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	Y	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	Y	Y		56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.	Y			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet S-2 Part I Date/Time Prepared: 10/31/2024 9:22 am

		V	XVIII	XIX	
		1.00	2.00	3.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N	63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet S-2 Part I Date/Time Prepared: 10/31/2024 9:22 am

				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	FAMILY MEDICINE	1350	0.00	4.55	0.000000	67.00

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

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		V	XIX	
		1.00	2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00
107.01	If this facility is a REH (line 3, column 4, is "12"), is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no. (see instructions)			107.01
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00

			1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.		N

		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet S-2 Part I | Date/Time Prepared: 10/31/2024 9:22 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	27,156	52,720	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	Y	Y	123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB1848	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: COMMUNITY HEALTH SYSTEMS	Contractor's Name: WPS, INC.	Contractor's Number: 10301	141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet S-2 Part I Date/Time Prepared: 10/31/2024 9:22 am

						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					N	149.00
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)						
155.00	Hospital	N	N	N	N		155.00
156.00	Subprovider - IPF	N	N	N	N		156.00
157.00	Subprovider - IRF	N	N	N	N		157.00
158.00	SUBPROVIDER						158.00
159.00	SNF	N	N	N	N		159.00
160.00	HOME HEALTH AGENCY	N	N	N	N		160.00
161.00	CMHC		N	N	N		161.00
						1.00	
	Multicampus						
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

			1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act			
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)		9.99	169.00
		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet S-2 Part II | Date/Time Prepared: 10/31/2024 9:22 am

		Y/N	Date	
		1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE			
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	09/10/2024	Y	09/10/2024	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet S-2 Part II | Date/Time Prepared: 10/31/2024 9:22 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			Y	12/31/2022	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KUZIWA		TSIGA		41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-669-2590		KUZIWA_TSIGA@CHS.NET		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0047	Period: From 06/01/2023 To 05/31/2024	Worksheet S-2 Part II Date/Time Prepared: 10/31/2024 9:22 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet S-3 Part I | Date/Time Prepared: 10/31/2024 9:22 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	48	17,568	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)		48	17,568	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	12	4,392	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		60	21,960	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						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		60				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet S-3 Part I | Date/Time Prepared: 10/31/2024 9:22 am

	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)	425	231	3,037			1.00
2.00	HMO and other (see instructions)	1,349	1,148				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	425	231	3,037			7.00
8.00	INTENSIVE CARE UNIT	76	12	490			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)	501	243	3,527	4.55	214.39	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits	0	0	0			15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			10			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				4.55	214.39	27.00
28.00	Observation Bed Days		0	808			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			30			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet S-3 Part I | Date/Time Prepared: 10/31/2024 9:22 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	136	518	1,114	1.00
2.00	HMO and other (see instructions)			380	0		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	136	518	1,114	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						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet S-3 Part II | Date/Time Prepared: 10/31/2024 9:22 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	17,887,267	0	17,887,267	445,935.00	40.11	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		0	0	0	0.00	0.00	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		273,993	0	273,993	3,377.00	81.14	11.00
12.00	Contract labor: Top level management and other management and administrative services		1,000	0	1,000	6.00	166.67	12.00
13.00	Contract labor: Physician-Part A - Administrative		24,846	0	24,846	194.70	127.61	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		2,245,859	0	2,245,859	55,707.00	40.32	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		5,683,829	0	5,683,829			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		0	0	0			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		502,271	0	502,271			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet S-3 Part II | Date/Time Prepared: 10/31/2024 9:22 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	126,707	0	126,707	2,423.00	52.29	26.00
27.00	Administrative & General	5.00	2,722,927	-179,328	2,543,599	67,118.00	37.90	27.00
28.00	Administrative & General under contract (see inst.)		16,591	0	16,591	342.00	48.51	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	913,899	0	913,899	32,267.00	28.32	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	373,751	0	373,751	17,536.00	21.31	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		1,086,108	0	1,086,108	44,532.00	24.39	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,101,811	123,124	1,224,935	2,202.00	556.28	38.00
39.00	Central Services and Supply	14.00	163,434	0	163,434	6,225.00	26.25	39.00
40.00	Pharmacy	15.00	647,176	0	647,176	11,282.00	57.36	40.00
41.00	Medical Records & Medical Records Library	16.00	60,069	0	60,069	2,188.00	27.45	41.00
42.00	Social Service	17.00	314,031	0	314,031	6,653.00	47.20	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet S-3 Part III Date/Time Prepared: 10/31/2024 9:22 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		18,989,966	0	18,989,966	490,809.00	38.69	1.00
2.00	Excluded area salaries (see instructions)		0	0	0	0.00	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)		18,989,966	0	18,989,966	490,809.00	38.69	3.00
4.00	Subtotal other wages & related costs (see inst.)		2,545,698	0	2,545,698	59,284.70	42.94	4.00
5.00	Subtotal wage-related costs (see inst.)		6,186,100	0	6,186,100	0.00	32.58	5.00
6.00	Total (sum of lines 3 thru 5)		27,721,764	0	27,721,764	550,093.70	50.39	6.00
7.00	Total overhead cost (see instructions)		7,526,504	-56,204	7,470,300	192,768.00	38.75	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet S-3 Part IV Date/Time Prepared: 10/31/2024 9:22 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	356,438	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	3,851,008	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	4,156	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	12,335	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	5,970	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	157,048	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	1,024,168	17.00
18.00	Medicare Taxes - Employers Portion Only	239,523	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	33,182	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	5,683,828	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet S-3 Part V Date/Time Prepared: 10/31/2024 9:22 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	273,993	5,683,828	1.00
2.00	Hospital	273,993	5,683,828	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0047	Period: From 06/01/2023 To 05/31/2024	Worksheet S-10 Parts I & II Date/Time Prepared: 10/31/2024 9:22 am

		1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.161241	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	18,169,466	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	134,754,208	6.00
7.00	Medicaid cost (line 1 times line 6)	21,727,903	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	3,558,437	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	3,558,437	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	12,754,754	9,367	12,764,121	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,056,589	9,367	2,065,956	21.00
22.00	Payments received from patients for amounts previously written off as charity care	2,941	0	2,941	22.00
23.00	Cost of charity care (see instructions)	2,053,648	9,367	2,063,015	23.00

		1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
25.01	Charges for insured patients' liability (see instructions)	0	25.01
26.00	Bad debt amount (see instructions)	2,950,673	26.00
27.00	Medicare reimbursable bad debts (see instructions)	68,498	27.00
27.01	Medicare allowable bad debts (see instructions)	105,382	27.01
28.00	Non-Medicare bad debt amount (see instructions)	2,845,291	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	495,662	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	2,558,677	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,117,114	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0047	Period: From 06/01/2023 To 05/31/2024	Worksheet S-10 Parts I & II Date/Time Prepared: 10/31/2024 9:22 am

		1.00	
	PART II - HOSPITAL DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.161241	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		5.00
6.00	Medicaid charges		6.00
7.00	Medicaid cost (line 1 times line 6)		7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)		8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP		9.00
10.00	Stand-alone CHIP charges		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)		12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)		16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	12,754,754	9,367	12,764,121	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,056,589	9,367	2,065,956	21.00
22.00	Payments received from patients for amounts previously written off as charity care	2,941	0	2,941	22.00
23.00	Cost of charity care (see instructions)	2,053,648	9,367	2,063,015	23.00

		1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
25.01	Charges for insured patients' liability (see instructions)	0	25.01
26.00	Bad debt amount (see instructions)	2,950,673	26.00
27.00	Medicare reimbursable bad debts (see instructions)	68,498	27.00
27.01	Medicare allowable bad debts (see instructions)	105,382	27.01
28.00	Non-Medicare bad debt amount (see instructions)	2,845,291	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	495,662	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	2,558,677	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,558,677	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet A | Date/Time Prepared: 10/31/2024 9:22 am

		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	CAP REL COSTS-BLDG & FIXT		2,593,919	2,593,919	4,018,632	6,612,551	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		6,543,419	6,543,419	407,442	6,950,861	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	126,707	75,627	202,334	4,518,838	4,721,172	4.00
5.01	00590	REVENUE CYCLE	1,060,894	4,180,438	5,241,332	-136,857	5,104,475	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	25,936	88,224	114,160	0	114,160	5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	1,636,097	12,907,922	14,544,019	-7,847,335	6,696,684	5.03
7.00	00700	OPERATION OF PLANT	913,899	2,590,707	3,504,606	329,712	3,834,318	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	159,082	159,082	0	159,082	8.00
9.00	00900	HOUSEKEEPING	373,751	191,536	565,287	-766	564,521	9.00
10.00	01000	DIETARY	0	1,458,790	1,458,790	-418,935	1,039,855	10.00
11.00	01100	CAFETERIA	0	0	0	483,126	483,126	11.00
13.00	01300	NURSING ADMINISTRATION	1,101,811	150,952	1,252,763	113,598	1,366,361	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	163,434	1,036,793	1,200,227	-935,951	264,276	14.00
15.00	01500	PHARMACY	647,176	1,298,527	1,945,703	-1,115,144	830,559	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	60,069	260,589	320,658	0	320,658	16.00
17.00	01700	SOCIAL SERVICE	314,031	45,455	359,486	0	359,486	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	517,634	517,634	0	517,634	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,084,574	1,575,648	2,660,222	57,448	2,717,670	30.00
31.00	03100	INTENSIVE CARE UNIT	1,238,255	190,920	1,429,175	-4,733	1,424,442	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	736,732	2,453,242	3,189,974	-676,275	2,513,699	50.00
51.00	05100	RECOVERY ROOM	429,043	116,306	545,349	-128	545,221	51.00
53.00	05300	ANESTHESIOLOGY	0	1,283,982	1,283,982	0	1,283,982	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,739,944	1,106,714	2,846,658	-47,869	2,798,789	54.00
59.00	05900	CARDIAC CATHETERIZATION	200,032	292,770	492,802	-97,046	395,756	59.00
60.00	06000	LABORATORY	1,398,697	1,026,186	2,424,883	-93,136	2,331,747	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	56,897	56,897	0	56,897	62.00
65.00	06500	RESPIRATORY THERAPY	631,430	154,840	786,270	-18,780	767,490	65.00
66.00	06600	PHYSICAL THERAPY	130,336	12,408	142,744	0	142,744	66.00
67.00	06700	OCCUPATIONAL THERAPY	99,960	8,742	108,702	0	108,702	67.00
68.00	06800	SPEECH PATHOLOGY	6,568	464	7,032	0	7,032	68.00
69.00	06900	ELECTROCARDIOLOGY	279,203	26,690	305,893	-324	305,569	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	552,295	552,295	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	362,504	362,504	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	907,872	907,872	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	36,490	3,152	39,642	0	39,642	90.00
91.00	09100	EMERGENCY	3,452,198	3,462,623	6,914,821	-358,188	6,556,633	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,887,267	45,871,198	63,758,465	0	63,758,465	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	17,887,267	45,871,198	63,758,465	0	63,758,465	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet A | Date/Time Prepared: 10/31/2024 9:22 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,119,201	7,731,752		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	69,719	7,020,580		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,721,172		4.00
5.01	00590	REVENUE CYCLE	0	5,104,475		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	114,160		5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	49,152	6,745,836		5.03
7.00	00700	OPERATION OF PLANT	-6,368	3,827,950		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	159,082		8.00
9.00	00900	HOUSEKEEPING	0	564,521		9.00
10.00	01000	DIETARY	0	1,039,855		10.00
11.00	01100	CAFETERIA	0	483,126		11.00
13.00	01300	NURSING ADMINISTRATION	0	1,366,361		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	264,276		14.00
15.00	01500	PHARMACY	0	830,559		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-213	320,445		16.00
17.00	01700	SOCIAL SERVICE	0	359,486		17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	517,634		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,323,030	1,394,640		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,424,442		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-505,808	2,007,891		50.00
51.00	05100	RECOVERY ROOM	0	545,221		51.00
53.00	05300	ANESTHESIOLOGY	-1,283,982	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,798,789		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	395,756		59.00
60.00	06000	LABORATORY	0	2,331,747		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	56,897		62.00
65.00	06500	RESPIRATORY THERAPY	0	767,490		65.00
66.00	06600	PHYSICAL THERAPY	0	142,744		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	108,702		67.00
68.00	06800	SPEECH PATHOLOGY	0	7,032		68.00
69.00	06900	ELECTROCARDIOLOGY	0	305,569		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	552,295		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	362,504		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	907,872		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	39,642		90.00
91.00	09100	EMERGENCY	-2,054,270	4,502,363		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,935,599	59,822,866		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	MEALS ON WHEELS	0	0		194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,935,599	59,822,866		200.00

RECLASSIFICATIONS | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet A-6 | Date/Time Prepared: 10/31/2024 9:22 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4,520,249		1.00
	0		0	4,520,249		
	C - LEASE AND RENTAL					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	398,559		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	963,446		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
	0		0	1,362,005		
	D - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	486,964		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,565,557		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	8,883		3.00
	0		0	3,061,404		
	E - REPAIRS & MAINTENANCE					
1.00	OPERATION OF PLANT	7.00	0	301,215		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
	0		0	301,215		
	F - CNO WAGES RECLASS					
1.00	NURSING ADMINISTRATION	13.00	179,328	0		1.00
	0		179,328	0		
	G - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	552,295		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	362,504		2.00
3.00	DIETARY	10.00	0	68,817		3.00
4.00	PHARMACY	15.00	0	35,210		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	11,253		5.00
6.00	LABORATORY	60.00	0	15,707		6.00
	0		0	1,045,786		
	H - DRUGS AND IV COSTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	907,872		1.00
	0		0	907,872		
	K - DIETARY					
1.00	CAFETERIA	11.00	0	483,126		1.00
	0		0	483,126		
	M - UTILITIES RECLASS					
1.00	OPERATION OF PLANT	7.00	0	25,890		1.00
2.00		0.00	0	0		2.00
	0		0	25,890		
	N - NON-CAPITALIZED EQUIPMENT					
1.00	OPERATION OF PLANT	7.00	0	2,942		1.00
	0		0	2,942		
	Q - SITTER COSTS					
1.00	ADULTS & PEDIATRICS	30.00	56,204	3,965		1.00
	TOTALS		56,204	3,965		
	R - DEPRECIATION EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,665		1.00
	TOTALS		0	2,665		
500.00	Grand Total: Increases		235,532	11,717,119		500.00

RECLASSIFICATIONS | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet A-6 | Date/Time Prepared: 10/31/2024 9:22 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE AND GENERAL	5.03	0	4,520,249	0		1.00
	0		0	4,520,249			
	C - LEASE AND RENTAL						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,411	10		1.00
2.00	REVENUE CYCLE	5.01	0	171	10		2.00
3.00	ADMINISTRATIVE AND GENERAL	5.03	0	56,745	0		3.00
4.00	OPERATION OF PLANT	7.00	0	335	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	43	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	103,556	0		6.00
7.00	PHARMACY	15.00	0	239,187	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	4	0		8.00
9.00	OPERATING ROOM	50.00	0	514,909	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	63	0		10.00
11.00	LABORATORY	60.00	0	101,147	0		11.00
12.00	EMERGENCY	91.00	0	344,434	0		12.00
	0		0	1,362,005			
	D - OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE AND GENERAL	5.03	0	3,061,404	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	0		0	3,061,404			
	E - REPAIRS & MAINTENANCE						
1.00	OPERATION OF PLANT	7.00	0	0	0		1.00
2.00	REVENUE CYCLE	5.01	0	119,650	0		2.00
3.00	ADMINISTRATIVE AND GENERAL	5.03	0	18,090	0		3.00
4.00	HOUSEKEEPING	9.00	0	766	0		4.00
5.00	DIETARY	10.00	0	4,626	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	5,518	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	4,770	0		7.00
8.00	PHARMACY	15.00	0	3,295	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	2,717	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	4,733	0		10.00
11.00	OPERATING ROOM	50.00	0	35,916	0		11.00
12.00	RECOVERY ROOM	51.00	0	128	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	59,059	0		13.00
14.00	CARDIAC CATHETERIZATION	59.00	0	3,809	0		14.00
15.00	LABORATORY	60.00	0	7,696	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	16,688	0		16.00
17.00	EMERGENCY	91.00	0	13,754	0		17.00
	0		0	301,215			
	F - CNO WAGES RECLASS						
1.00	ADMINISTRATIVE AND GENERAL	5.03	179,328	0	0		1.00
	0		179,328	0			
	G - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	827,625	0		1.00
2.00	OPERATING ROOM	50.00	0	122,508	0		2.00
3.00	CARDIAC CATHETERIZATION	59.00	0	93,237	0		3.00
4.00	RESPIRATORY THERAPY	65.00	0	2,092	0		4.00
5.00	ELECTROCARDIOLOGY	69.00	0	324	0		5.00
6.00		0.00	0	0	0		6.00
	0		0	1,045,786			
	H - DRUGS AND IV COSTS						
1.00	PHARMACY	15.00	0	907,872	0		1.00
	0		0	907,872			
	K - DIETARY						
1.00	DIETARY	10.00	0	483,126	0		1.00
	0		0	483,126			
	M - UTILITIES RECLASS						
1.00	REVENUE CYCLE	5.01	0	17,036	0		1.00
2.00	ADMINISTRATIVE AND GENERAL	5.03	0	8,854	0		2.00
	0		0	25,890			
	N - NON-CAPITALIZED EQUIPMENT						
1.00	OPERATING ROOM	50.00	0	2,942	0		1.00
	0		0	2,942			
	Q - SITTER COSTS						
1.00	NURSING ADMINISTRATION	13.00	56,204	3,965	0		1.00
	TOTALS		56,204	3,965			
	R - DEPRECIATION EXPENSE						
1.00	ADMINISTRATIVE AND GENERAL	5.03	0	2,665	9		1.00
	TOTALS		0	2,665			
500.00	Grand Total: Decreases		235,532	11,717,119			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet A-7 Part I | Date/Time Prepared: 10/31/2024 9:22 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,010,000	0	0	0	0	1.00
2.00	Land Improvements	415,730	0	0	0	19,980	2.00
3.00	Buildings and Fixtures	89,226,300	19,803	0	19,803	0	3.00
4.00	Building Improvements	258,682	0	0	0	0	4.00
5.00	Fixed Equipment	2,737,632	0	0	0	16,298	5.00
6.00	Movable Equipment	24,860,358	85,182	0	85,182	351,610	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	118,508,702	104,985	0	104,985	387,888	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	118,508,702	104,985	0	104,985	387,888	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,010,000	0	1.00
2.00	Land Improvements	395,750	0	2.00
3.00	Buildings and Fixtures	89,246,103	0	3.00
4.00	Building Improvements	258,682	0	4.00
5.00	Fixed Equipment	2,721,334	0	5.00
6.00	Movable Equipment	24,593,930	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	118,225,799	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	118,225,799	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet A-7 Part II | Date/Time Prepared: 10/31/2024 9:22 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,593,919	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,543,419	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	9,137,338	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	2,593,919		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	6,543,419		2.00
3.00	Total (sum of lines 1-2)	0	9,137,338		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet A-7 Part III Date/Time Prepared: 10/31/2024 9:22 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	93,631,868	0	93,631,868	0.791975	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	24,593,930	0	24,593,930	0.208025	0	2.00
3.00	Total (sum of lines 1-2)	118,225,798	0	118,225,798	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,648,064	963,446	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	6,613,138	398,559	2.00
3.00	Total (sum of lines 1-2)	0	0	0	9,261,202	1,362,005	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,067,721	486,964	2,565,557	0	7,731,752	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	8,883	0	0	7,020,580	2.00
3.00	Total (sum of lines 1-2)	1,067,721	495,847	2,565,557	0	14,752,332	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet A-8 | Date/Time Prepared: 10/31/2024 9:22 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-6,368	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	-4,994,985			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	1,430,359			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-213	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
19.01	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
20.00	Vending machines	B	-452	ADMINISTRATIVE AND GENERAL	5.03	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)	A	-13,605	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

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet A-8 | Date/Time Prepared: 10/31/2024 9:22 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	PARKING GARAGE & MISC INCOME	B	-183,347	ADMINISTRATIVE AND GENERAL	5.03	0	33.00
33.01	MARKETING & RECRUITING EXPENSE	A	-48,175	ADMINISTRATIVE AND GENERAL	5.03	0	33.01
33.02	RENTAL INCOME	B	210	CAP REL COSTS-BLDG & FIXT	1.00	9	33.02
33.06	PENALTIES	A	-54	ADMINISTRATIVE AND GENERAL	5.03	0	33.06
33.09	PATIENT TV DEPRECIATION	A	-1,402	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.09
33.12	LOBBYING EXPENSE IN DUES	A	-14,425	ADMINISTRATIVE AND GENERAL	5.03	0	33.12
33.13	CHARITABLE CONTRIBUTIONS	A	-94,421	ADMINISTRATIVE AND GENERAL	5.03	0	33.13
33.14	RECRUITING FEES	A	-8,721	ADMINISTRATIVE AND GENERAL	5.03	0	33.14
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,935,599				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet A-8-1 | Date/Time Prepared: 10/31/2024 9:22 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	0.00		CAPITAL-RELATED INTEREST	0	0	1.00
2.00	0.00		PASI CAPITAL COSTS - BLDG &	0	0	2.00
3.00	0.00		PASI CAPITAL COSTS - MOVEABL	0	0	3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT	Capital-Related Interest	1,067,721	0	4.00
4.01	1.00	CAP REL COSTS-BLDG & FIXT	PASI Capital Costs - Bldg &	405	0	4.01
4.02	2.00	CAP REL COSTS-MVBLE EQUIP	PASI Capital Costs - Moveabl	868	0	4.02
4.03	5.03	ADMINISTRATIVE AND GENERAL	PASI Operating Costs	254,724	230,644	4.03
4.04	5.03	ADMINISTRATIVE AND GENERAL	Shared Service Center Alloca	1,231,309	728,284	4.04
4.05	1.00	CAP REL COSTS-BLDG & FIXT	New Capital - Building & Fix	50,865	0	4.05
4.06	2.00	CAP REL COSTS-MVBLE EQUIP	New Capital - Movable Equipm	70,253	0	4.06
4.07	5.03	ADMINISTRATIVE AND GENERAL	Non-Capital Home Office Cost	1,905,847	0	4.07
4.08	5.03	ADMINISTRATIVE AND GENERAL	Malpractice Costs	79,876	214,283	4.08
4.09	5.03	ADMINISTRATIVE AND GENERAL	Management Fees	0	1,111,565	4.09
4.10	5.03	ADMINISTRATIVE AND GENERAL	401K Fees	0	5,004	4.10
4.11	5.03	ADMINISTRATIVE AND GENERAL	Audit Fees	0	27,745	4.11
4.12	5.03	ADMINISTRATIVE AND GENERAL	Corporate Overhead Allocatio	0	584,243	4.12
4.13	5.03	ADMINISTRATIVE AND GENERAL	HIIM Allocation	0	210,241	4.13
4.14	5.03	ADMINISTRATIVE AND GENERAL	Contract Management	0	108,188	4.14
4.15	5.03	ADMINISTRATIVE AND GENERAL	PASI Lien Unit Collection Fe	0	11,312	4.15
4.16	0.00		CIG Leased Equipment (Per Ex	0	0	4.16
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			4,661,868	3,231,509	5.00

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

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

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

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

6.00	B		0.00	CHS, INC	100.00	6.00
7.00	B		0.00	PASI	100.00	7.00
8.00	C		33.00	SHARED LAUNDRY	33.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet A-8-1 | Date/Time Prepared: 10/31/2024 9:22 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	0	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	1,067,721	11		4.00
4.01	405	9		4.01
4.02	868	9		4.02
4.03	24,080	0		4.03
4.04	503,025	0		4.04
4.05	50,865	9		4.05
4.06	70,253	9		4.06
4.07	1,905,847	0		4.07
4.08	-134,407	0		4.08
4.09	-1,111,565	0		4.09
4.10	-5,004	0		4.10
4.11	-27,745	0		4.11
4.12	-584,243	0		4.12
4.13	-210,241	0		4.13
4.14	-108,188	0		4.14
4.15	-11,312	0		4.15
4.16	0	0		4.16
5.00	1,430,359			5.00

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

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

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

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

6.00	OWNER		6.00
7.00	DEBT COLLECTION		7.00
8.00	LAUNDRY		8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet A-8-2 | Date/Time Prepared: 10/31/2024 9:22 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.03	ADMINISTRATIVE AND GENERAL	-158,500	-158,500	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,309,425	1,309,425	0	0	0	2.00
3.00	50.00	OPERATING ROOM	505,808	505,808	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	1,283,982	1,283,982	0	0	0	4.00
5.00	91.00	EMERGENCY	2,054,270	2,054,270	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			4,994,985	4,994,985	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.03	ADMINISTRATIVE AND GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.03	ADMINISTRATIVE AND GENERAL	0	0	0	-158,500		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,309,425		2.00
3.00	50.00	OPERATING ROOM	0	0	0	505,808		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	1,283,982		4.00
5.00	91.00	EMERGENCY	0	0	0	2,054,270		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	4,994,985		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet B Part I Date/Time Prepared: 10/31/2024 9:22 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	REVENUE CYCLE	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	7,731,752	7,731,752				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	7,020,580		7,020,580			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,721,172	31,633	28,724	4,781,529		4.00
5.01	00590	REVENUE CYCLE	5,104,475	0	0	285,616	5,390,091	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	114,160	158,293	143,733	6,983	0	5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	6,745,836	795,986	722,771	392,194	0	5.03
7.00	00700	OPERATION OF PLANT	3,827,950	1,236,318	1,122,601	246,042	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	159,082	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	564,521	0	0	100,622	0	9.00
10.00	01000	DIETARY	1,039,855	261,049	237,037	0	0	10.00
11.00	01100	CAFETERIA	483,126	171,259	155,507	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,366,361	0	0	329,779	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	264,276	236,722	214,948	44,000	0	14.00
15.00	01500	PHARMACY	830,559	125,435	113,898	174,234	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	320,445	0	0	16,172	0	16.00
17.00	01700	SOCIAL SERVICE	359,486	0	0	84,544	0	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	517,634	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,394,640	1,493,103	1,355,765	307,123	195,425	30.00
31.00	03100	INTENSIVE CARE UNIT	1,424,442	558,715	507,324	333,365	112,209	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,007,891	1,017,081	923,529	198,344	387,396	50.00
51.00	05100	RECOVERY ROOM	545,221	175,398	159,265	115,508	51,764	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	52,031	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,798,789	575,482	522,548	468,431	1,507,453	54.00
59.00	05900	CARDIAC CATHETERIZATION	395,756	0	0	53,853	65,874	59.00
60.00	06000	LABORATORY	2,331,747	136,838	124,252	376,560	607,235	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	56,897	0	0	0	4,618	62.00
65.00	06500	RESPIRATORY THERAPY	767,490	42,403	38,503	169,995	128,614	65.00
66.00	06600	PHYSICAL THERAPY	142,744	0	0	35,089	18,143	66.00
67.00	06700	OCCUPATIONAL THERAPY	108,702	0	0	26,911	20,769	67.00
68.00	06800	SPEECH PATHOLOGY	7,032	0	0	1,768	1,443	68.00
69.00	06900	ELECTROCARDIOLOGY	305,569	0	0	75,168	230,853	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	552,295	0	0	0	431,931	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	362,504	0	0	0	57,002	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	907,872	0	0	0	433,402	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	39,642	0	0	9,824	2,224	90.00
91.00	09100	EMERGENCY	4,502,363	716,037	650,175	929,404	1,081,705	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	59,822,866	7,731,752	7,020,580	4,781,529	5,390,091	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
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)	59,822,866	7,731,752	7,020,580	4,781,529	5,390,091	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet B Part I | Date/Time Prepared: 10/31/2024 9:22 am

		Cost Center Description	PURCHASING RECEIVING AND STORES	Subtotal	ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.02	5A.02	5.03	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	423,169					5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	0	8,656,787	8,656,787			5.03
7.00	00700	OPERATION OF PLANT	5,982	6,438,893	1,089,396	7,528,289		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	180	159,262	26,946	0	186,208	8.00
9.00	00900	HOUSEKEEPING	478	665,621	112,616	0	0	9.00
10.00	01000	DIETARY	61,013	1,598,954	270,527	356,701	0	10.00
11.00	01100	CAFETERIA	0	809,892	137,026	234,011	0	11.00
13.00	01300	NURSING ADMINISTRATION	241	1,696,381	287,011	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	128	760,074	128,597	323,460	0	14.00
15.00	01500	PHARMACY	0	1,244,126	210,494	171,397	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	336,617	56,952	0	0	16.00
17.00	01700	SOCIAL SERVICE	343	444,373	75,183	0	0	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	517,634	87,578	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,957	4,763,013	805,854	2,040,195	40,988	30.00
31.00	03100	INTENSIVE CARE UNIT	7,771	2,943,826	498,066	763,436	19,643	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	97,165	4,631,406	783,588	1,389,755	6,912	50.00
51.00	05100	RECOVERY ROOM	1	1,047,157	177,168	239,667	0	51.00
53.00	05300	ANESTHESIOLOGY	0	52,031	8,803	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,942	5,888,645	996,300	786,346	34,785	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	515,483	87,215	0	0	59.00
60.00	06000	LABORATORY	55,415	3,632,047	614,506	186,978	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	5,059	66,574	11,264	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	7,669	1,154,674	195,359	57,940	0	65.00
66.00	06600	PHYSICAL THERAPY	49	196,025	33,165	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	156,382	26,458	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	10,243	1,733	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	533	612,123	103,565	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	70,051	1,054,277	178,373	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,935	443,441	75,026	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,341,274	226,930	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	21	51,711	8,749	0	0	90.00
91.00	09100	EMERGENCY	54,236	7,933,920	1,342,339	978,403	83,880	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	423,169	59,822,866	8,656,787	7,528,289	186,208	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	423,169	59,822,866	8,656,787	7,528,289	186,208	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet B Part I | Date/Time Prepared: 10/31/2024 9:22 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00591	ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	778,237					9.00
10.00	01000	DIETARY	36,874	2,263,056				10.00
11.00	01100	CAFETERIA	24,191	0	1,205,120			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	82,836	2,066,228		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	33,438	0	23,213	0	1,268,782	14.00
15.00	01500	PHARMACY	17,718	0	42,078	5,591	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	8,152	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	24,843	0	1,225	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	210,904	659,445	109,853	327,380	60,580	30.00
31.00	03100	INTENSIVE CARE UNIT	78,920	488,031	95,723	405,426	27,763	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	143,666	0	50,928	122,750	347,118	50.00
51.00	05100	RECOVERY ROOM	24,776	0	37,187	166,725	4	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	81,289	0	153,483	8,194	56,955	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	24,049	0	59.00
60.00	06000	LABORATORY	19,329	0	153,949	12	197,975	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	18,075	62.00
65.00	06500	RESPIRATORY THERAPY	5,990	0	56,052	0	27,399	65.00
66.00	06600	PHYSICAL THERAPY	0	0	9,937	0	174	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	8,152	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	388	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	24,300	410	1,905	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	250,262	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	85,510	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	3,183	13,912	74	90.00
91.00	09100	EMERGENCY	101,142	0	320,863	991,779	193,763	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	778,237	1,147,476	1,205,120	2,066,228	1,268,782	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,115,580	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	778,237	2,263,056	1,205,120	2,066,228	1,268,782	202.00

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		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	Subtotal	
			15.00	16.00	17.00	22.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00591	ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	1,691,404					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	401,721				16.00
17.00	01700	SOCIAL SERVICE	0	0	545,624			17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	605,212		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	14,567	469,821	605,212	10,107,812	30.00
31.00	03100	INTENSIVE CARE UNIT	0	8,364	75,803	0	5,405,001	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	28,877	0	0	7,505,000	50.00
51.00	05100	RECOVERY ROOM	0	3,859	0	0	1,696,543	51.00
53.00	05300	ANESTHESIOLOGY	0	3,879	0	0	64,713	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	112,301	0	0	8,118,298	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	4,910	0	0	631,657	59.00
60.00	06000	LABORATORY	0	45,265	0	0	4,850,061	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	344	0	0	96,257	62.00
65.00	06500	RESPIRATORY THERAPY	0	9,587	0	0	1,507,001	65.00
66.00	06600	PHYSICAL THERAPY	0	1,352	0	0	240,653	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,548	0	0	192,540	67.00
68.00	06800	SPEECH PATHOLOGY	0	108	0	0	12,472	68.00
69.00	06900	ELECTROCARDIOLOGY	0	17,208	0	0	759,511	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	32,197	0	0	1,515,109	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,249	0	0	608,226	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,691,404	32,307	0	0	3,291,915	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	166	0	0	77,795	90.00
91.00	09100	EMERGENCY	0	80,633	0	0	12,026,722	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,691,404	401,721	545,624	605,212	58,707,286	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	1,115,580	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,691,404	401,721	545,624	605,212	59,822,866	202.00

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		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00590	REVENUE CYCLE				5.01
5.02	00560	PURCHASING RECEIVING AND STORES				5.02
5.03	00591	ADMINISTRATIVE AND GENERAL				5.03
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-605,212	9,502,600		30.00
31.00	03100	INTENSIVE CARE UNIT	0	5,405,001		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	7,505,000		50.00
51.00	05100	RECOVERY ROOM	0	1,696,543		51.00
53.00	05300	ANESTHESIOLOGY	0	64,713		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,118,298		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	631,657		59.00
60.00	06000	LABORATORY	0	4,850,061		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	96,257		62.00
65.00	06500	RESPIRATORY THERAPY	0	1,507,001		65.00
66.00	06600	PHYSICAL THERAPY	0	240,653		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	192,540		67.00
68.00	06800	SPEECH PATHOLOGY	0	12,472		68.00
69.00	06900	ELECTROCARDIOLOGY	0	759,511		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,515,109		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	608,226		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,291,915		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	77,795		90.00
91.00	09100	EMERGENCY	0	12,026,722		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-605,212	58,102,074		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,115,580		192.00
194.00	07950	MEALS ON WHEELS	0	0		194.00
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	-605,212	59,217,654		202.00

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		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			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	31,633	28,724	60,357	60,357	4.00
5.01	00590	REVENUE CYCLE	0	0	0	0	3,605	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	158,293	143,733	302,026	88	5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	0	795,986	722,771	1,518,757	4,950	5.03
7.00	00700	OPERATION OF PLANT	0	1,236,318	1,122,601	2,358,919	3,105	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	1,270	9.00
10.00	01000	DIETARY	0	261,049	237,037	498,086	0	10.00
11.00	01100	CAFETERIA	0	171,259	155,507	326,766	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	4,162	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	236,722	214,948	451,670	555	14.00
15.00	01500	PHARMACY	0	125,435	113,898	239,333	2,199	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	204	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	1,067	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,493,103	1,355,765	2,848,868	3,876	30.00
31.00	03100	INTENSIVE CARE UNIT	0	558,715	507,324	1,066,039	4,208	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,017,081	923,529	1,940,610	2,503	50.00
51.00	05100	RECOVERY ROOM	0	175,398	159,265	334,663	1,458	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	575,482	522,548	1,098,030	5,912	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	680	59.00
60.00	06000	LABORATORY	0	136,838	124,252	261,090	4,753	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	42,403	38,503	80,906	2,146	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	443	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	340	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	22	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	949	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	124	90.00
91.00	09100	EMERGENCY	0	716,037	650,175	1,366,212	11,738	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	7,731,752	7,020,580	14,752,332	60,357	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	7,731,752	7,020,580	14,752,332	60,357	202.00

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		Cost Center Description	REVENUE CYCLE	PURCHASING RECEIVING AND STORES	ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5.02	5.03	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	REVENUE CYCLE	3,605					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	302,114				5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	0	0	1,523,707			5.03
7.00	00700	OPERATION OF PLANT	0	4,270	191,750	2,558,044		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	129	4,743	0	4,872	8.00
9.00	00900	HOUSEKEEPING	0	342	19,822	0	0	9.00
10.00	01000	DIETARY	0	43,559	47,617	121,204	0	10.00
11.00	01100	CAFETERIA	0	0	24,119	79,515	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	172	50,518	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	91	22,635	109,909	0	14.00
15.00	01500	PHARMACY	0	0	37,050	58,239	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	10,024	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	245	13,233	0	0	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	15,415	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	131	12,106	141,843	693,239	1,072	30.00
31.00	03100	INTENSIVE CARE UNIT	75	5,548	87,667	259,409	514	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	259	69,367	137,923	472,226	181	50.00
51.00	05100	RECOVERY ROOM	35	1	31,184	81,437	0	51.00
53.00	05300	ANESTHESIOLOGY	35	0	1,549	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,009	11,382	175,364	267,193	910	54.00
59.00	05900	CARDIAC CATHETERIZATION	44	0	15,351	0	0	59.00
60.00	06000	LABORATORY	406	39,563	108,162	63,533	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	3	3,612	1,983	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	86	5,475	34,386	19,688	0	65.00
66.00	06600	PHYSICAL THERAPY	12	35	5,838	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	14	0	4,657	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1	0	305	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	154	381	18,229	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	289	50,012	31,396	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	38	17,088	13,206	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	290	0	39,943	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1	15	1,540	0	0	90.00
91.00	09100	EMERGENCY	723	38,721	236,255	332,452	2,195	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,605	302,114	1,523,707	2,558,044	4,872	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,605	302,114	1,523,707	2,558,044	4,872	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet B Part II | Date/Time Prepared: 10/31/2024 9:22 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00591	ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	21,434					9.00
10.00	01000	DIETARY	1,016	711,482				10.00
11.00	01100	CAFETERIA	666	0	431,066			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	29,630	84,482		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	921	0	8,303	0	594,084	14.00
15.00	01500	PHARMACY	488	0	15,051	229	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	2,916	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	8,886	0	574	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,808	207,323	39,294	13,386	28,366	30.00
31.00	03100	INTENSIVE CARE UNIT	2,174	153,432	34,240	16,577	13,000	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,957	0	18,217	5,019	162,532	50.00
51.00	05100	RECOVERY ROOM	682	0	13,302	6,817	2	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,239	0	54,900	335	26,668	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	983	0	59.00
60.00	06000	LABORATORY	532	0	55,067	0	92,698	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	8,463	62.00
65.00	06500	RESPIRATORY THERAPY	165	0	20,050	0	12,829	65.00
66.00	06600	PHYSICAL THERAPY	0	0	3,554	0	81	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	2,916	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	139	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	8,692	17	892	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	117,181	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	40,038	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	1,139	569	34	90.00
91.00	09100	EMERGENCY	2,786	0	114,770	40,550	90,726	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,434	360,755	431,066	84,482	594,084	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	350,727	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	21,434	711,482	431,066	84,482	594,084	202.00

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		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	Subtotal	
			15.00	16.00	17.00	22.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00591	ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	352,589					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	13,144				16.00
17.00	01700	SOCIAL SERVICE	0	0	24,005			17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	15,415		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	470	20,670		4,016,452	30.00
31.00	03100	INTENSIVE CARE UNIT	0	270	3,335		1,646,488	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	932	0		2,813,726	50.00
51.00	05100	RECOVERY ROOM	0	125	0		469,706	51.00
53.00	05300	ANESTHESIOLOGY	0	125	0		1,709	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,800	0		1,647,742	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	159	0		17,217	59.00
60.00	06000	LABORATORY	0	1,461	0		627,265	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	11	0		14,072	62.00
65.00	06500	RESPIRATORY THERAPY	0	310	0		176,041	65.00
66.00	06600	PHYSICAL THERAPY	0	44	0		10,007	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	50	0		7,977	67.00
68.00	06800	SPEECH PATHOLOGY	0	3	0		470	68.00
69.00	06900	ELECTROCARDIOLOGY	0	556	0		29,870	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,040	0		199,918	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	137	0		70,507	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	352,589	1,043	0		393,865	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	5	0		3,427	90.00
91.00	09100	EMERGENCY	0	2,603	0		2,239,731	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	352,589	13,144	24,005	0	14,386,190	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		350,727	192.00
194.00	07950	MEALS ON WHEELS	0	0	0		0	194.00
200.00		Cross Foot Adjustments				15,415	15,415	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	352,589	13,144	24,005	15,415	14,752,332	202.00

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		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00590	REVENUE CYCLE				5.01
5.02	00560	PURCHASING RECEIVING AND STORES				5.02
5.03	00591	ADMINISTRATIVE AND GENERAL				5.03
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	4,016,452		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,646,488		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,813,726		50.00
51.00	05100	RECOVERY ROOM	0	469,706		51.00
53.00	05300	ANESTHESIOLOGY	0	1,709		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,647,742		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	17,217		59.00
60.00	06000	LABORATORY	0	627,265		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	14,072		62.00
65.00	06500	RESPIRATORY THERAPY	0	176,041		65.00
66.00	06600	PHYSICAL THERAPY	0	10,007		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,977		67.00
68.00	06800	SPEECH PATHOLOGY	0	470		68.00
69.00	06900	ELECTROCARDIOLOGY	0	29,870		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	199,918		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	70,507		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	393,865		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	3,427		90.00
91.00	09100	EMERGENCY	0	2,239,731		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	14,386,190		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	350,727		192.00
194.00	07950	MEALS ON WHEELS	0	0		194.00
200.00		Cross Foot Adjustments	0	15,415		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	14,752,332		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet B-1 | Date/Time Prepared: 10/31/2024 9:22 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FOOTAGE)	MVBLE EQUIP (SQUARE FOOTAGE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	REVENUE CYCLE (GROSS CHARGES)	PURCHASING RECEIVING AND STORES (COSTED REQUIS.)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	183,069					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		183,069				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	749	749	17,760,560			4.00
5.01	00590	REVENUE CYCLE	0	0	1,060,894	360,342,441		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	3,748	3,748	25,936	0	4,583,108	5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	18,847	18,847	1,456,769	0	0	5.03
7.00	00700	OPERATION OF PLANT	29,273	29,273	913,899	0	64,783	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	1,950	8.00
9.00	00900	HOUSEKEEPING	0	0	373,751	0	5,182	9.00
10.00	01000	DIETARY	6,181	6,181	0	0	660,800	10.00
11.00	01100	CAFETERIA	4,055	4,055	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,224,935	0	2,605	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,605	5,605	163,434	0	1,386	14.00
15.00	01500	PHARMACY	2,970	2,970	647,176	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	60,069	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	314,031	0	3,715	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,353	35,353	1,140,778	13,064,887	183,653	30.00
31.00	03100	INTENSIVE CARE UNIT	13,229	13,229	1,238,255	7,501,625	84,167	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,082	24,082	736,732	25,898,920	1,052,309	50.00
51.00	05100	RECOVERY ROOM	4,153	4,153	429,043	3,460,631	11	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,478,487	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,626	13,626	1,739,944	100,773,191	172,664	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	200,032	4,403,940	0	59.00
60.00	06000	LABORATORY	3,240	3,240	1,398,697	40,595,977	600,176	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	308,706	54,796	62.00
65.00	06500	RESPIRATORY THERAPY	1,004	1,004	631,430	8,598,309	83,062	65.00
66.00	06600	PHYSICAL THERAPY	0	0	130,336	1,212,960	526	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	99,960	1,388,462	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	6,568	96,453	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	279,203	15,433,389	5,776	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	28,876,278	758,688	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,810,779	259,229	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	28,974,624	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	36,490	148,661	223	90.00
91.00	09100	EMERGENCY	16,954	16,954	3,452,198	72,316,162	587,407	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	183,069	183,069	17,760,560	360,342,441	4,583,108	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
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)	7,731,752	7,020,580	4,781,529	5,390,091	423,169	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	42.234087	38.349366	0.269222	0.014958	0.092332	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			60,357	3,605	302,114	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.003398	0.000010	0.065919	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: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet B-1 | Date/Time Prepared: 10/31/2024 9:22 am

		Cost Center Description	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM.COST)	OPERATION OF PLANT (SQUARE FOOTAGE)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FOOTAGE)	
			5A.03	5.03	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	-8,656,787	51,166,079				5.03
7.00	00700	OPERATION OF PLANT	0	6,438,893	130,452			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	159,262	0	202,639		8.00
9.00	00900	HOUSEKEEPING	0	665,621	0	0	130,452	9.00
10.00	01000	DIETARY	0	1,598,954	6,181	0	6,181	10.00
11.00	01100	CAFETERIA	0	809,892	4,055	0	4,055	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,696,381	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	760,074	5,605	0	5,605	14.00
15.00	01500	PHARMACY	0	1,244,126	2,970	0	2,970	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	336,617	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	444,373	0	0	0	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	517,634	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	4,763,013	35,353	44,605	35,353	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,943,826	13,229	21,376	13,229	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,631,406	24,082	7,522	24,082	50.00
51.00	05100	RECOVERY ROOM	0	1,047,157	4,153	0	4,153	51.00
53.00	05300	ANESTHESIOLOGY	0	52,031	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,888,645	13,626	37,854	13,626	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	515,483	0	0	0	59.00
60.00	06000	LABORATORY	0	3,632,047	3,240	0	3,240	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	66,574	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	1,154,674	1,004	0	1,004	65.00
66.00	06600	PHYSICAL THERAPY	0	196,025	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	156,382	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	10,243	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	612,123	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,054,277	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	443,441	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,341,274	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	51,711	0	0	0	90.00
91.00	09100	EMERGENCY	0	7,933,920	16,954	91,282	16,954	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-8,656,787	51,166,079	130,452	202,639	130,452	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
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)		8,656,787	7,528,289	186,208	778,237	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.169190	57.709265	0.918915	5.965696	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		1,523,707	2,558,044	4,872	21,434	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.029780	19.609082	0.024043	0.164306	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: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet B-1 | Date/Time Prepared: 10/31/2024 9:22 am

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (GROSS SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00591	ADMINISTRATIVE AND GENERAL						5.03
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	35,831					10.00
11.00	01100	CAFETERIA	0	15,523				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,067	5,578,704			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	299	0	3,846,402		14.00
15.00	01500	PHARMACY	0	542	15,095	0	1,065,017	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	105	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	320	0	3,715	0	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,441	1,415	883,908	183,653	0	30.00
31.00	03100	INTENSIVE CARE UNIT	7,727	1,233	1,094,629	84,167	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	656	331,419	1,052,309	0	50.00
51.00	05100	RECOVERY ROOM	0	479	450,147	11	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,977	22,123	172,664	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	64,931	0	0	59.00
60.00	06000	LABORATORY	0	1,983	32	600,176	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	54,796	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	722	0	83,062	0	65.00
66.00	06600	PHYSICAL THERAPY	0	128	0	526	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	105	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	5	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	313	1,107	5,776	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	758,688	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	259,229	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,065,017	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	41	37,562	223	0	90.00
91.00	09100	EMERGENCY	0	4,133	2,677,751	587,407	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,168	15,523	5,578,704	3,846,402	1,065,017	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	17,663	0	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,263,056	1,205,120	2,066,228	1,268,782	1,691,404	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	63.159164	77.634478	0.370378	0.329862	1.588147	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	711,482	431,066	84,482	594,084	352,589	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	19.856605	27.769503	0.015144	0.154452	0.331064	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: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet B-1 | Date/Time Prepared: 10/31/2024 9:22 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ROTATIONS)		
			16.00	17.00	22.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	REVENUE CYCLE					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00591	ADMINISTRATIVE AND GENERAL					5.03
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	360,342,441				16.00
17.00	01700	SOCIAL SERVICE	0	3,527			17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	100		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	13,064,887	3,037	100		30.00
31.00	03100	INTENSIVE CARE UNIT	7,501,625	490	0		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	25,898,920	0	0		50.00
51.00	05100	RECOVERY ROOM	3,460,631	0	0		51.00
53.00	05300	ANESTHESIOLOGY	3,478,487	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	100,773,191	0	0		54.00
59.00	05900	CARDIAC CATHETERIZATION	4,403,940	0	0		59.00
60.00	06000	LABORATORY	40,595,977	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	308,706	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	8,598,309	0	0		65.00
66.00	06600	PHYSICAL THERAPY	1,212,960	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,388,462	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	96,453	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	15,433,389	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	28,876,278	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,810,779	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,974,624	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	148,661	0	0		90.00
91.00	09100	EMERGENCY	72,316,162	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	360,342,441	3,527	100		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
194.00	07950	MEALS ON WHEELS	0	0	0		194.00
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)	401,721	545,624	605,212		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.001115	154.699178	6,052.120000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	13,144	24,005	15,415		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000036	6.806067	154.150000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet C Part I Date/Time Prepared: 10/31/2024 9:22 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,502,600		9,502,600	0	9,502,600	30.00
31.00	03100	INTENSIVE CARE UNIT	5,405,001		5,405,001	0	5,405,001	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,505,000		7,505,000	0	7,505,000	50.00
51.00	05100	RECOVERY ROOM	1,696,543		1,696,543	0	1,696,543	51.00
53.00	05300	ANESTHESIOLOGY	64,713		64,713	0	64,713	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,118,298		8,118,298	0	8,118,298	54.00
59.00	05900	CARDIAC CATHETERIZATION	631,657		631,657	0	631,657	59.00
60.00	06000	LABORATORY	4,850,061		4,850,061	0	4,850,061	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	96,257		96,257	0	96,257	62.00
65.00	06500	RESPIRATORY THERAPY	1,507,001	0	1,507,001	0	1,507,001	65.00
66.00	06600	PHYSICAL THERAPY	240,653	0	240,653	0	240,653	66.00
67.00	06700	OCCUPATIONAL THERAPY	192,540	0	192,540	0	192,540	67.00
68.00	06800	SPEECH PATHOLOGY	12,472	0	12,472	0	12,472	68.00
69.00	06900	ELECTROCARDIOLOGY	759,511		759,511	0	759,511	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,515,109		1,515,109	0	1,515,109	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	608,226		608,226	0	608,226	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,291,915		3,291,915	0	3,291,915	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	77,795		77,795	0	77,795	90.00
91.00	09100	EMERGENCY	12,026,722		12,026,722	0	12,026,722	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,996,907		1,996,907		1,996,907	92.00
200.00		Subtotal (see instructions)	60,098,981	0	60,098,981	0	60,098,981	200.00
201.00		Less Observation Beds	1,996,907		1,996,907		1,996,907	201.00
202.00		Total (see instructions)	58,102,074	0	58,102,074	0	58,102,074	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet C Part I Date/Time Prepared: 10/31/2024 9:22 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,915,126		9,915,126			30.00
31.00	03100	INTENSIVE CARE UNIT	7,501,625		7,501,625			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,204,189	21,694,731	25,898,920	0.289780	0.000000	50.00
51.00	05100	RECOVERY ROOM	572,680	2,887,951	3,460,631	0.490241	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	620,516	2,857,971	3,478,487	0.018604	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,227,621	90,545,570	100,773,191	0.080560	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	1,107,702	3,296,238	4,403,940	0.143430	0.000000	59.00
60.00	06000	LABORATORY	10,200,239	30,395,738	40,595,977	0.119471	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	139,859	168,847	308,706	0.311808	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	6,486,330	2,111,979	8,598,309	0.175267	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	973,114	239,846	1,212,960	0.198401	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,191,278	197,184	1,388,462	0.138671	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	76,268	20,185	96,453	0.129307	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,814,610	12,618,779	15,433,389	0.049212	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,060,164	22,816,114	28,876,278	0.052469	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,291,647	2,519,132	3,810,779	0.159607	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,902,070	18,072,554	28,974,624	0.113614	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	10,748	137,913	148,661	0.523305	0.000000	90.00
91.00	09100	EMERGENCY	5,649,939	66,666,223	72,316,162	0.166308	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	623,906	2,525,855	3,149,761	0.633987	0.000000	92.00
200.00		Subtotal (see instructions)	80,569,631	279,772,810	360,342,441			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	80,569,631	279,772,810	360,342,441			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet C Part I Date/Time Prepared: 10/31/2024 9:22 am

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		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.289780		50.00
51.00	05100	RECOVERY ROOM	0.490241		51.00
53.00	05300	ANESTHESIOLOGY	0.018604		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.080560		54.00
59.00	05900	CARDIAC CATHETERIZATION	0.143430		59.00
60.00	06000	LABORATORY	0.119471		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.311808		62.00
65.00	06500	RESPIRATORY THERAPY	0.175267		65.00
66.00	06600	PHYSICAL THERAPY	0.198401		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.138671		67.00
68.00	06800	SPEECH PATHOLOGY	0.129307		68.00
69.00	06900	ELECTROCARDIOLOGY	0.049212		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.052469		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.159607		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.113614		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.523305		90.00
91.00	09100	EMERGENCY	0.166308		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.633987		92.00
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: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet C Part I Date/Time Prepared: 10/31/2024 9:22 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,502,600		9,502,600	0	9,502,600	30.00
31.00	03100	INTENSIVE CARE UNIT	5,405,001		5,405,001	0	5,405,001	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,505,000		7,505,000	0	7,505,000	50.00
51.00	05100	RECOVERY ROOM	1,696,543		1,696,543	0	1,696,543	51.00
53.00	05300	ANESTHESIOLOGY	64,713		64,713	0	64,713	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,118,298		8,118,298	0	8,118,298	54.00
59.00	05900	CARDIAC CATHETERIZATION	631,657		631,657	0	631,657	59.00
60.00	06000	LABORATORY	4,850,061		4,850,061	0	4,850,061	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	96,257		96,257	0	96,257	62.00
65.00	06500	RESPIRATORY THERAPY	1,507,001	0	1,507,001	0	1,507,001	65.00
66.00	06600	PHYSICAL THERAPY	240,653	0	240,653	0	240,653	66.00
67.00	06700	OCCUPATIONAL THERAPY	192,540	0	192,540	0	192,540	67.00
68.00	06800	SPEECH PATHOLOGY	12,472	0	12,472	0	12,472	68.00
69.00	06900	ELECTROCARDIOLOGY	759,511		759,511	0	759,511	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,515,109		1,515,109	0	1,515,109	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	608,226		608,226	0	608,226	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,291,915		3,291,915	0	3,291,915	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	77,795		77,795	0	77,795	90.00
91.00	09100	EMERGENCY	12,026,722		12,026,722	0	12,026,722	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,996,907		1,996,907		1,996,907	92.00
200.00		Subtotal (see instructions)	60,098,981	0	60,098,981	0	60,098,981	200.00
201.00		Less Observation Beds	1,996,907		1,996,907		1,996,907	201.00
202.00		Total (see instructions)	58,102,074	0	58,102,074	0	58,102,074	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet C Part I Date/Time Prepared: 10/31/2024 9:22 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,915,126		9,915,126			30.00
31.00	03100	INTENSIVE CARE UNIT	7,501,625		7,501,625			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,204,189	21,694,731	25,898,920	0.289780	0.000000	50.00
51.00	05100	RECOVERY ROOM	572,680	2,887,951	3,460,631	0.490241	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	620,516	2,857,971	3,478,487	0.018604	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,227,621	90,545,570	100,773,191	0.080560	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	1,107,702	3,296,238	4,403,940	0.143430	0.000000	59.00
60.00	06000	LABORATORY	10,200,239	30,395,738	40,595,977	0.119471	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	139,859	168,847	308,706	0.311808	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	6,486,330	2,111,979	8,598,309	0.175267	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	973,114	239,846	1,212,960	0.198401	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,191,278	197,184	1,388,462	0.138671	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	76,268	20,185	96,453	0.129307	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,814,610	12,618,779	15,433,389	0.049212	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,060,164	22,816,114	28,876,278	0.052469	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,291,647	2,519,132	3,810,779	0.159607	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,902,070	18,072,554	28,974,624	0.113614	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	10,748	137,913	148,661	0.523305	0.000000	90.00
91.00	09100	EMERGENCY	5,649,939	66,666,223	72,316,162	0.166308	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	623,906	2,525,855	3,149,761	0.633987	0.000000	92.00
200.00		Subtotal (see instructions)	80,569,631	279,772,810	360,342,441			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	80,569,631	279,772,810	360,342,441			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet C Part I Date/Time Prepared: 10/31/2024 9:22 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.289780		50.00
51.00	05100	RECOVERY ROOM	0.490241		51.00
53.00	05300	ANESTHESIOLOGY	0.018604		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.080560		54.00
59.00	05900	CARDIAC CATHETERIZATION	0.143430		59.00
60.00	06000	LABORATORY	0.119471		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.311808		62.00
65.00	06500	RESPIRATORY THERAPY	0.175267		65.00
66.00	06600	PHYSICAL THERAPY	0.198401		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.138671		67.00
68.00	06800	SPEECH PATHOLOGY	0.129307		68.00
69.00	06900	ELECTROCARDIOLOGY	0.049212		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.052469		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.159607		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.113614		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.523305		90.00
91.00	09100	EMERGENCY	0.166308		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.633987		92.00
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: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet C Part II | Date/Time Prepared: 10/31/2024 9:22 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,505,000	2,813,726	4,691,274	0	0	50.00
51.00	05100	RECOVERY ROOM	1,696,543	469,706	1,226,837	0	0	51.00
53.00	05300	ANESTHESIOLOGY	64,713	1,709	63,004	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,118,298	1,647,742	6,470,556	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	631,657	17,217	614,440	0	0	59.00
60.00	06000	LABORATORY	4,850,061	627,265	4,222,796	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	96,257	14,072	82,185	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,507,001	176,041	1,330,960	0	0	65.00
66.00	06600	PHYSICAL THERAPY	240,653	10,007	230,646	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	192,540	7,977	184,563	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	12,472	470	12,002	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	759,511	29,870	729,641	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,515,109	199,918	1,315,191	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	608,226	70,507	537,719	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,291,915	393,865	2,898,050	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	77,795	3,427	74,368	0	0	90.00
91.00	09100	EMERGENCY	12,026,722	2,239,731	9,786,991	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,996,907	844,031	1,152,876	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	45,191,380	9,567,281	35,624,099	0	0	200.00
201.00		Less Observation Beds	1,996,907	844,031	1,152,876	0	0	201.00
202.00		Total (line 200 minus line 201)	43,194,473	8,723,250	34,471,223	0	0	202.00

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

Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet C Part II | Date/Time Prepared: 10/31/2024 9:22 am

Title XIX | Hospital | PPS

		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		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	7,505,000	25,898,920	0.289780		50.00
51.00	05100	RECOVERY ROOM	1,696,543	3,460,631	0.490241		51.00
53.00	05300	ANESTHESIOLOGY	64,713	3,478,487	0.018604		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,118,298	100,773,191	0.080560		54.00
59.00	05900	CARDIAC CATHETERIZATION	631,657	4,403,940	0.143430		59.00
60.00	06000	LABORATORY	4,850,061	40,595,977	0.119471		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	96,257	308,706	0.311808		62.00
65.00	06500	RESPIRATORY THERAPY	1,507,001	8,598,309	0.175267		65.00
66.00	06600	PHYSICAL THERAPY	240,653	1,212,960	0.198401		66.00
67.00	06700	OCCUPATIONAL THERAPY	192,540	1,388,462	0.138671		67.00
68.00	06800	SPEECH PATHOLOGY	12,472	96,453	0.129307		68.00
69.00	06900	ELECTROCARDIOLOGY	759,511	15,433,389	0.049212		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,515,109	28,876,278	0.052469		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	608,226	3,810,779	0.159607		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,291,915	28,974,624	0.113614		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	77,795	148,661	0.523305		90.00
91.00	09100	EMERGENCY	12,026,722	72,316,162	0.166308		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,996,907	3,149,761	0.633987		92.00
200.00		Subtotal (sum of lines 50 thru 199)	45,191,380	342,925,690			200.00
201.00		Less Observation Beds	1,996,907	0			201.00
202.00		Total (line 200 minus line 201)	43,194,473	342,925,690			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet D Part I Date/Time Prepared: 10/31/2024 9:22 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	4,016,452	0	4,016,452	3,845	1,044.59	30.00
31.00	INTENSIVE CARE UNIT	1,646,488		1,646,488	490	3,360.18	31.00
200.00	Total (lines 30 through 199)	5,662,940		5,662,940	4,335		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	425	443,951		30.00
31.00	INTENSIVE CARE UNIT	76	255,374		31.00
200.00	Total (lines 30 through 199)	501	699,325		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet D Part II Date/Time Prepared: 10/31/2024 9:22 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,813,726	25,898,920	0.108643	343,986	37,372	50.00
51.00	05100	RECOVERY ROOM	469,706	3,460,631	0.135728	59,934	8,135	51.00
53.00	05300	ANESTHESIOLOGY	1,709	3,478,487	0.000491	62,722	31	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,647,742	100,773,191	0.016351	1,484,606	24,275	54.00
59.00	05900	CARDIAC CATHETERIZATION	17,217	4,403,940	0.003909	107,508	420	59.00
60.00	06000	LABORATORY	627,265	40,595,977	0.015451	1,261,946	19,498	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	14,072	308,706	0.045584	23,976	1,093	62.00
65.00	06500	RESPIRATORY THERAPY	176,041	8,598,309	0.020474	807,020	16,523	65.00
66.00	06600	PHYSICAL THERAPY	10,007	1,212,960	0.008250	162,958	1,344	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,977	1,388,462	0.005745	178,174	1,024	67.00
68.00	06800	SPEECH PATHOLOGY	470	96,453	0.004873	20,331	99	68.00
69.00	06900	ELECTROCARDIOLOGY	29,870	15,433,389	0.001935	75,514	146	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	199,918	28,876,278	0.006923	798,650	5,529	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	70,507	3,810,779	0.018502	152,329	2,818	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	393,865	28,974,624	0.013593	1,328,031	18,052	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,427	148,661	0.023052	0	0	90.00
91.00	09100	EMERGENCY	2,239,731	72,316,162	0.030971	530,391	16,427	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	844,031	3,149,761	0.267967	60,645	16,251	92.00
200.00		Total (lines 50 through 199)	9,567,281	342,925,690		7,458,721	169,037	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet D Part III Date/Time Prepared: 10/31/2024 9:22 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	3,845	0.00	425	30.00
31.00	03100	INTENSIVE CARE UNIT		0	490	0.00	76	31.00
200.00		Total (lines 30 through 199)		0	4,335		501	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet D Part IV Date/Time Prepared: 10/31/2024 9:22 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet D Part IV | Date/Time Prepared: 10/31/2024 9:22 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	25,898,920	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	3,460,631	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,478,487	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	100,773,191	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	4,403,940	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	40,595,977	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	308,706	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,598,309	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,212,960	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,388,462	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	96,453	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	15,433,389	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	28,876,278	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,810,779	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	28,974,624	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	148,661	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	72,316,162	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,149,761	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	342,925,690		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet D Part IV Date/Time Prepared: 10/31/2024 9:22 am

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	343,986	0	2,383,345	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	59,934	0	311,958	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	62,722	0	325,701	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,484,606	0	7,475,653	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	107,508	0	408,786	0	59.00
60.00	06000	LABORATORY	0.000000	1,261,946	0	1,215,766	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	23,976	0	45,580	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	807,020	0	322,618	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	162,958	0	4,743	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	178,174	0	6,343	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	20,331	0	1,916	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	75,514	0	241,674	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	798,650	0	4,289,247	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	152,329	0	861,087	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,328,031	0	1,631,370	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	5,683	0	90.00
91.00	09100	EMERGENCY	0.000000	530,391	0	2,486,575	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	60,645	0	229,519	0	92.00
200.00		Total (lines 50 through 199)		7,458,721	0	22,247,564	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet D Part V Date/Time Prepared: 10/31/2024 9:22 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.289780	2,383,345	0	0	690,646	50.00
51.00	05100	RECOVERY ROOM	0.490241	311,958	0	0	152,935	51.00
53.00	05300	ANESTHESIOLOGY	0.018604	325,701	0	0	6,059	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.080560	7,475,653	0	0	602,239	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.143430	408,786	0	0	58,632	59.00
60.00	06000	LABORATORY	0.119471	1,215,766	0	0	145,249	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.311808	45,580	0	0	14,212	62.00
65.00	06500	RESPIRATORY THERAPY	0.175267	322,618	0	0	56,544	65.00
66.00	06600	PHYSICAL THERAPY	0.198401	4,743	0	0	941	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.138671	6,343	0	0	880	67.00
68.00	06800	SPEECH PATHOLOGY	0.129307	1,916	0	0	248	68.00
69.00	06900	ELECTROCARDIOLOGY	0.049212	241,674	0	0	11,893	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.052469	4,289,247	0	0	225,053	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.159607	861,087	0	0	137,436	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.113614	1,631,370	0	5,937	185,346	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.523305	5,683	0	215	2,974	90.00
91.00	09100	EMERGENCY	0.166308	2,486,575	0	0	413,537	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.633987	229,519	0	0	145,512	92.00
200.00		Subtotal (see instructions)		22,247,564	0	6,152	2,850,336	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		22,247,564	0	6,152	2,850,336	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet D Part V Date/Time Prepared: 10/31/2024 9:22 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	675	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	113	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	788	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	788	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet D Part I Date/Time Prepared: 10/31/2024 9:22 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	4,016,452	0	4,016,452	3,845	1,044.59	30.00
31.00	INTENSIVE CARE UNIT	1,646,488		1,646,488	490	3,360.18	31.00
200.00	Total (lines 30 through 199)	5,662,940		5,662,940	4,335		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	231	241,300		30.00
31.00	INTENSIVE CARE UNIT	12	40,322		31.00
200.00	Total (lines 30 through 199)	243	281,622		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet D Part II Date/Time Prepared: 10/31/2024 9:22 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,813,726	25,898,920	0.108643	239,843	26,057	50.00
51.00	05100	RECOVERY ROOM	469,706	3,460,631	0.135728	35,782	4,857	51.00
53.00	05300	ANESTHESIOLOGY	1,709	3,478,487	0.000491	26,569	13	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,647,742	100,773,191	0.016351	923,319	15,097	54.00
59.00	05900	CARDIAC CATHETERIZATION	17,217	4,403,940	0.003909	0	0	59.00
60.00	06000	LABORATORY	627,265	40,595,977	0.015451	745,211	11,514	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	14,072	308,706	0.045584	24,018	1,095	62.00
65.00	06500	RESPIRATORY THERAPY	176,041	8,598,309	0.020474	392,428	8,035	65.00
66.00	06600	PHYSICAL THERAPY	10,007	1,212,960	0.008250	60,402	498	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,977	1,388,462	0.005745	59,816	344	67.00
68.00	06800	SPEECH PATHOLOGY	470	96,453	0.004873	5,559	27	68.00
69.00	06900	ELECTROCARDIOLOGY	29,870	15,433,389	0.001935	43,610	84	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	199,918	28,876,278	0.006923	130,729	905	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	70,507	3,810,779	0.018502	361,943	6,697	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	393,865	28,974,624	0.013593	658,933	8,957	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,427	148,661	0.023052	663	15	90.00
91.00	09100	EMERGENCY	2,239,731	72,316,162	0.030971	388,242	12,024	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	844,031	3,149,761	0.267967	49,902	13,372	92.00
200.00		Total (lines 50 through 199)	9,567,281	342,925,690		4,146,969	109,591	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet D Part III Date/Time Prepared: 10/31/2024 9:22 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	3,845	0.00	231	30.00
31.00	03100	INTENSIVE CARE UNIT		0	490	0.00	12	31.00
200.00		Total (lines 30 through 199)		0	4,335		243	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet D Part IV | Date/Time Prepared: 10/31/2024 9:22 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet D Part IV | Date/Time Prepared: 10/31/2024 9:22 am

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	25,898,920	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	3,460,631	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,478,487	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	100,773,191	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	4,403,940	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	40,595,977	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	308,706	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,598,309	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,212,960	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,388,462	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	96,453	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	15,433,389	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	28,876,278	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,810,779	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	28,974,624	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	148,661	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	72,316,162	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,149,761	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	342,925,690		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet D Part IV | Date/Time Prepared: 10/31/2024 9:22 am

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	239,843	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	35,782	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	26,569	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	923,319	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	745,211	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	24,018	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	392,428	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	60,402	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	59,816	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	5,559	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	43,610	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	130,729	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	361,943	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	658,933	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	663	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	388,242	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	49,902	0	0	0	92.00
200.00		Total (lines 50 through 199)		4,146,969	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet D Part V Date/Time Prepared: 10/31/2024 9:22 am

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		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.289780	0	0	107,890	0	50.00
51.00	05100	RECOVERY ROOM	0.490241	0	0	23,574	0	51.00
53.00	05300	ANESTHESIOLOGY	0.018604	0	0	27,322	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.080560	0	0	5,555,891	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.143430	0	0	70,145	0	59.00
60.00	06000	LABORATORY	0.119471	0	0	1,757,898	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.311808	0	0	13,019	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.175267	0	0	288,500	0	65.00
66.00	06600	PHYSICAL THERAPY	0.198401	0	0	6,474	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.138671	0	0	7,689	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.129307	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.049212	0	0	182,580	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.052469	0	0	112,769	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.159607	0	0	18,409	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.113614	0	0	834,441	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.523305	0	0	7,168	0	90.00
91.00	09100	EMERGENCY	0.166308	0	0	4,513,497	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.633987	0	0	177,306	0	92.00
200.00		Subtotal (see instructions)		0	0	13,704,572	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	13,704,572	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet D Part V Date/Time Prepared: 10/31/2024 9:22 am

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		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	31,264		50.00
51.00	05100	RECOVERY ROOM	0	11,557		51.00
53.00	05300	ANESTHESIOLOGY	0	508		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	447,583		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	10,061		59.00
60.00	06000	LABORATORY	0	210,018		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	4,059		62.00
65.00	06500	RESPIRATORY THERAPY	0	50,565		65.00
66.00	06600	PHYSICAL THERAPY	0	1,284		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,066		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	8,985		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,917		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,938		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	94,804		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	3,751		90.00
91.00	09100	EMERGENCY	0	750,631		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	112,410		92.00
200.00		Subtotal (see instructions)	0	1,747,401		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	1,747,401		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet D-1 | Date/Time Prepared: 10/31/2024 9:22 am

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	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,845	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,845	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)	3,037	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)	425	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)	9,502,600	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)	9,502,600	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)	9,502,600	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)	2,471.42	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,050,354	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,050,354	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet D-1 | Date/Time Prepared: 10/31/2024 9:22 am

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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	5,405,001	490	11,030.61	76	838,326	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)	972,075	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	2,860,755	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)	699,325	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	169,037	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	868,362	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,992,393	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
55.03	CAR T-cell amount paid as an interim payment	0	55.03
56.00	Target amount ((line 54 x sum of lines 55, 55.01, and 55.02) plus line 55.03)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	808	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,471.42	88.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet D-1 | Date/Time Prepared: 10/31/2024 9:22 am

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	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,996,907	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	4,016,452	9,502,600	0.422669	1,996,907	844,031	90.00
91.00	Nursing Program cost	0	9,502,600	0.000000	1,996,907	0	91.00
92.00	Allied health cost	0	9,502,600	0.000000	1,996,907	0	92.00
93.00	All other Medical Education	0	9,502,600	0.000000	1,996,907	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet D-1 | Date/Time Prepared: 10/31/2024 9:22 am

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	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,845	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,845	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)	3,037	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)	231	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)	9,502,600	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)	9,502,600	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)	9,502,600	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)	2,471.42	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	570,898	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)	570,898	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet D-1 | Date/Time Prepared: 10/31/2024 9:22 am

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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	5,405,001	490	11,030.61	12	132,367	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)	586,409	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	1,289,674	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)	281,622	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	109,591	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	391,213	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	898,461	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
55.03	CAR T-cell amount paid as an interim payment	0	55.03
56.00	Target amount ((line 54 x sum of lines 55, 55.01, and 55.02) plus line 55.03)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	808	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,471.42	88.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet D-1 | Date/Time Prepared: 10/31/2024 9:22 am

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	Cost Center Description					1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,996,907	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	4,016,452	9,502,600	0.422669	1,996,907	844,031	90.00
91.00	Nursing Program cost	0	9,502,600	0.000000	1,996,907	0	91.00
92.00	Allied health cost	0	9,502,600	0.000000	1,996,907	0	92.00
93.00	All other Medical Education	0	9,502,600	0.000000	1,996,907	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet D-3 | Date/Time Prepared: 10/31/2024 9:22 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,663,133		30.00
31.00	03100	INTENSIVE CARE UNIT		446,868		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.289780	343,986	99,680	50.00
51.00	05100	RECOVERY ROOM	0.490241	59,934	29,382	51.00
53.00	05300	ANESTHESIOLOGY	0.018604	62,722	1,167	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.080560	1,484,606	119,600	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.143430	107,508	15,420	59.00
60.00	06000	LABORATORY	0.119471	1,261,946	150,766	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.311808	23,976	7,476	62.00
65.00	06500	RESPIRATORY THERAPY	0.175267	807,020	141,444	65.00
66.00	06600	PHYSICAL THERAPY	0.198401	162,958	32,331	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.138671	178,174	24,708	67.00
68.00	06800	SPEECH PATHOLOGY	0.129307	20,331	2,629	68.00
69.00	06900	ELECTROCARDIOLOGY	0.049212	75,514	3,716	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.052469	798,650	41,904	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.159607	152,329	24,313	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.113614	1,328,031	150,883	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.523305	0	0	90.00
91.00	09100	EMERGENCY	0.166308	530,391	88,208	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.633987	60,645	38,448	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		7,458,721	972,075	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		7,458,721		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet D-3 | Date/Time Prepared: 10/31/2024 9:22 am

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		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,045,834		30.00
31.00	03100	INTENSIVE CARE UNIT		40,994		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.289780	239,843	69,502	50.00
51.00	05100	RECOVERY ROOM	0.490241	35,782	17,542	51.00
53.00	05300	ANESTHESIOLOGY	0.018604	26,569	494	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.080560	923,319	74,383	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.143430	0	0	59.00
60.00	06000	LABORATORY	0.119471	745,211	89,031	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.311808	24,018	7,489	62.00
65.00	06500	RESPIRATORY THERAPY	0.175267	392,428	68,780	65.00
66.00	06600	PHYSICAL THERAPY	0.198401	60,402	11,984	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.138671	59,816	8,295	67.00
68.00	06800	SPEECH PATHOLOGY	0.129307	5,559	719	68.00
69.00	06900	ELECTROCARDIOLOGY	0.049212	43,610	2,146	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.052469	130,729	6,859	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.159607	361,943	57,769	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.113614	658,933	74,864	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.523305	663	347	90.00
91.00	09100	EMERGENCY	0.166308	388,242	64,568	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.633987	49,902	31,637	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,146,969	586,409	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		4,146,969		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0047	Period: From 06/01/2023 To 05/31/2024	Worksheet E Part A Date/Time Prepared: 10/31/2024 9:22 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	383,593	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	767,187	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	39,729	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	79,459	2.04
3.00	Managed Care Simulated Payments	3,212,779	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	57.77	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	8.95	5.00
5.01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)	0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	1.89	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)	0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	-7.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	0.06	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	4.55	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.06	12.00
13.00	Total allowable FTE count for the prior year.	0.69	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.69	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.48	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.48	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.008309	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.001076	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.001076	21.00
22.00	IME payment adjustment (see instructions)	678	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	1,892	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	4.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	4.49	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	4.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.069240	26.00
27.00	IME payments adjustment factor. (see instructions)	0.018140	27.00
28.00	IME add-on adjustment amount (see instructions)	20,875	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	58,280	28.01
29.00	Total IME payment (sum of lines 22 and 28)	21,553	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	60,172	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	12.50	30.00
31.00	Percentage of Medicaid patient days (see instructions)	39.11	31.00
32.00	Sum of lines 30 and 31	51.61	32.00
33.00	Allowable disproportionate share percentage (see instructions)	12.00	33.00
34.00	Disproportionate share adjustment (see instructions)	34,524	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0047	Period: From 06/01/2023 To 05/31/2024	Worksheet E Part A Date/Time Prepared: 10/31/2024 9:22 am
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		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Payment Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital UCP, including supplemental UCP (see instructions)	1,157,729	993,039	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	386,967	662,026	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	1,048,993		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)	0		40.00

		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	2,375,038		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	2,435,210	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	215,723	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	156,408	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
55.01	Cellular therapy acquisition cost (see instructions)	0	55.01
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	2,807,341	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	2,807,341	61.00
62.00	Deductibles billed to program beneficiaries	164,832	62.00
63.00	Coinsurance billed to program beneficiaries	0	63.00
64.00	Allowable bad debts (see instructions)	52,357	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	34,032	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	7,085	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	2,676,541	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)	0	70.75
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	0	70.93
70.94	HRR adjustment amount (see instructions)	0	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet E Part A | Date/Time Prepared: 10/31/2024 9:22 am

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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3	0	0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		2,676,541	71.00
71.01	Sequestration adjustment (see instructions)		53,531	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		2,140,210	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		482,800	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		579,588	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	788	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	2,850,336	2.00
3.00	OPPS or REH payments	1,608,710	3.00
4.00	Outlier payment (see instructions)	383,032	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	788	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	6,152	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	6,152	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	6,152	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	5,364	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	788	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	1,991,742	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	523	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	328,328	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,663,679	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	155,813	28.00
28.50	REH facility payment amount (see instructions)		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	1,819,492	30.00
31.00	Primary payer payments	1,265	31.00
32.00	Subtotal (line 30 minus line 31)	1,818,227	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	53,025	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	34,466	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	39,344	36.00
37.00	Subtotal (see instructions)	1,852,693	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-306	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,852,999	40.00
40.01	Sequestration adjustment (see instructions)	37,060	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	1,793,548	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	22,391	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0047	Period: From 06/01/2023 To 05/31/2024	Worksheet E Part B Date/Time Prepared: 10/31/2024 9:22 am
	Title XVIII	Hospital	PPS

		1.00	
94.00	Total (sum of lines 91 and 93)	0	94.00
		1.00	
	MEDICARE PART B ANCILLARY COSTS		
200.00	Part B Combined Billed Days	0	200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet E-1 Part I | Date/Time Prepared: 10/31/2024 9:22 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,041,110		1,689,448	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	01/10/2024	50,700	01/10/2024	70,400	3.01
3.02		02/07/2024	48,400	02/07/2024	33,700	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		99,100		104,100	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,140,210		1,793,548	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		482,800		22,391	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,623,010		1,815,939	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0047	Period: From 06/01/2023 To 05/31/2024	Worksheet E-1 Part II Date/Time Prepared: 10/31/2024 9:22 am
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days (see instructions)		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days (see instructions)		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet E-3 Part VII Date/Time Prepared: 10/31/2024 9:22 am

Title XIX | Hospital | PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		1,747,401	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	1,747,401	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	1,747,401	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	1,039,795		8.00
9.00	Ancillary service charges	4,146,969	13,704,572	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	5,186,764	13,704,572	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	5,186,764	13,704,572	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	5,186,764	11,957,171	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	1,747,401	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	1,747,401	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	1,747,401	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	1,747,401	36.00
37.00	ELIMINATE SETTLEMENT	0	-1,747,401	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet E-4 | Date/Time Prepared: 10/31/2024 9:22 am

Title XVIII | Hospital | PPS

				1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			7.63	1.00
1.01	FTE cap adjustment under §131 of the CAA 2021 (see instructions)			0.00	1.01
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
2.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)			0.00	2.26
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
3.02	Adjustment (increase or decrease) to the hospital's rural track FTE limitation(s) for rural track programs with a rural track Medicare GME affiliation agreement in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)			0.00	3.02
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			-7.50	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
4.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)			0.00	4.21
5.00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lines 2.26 through 2.49, minus lines 3 and 3.01, plus or minus line 3.02, plus or minus line 4, plus lines 4.01 through 4.27			0.13	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			4.55	6.00
7.00	Enter the lesser of line 5 or line 6			0.13	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	4.55	0.00	4.55	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6. For cost reporting periods beginning on or after October 1, 2022, or if Worksheet S-2, Part I, line 68, is "Y", see instructions.	0.13	0.00	0.13	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.13	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.69	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.69	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.50	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.50	0.00		17.00
18.00	Per resident amount	124,558.63	117,946.09		18.00
18.01	Per resident amount under §131 of the CAA 2021	0.00	0.00		18.01
19.00	Approved amount for resident costs	62,279	0	62,279	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			5.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			4.42	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			4.42	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			123,870.17	23.00
24.00	Multiply line 22 time line 23			547,506	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			609,785	25.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet E-4 | Date/Time Prepared: 10/31/2024 9:22 am

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		Inpatient Part A	Managed Care Prior to 1/1	Managed Care On or after 1/1	Total	
		1.00	2.00	2.01	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	501	787	562		26.00
27.00	Total Inpatient Days (see instructions)	3,527	3,527	3,527		27.00
28.00	Ratio of inpatient days to total inpatient days	0.142047	0.223136	0.159342		28.00
29.00	Program direct GME amount	86,618	136,065	97,164	319,847	29.00
29.01	Percent reduction for MA DGME		3.27	3.27		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		4,449	3,177	7,626	30.00
31.00	Net Program direct GME amount				312,221	31.00

		1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS)		
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)	0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)	0	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)	0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)	0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)	0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY		
	Part A Reasonable Cost		
37.00	Reasonable cost (see instructions)	2,860,755	37.00
38.00	Organ acquisition and HSCT acquisition costs (see instructions)	0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)	0	39.00
40.00	Primary payer payments (see instructions)	0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	2,860,755	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	2,851,124	42.00
43.00	Primary payer payments (see instructions)	1,265	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	2,849,859	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	5,710,614	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.500954	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.499046	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	312,221	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	156,408	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	155,813	50.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0047	Period: From 06/01/2023 To 05/31/2024	Worksheet E-5 Date/Time Prepared: 10/31/2024 9:22 am
	Title XVIII		PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR		
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2	0	2.00
3.00	Operating outlier reconciliation adjustment amount (see instructions)	0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instructions)	0	4.00
5.00	The rate used to calculate the time value of money (see instructions)	0.00	5.00
6.00	Time value of money for operating expenses (see instructions)	0	6.00
7.00	Time value of money for capital related expenses (see instructions)	0	7.00

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

Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet G | Date/Time Prepared: 10/31/2024 9:22 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-364,100	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	18,269,571	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-5,790,478	0	0	0	6.00
7.00	Inventory	1,894,168	0	0	0	7.00
8.00	Prepaid expenses	1,385,056	0	0	0	8.00
9.00	Other current assets	492,603	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)	15,886,820	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,010,000	0	0	0	12.00
13.00	Land improvements	395,750	0	0	0	13.00
14.00	Accumulated depreciation	-316,600	0	0	0	14.00
15.00	Buildings	89,246,103	0	0	0	15.00
16.00	Accumulated depreciation	-6,819,954	0	0	0	16.00
17.00	Leasehold improvements	348,528	0	0	0	17.00
18.00	Accumulated depreciation	-106,254	0	0	0	18.00
19.00	Fixed equipment	1,109,511	0	0	0	19.00
20.00	Accumulated depreciation	-313,676	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	22,194,580	0	0	0	23.00
24.00	Accumulated depreciation	-11,283,117	0	0	0	24.00
25.00	Minor equipment depreciable	4,011,173	0	0	0	25.00
26.00	Accumulated depreciation	-1,637,688	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)	97,838,356	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	19,576,209	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	19,576,209	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	133,301,385	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,687,668	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,784,275	0	0	0	38.00
39.00	Payroll taxes payable	5,810	0	0	0	39.00
40.00	Notes and loans payable (short term)	611,218	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	196,822,723	0	0	0	43.00
44.00	Other current liabilities	3,481,456	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	204,393,150	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	11,733,771	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	465,500	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	12,199,271	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	216,592,421	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-83,291,036				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-83,291,036	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	133,301,385	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet G-1 | Date/Time Prepared: 10/31/2024 9:22 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-59,134,000		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-9,146,615				2.00
3.00	Total (sum of line 1 and line 2)		-68,280,615		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)		-68,280,615		0		11.00
12.00	DEDUCTIONS	15,010,421		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)		15,010,421		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-83,291,036		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet G-2 Parts I & II | Date/Time Prepared: 10/31/2024 9:22 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	9,915,126		9,915,126	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	9,915,126		9,915,126	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	7,501,625		7,501,625	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	7,501,625		7,501,625	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	17,416,751		17,416,751	17.00
18.00	Ancillary services	57,492,012	210,442,819	267,934,831	18.00
19.00	Outpatient services	5,660,687	69,329,991	74,990,678	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	IP CONTRACTED HOSPICE	138,282	0	138,282	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	80,707,732	279,772,810	360,480,542	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		63,758,465		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		63,758,465		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0047 | Period: From 06/01/2023 To 05/31/2024 | Worksheet G-3 | Date/Time Prepared: 10/31/2024 9:22 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	360,480,542	1.00
2.00	Less contractual allowances and discounts on patients' accounts	306,687,456	2.00
3.00	Net patient revenues (line 1 minus line 2)	53,793,086	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	63,758,465	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-9,965,379	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	818,764	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	818,764	25.00
26.00	Total (line 5 plus line 25)	-9,146,615	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)	-9,146,615	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0047	Period: From 06/01/2023 To 05/31/2024	Worksheet L Parts I-III Date/Time Prepared: 10/31/2024 9:22 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	88,391	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	115,054	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	9.72	3.00
4.00	Number of interns & residents (see instructions)	4.48	4.00
5.00	Indirect medical education percentage (see instructions)	13.89	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	12,278	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	215,723	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00