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: 15-0150	Period: From 04/01/2023 To 03/31/2024	Worksheet S Parts I-III Date/Time Prepared: 9/3/2024 12:05 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 9/3/2024 Time: 12:05 pm
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 DUPONT HOSPITAL (15-0150) for the cost reporting period beginning 04/01/2023 and ending 03/31/2024 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				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	181,421	6,400	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	181,421	6,400	0	0	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet S-2 Part I | Date/Time Prepared: 9/3/2024 12:05 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2520 E. DUPONT ROAD	PO Box:			1.00
2.00	City: FORT WAYNE	State: IN	Zip Code: 46825-	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	DUPONT HOSPITAL	150150	23060	1	05/24/2001	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:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	04/01/2023	03/31/2024	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: 15-0150	Period: From 04/01/2023 To 03/31/2024	Worksheet S-2 Part I Date/Time Prepared: 9/3/2024 12:05 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,358	1,540	0	180	8,200	492	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	Y	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.				57.00
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: 15-0150	Period: From 04/01/2023 To 03/31/2024	Worksheet S-2 Part I Date/Time Prepared: 9/3/2024 12:05 pm

		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: 15-0150	Period: From 04/01/2023 To 03/31/2024	Worksheet S-2 Part I Date/Time Prepared: 9/3/2024 12:05 pm

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

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0150	Period: From 04/01/2023 To 03/31/2024	Worksheet S-2 Part I Date/Time Prepared: 9/3/2024 12:05 pm

		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)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	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

		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)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
107.01	If this facility is a REH (line 3, column 4, is "12"), is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no. (see instructions)			107.01
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	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.	N	N	N	N	109.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0150	Period: From 04/01/2023 To 03/31/2024	Worksheet S-2 Part I Date/Time Prepared: 9/3/2024 12:05 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	92,397	118,018	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.	Y	5.03	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: CHS/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.	Y		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet S-2 Part I | Date/Time Prepared: 9/3/2024 12:05 pm

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

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

		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: 15-0150	Period: From 04/01/2023 To 03/31/2024	Worksheet S-2 Part II Date/Time Prepared: 9/3/2024 12:05 pm

		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.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

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

		Part A		Part B		
		Y/N	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	06/05/2024	Y	06/05/2024	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: 15-0150	Period: From 04/01/2023 To 03/31/2024	Worksheet S-2 Part II Date/Time Prepared: 9/3/2024 12:05 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00

		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	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, INC.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(615) 465-3416	KUZIWA_TSIGA@CHS.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet S-2 Part II Date/Time Prepared: 9/3/2024 12:05 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet S-3 Part I | Date/Time Prepared: 9/3/2024 12:05 pm

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	88	32,208	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)		88	32,208	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	10	3,660	0.00	0	8.00
8.01	NEONATAL INTENSIVE CARE UNIT	31.01	33	12,078	0.00	0	8.01
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		131	47,946	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)		131				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet S-3 Part I | Date/Time Prepared: 9/3/2024 12:05 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,046	227	9,929			1.00
2.00	HMO and other (see instructions)	2,083	8,439				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,046	227	9,929			7.00
8.00	INTENSIVE CARE UNIT	170	9	607			8.00
8.01	NEONATAL INTENSIVE CARE UNIT	0	951	6,622			8.01
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		1,652	5,795			13.00
14.00	Total (see instructions)	1,216	2,839	22,953	0.00	593.03	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)			74			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	593.03	27.00
28.00	Observation Bed Days		0	1,966			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			839			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	492	1,208			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet S-3 Part I Date/Time Prepared: 9/3/2024 12:05 pm

	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	373	1,326	4,907	1.00
2.00	HMO and other (see instructions)			547	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
8.01	NEONATAL INTENSIVE CARE UNIT						8.01
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	373	1,326	4,907	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

		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	51,067,185	0	51,067,185	1,233,512.00	41.40	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)		367,149	610,983	978,132	19,874.00	49.22	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,541,017	0	1,541,017	15,904.00	96.89	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		429,361	0	429,361	943.00	455.31	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		6,380,602	0	6,380,602	171,771.00	37.15	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)		12,472,076	0	12,472,076			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		224,803	0	224,803			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)		1,497,796	0	1,497,796			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: 15-0150	Period: From 04/01/2023 To 03/31/2024	Worksheet S-3 Part II Date/Time Prepared: 9/3/2024 12:05 pm

		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	363,379	0	363,379	7,725.00	47.04	26.00
27.00	Administrative & General	5.00	5,651,034	-907,522	4,743,512	129,871.00	36.52	27.00
28.00	Administrative & General under contract (see inst.)		87,533	0	87,533	2,440.00	35.87	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,174,519	0	1,174,519	40,189.00	29.22	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	368,909	0	368,909	18,918.00	19.50	32.00
33.00	Housekeeping under contract (see instructions)		781,613	0	781,613	30,689.00	25.47	33.00
34.00	Dietary	10.00	422,594	-198,206	224,388	5,494.56	40.84	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	198,206	198,206	4,853.44	40.84	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,526,067	242,334	2,768,401	62,683.00	44.17	38.00
39.00	Central Services and Supply	14.00	644,895	0	644,895	27,069.00	23.82	39.00
40.00	Pharmacy	15.00	1,774,371	0	1,774,371	31,656.00	56.05	40.00
41.00	Medical Records & Medical Records Library	16.00	188,817	0	188,817	4,777.00	39.53	41.00
42.00	Social Service	17.00	666,068	0	666,068	14,352.00	46.41	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION	Provider CCN: 15-0150	Period: From 04/01/2023 To 03/31/2024	Worksheet S-3 Part III Date/Time Prepared: 9/3/2024 12:05 pm

		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)		51,936,331	0	51,936,331	1,266,641.00	41.00	1.00
2.00	Excluded area salaries (see instructions)		367,149	610,983	978,132	19,874.00	49.22	2.00
3.00	Subtotal salaries (line 1 minus line 2)		51,569,182	-610,983	50,958,199	1,246,767.00	40.87	3.00
4.00	Subtotal other wages & related costs (see inst.)		8,350,980	0	8,350,980	188,618.00	44.27	4.00
5.00	Subtotal wage-related costs (see inst.)		13,969,872	0	13,969,872	0.00	27.41	5.00
6.00	Total (sum of lines 3 thru 5)		73,890,034	-610,983	73,279,051	1,435,385.00	51.05	6.00
7.00	Total overhead cost (see instructions)		14,649,799	-665,188	13,984,611	380,717.00	36.73	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet S-3 Part IV Date/Time Prepared: 9/3/2024 12:05 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	967,938	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)	7,680,117	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	14,714	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	28,250	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	-11	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	11,959	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	330,185	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	2,894,273	17.00
18.00	Medicare Taxes - Employers Portion Only	676,886	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	92,568	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)	12,696,879	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: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet S-3 Part V | Date/Time Prepared: 9/3/2024 12:05 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	1,541,017	12,696,879	1.00
2.00	Hospital	1,541,017	12,696,879	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	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet S-10 Parts I & II | Date/Time Prepared: 9/3/2024 12:05 pm

Line	Description	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)	0.132690	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	35,576,636	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	221,916,233	6.00
7.00	Medicaid cost (line 1 times line 6)	29,446,065	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	0	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)	0	19.00

Line	Description	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)	10,247,042	26,279	10,273,321	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,359,680	26,279	1,385,959	21.00
22.00	Payments received from patients for amounts previously written off as charity care	1,827	0	1,827	22.00
23.00	Cost of charity care (see instructions)	1,357,853	26,279	1,384,132	23.00

Line	Description	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)	3,064,305	26.00
27.00	Medicare reimbursable bad debts (see instructions)	44,219	27.00
27.01	Medicare allowable bad debts (see instructions)	68,030	27.01
28.00	Non-Medicare bad debt amount (see instructions)	2,996,275	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	421,387	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	1,805,519	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,805,519	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0150	Period: From 04/01/2023 To 03/31/2024	Worksheet S-10 Parts I & II Date/Time Prepared: 9/3/2024 12:05 pm

		1.00	
	PART II - HOSPITAL DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.132690	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)	10,247,042	26,279	10,273,321	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,359,680	26,279	1,385,959	21.00
22.00	Payments received from patients for amounts previously written off as charity care	1,827	0	1,827	22.00
23.00	Cost of charity care (see instructions)	1,357,853	26,279	1,384,132	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)	3,064,305	26.00
27.00	Medicare reimbursable bad debts (see instructions)	44,219	27.00
27.01	Medicare allowable bad debts (see instructions)	68,030	27.01
28.00	Non-Medicare bad debt amount (see instructions)	2,996,275	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	421,387	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	1,805,519	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,805,519	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet A | Date/Time Prepared: 9/3/2024 12:05 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		3,225,570	3,225,570	490,851	3,716,421	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		13,794,469	13,794,469	1,036,405	14,830,874	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	363,379	291,197	654,576	9,526,741	10,181,317	4.00
5.01	00570	ADMITTING	0	0	0	2,256,577	2,256,577	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	2,063,269	2,063,269	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	5,651,034	59,258,034	64,909,068	-15,550,318	49,358,750	5.03
7.00	00700	OPERATION OF PLANT	1,174,519	4,607,465	5,781,984	955,904	6,737,888	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	541,372	541,372	0	541,372	8.00
9.00	00900	HOUSEKEEPING	368,909	1,125,513	1,494,422	-2,846	1,491,576	9.00
10.00	01000	DIETARY	422,594	2,754,713	3,177,307	-1,496,649	1,680,658	10.00
11.00	01100	CAFETERIA	0	0	0	1,484,555	1,484,555	11.00
13.00	01300	NURSING ADMINISTRATION	2,526,067	457,798	2,983,865	235,891	3,219,756	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	644,895	10,877,504	11,522,399	-9,591,925	1,930,474	14.00
15.00	01500	PHARMACY	1,774,371	4,647,549	6,421,920	-4,404,105	2,017,815	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	188,817	676,799	865,616	-11,342	854,274	16.00
17.00	01700	SOCIAL SERVICE	666,068	52,513	718,581	0	718,581	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,466,444	3,742,499	15,208,943	-3,701,237	11,507,706	30.00
31.00	03100	INTENSIVE CARE UNIT	1,385,674	487,415	1,873,089	-8,299	1,864,790	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	5,688,864	2,231,678	7,920,542	-3,212,083	4,708,459	31.01
43.00	04300	NURSERY	0	173,939	173,939	3,194,930	3,368,869	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,714,756	11,326,317	16,041,073	2,766,162	18,807,235	50.00
51.00	05100	RECOVERY ROOM	3,063,397	758,359	3,821,756	-3,821,756	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,387	2,285,845	2,287,232	3,660,202	5,947,434	52.00
53.00	05300	ANESTHESIOLOGY	0	2,385,676	2,385,676	-2,385,676	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,377,462	831,752	3,209,214	794,397	4,003,611	54.00
54.01	05401	ULTRA SOUND	499,482	72,862	572,344	5,145	577,489	54.01
56.00	05600	RADIOISOTOPE	110,384	237,696	348,080	-17,687	330,393	56.00
57.00	05700	CT SCAN	0	621,837	621,837	-621,837	0	57.00
58.00	05800	MRI	274,422	65,100	339,522	-1,675	337,847	58.00
60.00	06000	LABORATORY	2,355,974	2,583,716	4,939,690	-170,001	4,769,689	60.00
65.00	06500	RESPIRATORY THERAPY	1,347,517	504,999	1,852,516	-9,184	1,843,332	65.00
66.00	06600	PHYSICAL THERAPY	221,050	18,262	239,312	316,673	555,985	66.00
67.00	06700	OCCUPATIONAL THERAPY	174,129	13,266	187,395	-187,395	0	67.00
68.00	06800	SPEECH PATHOLOGY	119,259	10,019	129,278	-129,278	0	68.00
69.00	06900	ELECTROCARDIOLOGY	18,376	464,543	482,919	0	482,919	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,368,493	3,368,493	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	8,540,030	8,540,030	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,373,781	4,373,781	73.00
74.00	07400	RENAL DIALYSIS	51,105	94,336	145,441	-6,888	138,553	74.00
76.00	03950	SLEEP LAB	407,343	132,220	539,563	-976	538,587	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	827,111	205,358	1,032,469	-837	1,031,632	90.00
91.00	09100	EMERGENCY	1,815,247	1,691,248	3,506,495	43,143	3,549,638	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	20,902	444,209	465,111	-465,111	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	50,720,938	133,693,647	184,414,585	-683,956	183,730,629	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	346,247	45,976	392,223	-384,907	7,316	192.00
194.00	07950	GUEST MEALS	0	0	0	0	0	194.00
194.01	07951	WOMENS RESOURCE CENTER	0	0	0	1,068,863	1,068,863	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	51,067,185	133,739,623	184,806,808	0	184,806,808	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet A | Date/Time Prepared: 9/3/2024 12:05 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,988,906	1,727,515	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-117,653	14,713,221	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	10,181,317	4.00
5.01	00570	ADMITTING	0	2,256,577	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	2,063,269	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	-21,612,619	27,746,131	5.03
7.00	00700	OPERATION OF PLANT	-7,337	6,730,551	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	541,372	8.00
9.00	00900	HOUSEKEEPING	0	1,491,576	9.00
10.00	01000	DIETARY	0	1,680,658	10.00
11.00	01100	CAFETERIA	-353,353	1,131,202	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,219,756	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,930,474	14.00
15.00	01500	PHARMACY	0	2,017,815	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-541	853,733	16.00
17.00	01700	SOCIAL SERVICE	0	718,581	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-2,049,921	9,457,785	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,864,790	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	-244,590	4,463,869	31.01
43.00	04300	NURSERY	0	3,368,869	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-2,385,867	16,421,368	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-1,448,355	4,499,079	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-352,800	3,650,811	54.00
54.01	05401	ULTRA SOUND	0	577,489	54.01
56.00	05600	RADIOISOTOPE	0	330,393	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	337,847	58.00
60.00	06000	LABORATORY	0	4,769,689	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,843,332	65.00
66.00	06600	PHYSICAL THERAPY	0	555,985	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	482,919	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,368,493	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,540,030	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,373,781	73.00
74.00	07400	RENAL DIALYSIS	-13,419	125,134	74.00
76.00	03950	SLEEP LAB	-7,500	531,087	76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	1,031,632	90.00
91.00	09100	EMERGENCY	-1,121,264	2,428,374	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0	0	95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-31,704,125	152,026,504	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,316	192.00
194.00	07950	GUEST MEALS	0	0	194.00
194.01	07951	WOMENS RESOURCE CENTER	0	1,068,863	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-31,704,125	153,102,683	200.00

RECLASSIFICATIONS | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet A-6 | Date/Time Prepared: 9/3/2024 12:05 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFIT RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	9,527,362	1.00
	0		0	9,527,362	
	B - RENTAL AND LEASE EXPENSES				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	94,933	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,029,464	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
	0		0	1,124,397	
	C - OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	318,853	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,531,248	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6,941	3.00
	0		0	1,857,042	
	D - REPAIRS & MAINTENANCE				
1.00	OPERATION OF PLANT	7.00	0	665,629	1.00
2.00	ULTRA SOUND	54.01	0	5,145	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
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
	0		0	670,774	
	E - CNO SALARIES				
1.00	NURSING ADMINISTRATION	13.00	275,637	0	1.00
	0		275,637	0	
	F - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	3,368,493	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	8,540,030	2.00
	0		0	11,908,523	
	G - DRUGS/IV SOLUTIONS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,373,781	1.00
	0		0	4,373,781	
	H - LABOR & DELIVERY COSTS				
1.00	ADULTS & PEDIATRICS	30.00	0	628,757	1.00
2.00	NURSERY	43.00	2,368,292	827,527	2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	4,300,632	0	3.00
	0		6,668,924	1,456,284	
	I - MISCELLANEOUS				
1.00	ADMITTING	5.01	1,099,045	1,157,532	1.00
2.00	CASHIERING/ACCOUNTS RECEIVABLE	5.02	0	2,063,269	2.00
	0		1,099,045	3,220,801	
	J - RADIOLOGY COSTS				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	621,837	1.00
	0		0	621,837	

RECLASSIFICATIONS	Provider CCN: 15-0150	Period: From 04/01/2023 To 03/31/2024	Worksheet A-6 Date/Time Prepared: 9/3/2024 12:05 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	K - DIETARY				
1.00	CAFETERIA	11.00	198,206	1,286,349	1.00
	0		198,206	1,286,349	
	L - MISC DEPT RECLASS				
1.00	WOMENS RESOURCE CENTER	194.01	976,150	92,713	1.00
2.00	OPERATING ROOM	50.00	3,063,397	3,143,551	2.00
3.00	PHYSICAL THERAPY	66.00	293,388	23,285	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	0		4,332,935	3,259,549	
	M - NON CAPITALIZED EQUIPMENT				
1.00	OPERATION OF PLANT	7.00	0	278,734	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	0	94	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
	0		0	278,828	
	N - SITTER COSTS				
1.00	ADULTS & PEDIATRICS	30.00	33,303	2,477	1.00
	0		33,303	2,477	
	O - INTEREST EXPENSE				
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	6,780	1.00
	0		0	6,780	
	P - RENT EXPENSE RECLASSIFICATION				
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	1,447,403	1.00
	TOTALS		0	1,447,403	
	Q - MOB RECLASSIFICATION				
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	344,265	25,886	1.00
2.00	OPERATION OF PLANT	7.00	0	11,541	2.00
3.00	HOUSEKEEPING	9.00	0	1,363	3.00
	TOTALS		344,265	38,790	
	R - AMBULANCE SERVICES				
1.00	EMERGENCY	91.00	20,902	30,209	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	414,000	2.00
	TOTALS		20,902	444,209	
500.00	Grand Total: Increases		12,973,217	41,525,186	500.00

RECLASSIFICATIONS	Provider CCN: 15-0150	Period: From 04/01/2023 To 03/31/2024	Worksheet A-6 Date/Time Prepared: 9/3/2024 12:05 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - EMPLOYEE BENEFIT RECLASS					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	9,527,362	0	1.00
	0		0	9,527,362		
	B - RENTAL AND LEASE EXPENSES					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	621	10	1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	31,922	10	2.00
3.00	DIETARY	10.00	0	1,575	0	3.00
4.00	NURSING ADMINISTRATION	13.00	0	319	0	4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	293,346	0	5.00
6.00	PHARMACY	15.00	0	9,390	0	6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	11,342	0	7.00
8.00	ADULTS & PEDIATRICS	30.00	0	3	0	8.00
9.00	INTENSIVE CARE UNIT	31.00	0	54	0	9.00
10.00	OPERATING ROOM	50.00	0	498,135	0	10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	128,136	0	11.00
12.00	LABORATORY	60.00	0	142,606	0	12.00
13.00	RENAL DIALYSIS	74.00	0	6,888	0	13.00
14.00	SLEEP LAB	76.00	0	28	0	14.00
15.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	32	0	15.00
	0		0	1,124,397		
	C - OTHER CAPITAL COSTS					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	1,857,042	12	1.00
2.00		0.00	0	0	13	2.00
3.00		0.00	0	0	12	3.00
	0		0	1,857,042		
	D - REPAIRS & MAINTENANCE					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	293,980	0	1.00
2.00	HOUSEKEEPING	9.00	0	4,209	0	2.00
3.00	DIETARY	10.00	0	9,355	0	3.00
4.00	NURSING ADMINISTRATION	13.00	0	3,349	0	4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	32,321	0	5.00
6.00	PHARMACY	15.00	0	20,934	0	6.00
7.00	ADULTS & PEDIATRICS	30.00	0	12,205	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	8,245	0	8.00
9.00	NEONATAL INTENSIVE CARE UNIT	31.01	0	11,928	0	9.00
10.00	OPERATING ROOM	50.00	0	85,450	0	10.00
11.00	RECOVERY ROOM	51.00	0	484	0	11.00
12.00	DELIVERY ROOM & LABOR ROOM	52.00	0	11,767	0	12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	113,304	0	13.00
14.00	RADIOISOTOPE	56.00	0	17,687	0	14.00
15.00	MRI	58.00	0	1,675	0	15.00
16.00	LABORATORY	60.00	0	24,596	0	16.00
17.00	RESPIRATORY THERAPY	65.00	0	8,903	0	17.00
18.00	SLEEP LAB	76.00	0	750	0	18.00
19.00	CLINIC	90.00	0	837	0	19.00
20.00	EMERGENCY	91.00	0	6,975	0	20.00
21.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,820	0	21.00
	0		0	670,774		
	E - CNO SALARIES					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	275,637	0	0	1.00
	0		275,637	0		
	F - MEDICAL SUPPLIES					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	9,165,450	0	1.00
2.00	OPERATING ROOM	50.00	0	2,743,073	0	2.00
	0		0	11,908,523		
	G - DRUGS/IV SOLUTIONS					
1.00	PHARMACY	15.00	0	4,373,781	0	1.00
	0		0	4,373,781		
	H - LABOR & DELIVERY COSTS					
1.00	ADULTS & PEDIATRICS	30.00	4,300,632	0	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	0	628,757	0	2.00
3.00	NEONATAL INTENSIVE CARE UNIT	31.01	2,368,292	827,527	0	3.00
	0		6,668,924	1,456,284		
	I - MISCELLANEOUS					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	1,099,045	3,220,801	0	1.00
2.00		0.00	0	0	0	2.00
	0		1,099,045	3,220,801		

RECLASSIFICATIONS | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet A-6 | Date/Time Prepared: 9/3/2024 12:05 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	J - RADIOLOGY COSTS					
1.00	CT SCAN	57.00	0	621,837	0	1.00
	0		0	621,837		
	K - DIETARY					
1.00	DIETARY	10.00	198,206	1,286,349	0	1.00
	0		198,206	1,286,349		
	L - MISC DEPT RECLASS					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	976,150	92,713	0	1.00
2.00	RECOVERY ROOM	51.00	3,063,397	757,875	0	2.00
3.00	OCCUPATIONAL THERAPY	67.00	174,129	13,266	0	3.00
4.00	SPEECH PATHOLOGY	68.00	119,259	10,019	0	4.00
5.00	ANESTHESIOLOGY	53.00	0	2,385,676	0	5.00
	0		4,332,935	3,259,549		
	M - NON CAPITALIZED EQUIPMENT					
1.00	DIETARY	10.00	0	1,164	0	1.00
2.00	NURSING ADMINISTRATION	13.00	0	298	0	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	100,808	0	3.00
4.00	ADULTS & PEDIATRICS	30.00	0	52,934	0	4.00
5.00	NEONATAL INTENSIVE CARE UNIT	31.01	0	4,336	0	5.00
6.00	NURSERY	43.00	0	889	0	6.00
7.00	OPERATING ROOM	50.00	0	114,128	0	7.00
8.00	LABORATORY	60.00	0	2,799	0	8.00
9.00	RESPIRATORY THERAPY	65.00	0	281	0	9.00
10.00	SLEEP LAB	76.00	0	198	0	10.00
11.00	EMERGENCY	91.00	0	993	0	11.00
	0		0	278,828		
	N - SITTER COSTS					
1.00	NURSING ADMINISTRATION	13.00	33,303	2,477	0	1.00
	0		33,303	2,477		
	O - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	6,780	11	1.00
	0		0	6,780		
	P - RENT EXPENSE RECLASSIFICATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,447,403	10	1.00
	TOTALS		0	1,447,403		
	Q - MOB RECLASSIFICATION					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	344,265	38,790	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		344,265	38,790		
	R - AMBULANCE SERVICES					
1.00	AMBULANCE SERVICES	95.00	20,902	444,209	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		20,902	444,209		
500.00	Grand Total: Decreases		12,973,217	41,525,186		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet A-7 Part I | Date/Time Prepared: 9/3/2024 12:05 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,060,000	0	0	0	0	1.00
2.00	Land Improvements	568,321	0	0	0	0	2.00
3.00	Buildings and Fixtures	63,665,717	1,367	0	1,367	0	3.00
4.00	Building Improvements	57,134,262	1,770,327	0	1,770,327	1,832,804	4.00
5.00	Fixed Equipment	3,533,473	17,642	0	17,642	0	5.00
6.00	Movable Equipment	48,706,723	1,076,242	0	1,076,242	0	6.00
7.00	HIT designated Assets	70,886	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	174,739,382	2,865,578	0	2,865,578	1,832,804	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	174,739,382	2,865,578	0	2,865,578	1,832,804	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,060,000	0	1.00
2.00	Land Improvements	568,321	0	2.00
3.00	Buildings and Fixtures	63,667,084	0	3.00
4.00	Building Improvements	57,071,785	0	4.00
5.00	Fixed Equipment	3,551,115	0	5.00
6.00	Movable Equipment	49,782,965	0	6.00
7.00	HIT designated Assets	70,886	0	7.00
8.00	Subtotal (sum of lines 1-7)	175,772,156	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	175,772,156	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0150

Period: From 04/01/2023 To 03/31/2024

Worksheet A-7 Part II

Date/Time Prepared: 9/3/2024 12:05 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	3,225,570	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	13,794,469	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	17,020,039	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	3,225,570	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	13,794,469	2.00
3.00	Total (sum of lines 1-2)	0	17,020,039	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet A-7 Part III | Date/Time Prepared: 9/3/2024 12:05 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	122,367,190	41,836,626	80,530,564	0.601264	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	53,404,967	0	53,404,967	0.398736	0	2.00
3.00	Total (sum of lines 1-2)	175,772,157	41,836,626	133,935,531	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	3,358,831	-1,702,518	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	13,979,220	727,060	2.00
3.00	Total (sum of lines 1-2)	0	0	0	17,338,051	-975,458	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	214,168	318,853	1,531,248	-1,993,067	1,727,515	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	6,941	0	0	14,713,221	2.00
3.00	Total (sum of lines 1-2)	214,168	325,794	1,531,248	-1,993,067	16,440,736	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet A-8 | Date/Time Prepared: 9/3/2024 12:05 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	0	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	7.00
8.00	Television and radio service (chapter 21)	A	-7,337	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	-7,636,166			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	-2,967,648			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-353,353	CAFETERIA	11.00	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	-541	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)	A	0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet A-8 | Date/Time Prepared: 9/3/2024 12:05 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	VENDING MACHINE INCOME	B	0	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.00
33.01	LOBBYING	A	-4,364	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.01
33.02	RENTAL INCOME	B	-350,048	CAP REL COSTS-BLDG & FIXT	1.00	10	33.02
33.03	EQUITY EARNINGS OFFSET	A	-1,993,067	CAP REL COSTS-BLDG & FIXT	1.00	14	33.03
34.00	PENALTIES	A	0	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	34.00
35.00	MISC INCOME	B	18,742	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	35.00
36.00	MARKETING DEPARTMENT	A	-279,084	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	36.00
42.01	MINORITY INTEREST	A	-17,568,721	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	42.01
43.00	PHYSICIAN RECRUITING	A	-472,289	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	43.00
44.00	CHARITABLE CONTRIBUTIONS	A	-89,749	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	44.00
45.01	LEGAL FEES	A	-500	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	45.01
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-31,704,125				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: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet A-8-1 | Date/Time Prepared: 9/3/2024 12:05 pm

	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			0	0	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT	Capital-Related Interest	220,948	0	4.00
4.01	1.00	CAP REL COSTS-BLDG & FIXT	PASI Capital Costs - Bldg &	914	0	4.01
4.02	2.00	CAP REL COSTS-MVBLE EQUIP	PASI Capital Costs - Moveabl	1,958	0	4.02
4.03	5.03	OTHER ADMINISTRATIVE AND GEN	PASI Operating Costs	574,448	568,220	4.03
4.04	5.03	OTHER ADMINISTRATIVE AND GEN	Shared Service Center Alloca	3,425,939	2,182,093	4.04
4.05	1.00	CAP REL COSTS-BLDG & FIXT	New Capital - Building & Fix	132,347	0	4.05
4.06	2.00	CAP REL COSTS-MVBLE EQUIP	New Capital - Movable Equipm	182,793	0	4.06
4.07	5.03	OTHER ADMINISTRATIVE AND GEN	Non-Capital Home Office Cost	4,958,912	0	4.07
4.08	5.03	OTHER ADMINISTRATIVE AND GEN	Malpractice Costs	210,415	792,538	4.08
4.09	2.00	CAP REL COSTS-MVBLE EQUIP	CIG Leased Equipment	31,821	334,225	4.09
4.10	5.03	OTHER ADMINISTRATIVE AND GEN	Management Fees	0	4,539,710	4.10
4.11	5.03	OTHER ADMINISTRATIVE AND GEN	401K Fees	0	4,817	4.11
4.12	5.03	OTHER ADMINISTRATIVE AND GEN	Audit Fees	0	223,001	4.12
4.13	5.03	OTHER ADMINISTRATIVE AND GEN	Corporate Overhead Allocatio	0	2,831,204	4.13
4.14	5.03	OTHER ADMINISTRATIVE AND GEN	HIIM Allocation	0	601,856	4.14
4.15	5.03	OTHER ADMINISTRATIVE AND GEN	Contract Management	0	723,378	4.15
4.16	5.03	OTHER ADMINISTRATIVE AND GEN	PASI Lien Unit Collection Fe	0	-92,899	4.16
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			9,740,495	12,708,143	5.00

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

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office: Name	Related Organization(s) and/or Home Office: 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.

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	B	CHS, INC.	72.03	CHS, INC.	72.03	6.00
7.00	B	HOSPITAL LAUNDR	100.00	HOSPITAL LAUNDR	100.00	7.00
8.00	B	LUTHERAN HEALTH	100.00	LUTHERAN HEALTH	100.00	8.00
9.00	B	PASI	100.00	PASI	100.00	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: 15-0150	Period: From 04/01/2023 To 03/31/2024	Worksheet A-8-1 Date/Time Prepared: 9/3/2024 12:05 pm

	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	220,948	11	4.00
4.01	914	9	4.01
4.02	1,958	9	4.02
4.03	6,228	0	4.03
4.04	1,243,846	0	4.04
4.05	132,347	9	4.05
4.06	182,793	9	4.06
4.07	4,958,912	0	4.07
4.08	-582,123	0	4.08
4.09	-302,404	10	4.09
4.10	-4,539,710	0	4.10
4.11	-4,817	0	4.11
4.12	-223,001	0	4.12
4.13	-2,831,204	0	4.13
4.14	-601,856	0	4.14
4.15	-723,378	0	4.15
4.16	92,899	0	4.16
5.00	-2,967,648		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.

	Type of Business	
6.00	HOSPITAL MANAGEMENT	6.00
7.00	LAUNDRY	7.00
8.00	HOSPITAL NETWOR	8.00
9.00	DEBT COLLECTION	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: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet A-8-2 | Date/Time Prepared: 9/3/2024 12:05 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.03	OTHER ADMINISTRATIVE AND GENERAL	12,450	12,450	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	2,049,921	2,049,921	0	0	0	2.00
3.00	31.01	NEONATAL INTENSIVE CARE UNIT	244,590	244,590	0	0	0	3.00
4.00	50.00	OPERATING ROOM	2,385,867	2,385,867	0	0	0	4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	1,448,355	1,448,355	0	0	0	5.00
6.00	74.00	RENAL DIALYSIS	13,419	13,419	0	0	0	6.00
7.00	76.00	SLEEP LAB	7,500	7,500	0	0	0	7.00
8.00	91.00	EMERGENCY	1,121,264	1,121,264	0	0	0	8.00
9.00	54.00	RADIOLOGY-DIAGNOSTIC	352,800	352,800	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			7,636,166	7,636,166	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	OTHER 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	31.01	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	5.00
6.00	74.00	RENAL DIALYSIS	0	0	0	0	0	6.00
7.00	76.00	SLEEP LAB	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	54.00	RADIOLOGY-DIAGNOSTIC	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	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	12,450		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	2,049,921		2.00
3.00	31.01	NEONATAL INTENSIVE CARE UNIT	0	0	0	244,590		3.00
4.00	50.00	OPERATING ROOM	0	0	0	2,385,867		4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	1,448,355		5.00
6.00	74.00	RENAL DIALYSIS	0	0	0	13,419		6.00
7.00	76.00	SLEEP LAB	0	0	0	7,500		7.00
8.00	91.00	EMERGENCY	0	0	0	1,121,264		8.00
9.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	352,800		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	7,636,166		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet B Part I | Date/Time Prepared: 9/3/2024 12:05 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,727,515	1,727,515				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	14,713,221		14,713,221			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	10,181,317	4,606	39,229	10,225,152		4.00
5.01	00570	ADMITTING	2,256,577	1,311	11,169	221,638	2,490,695	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,063,269	1,199	10,216	0	0	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	27,746,131	31,538	268,607	734,958	0	5.03
7.00	00700	OPERATION OF PLANT	6,730,551	498,040	4,241,790	236,858	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	541,372	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,491,576	5,581	47,537	74,396	0	9.00
10.00	01000	DIETARY	1,680,658	24,237	206,427	45,251	0	10.00
11.00	01100	CAFETERIA	1,131,202	21,414	182,385	39,971	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,219,756	0	0	558,287	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,930,474	16,920	144,110	130,052	0	14.00
15.00	01500	PHARMACY	2,017,815	9,508	80,977	357,827	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	853,733	5,965	50,806	38,078	0	16.00
17.00	01700	SOCIAL SERVICE	718,581	0	0	134,322	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,457,785	368,673	3,139,986	1,451,802	125,810	30.00
31.00	03100	INTENSIVE CARE UNIT	1,864,790	53,912	459,165	279,441	8,707	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	4,463,869	77,781	662,458	669,640	91,031	31.01
43.00	04300	NURSERY	3,368,869	24,453	208,265	477,599	64,925	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,421,368	387,385	3,299,351	1,568,592	833,381	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,499,079	0	0	867,562	58,672	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,650,811	57,910	493,217	479,448	154,160	54.00
54.01	05401	ULTRA SOUND	577,489	10,331	87,992	100,728	25,508	54.01
56.00	05600	RADIOISOTOPE	330,393	6,277	53,463	22,260	19,792	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	337,847	13,786	117,413	55,341	27,649	58.00
60.00	06000	LABORATORY	4,769,689	15,753	134,167	475,115	187,093	60.00
65.00	06500	RESPIRATORY THERAPY	1,843,332	0	0	271,746	32,612	65.00
66.00	06600	PHYSICAL THERAPY	555,985	4,782	40,727	103,744	11,403	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	482,919	0	0	3,706	34,967	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,368,493	0	0	0	213,775	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,540,030	0	0	0	224,504	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,373,781	0	0	0	225,254	73.00
74.00	07400	RENAL DIALYSIS	125,134	0	0	10,306	1,398	74.00
76.00	03950	SLEEP LAB	531,087	17,880	152,283	82,146	16,085	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,031,632	0	0	166,799	10,321	90.00
91.00	09100	EMERGENCY	2,428,374	63,755	543,002	370,285	123,548	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	100	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	152,026,504	1,722,997	14,674,742	10,027,898	2,490,695	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,518	38,479	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,316	0	0	400	0	192.00
194.00	07950	GUEST MEALS	0	0	0	0	0	194.00
194.01	07951	WOMENS RESOURCE CENTER	1,068,863	0	0	196,854	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	153,102,683	1,727,515	14,713,221	10,225,152	2,490,695	202.00

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER 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	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,074,684					5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	0	28,781,234	28,781,234			5.03
7.00	00700	OPERATION OF PLANT	0	11,707,239	2,710,308	14,417,547		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	541,372	125,331	0	666,703	8.00
9.00	00900	HOUSEKEEPING	0	1,619,090	374,831	67,576	0	9.00
10.00	01000	DIETARY	0	1,956,573	452,960	293,443	0	10.00
11.00	01100	CAFETERIA	0	1,374,972	318,316	259,268	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,778,043	874,643	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,221,556	514,306	204,859	0	14.00
15.00	01500	PHARMACY	0	2,466,127	570,926	115,112	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	948,582	219,603	72,223	0	16.00
17.00	01700	SOCIAL SERVICE	0	852,903	197,453	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	104,813	14,648,869	3,391,316	4,463,611	160,648	30.00
31.00	03100	INTENSIVE CARE UNIT	7,254	2,673,269	618,880	652,720	42,693	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	75,838	6,040,617	1,398,445	941,710	19,120	31.01
43.00	04300	NURSERY	54,089	4,198,200	971,913	296,057	8,126	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	693,971	23,204,048	5,371,850	4,690,158	161,603	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	48,880	5,474,193	1,267,314	0	139,615	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	128,431	4,963,977	1,149,195	701,127	40,338	54.00
54.01	05401	ULTRA SOUND	21,251	823,299	190,599	125,084	0	54.01
56.00	05600	RADIOISOTOPE	16,489	448,674	103,871	75,999	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	23,034	575,070	133,133	166,907	14,367	58.00
60.00	06000	LABORATORY	155,868	5,737,685	1,328,314	190,724	0	60.00
65.00	06500	RESPIRATORY THERAPY	27,169	2,174,859	503,495	0	0	65.00
66.00	06600	PHYSICAL THERAPY	9,500	726,141	168,107	57,895	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	29,131	550,723	127,496	0	10,363	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	178,097	3,760,365	870,551	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	187,035	8,951,569	2,072,351	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	187,660	4,786,695	1,108,153	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,165	138,003	31,949	0	0	74.00
76.00	03950	SLEEP LAB	13,400	812,881	188,188	216,476	10,892	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	8,598	1,217,350	281,825	0	0	90.00
91.00	09100	EMERGENCY	102,928	3,631,892	840,808	771,898	58,938	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	83	183	42	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,074,684	151,786,253	28,476,472	14,362,847	666,703	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	42,997	9,954	54,700	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,716	1,786	0	0	192.00
194.00	07950	GUEST MEALS	0	0	0	0	0	194.00
194.01	07951	WOMENS RESOURCE CENTER	0	1,265,717	293,022	0	0	194.01
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)	2,074,684	153,102,683	28,781,234	14,417,547	666,703	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet B Part I Date/Time Prepared: 9/3/2024 12:05 pm

		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	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00560	OTHER 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	2,061,497					9.00
10.00	01000	DIETARY	42,156	2,745,132				10.00
11.00	01100	CAFETERIA	37,246	0	1,989,802			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	120,647	4,773,333		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	29,430	0	52,078	99	3,022,328	14.00
15.00	01500	PHARMACY	16,537	0	60,924	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,375	0	9,207	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	27,620	0	144	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	641,236	1,192,827	325,556	1,919,366	63,839	30.00
31.00	03100	INTENSIVE CARE UNIT	93,769	72,920	51,677	231,559	15,404	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	135,285	0	128,613	1,060,996	61,735	31.01
43.00	04300	NURSERY	42,531	0	91,746	0	21,334	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	673,781	1,065,996	375,834	1,008,412	913,716	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	182,172	229	98,152	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	100,723	0	111,080	58,776	42,643	54.00
54.01	05401	ULTRA SOUND	17,969	0	21,015	0	2,506	54.01
56.00	05600	RADIOISOTOPE	10,918	0	4,163	0	23,030	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	23,978	0	13,009	0	3,053	58.00
60.00	06000	LABORATORY	27,399	0	150,389	10,609	132,366	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	58,963	0	34,945	65.00
66.00	06600	PHYSICAL THERAPY	8,317	0	20,495	0	215	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	320	0	57,104	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	415,268	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,052,807	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	2,162	6,991	8,255	74.00
76.00	03950	SLEEP LAB	31,099	0	23,377	0	11,196	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	33,744	159,788	17,906	90.00
91.00	09100	EMERGENCY	110,890	158,056	72,533	314,402	43,631	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	2,076	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,053,639	2,489,799	1,937,324	4,773,303	3,019,249	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,858	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	14,330	30	135	192.00
194.00	07950	GUEST MEALS	0	255,333	0	0	0	194.00
194.01	07951	WOMENS RESOURCE CENTER	0	0	38,148	0	2,944	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,061,497	2,745,132	1,989,802	4,773,333	3,022,328	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet B Part I | Date/Time Prepared: 9/3/2024 12:05 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
		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	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00560	OTHER 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	3,229,626					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,259,990				16.00
17.00	01700	SOCIAL SERVICE	0	0	1,078,120			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	63,624	466,712	27,337,604	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,403	26,142	4,483,436	0	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	46,036	313,237	10,145,794	0	31.01
43.00	04300	NURSERY	0	32,834	272,029	5,934,770	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	421,864	0	37,887,262	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	29,671	0	7,191,346	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	77,961	0	7,245,820	0	54.00
54.01	05401	ULTRA SOUND	0	12,900	0	1,193,372	0	54.01
56.00	05600	RADIOISOTOPE	0	10,009	0	676,664	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	13,982	0	943,499	0	58.00
60.00	06000	LABORATORY	0	94,616	0	7,672,102	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	16,492	0	2,788,754	0	65.00
66.00	06600	PHYSICAL THERAPY	0	5,767	0	986,937	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	17,683	0	763,689	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	108,109	0	5,154,293	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	113,535	0	12,190,262	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,229,626	113,914	0	9,238,388	0	73.00
74.00	07400	RENAL DIALYSIS	0	707	0	188,067	0	74.00
76.00	03950	SLEEP LAB	0	8,134	0	1,302,243	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	5,219	0	1,715,832	0	90.00
91.00	09100	EMERGENCY	0	62,480	0	6,065,528	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	50	0	2,351	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,229,626	1,259,990	1,078,120	151,108,013	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	115,509	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	23,997	0	192.00
194.00	07950	GUEST MEALS	0	0	0	255,333	0	194.00
194.01	07951	WOMENS RESOURCE CENTER	0	0	0	1,599,831	0	194.01
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)	3,229,626	1,259,990	1,078,120	153,102,683	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet B Part I | Date/Time Prepared: 9/3/2024 12:05 pm

		Cost Center Description	Total	
			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	00570	ADMITTING		5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE		5.02
5.03	00560	OTHER 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
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	27,337,604	30.00
31.00	03100	INTENSIVE CARE UNIT	4,483,436	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	10,145,794	31.01
43.00	04300	NURSERY	5,934,770	43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	37,887,262	50.00
51.00	05100	RECOVERY ROOM	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,191,346	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,245,820	54.00
54.01	05401	ULTRA SOUND	1,193,372	54.01
56.00	05600	RADIOISOTOPE	676,664	56.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MRI	943,499	58.00
60.00	06000	LABORATORY	7,672,102	60.00
65.00	06500	RESPIRATORY THERAPY	2,788,754	65.00
66.00	06600	PHYSICAL THERAPY	986,937	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	763,689	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,154,293	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,190,262	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,238,388	73.00
74.00	07400	RENAL DIALYSIS	188,067	74.00
76.00	03950	SLEEP LAB	1,302,243	76.00
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	1,715,832	90.00
91.00	09100	EMERGENCY	6,065,528	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	2,351	95.00
	SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	151,108,013	118.00
	NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	115,509	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	23,997	192.00
194.00	07950	GUEST MEALS	255,333	194.00
194.01	07951	WOMENS RESOURCE CENTER	1,599,831	194.01
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	153,102,683	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet B Part II Date/Time Prepared: 9/3/2024 12:05 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,606	39,229	43,835	43,835	4.00
5.01	00570	ADMITTING	0	1,311	11,169	12,480	951	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	1,199	10,216	11,415	0	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	0	31,538	268,607	300,145	3,152	5.03
7.00	00700	OPERATION OF PLANT	0	498,040	4,241,790	4,739,830	1,016	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	5,581	47,537	53,118	319	9.00
10.00	01000	DIETARY	0	24,237	206,427	230,664	194	10.00
11.00	01100	CAFETERIA	0	21,414	182,385	203,799	171	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	2,395	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	16,920	144,110	161,030	558	14.00
15.00	01500	PHARMACY	0	9,508	80,977	90,485	1,535	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,965	50,806	56,771	163	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	576	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	368,673	3,139,986	3,508,659	6,227	30.00
31.00	03100	INTENSIVE CARE UNIT	0	53,912	459,165	513,077	1,199	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	77,781	662,458	740,239	2,872	31.01
43.00	04300	NURSERY	0	24,453	208,265	232,718	2,049	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	387,385	3,299,351	3,686,736	6,706	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	3,721	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	57,910	493,217	551,127	2,057	54.00
54.01	05401	ULTRA SOUND	0	10,331	87,992	98,323	432	54.01
56.00	05600	RADIOISOTOPE	0	6,277	53,463	59,740	95	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	13,786	117,413	131,199	237	58.00
60.00	06000	LABORATORY	0	15,753	134,167	149,920	2,038	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	1,166	65.00
66.00	06600	PHYSICAL THERAPY	0	4,782	40,727	45,509	445	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	16	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
74.00	07400	RENAL DIALYSIS	0	0	0	0	44	74.00
76.00	03950	SLEEP LAB	0	17,880	152,283	170,163	352	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	715	90.00
91.00	09100	EMERGENCY	0	63,755	543,002	606,757	1,588	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,722,997	14,674,742	16,397,739	42,989	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,518	38,479	42,997	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	2	192.00
194.00	07950	GUEST MEALS	0	0	0	0	0	194.00
194.01	07951	WOMENS RESOURCE CENTER	0	0	0	0	844	194.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,727,515	14,713,221	16,440,736	43,835	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet B Part II Date/Time Prepared: 9/3/2024 12:05 pm

		Cost Center Description	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	OTHER 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	00570	ADMITTING	13,431					5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	11,415				5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	0	0	303,297			5.03
7.00	00700	OPERATION OF PLANT	0	0	28,566	4,769,412		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,321	0	1,321	8.00
9.00	00900	HOUSEKEEPING	0	0	3,951	22,355	0	9.00
10.00	01000	DIETARY	0	0	4,774	97,073	0	10.00
11.00	01100	CAFETERIA	0	0	3,355	85,767	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	9,218	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	5,421	67,768	0	14.00
15.00	01500	PHARMACY	0	0	6,017	38,080	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	2,315	23,892	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	2,081	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	690	575	35,743	1,476,590	318	30.00
31.00	03100	INTENSIVE CARE UNIT	48	40	6,523	215,924	85	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	499	416	14,739	311,523	38	31.01
43.00	04300	NURSERY	356	297	10,244	97,938	16	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,335	3,838	56,569	1,551,531	319	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	322	268	13,357	0	277	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	846	705	12,112	231,937	80	54.00
54.01	05401	ULTRA SOUND	140	117	2,009	41,378	0	54.01
56.00	05600	RADIOISOTOPE	109	91	1,095	25,141	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	152	126	1,403	55,214	28	58.00
60.00	06000	LABORATORY	1,027	855	14,000	63,093	0	60.00
65.00	06500	RESPIRATORY THERAPY	179	149	5,307	0	0	65.00
66.00	06600	PHYSICAL THERAPY	63	52	1,772	19,152	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	192	160	1,344	0	21	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,173	977	9,175	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,232	1,027	21,842	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,236	1,030	11,680	0	0	73.00
74.00	07400	RENAL DIALYSIS	8	6	337	0	0	74.00
76.00	03950	SLEEP LAB	88	74	1,983	71,612	22	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	57	47	2,970	0	0	90.00
91.00	09100	EMERGENCY	678	565	8,862	255,349	117	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,431	11,415	300,085	4,751,317	1,321	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	105	18,095	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	19	0	0	192.00
194.00	07950	GUEST MEALS	0	0	0	0	0	194.00
194.01	07951	WOMENS RESOURCE CENTER	0	0	3,088	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	13,431	11,415	303,297	4,769,412	1,321	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet B Part II | Date/Time Prepared: 9/3/2024 12:05 pm

		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	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00560	OTHER 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	79,743					9.00
10.00	01000	DIETARY	1,631	334,336				10.00
11.00	01100	CAFETERIA	1,441	0	294,533			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	17,858	29,471		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,138	0	7,709	1	243,625	14.00
15.00	01500	PHARMACY	640	0	9,018	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	401	0	1,363	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	4,088	0	12	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,804	145,277	48,189	11,846	5,146	30.00
31.00	03100	INTENSIVE CARE UNIT	3,627	8,881	7,649	1,430	1,242	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	5,233	0	19,037	6,552	4,976	31.01
43.00	04300	NURSERY	1,645	0	13,580	0	1,720	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,064	129,830	55,633	6,227	73,650	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	26,965	1	7,912	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,896	0	16,442	363	3,437	54.00
54.01	05401	ULTRA SOUND	695	0	3,111	0	202	54.01
56.00	05600	RADIOISOTOPE	422	0	616	0	1,856	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	928	0	1,926	0	246	58.00
60.00	06000	LABORATORY	1,060	0	22,261	66	10,669	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	8,728	0	2,817	65.00
66.00	06600	PHYSICAL THERAPY	322	0	3,034	0	17	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	47	0	4,603	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	33,473	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	84,872	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	320	43	665	74.00
76.00	03950	SLEEP LAB	1,203	0	3,460	0	902	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	4,995	987	1,443	90.00
91.00	09100	EMERGENCY	4,289	19,250	10,736	1,942	3,517	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	13	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	79,439	303,238	286,765	29,471	243,377	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	304	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	2,121	0	11	192.00
194.00	07950	GUEST MEALS	0	31,098	0	0	0	194.00
194.01	07951	WOMENS RESOURCE CENTER	0	0	5,647	0	237	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	79,743	334,336	294,533	29,471	243,625	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet B Part II Date/Time Prepared: 9/3/2024 12:05 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
	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	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00560	OTHER 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	145,775					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	84,905				16.00
17.00	01700	SOCIAL SERVICE	0	0	6,757			17.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	4,314	2,925	5,271,303	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	299	164	760,188	0	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	3,122	1,963	1,111,209	0	31.01
43.00	04300	NURSERY	0	2,227	1,705	364,495	0	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	28,069	0	5,629,507	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,012	0	54,835	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,287	0	828,289	0	54.00
54.01	05401	ULTRA SOUND	0	875	0	147,282	0	54.01
56.00	05600	RADIOISOTOPE	0	679	0	89,844	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	948	0	192,407	0	58.00
60.00	06000	LABORATORY	0	6,416	0	271,405	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,118	0	19,464	0	65.00
66.00	06600	PHYSICAL THERAPY	0	391	0	70,757	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	1,199	0	7,582	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,331	0	52,129	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,699	0	116,672	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	145,775	7,725	0	167,446	0	73.00
74.00	07400	RENAL DIALYSIS	0	48	0	1,471	0	74.00
76.00	03950	SLEEP LAB	0	552	0	250,411	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	354	0	11,568	0	90.00
91.00	09100	EMERGENCY	0	4,237	0	917,887	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	3	0	17	0	95.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	145,775	84,905	6,757	16,336,168	0	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	61,501	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	2,153	0	192.00
194.00	07950	GUEST MEALS	0	0	0	31,098	0	194.00
194.01	07951	WOMENS RESOURCE CENTER	0	0	0	9,816	0	194.01
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)	145,775	84,905	6,757	16,440,736	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet B Part II | Date/Time Prepared: 9/3/2024 12:05 pm

		Cost Center Description	Total	
			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	00570	ADMITTING		5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE		5.02
5.03	00560	OTHER 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
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	5,271,303	30.00
31.00	03100	INTENSIVE CARE UNIT	760,188	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	1,111,209	31.01
43.00	04300	NURSERY	364,495	43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	5,629,507	50.00
51.00	05100	RECOVERY ROOM	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	54,835	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	828,289	54.00
54.01	05401	ULTRA SOUND	147,282	54.01
56.00	05600	RADIOISOTOPE	89,844	56.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MRI	192,407	58.00
60.00	06000	LABORATORY	271,405	60.00
65.00	06500	RESPIRATORY THERAPY	19,464	65.00
66.00	06600	PHYSICAL THERAPY	70,757	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	7,582	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	52,129	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	116,672	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	167,446	73.00
74.00	07400	RENAL DIALYSIS	1,471	74.00
76.00	03950	SLEEP LAB	250,411	76.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	11,568	90.00
91.00	09100	EMERGENCY	917,887	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	17	95.00
		SPECIAL PURPOSE COST CENTERS		
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,336,168	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	61,501	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,153	192.00
194.00	07950	GUEST MEALS	31,098	194.00
194.01	07951	WOMENS RESOURCE CENTER	9,816	194.01
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	16,440,736	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet B-1 | Date/Time Prepared: 9/3/2024 12:05 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	216,037					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		216,037				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	576	576	50,703,806			4.00
5.01	00570	ADMITTING	164	164	1,099,045	1,138,801,130		5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	150	150	0	0	1,138,801,130	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	3,944	3,944	3,644,467	0	0	5.03
7.00	00700	OPERATION OF PLANT	62,283	62,283	1,174,519	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	698	698	368,909	0	0	9.00
10.00	01000	DIETARY	3,031	3,031	224,388	0	0	10.00
11.00	01100	CAFETERIA	2,678	2,678	198,206	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	2,768,401	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,116	2,116	644,895	0	0	14.00
15.00	01500	PHARMACY	1,189	1,189	1,774,371	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	746	746	188,817	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	666,068	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	46,105	46,105	7,199,115	57,526,179	57,526,179	30.00
31.00	03100	INTENSIVE CARE UNIT	6,742	6,742	1,385,674	3,981,110	3,981,110	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	9,727	9,727	3,320,572	41,623,741	41,623,741	31.01
43.00	04300	NURSERY	3,058	3,058	2,368,292	29,686,795	29,686,795	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	48,445	48,445	7,778,153	380,999,962	380,999,962	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	4,302,019	26,827,419	26,827,419	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,242	7,242	2,377,462	70,489,224	70,489,224	54.00
54.01	05401	ULTRA SOUND	1,292	1,292	499,482	11,663,487	11,663,487	54.01
56.00	05600	RADIOISOTOPE	785	785	110,384	9,050,004	9,050,004	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	1,724	1,724	274,422	12,642,287	12,642,287	58.00
60.00	06000	LABORATORY	1,970	1,970	2,355,974	85,547,711	85,547,711	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,347,517	14,911,630	14,911,630	65.00
66.00	06600	PHYSICAL THERAPY	598	598	514,438	5,214,016	5,214,016	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	18,376	15,988,540	15,988,540	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	97,747,970	97,747,970	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	102,653,857	102,653,857	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	102,996,796	102,996,796	73.00
74.00	07400	RENAL DIALYSIS	0	0	51,105	639,200	639,200	74.00
76.00	03950	SLEEP LAB	2,236	2,236	407,343	7,354,704	7,354,704	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	827,111	4,719,102	4,719,102	90.00
91.00	09100	EMERGENCY	7,973	7,973	1,836,149	56,491,858	56,491,858	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	45,538	45,538	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	215,472	215,472	49,725,674	1,138,801,130	1,138,801,130	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	565	565	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,982	0	0	192.00
194.00	07950	GUEST MEALS	0	0	0	0	0	194.00
194.01	07951	WOMENS RESOURCE CENTER	0	0	976,150	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,727,515	14,713,221	10,225,152	2,490,695	2,074,684	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.996385	68.105098	0.201664	0.002187	0.001822	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			43,835	13,431	11,415	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000865	0.000012	0.000010	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: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet B-1 | Date/Time Prepared: 9/3/2024 12:05 pm

		Cost Center Description	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
			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	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	-28,781,234	124,321,449				5.03
7.00	00700	OPERATION OF PLANT	0	11,707,239	148,920			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	541,372	0	572,239		8.00
9.00	00900	HOUSEKEEPING	0	1,619,090	698	0	148,222	9.00
10.00	01000	DIETARY	0	1,956,573	3,031	0	3,031	10.00
11.00	01100	CAFETERIA	0	1,374,972	2,678	0	2,678	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,778,043	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,221,556	2,116	0	2,116	14.00
15.00	01500	PHARMACY	0	2,466,127	1,189	0	1,189	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	948,582	746	0	746	16.00
17.00	01700	SOCIAL SERVICE	0	852,903	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	14,648,869	46,105	137,886	46,105	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,673,269	6,742	36,644	6,742	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	6,040,617	9,727	16,411	9,727	31.01
43.00	04300	NURSERY	0	4,198,200	3,058	6,975	3,058	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	23,204,048	48,445	138,705	48,445	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,474,193	0	119,833	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,963,977	7,242	34,623	7,242	54.00
54.01	05401	ULTRA SOUND	0	823,299	1,292	0	1,292	54.01
56.00	05600	RADIOISOTOPE	0	448,674	785	0	785	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	575,070	1,724	12,331	1,724	58.00
60.00	06000	LABORATORY	0	5,737,685	1,970	0	1,970	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,174,859	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	726,141	598	0	598	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	550,723	0	8,895	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,760,365	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,951,569	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,786,695	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	138,003	0	0	0	74.00
76.00	03950	SLEEP LAB	0	812,881	2,236	9,349	2,236	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,217,350	0	0	0	90.00
91.00	09100	EMERGENCY	0	3,631,892	7,973	50,587	7,973	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	183	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-28,781,234	123,005,019	148,355	572,239	147,657	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	42,997	565	0	565	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,716	0	0	0	192.00
194.00	07950	GUEST MEALS	0	0	0	0	0	194.00
194.01	07951	WOMENS RESOURCE CENTER	0	1,265,717	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		28,781,234	14,417,547	666,703	2,061,497	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.231507	96.814041	1.165078	13.908172	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		303,297	4,769,412	1,321	79,743	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.002440	32.026672	0.002308	0.537997	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: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet B-1 | Date/Time Prepared: 9/3/2024 12:05 pm

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (NURSING 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	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00560	OTHER 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	73,936					10.00
11.00	01100	CAFETERIA	0	49,709				11.00
13.00	01300	NURSING ADMINISTRATION	0	3,014	23,790,481			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,301	495	24,516,012		14.00
15.00	01500	PHARMACY	0	1,522	0	0	4,373,781	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	230	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	690	0	1,165	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	32,127	8,133	9,566,164	517,838	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,964	1,291	1,154,102	124,948	0	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	3,213	5,288,057	500,767	0	31.01
43.00	04300	NURSERY	0	2,292	0	173,050	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	28,711	9,389	5,025,977	7,411,713	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,551	1,142	796,168	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,775	292,942	345,901	0	54.00
54.01	05401	ULTRA SOUND	0	525	0	20,326	0	54.01
56.00	05600	RADIOISOTOPE	0	104	0	186,808	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	325	0	24,764	0	58.00
60.00	06000	LABORATORY	0	3,757	52,877	1,073,701	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,473	0	283,459	0	65.00
66.00	06600	PHYSICAL THERAPY	0	512	0	1,741	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	8	0	463,204	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,368,493	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	8,540,030	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	4,373,781	73.00
74.00	07400	RENAL DIALYSIS	0	54	34,842	66,964	0	74.00
76.00	03950	SLEEP LAB	0	584	0	90,820	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	843	796,393	145,250	0	90.00
91.00	09100	EMERGENCY	4,257	1,812	1,566,994	353,921	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	10,347	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	67,059	48,398	23,790,332	24,491,031	4,373,781	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	358	149	1,097	0	192.00
194.00	07950	GUEST MEALS	6,877	0	0	0	0	194.00
194.01	07951	WOMENS RESOURCE CENTER	0	953	0	23,884	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,745,132	1,989,802	4,773,333	3,022,328	3,229,626	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	37.128490	40.029009	0.200640	0.123280	0.738406	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	334,336	294,533	29,471	243,625	145,775	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.521965	5.925144	0.001239	0.009937	0.033329	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: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet B-1 | Date/Time Prepared: 9/3/2024 12:05 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
			16.00	17.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00570	ADMITTING			5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.02
5.03	00560	OTHER 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	1,138,801,130		16.00
17.00	01700	SOCIAL SERVICE	0	22,971	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	57,526,179	9,944	30.00
31.00	03100	INTENSIVE CARE UNIT	3,981,110	557	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	41,623,741	6,674	31.01
43.00	04300	NURSERY	29,686,795	5,796	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	380,999,962	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	26,827,419	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	70,489,224	0	54.00
54.01	05401	ULTRA SOUND	11,663,487	0	54.01
56.00	05600	RADIOISOTOPE	9,050,004	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	12,642,287	0	58.00
60.00	06000	LABORATORY	85,547,711	0	60.00
65.00	06500	RESPIRATORY THERAPY	14,911,630	0	65.00
66.00	06600	PHYSICAL THERAPY	5,214,016	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	15,988,540	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	97,747,970	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	102,653,857	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	102,996,796	0	73.00
74.00	07400	RENAL DIALYSIS	639,200	0	74.00
76.00	03950	SLEEP LAB	7,354,704	0	76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	4,719,102	0	90.00
91.00	09100	EMERGENCY	56,491,858	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	45,538	0	95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,138,801,130	22,971	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	GUEST MEALS	0	0	194.00
194.01	07951	WOMENS RESOURCE CENTER	0	0	194.01
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,259,990	1,078,120	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.001106	46.933960	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	84,905	6,757	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000075	0.294153	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: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet C Part I | Date/Time Prepared: 9/3/2024 12:05 pm

Title XVIII | 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	27,337,604		27,337,604	0	27,337,604	30.00
31.00	03100	INTENSIVE CARE UNIT	4,483,436		4,483,436	0	4,483,436	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	10,145,794		10,145,794	0	10,145,794	31.01
43.00	04300	NURSERY	5,934,770		5,934,770	0	5,934,770	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	37,887,262		37,887,262	0	37,887,262	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,191,346		7,191,346	0	7,191,346	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,245,820		7,245,820	0	7,245,820	54.00
54.01	05401	ULTRA SOUND	1,193,372		1,193,372	0	1,193,372	54.01
56.00	05600	RADIOISOTOPE	676,664		676,664	0	676,664	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	943,499		943,499	0	943,499	58.00
60.00	06000	LABORATORY	7,672,102		7,672,102	0	7,672,102	60.00
65.00	06500	RESPIRATORY THERAPY	2,788,754	0	2,788,754	0	2,788,754	65.00
66.00	06600	PHYSICAL THERAPY	986,937	0	986,937	0	986,937	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	763,689		763,689	0	763,689	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,154,293		5,154,293	0	5,154,293	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,190,262		12,190,262	0	12,190,262	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,238,388		9,238,388	0	9,238,388	73.00
74.00	07400	RENAL DIALYSIS	188,067		188,067	0	188,067	74.00
76.00	03950	SLEEP LAB	1,302,243		1,302,243	0	1,302,243	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,715,832		1,715,832	0	1,715,832	90.00
91.00	09100	EMERGENCY	6,065,528		6,065,528	0	6,065,528	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,518,340		4,518,340		4,518,340	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,351		2,351	0	2,351	95.00
200.00		Subtotal (see instructions)	155,626,353	0	155,626,353	0	155,626,353	200.00
201.00		Less Observation Beds	4,518,340		4,518,340		4,518,340	201.00
202.00		Total (see instructions)	151,108,013	0	151,108,013	0	151,108,013	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet C Part I Date/Time Prepared: 9/3/2024 12:05 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges					
			Inpatient	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	49,247,390		49,247,390			30.00
31.00	03100	INTENSIVE CARE UNIT	3,981,110		3,981,110			31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	41,623,741		41,623,741			31.01
43.00	04300	NURSERY	29,686,795		29,686,795			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	67,910,208	313,089,754	380,999,962	0.099442	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	26,441,959	385,460	26,827,419	0.268060	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,033,135	59,456,089	70,489,224	0.102793	0.000000	54.00
54.01	05401	ULTRA SOUND	1,537,402	10,126,085	11,663,487	0.102317	0.000000	54.01
56.00	05600	RADIOISOTOPE	377,486	8,672,518	9,050,004	0.074769	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	760,066	11,882,221	12,642,287	0.074630	0.000000	58.00
60.00	06000	LABORATORY	31,569,278	53,978,433	85,547,711	0.089682	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	12,224,023	2,687,607	14,911,630	0.187019	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,394,286	819,730	5,214,016	0.189285	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	4,148,293	11,840,247	15,988,540	0.047765	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	37,144,661	60,603,309	97,747,970	0.052730	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,824,992	82,828,865	102,653,857	0.118751	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	44,911,123	58,085,673	102,996,796	0.089696	0.000000	73.00
74.00	07400	RENAL DIALYSIS	639,200	0	639,200	0.294222	0.000000	74.00
76.00	03950	SLEEP LAB	109,372	7,245,332	7,354,704	0.177063	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	384,407	4,334,695	4,719,102	0.363593	0.000000	90.00
91.00	09100	EMERGENCY	10,203,996	46,287,862	56,491,858	0.107370	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,677,533	6,601,256	8,278,789	0.545773	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	39,744	5,794	45,538	0.051627	0.000000	95.00
200.00		Subtotal (see instructions)	399,870,200	738,930,930	1,138,801,130			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	399,870,200	738,930,930	1,138,801,130			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet C Part I | Date/Time Prepared: 9/3/2024 12:05 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		31.01
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.099442	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.268060	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.102793	54.00
54.01	05401	ULTRA SOUND	0.102317	54.01
56.00	05600	RADIOISOTOPE	0.074769	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.074630	58.00
60.00	06000	LABORATORY	0.089682	60.00
65.00	06500	RESPIRATORY THERAPY	0.187019	65.00
66.00	06600	PHYSICAL THERAPY	0.189285	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.047765	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.052730	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.118751	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.089696	73.00
74.00	07400	RENAL DIALYSIS	0.294222	74.00
76.00	03950	SLEEP LAB	0.177063	76.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.363593	90.00
91.00	09100	EMERGENCY	0.107370	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.545773	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.051627	95.00
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: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet C Part I | Date/Time Prepared: 9/3/2024 12:05 pm

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	27,337,604		27,337,604	0	27,337,604	30.00
31.00	03100	INTENSIVE CARE UNIT	4,483,436		4,483,436	0	4,483,436	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	10,145,794		10,145,794	0	10,145,794	31.01
43.00	04300	NURSERY	5,934,770		5,934,770	0	5,934,770	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	37,887,262		37,887,262	0	37,887,262	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,191,346		7,191,346	0	7,191,346	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,245,820		7,245,820	0	7,245,820	54.00
54.01	05401	ULTRA SOUND	1,193,372		1,193,372	0	1,193,372	54.01
56.00	05600	RADIOISOTOPE	676,664		676,664	0	676,664	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	943,499		943,499	0	943,499	58.00
60.00	06000	LABORATORY	7,672,102		7,672,102	0	7,672,102	60.00
65.00	06500	RESPIRATORY THERAPY	2,788,754	0	2,788,754	0	2,788,754	65.00
66.00	06600	PHYSICAL THERAPY	986,937	0	986,937	0	986,937	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	763,689		763,689	0	763,689	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,154,293		5,154,293	0	5,154,293	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,190,262		12,190,262	0	12,190,262	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,238,388		9,238,388	0	9,238,388	73.00
74.00	07400	RENAL DIALYSIS	188,067		188,067	0	188,067	74.00
76.00	03950	SLEEP LAB	1,302,243		1,302,243	0	1,302,243	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,715,832		1,715,832	0	1,715,832	90.00
91.00	09100	EMERGENCY	6,065,528		6,065,528	0	6,065,528	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,518,340		4,518,340		4,518,340	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,351		2,351	0	2,351	95.00
200.00		Subtotal (see instructions)	155,626,353	0	155,626,353	0	155,626,353	200.00
201.00		Less Observation Beds	4,518,340		4,518,340		4,518,340	201.00
202.00		Total (see instructions)	151,108,013	0	151,108,013	0	151,108,013	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet C Part I Date/Time Prepared: 9/3/2024 12:05 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	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	49,247,390		49,247,390			30.00
31.00	03100	INTENSIVE CARE UNIT	3,981,110		3,981,110			31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	41,623,741		41,623,741			31.01
43.00	04300	NURSERY	29,686,795		29,686,795			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	67,910,208	313,089,754	380,999,962	0.099442	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	26,441,959	385,460	26,827,419	0.268060	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,033,135	59,456,089	70,489,224	0.102793	0.000000	54.00
54.01	05401	ULTRA SOUND	1,537,402	10,126,085	11,663,487	0.102317	0.000000	54.01
56.00	05600	RADIOISOTOPE	377,486	8,672,518	9,050,004	0.074769	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	760,066	11,882,221	12,642,287	0.074630	0.000000	58.00
60.00	06000	LABORATORY	31,569,278	53,978,433	85,547,711	0.089682	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	12,224,023	2,687,607	14,911,630	0.187019	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,394,286	819,730	5,214,016	0.189285	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	4,148,293	11,840,247	15,988,540	0.047765	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	37,144,661	60,603,309	97,747,970	0.052730	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,824,992	82,828,865	102,653,857	0.118751	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	44,911,123	58,085,673	102,996,796	0.089696	0.000000	73.00
74.00	07400	RENAL DIALYSIS	639,200	0	639,200	0.294222	0.000000	74.00
76.00	03950	SLEEP LAB	109,372	7,245,332	7,354,704	0.177063	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	384,407	4,334,695	4,719,102	0.363593	0.000000	90.00
91.00	09100	EMERGENCY	10,203,996	46,287,862	56,491,858	0.107370	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,677,533	6,601,256	8,278,789	0.545773	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	39,744	5,794	45,538	0.051627	0.000000	95.00
200.00		Subtotal (see instructions)	399,870,200	738,930,930	1,138,801,130			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	399,870,200	738,930,930	1,138,801,130			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet C Part I | Date/Time Prepared: 9/3/2024 12:05 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		31.01
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.099442	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.268060	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.102793	54.00
54.01	05401	ULTRA SOUND	0.102317	54.01
56.00	05600	RADIOISOTOPE	0.074769	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.074630	58.00
60.00	06000	LABORATORY	0.089682	60.00
65.00	06500	RESPIRATORY THERAPY	0.187019	65.00
66.00	06600	PHYSICAL THERAPY	0.189285	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.047765	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.052730	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.118751	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.089696	73.00
74.00	07400	RENAL DIALYSIS	0.294222	74.00
76.00	03950	SLEEP LAB	0.177063	76.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.363593	90.00
91.00	09100	EMERGENCY	0.107370	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.545773	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.051627	95.00
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: 15-0150

Period: From 04/01/2023 To 03/31/2024

Worksheet C Part II

Date/Time Prepared: 9/3/2024 12:05 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	37,887,262	5,629,507	32,257,755	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,191,346	54,835	7,136,511	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,245,820	828,289	6,417,531	0	0	54.00
54.01	05401	ULTRA SOUND	1,193,372	147,282	1,046,090	0	0	54.01
56.00	05600	RADIOISOTOPE	676,664	89,844	586,820	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	943,499	192,407	751,092	0	0	58.00
60.00	06000	LABORATORY	7,672,102	271,405	7,400,697	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,788,754	19,464	2,769,290	0	0	65.00
66.00	06600	PHYSICAL THERAPY	986,937	70,757	916,180	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	763,689	7,582	756,107	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,154,293	52,129	5,102,164	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,190,262	116,672	12,073,590	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,238,388	167,446	9,070,942	0	0	73.00
74.00	07400	RENAL DIALYSIS	188,067	1,471	186,596	0	0	74.00
76.00	03950	SLEEP LAB	1,302,243	250,411	1,051,832	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,715,832	11,568	1,704,264	0	0	90.00
91.00	09100	EMERGENCY	6,065,528	917,887	5,147,641	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,518,340	871,235	3,647,105	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	2,351	17	2,334	0	0	95.00
200.00		Subtotal (sum of lines 50 thru 199)	107,724,749	9,700,208	98,024,541	0	0	200.00
201.00		Less Observation Beds	4,518,340	871,235	3,647,105	0	0	201.00
202.00		Total (line 200 minus line 201)	103,206,409	8,828,973	94,377,436	0	0	202.00

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

Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet C Part II | Date/Time Prepared: 9/3/2024 12:05 pm

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	37,887,262	380,999,962	0.099442			50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,191,346	26,827,419	0.268060			52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,245,820	70,489,224	0.102793			54.00
54.01	05401	ULTRA SOUND	1,193,372	11,663,487	0.102317			54.01
56.00	05600	RADIOISOTOPE	676,664	9,050,004	0.074769			56.00
57.00	05700	CT SCAN	0	0	0.000000			57.00
58.00	05800	MRI	943,499	12,642,287	0.074630			58.00
60.00	06000	LABORATORY	7,672,102	85,547,711	0.089682			60.00
65.00	06500	RESPIRATORY THERAPY	2,788,754	14,911,630	0.187019			65.00
66.00	06600	PHYSICAL THERAPY	986,937	5,214,016	0.189285			66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	763,689	15,988,540	0.047765			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,154,293	97,747,970	0.052730			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,190,262	102,653,857	0.118751			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,238,388	102,996,796	0.089696			73.00
74.00	07400	RENAL DIALYSIS	188,067	639,200	0.294222			74.00
76.00	03950	SLEEP LAB	1,302,243	7,354,704	0.177063			76.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,715,832	4,719,102	0.363593			90.00
91.00	09100	EMERGENCY	6,065,528	56,491,858	0.107370			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,518,340	8,278,789	0.545773			92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	2,351	45,538	0.051627			95.00
200.00		Subtotal (sum of lines 50 thru 199)	107,724,749	1,014,262,094				200.00
201.00		Less Observation Beds	4,518,340	0				201.00
202.00		Total (line 200 minus line 201)	103,206,409	1,014,262,094				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet D Part I Date/Time Prepared: 9/3/2024 12:05 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	5,271,303	0	5,271,303	11,895	443.15	30.00
31.00	INTENSIVE CARE UNIT	760,188		760,188	607	1,252.37	31.00
31.01	NEONATAL INTENSIVE CARE UNIT	1,111,209		1,111,209	6,622	167.81	31.01
43.00	NURSERY	364,495		364,495	5,795	62.90	43.00
200.00	Total (lines 30 through 199)	7,507,195		7,507,195	24,919		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	1,046	463,535	30.00
31.00	INTENSIVE CARE UNIT	170	212,903	31.00
31.01	NEONATAL INTENSIVE CARE UNIT	0	0	31.01
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	1,216	676,438	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet D Part II Date/Time Prepared: 9/3/2024 12:05 pm

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	5,629,507	380,999,962	0.014776	6,846,224	101,160	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	54,835	26,827,419	0.002044	29,932	61	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	828,289	70,489,224	0.011751	1,954,374	22,966	54.00
54.01	05401	ULTRA SOUND	147,282	11,663,487	0.012628	151,181	1,909	54.01
56.00	05600	RADIOISOTOPE	89,844	9,050,004	0.009928	105,892	1,051	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	192,407	12,642,287	0.015219	99,005	1,507	58.00
60.00	06000	LABORATORY	271,405	85,547,711	0.003173	2,585,501	8,204	60.00
65.00	06500	RESPIRATORY THERAPY	19,464	14,911,630	0.001305	1,133,252	1,479	65.00
66.00	06600	PHYSICAL THERAPY	70,757	5,214,016	0.013571	602,794	8,181	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	7,582	15,988,540	0.000474	711,105	337	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	52,129	97,747,970	0.000533	2,530,667	1,349	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	116,672	102,653,857	0.001137	4,191,911	4,766	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	167,446	102,996,796	0.001626	3,617,186	5,882	73.00
74.00	07400	RENAL DIALYSIS	1,471	639,200	0.002301	149,494	344	74.00
76.00	03950	SLEEP LAB	250,411	7,354,704	0.034048	7,766	264	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	11,568	4,719,102	0.002451	230	1	90.00
91.00	09100	EMERGENCY	917,887	56,491,858	0.016248	1,465,569	23,813	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	871,235	8,278,789	0.105237	269,082	28,317	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	9,700,191	1,014,216,556		26,451,165	211,591	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0150	Period: From 04/01/2023 To 03/31/2024	Worksheet D Part III Date/Time Prepared: 9/3/2024 12:05 pm
	Title XVIII	Hospital	PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	31.01
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	11,895	0.00	1,046	30.00
31.00	03100	INTENSIVE CARE UNIT		0	607	0.00	170	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		0	6,622	0.00	0	31.01
43.00	04300	NURSERY		0	5,795	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	24,919		1,216	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
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	31.01
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet D Part IV Date/Time Prepared: 9/3/2024 12:05 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	SLEEP LAB	0	0	0	0	0	76.00
		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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0150

Period: From 04/01/2023 To 03/31/2024

Worksheet D Part IV Date/Time Prepared: 9/3/2024 12:05 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	380,999,962	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	26,827,419	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	70,489,224	0.000000	54.00
54.01	05401	ULTRA SOUND	0	0	0	11,663,487	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	9,050,004	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	12,642,287	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	85,547,711	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	14,911,630	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,214,016	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	15,988,540	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	97,747,970	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	102,653,857	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	102,996,796	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	639,200	0.000000	74.00
76.00	03950	SLEEP LAB	0	0	0	7,354,704	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	4,719,102	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	56,491,858	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	8,278,789	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	1,014,216,556		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet D Part IV | Date/Time Prepared: 9/3/2024 12:05 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	6,846,224	0	35,346,613	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	29,932	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,954,374	0	7,215,639	0	54.00
54.01	05401	ULTRA SOUND	0.000000	151,181	0	837,946	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	105,892	0	1,880,688	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	99,005	0	1,518,492	0	58.00
60.00	06000	LABORATORY	0.000000	2,585,501	0	2,859,750	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,133,252	0	313,042	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	602,794	0	30,185	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	711,105	0	1,914,463	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	2,530,667	0	6,862,167	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	4,191,911	0	14,562,319	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	3,617,186	0	11,596,527	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	149,494	0	0	0	74.00
76.00	03950	SLEEP LAB	0.000000	7,766	0	467,932	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	230	0	609,546	0	90.00
91.00	09100	EMERGENCY	0.000000	1,465,569	0	2,944,255	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	269,082	0	702,435	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		26,451,165	0	89,661,999	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet D Part V | Date/Time Prepared: 9/3/2024 12:05 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.099442	35,346,613	0	0	3,514,938	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.268060	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.102793	7,215,639	0	0	741,717	54.00
54.01	05401	ULTRA SOUND	0.102317	837,946	0	0	85,736	54.01
56.00	05600	RADIOISOTOPE	0.074769	1,880,688	0	0	140,617	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.074630	1,518,492	0	0	113,325	58.00
60.00	06000	LABORATORY	0.089682	2,859,750	14,800	0	256,468	60.00
65.00	06500	RESPIRATORY THERAPY	0.187019	313,042	0	0	58,545	65.00
66.00	06600	PHYSICAL THERAPY	0.189285	30,185	0	0	5,714	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.047765	1,914,463	0	0	91,444	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.052730	6,862,167	0	0	361,842	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.118751	14,562,319	0	0	1,729,290	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.089696	11,596,527	0	23,545	1,040,162	73.00
74.00	07400	RENAL DIALYSIS	0.294222	0	0	0	0	74.00
76.00	03950	SLEEP LAB	0.177063	467,932	0	0	82,853	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.363593	609,546	0	0	221,627	90.00
91.00	09100	EMERGENCY	0.107370	2,944,255	0	0	316,125	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.545773	702,435	0	0	383,370	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.051627		0			95.00
200.00		Subtotal (see instructions)		89,661,999	14,800	23,545	9,143,773	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		89,661,999	14,800	23,545	9,143,773	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet D Part V Date/Time Prepared: 9/3/2024 12:05 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401	ULTRA SOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	1,327	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
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	2,112	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	SLEEP LAB	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	1,327	2,112	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	1,327	2,112	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 15-0150	Period: From 04/01/2023 To 03/31/2024	Worksheet D Part I Date/Time Prepared: 9/3/2024 12:05 pm
	Title XIX	Hospital	PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	5,271,303	0	5,271,303	11,895	443.15	30.00
31.00	INTENSIVE CARE UNIT	760,188		760,188	607	1,252.37	31.00
31.01	NEONATAL INTENSIVE CARE UNIT	1,111,209		1,111,209	6,622	167.81	31.01
43.00	NURSERY	364,495		364,495	5,795	62.90	43.00
200.00	Total (lines 30 through 199)	7,507,195		7,507,195	24,919		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	227	100,595	30.00
31.00	INTENSIVE CARE UNIT	9	11,271	31.00
31.01	NEONATAL INTENSIVE CARE UNIT	951	159,587	31.01
43.00	NURSERY	1,652	103,911	43.00
200.00	Total (lines 30 through 199)	2,839	375,364	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet D Part II Date/Time Prepared: 9/3/2024 12:05 pm

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	5,629,507	380,999,962	0.014776	1,384,290	20,454	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	54,835	26,827,419	0.002044	505,552	1,033	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	828,289	70,489,224	0.011751	282,772	3,323	54.00
54.01	05401	ULTRA SOUND	147,282	11,663,487	0.012628	78,996	998	54.01
56.00	05600	RADIOISOTOPE	89,844	9,050,004	0.009928	15,743	156	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	192,407	12,642,287	0.015219	35,709	543	58.00
60.00	06000	LABORATORY	271,405	85,547,711	0.003173	1,483,733	4,708	60.00
65.00	06500	RESPIRATORY THERAPY	19,464	14,911,630	0.001305	862,095	1,125	65.00
66.00	06600	PHYSICAL THERAPY	70,757	5,214,016	0.013571	304,474	4,132	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	7,582	15,988,540	0.000474	161,529	77	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	52,129	97,747,970	0.000533	1,898,193	1,012	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	116,672	102,653,857	0.001137	50,359	57	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	167,446	102,996,796	0.001626	1,932,569	3,142	73.00
74.00	07400	RENAL DIALYSIS	1,471	639,200	0.002301	0	0	74.00
76.00	03950	SLEEP LAB	250,411	7,354,704	0.034048	10,737	366	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	11,568	4,719,102	0.002451	20,366	50	90.00
91.00	09100	EMERGENCY	917,887	56,491,858	0.016248	237,052	3,852	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	871,235	8,278,789	0.105237	19,881	2,092	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	9,700,191	1,014,216,556		9,284,050	47,120	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet D Part III Date/Time Prepared: 9/3/2024 12:05 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	31.01
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	11,895	0.00	227	30.00
31.00	03100	INTENSIVE CARE UNIT		0	607	0.00	9	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		0	6,622	0.00	951	31.01
43.00	04300	NURSERY		0	5,795	0.00	1,652	43.00
200.00		Total (lines 30 through 199)		0	24,919		2,839	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
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	31.01
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0150	Period: From 04/01/2023 To 03/31/2024	Worksheet D Part IV Date/Time Prepared: 9/3/2024 12:05 pm
	Title XIX	Hospital	PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	SLEEP LAB	0	0	0	0	0	76.00
		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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet D Part IV | Date/Time Prepared: 9/3/2024 12:05 pm

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	380,999,962	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	26,827,419	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	70,489,224	0.000000	54.00
54.01	05401	ULTRA SOUND	0	0	0	11,663,487	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	9,050,004	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	12,642,287	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	85,547,711	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	14,911,630	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,214,016	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	15,988,540	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	97,747,970	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	102,653,857	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	102,996,796	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	639,200	0.000000	74.00
76.00	03950	SLEEP LAB	0	0	0	7,354,704	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	4,719,102	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	56,491,858	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	8,278,789	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	1,014,216,556		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet D Part IV | Date/Time Prepared: 9/3/2024 12:05 pm

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	1,384,290	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	505,552	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	282,772	0	0	0	54.00
54.01	05401	ULTRA SOUND	0.000000	78,996	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	15,743	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	35,709	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	1,483,733	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	862,095	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	304,474	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	161,529	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,898,193	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	50,359	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,932,569	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	SLEEP LAB	0.000000	10,737	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	20,366	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	237,052	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	19,881	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		9,284,050	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet D Part V Date/Time Prepared: 9/3/2024 12:05 pm

Title XIX | 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	0.099442	0	0	2,330,654	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.268060	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.102793	0	0	794,271	0	54.00
54.01	05401	ULTRA SOUND	0.102317	0	0	108,376	0	54.01
56.00	05600	RADIOISOTOPE	0.074769	0	0	18,541	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.074630	0	0	69,722	0	58.00
60.00	06000	LABORATORY	0.089682	0	0	611,626	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.187019	0	0	13,201	0	65.00
66.00	06600	PHYSICAL THERAPY	0.189285	0	0	4,650	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.047765	0	0	61,136	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.052730	0	0	254,823	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.118751	0	0	524,105	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.089696	0	0	535,869	0	73.00
74.00	07400	RENAL DIALYSIS	0.294222	0	0	0	0	74.00
76.00	03950	SLEEP LAB	0.177063	0	0	63,147	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.363593	0	0	10,592	0	90.00
91.00	09100	EMERGENCY	0.107370	0	0	1,221,196	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.545773	0	0	51,156	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.051627	0	0			95.00
200.00		Subtotal (see instructions)		0	0	6,673,065	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	6,673,065	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet D Part V Date/Time Prepared: 9/3/2024 12:05 pm

Title XIX | Hospital | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	231,765	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	81,645	54.00
54.01	05401	ULTRA SOUND	0	11,089	54.01
56.00	05600	RADIOISOTOPE	0	1,386	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	5,203	58.00
60.00	06000	LABORATORY	0	54,852	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,469	65.00
66.00	06600	PHYSICAL THERAPY	0	880	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	2,920	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	13,437	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	62,238	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	48,065	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	SLEEP LAB	0	11,181	76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	3,851	90.00
91.00	09100	EMERGENCY	0	131,120	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	27,920	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	0	690,021	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	690,021	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet D-1 | Date/Time Prepared: 9/3/2024 12:05 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	11,895	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	11,895	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)	9,929	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,046	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)	27,337,604	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)	27,337,604	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)	27,337,604	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)	2,298.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,403,959	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,403,959	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet D-1 | Date/Time Prepared: 9/3/2024 12:05 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,483,436	607	7,386.22	170	1,255,657	43.00
43.01	NEONATAL INTENSIVE CARE UNIT	10,145,794	6,622	1,532.13	0	0	43.01
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,817,717	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	6,477,333	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)	676,438	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	211,591	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	888,029	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	5,589,304	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,966	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,298.24	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0150	Period: From 04/01/2023 To 03/31/2024	Worksheet D-1 Date/Time Prepared: 9/3/2024 12:05 pm
	Title XVIII	Hospital	PPS

	Cost Center Description	1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	4,518,340	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	5,271,303	27,337,604	0.192822	4,518,340	871,235	90.00
91.00	Nursing Program cost	0	27,337,604	0.000000	4,518,340	0	91.00
92.00	Allied health cost	0	27,337,604	0.000000	4,518,340	0	92.00
93.00	All other Medical Education	0	27,337,604	0.000000	4,518,340	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0150	Period: From 04/01/2023 To 03/31/2024	Worksheet D-1 Date/Time Prepared: 9/3/2024 12:05 pm
	Title XIX	Hospital	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	11,895	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	11,895	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)	9,929	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)	227	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)	5,795	15.00
16.00	Nursery days (title V or XIX only)	1,652	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)	27,337,604	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)	27,337,604	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)	27,337,604	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)	2,298.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	521,700	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)	521,700	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet D-1 | Date/Time Prepared: 9/3/2024 12:05 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	5,934,770	5,795	1,024.12	1,652	1,691,846	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,483,436	607	7,386.22	9	66,476	43.00
43.01	NEONATAL INTENSIVE CARE UNIT	10,145,794	6,622	1,532.13	951	1,457,056	43.01
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)	998,831	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	4,735,909	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)	375,364	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	47,120	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	422,484	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	4,313,425	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,966	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,298.24	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0150	Period: From 04/01/2023 To 03/31/2024	Worksheet D-1 Date/Time Prepared: 9/3/2024 12:05 pm
	Title XIX	Hospital	PPS

	Cost Center Description						
						1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					4,518,340	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	5,271,303	27,337,604	0.192822	4,518,340	871,235	90.00
91.00	Nursing Program cost	0	27,337,604	0.000000	4,518,340	0	91.00
92.00	Allied health cost	0	27,337,604	0.000000	4,518,340	0	92.00
93.00	All other Medical Education	0	27,337,604	0.000000	4,518,340	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet D-3 | Date/Time Prepared: 9/3/2024 12:05 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		4,222,548		30.00
31.00	03100	INTENSIVE CARE UNIT		1,104,645		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		0		31.01
43.00	04300	NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.099442	6,846,224	680,802	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.268060	29,932	8,024	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.102793	1,954,374	200,896	54.00
54.01	05401	ULTRA SOUND	0.102317	151,181	15,468	54.01
56.00	05600	RADIOISOTOPE	0.074769	105,892	7,917	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.074630	99,005	7,389	58.00
60.00	06000	LABORATORY	0.089682	2,585,501	231,873	60.00
65.00	06500	RESPIRATORY THERAPY	0.187019	1,133,252	211,940	65.00
66.00	06600	PHYSICAL THERAPY	0.189285	602,794	114,100	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.047765	711,105	33,966	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.052730	2,530,667	133,442	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.118751	4,191,911	497,794	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.089696	3,617,186	324,447	73.00
74.00	07400	RENAL DIALYSIS	0.294222	149,494	43,984	74.00
76.00	03950	SLEEP LAB	0.177063	7,766	1,375	76.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.363593	230	84	90.00
91.00	09100	EMERGENCY	0.107370	1,465,569	157,358	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.545773	269,082	146,858	92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		26,451,165	2,817,717	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)		26,451,165		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet D-3 | Date/Time Prepared: 9/3/2024 12:05 pm

Title XIX | 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		1,026,885		30.00
31.00	03100	INTENSIVE CARE UNIT		173,415		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		4,030,204		31.01
43.00	04300	NURSERY		2,779,574		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.099442	1,384,290	137,657	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.268060	505,552	135,518	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.102793	282,772	29,067	54.00
54.01	05401	ULTRA SOUND	0.102317	78,996	8,083	54.01
56.00	05600	RADIOISOTOPE	0.074769	15,743	1,177	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.074630	35,709	2,665	58.00
60.00	06000	LABORATORY	0.089682	1,483,733	133,064	60.00
65.00	06500	RESPIRATORY THERAPY	0.187019	862,095	161,228	65.00
66.00	06600	PHYSICAL THERAPY	0.189285	304,474	57,632	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.047765	161,529	7,715	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.052730	1,898,193	100,092	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.118751	50,359	5,980	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.089696	1,932,569	173,344	73.00
74.00	07400	RENAL DIALYSIS	0.294222	0	0	74.00
76.00	03950	SLEEP LAB	0.177063	10,737	1,901	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.363593	20,366	7,405	90.00
91.00	09100	EMERGENCY	0.107370	237,052	25,452	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.545773	19,881	10,851	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		9,284,050	998,831	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)		9,284,050		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0150	Period: From 04/01/2023 To 03/31/2024	Worksheet E Part A Date/Time Prepared: 9/3/2024 12:05 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	1,890,035	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1,739,716	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)	291,622	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	315,815	2.04
3.00	Managed Care Simulated Payments	5,428,018	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	125.43	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
5.01	FTE cap adjustment for 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.	0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)	0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	4.80	30.00
31.00	Percentage of Medicaid patient days (see instructions)	47.08	31.00
32.00	Sum of lines 30 and 31	51.88	32.00
33.00	Allowable disproportionate share percentage (see instructions)	32.02	33.00
34.00	Disproportionate share adjustment (see instructions)	290,561	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0150	Period: From 04/01/2023 To 03/31/2024	Worksheet E Part A Date/Time Prepared: 9/3/2024 12:05 pm
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Payment Adjustment			
35.00	Total uncompensated care amount (see instructions)	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)	316,618	258,710	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	158,743	129,355	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	288,098		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)	4,815,847		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)	4,815,847	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	456,927	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	4,333	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)	5,277,107	59.00
60.00	Primary payer payments	2,995	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	5,274,112	61.00
62.00	Deductibles billed to program beneficiaries	417,952	62.00
63.00	Coinsurance billed to program beneficiaries	400	63.00
64.00	Allowable bad debts (see instructions)	1,642	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	1,067	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,642	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	4,856,827	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)	-15,257	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: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet E Part A Date/Time Prepared: 9/3/2024 12:05 pm

Title XVIII | Hospital | PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	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)		25,472	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		4,816,098	71.00
71.01	Sequestration adjustment (see instructions)		96,322	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		4,538,355	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)		181,421	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		1,164,583	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

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 9/3/2024 12:05 pm

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	1,890,035	1,890,035		1,890,035	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,739,716		1,739,716	1,739,716	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	291,622	291,622		291,622	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	315,815		315,815	315,815	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	5,428,018	2,567,199	2,860,819	5,428,018	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.3202	0.3202	0.3202		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	290,561	151,297	139,264	290,561	11.00
11.01	Uncompensated care payments	36.00	288,098	158,743	129,355	288,098	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	4,815,847	2,491,697	2,324,150	4,815,847	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	4,815,847	2,491,697	2,324,150	4,815,847	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	456,927	228,463	228,464	456,927	16.00
17.00	Special add-on payments for new technologies	54.00	4,333	2,166	2,167	4,333	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			2,722,326	2,554,781	5,277,107	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5	Provider CCN: 15-0150	Period: From 04/01/2023 To 03/31/2024	Worksheet E Part A Exhibit 5 Date/Time Prepared: 9/3/2024 12:05 pm
	Title XVIII	Hospital	PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	276,878	138,439	138,439	276,878	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	149,371	74,685	74,686	149,371	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1108	0.1108	0.1108		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	30,678	15,339	15,339	30,678	25.00
26.00	Total prospective capital payments (see instructions)	12.00	456,927	228,463	228,464	456,927	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-15,257	-7,628	-7,629	-15,257	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	25,472	25,472	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet E Part B | Date/Time Prepared: 9/3/2024 12:05 pm

Title XVIII | Hospital | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,439	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	9,143,773	2.00
3.00	OPPS or REH payments	7,689,282	3.00
4.00	Outlier payment (see instructions)	736,038	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)	3,439	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	38,345	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)	38,345	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)	38,345	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	34,906	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)	3,439	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)	8,425,320	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	5,117	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,259,259	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)	7,164,383	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount (see instructions)		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	7,164,383	30.00
31.00	Primary payer payments	2,466	31.00
32.00	Subtotal (line 30 minus line 31)	7,161,917	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)	66,388	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	43,152	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	66,616	36.00
37.00	Subtotal (see instructions)	7,205,069	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-326	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)	7,205,395	40.00
40.01	Sequestration adjustment (see instructions)	144,108	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	7,054,887	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)	6,400	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: 15-0150	Period: From 04/01/2023 To 03/31/2024	Worksheet E Part B Date/Time Prepared: 9/3/2024 12:05 pm
	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: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet E-1 Part I | Date/Time Prepared: 9/3/2024 12:05 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,538,355		7,054,887	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,538,355		7,054,887	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		181,421		6,400	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,719,776		7,061,287	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: 15-0150	Period: From 04/01/2023 To 03/31/2024	Worksheet E-1 Part II Date/Time Prepared: 9/3/2024 12:05 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet E-3 Part VII Date/Time Prepared: 9/3/2024 12:05 pm

Title XIX | Hospital | PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		690,021	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	690,021	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	690,021	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	8,010,078		8.00
9.00	Ancillary service charges	9,284,050	6,673,065	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)	17,294,128	6,673,065	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)	17,294,128	6,673,065	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	17,294,128	5,983,044	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	690,021	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	690,021	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	690,021	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	690,021	36.00
37.00	ADJUSTMENT TO OFFSET SETTLEMENT	0	-690,021	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

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0150	Period: From 04/01/2023 To 03/31/2024	Worksheet E-5 Date/Time Prepared: 9/3/2024 12:05 pm
	Title XVIII		PPS

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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)	Provider CCN: 15-0150	Period: From 04/01/2023 To 03/31/2024	Worksheet G Date/Time Prepared: 9/3/2024 12:05 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-1,318,761	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	55,025,255	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,424,683	0	0	0	6.00
7.00	Inventory	5,271,594	0	0	0	7.00
8.00	Prepaid expenses	1,867,248	0	0	0	8.00
9.00	Other current assets	131,224	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)	56,551,877	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,060,000	0	0	0	12.00
13.00	Land improvements	568,321	0	0	0	13.00
14.00	Accumulated depreciation	-453,770	0	0	0	14.00
15.00	Buildings	63,633,450	0	0	0	15.00
16.00	Accumulated depreciation	-21,270,187	0	0	0	16.00
17.00	Leasehold improvements	17,302,584	0	0	0	17.00
18.00	Accumulated depreciation	-1,680,081	0	0	0	18.00
19.00	Fixed equipment	2,596,932	0	0	0	19.00
20.00	Accumulated depreciation	-7,907,097	0	0	0	20.00
21.00	Automobiles and trucks	5,628	0	0	0	21.00
22.00	Accumulated depreciation	-469	0	0	0	22.00
23.00	Major movable equipment	68,596,761	0	0	0	23.00
24.00	Accumulated depreciation	-28,193,358	0	0	0	24.00
25.00	Minor equipment depreciable	12,707,201	0	0	0	25.00
26.00	Accumulated depreciation	-9,218,651	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)	97,747,264	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	7,451,449	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	7,451,449	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	161,750,590	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,419,573	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,951,401	0	0	0	38.00
39.00	Payroll taxes payable	335,339	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,564,715	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	-502,691,739	0	0	0	43.00
44.00	Other current liabilities	2,067,460	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-489,353,251	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	8,334	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	81,752,104	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	81,760,438	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-407,592,813	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	569,343,403				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)	569,343,403	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	161,750,590	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet G-1 | Date/Time Prepared: 9/3/2024 12:05 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		527,082,731		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		42,260,672				2.00
3.00	Total (sum of line 1 and line 2)		569,343,403		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)		569,343,403		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		569,343,403		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet G-2 Parts I & II Date/Time Prepared: 9/3/2024 12:05 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	78,934,185		78,934,185	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)	78,934,185		78,934,185	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	3,981,110		3,981,110	11.00
11.01	NEONATAL INTENSIVE CARE UNIT	41,623,741		41,623,741	11.01
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)	45,604,851		45,604,851	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	124,539,036		124,539,036	17.00
18.00	Ancillary services	263,065,227	681,701,323	944,766,550	18.00
19.00	Outpatient services	12,265,936	57,229,607	69,495,543	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	IP CONTRACTED HOSPICE	303,248	0	303,248	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	400,173,447	738,930,930	1,139,104,377	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		184,806,808		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)		184,806,808		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0150 | Period: From 04/01/2023 To 03/31/2024 | Worksheet G-3 | Date/Time Prepared: 9/3/2024 12:05 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,139,104,377	1.00
2.00	Less contractual allowances and discounts on patients' accounts	912,719,358	2.00
3.00	Net patient revenues (line 1 minus line 2)	226,385,019	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	184,806,808	4.00
5.00	Net income from service to patients (line 3 minus line 4)	41,578,211	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)	682,461	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	682,461	25.00
26.00	Total (line 5 plus line 25)	42,260,672	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)	42,260,672	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0150	Period: From 04/01/2023 To 03/31/2024	Worksheet L Parts I-III Date/Time Prepared: 9/3/2024 12:05 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	276,878	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	149,371	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)	52.47	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	4.80	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	47.08	8.00
9.00	Sum of lines 7 and 8	51.88	9.00
10.00	Allowable disproportionate share percentage (see instructions)	11.08	10.00
11.00	Disproportionate share adjustment (see instructions)	30,678	11.00
12.00	Total prospective capital payments (see instructions)	456,927	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