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: 15-0133	Period: From 03/01/2023 To 02/29/2024	Worksheet S Parts I-III Date/Time Prepared: 7/30/2024 1:58 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 7/30/2024 Time: 1:58 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 KOSCIUSKO COMMUNITY HOSPITAL (15-0133) for the cost reporting period beginning 03/01/2023 and ending 02/29/2024 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	-93,857	35,436	0	641,686	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	-93,857	35,436	0	641,686	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: 15-0133	Period: From 03/01/2023 To 02/29/2024	Worksheet S-2 Part I Date/Time Prepared: 7/30/2024 1:58 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2101 EAST DUBOIS DRIVE	PO Box:			1.00
2.00	City: WARSAW	State: IN	Zip Code: 46580-	County: KOSCIUSKO	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	KOSCIUSKO COMMUNITY HOSPITAL	150133	99915	1	07/01/1966	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	KOSCIUSKO COMMUNITY HOSPITAL	15U133	99915		03/01/2020	N	P	P	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)	03/01/2023	02/29/2024	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)	N	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: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet S-2 Part I Date/Time Prepared: 7/30/2024 1:58 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.	286	94	0	0	1,822	162	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.	2		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.	2		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.	1		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.	03/01/2023	02/29/2024	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)	Y	Y	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	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.				57.00
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: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet S-2 Part I Date/Time Prepared: 7/30/2024 1:58 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

		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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet S-2 Part I Date/Time Prepared: 7/30/2024 1:58 pm

		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.	Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0133	Period: From 03/01/2023 To 02/29/2024	Worksheet S-2 Part I Date/Time Prepared: 7/30/2024 1:58 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	77,902	98,005	0	118.01

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

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: CHS/COMMUNITY HEALTH SYSTEMS, INC.	Contractor's Name: WPS	Contractor's Number: 52280	141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	143.00

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

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

		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: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet S-2 Part II Date/Time Prepared: 7/30/2024 1:58 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	05/07/2024	Y	05/07/2024	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: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet S-2 Part II Date/Time Prepared: 7/30/2024 1:58 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.	Y	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 SYSTEM		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: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet S-2 Part II Date/Time Prepared: 7/30/2024 1:58 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.	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: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet S-3 Part I | Date/Time Prepared: 7/30/2024 1:58 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	58	21,228	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)		58	21,228	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	14	5,124	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		72	26,352	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)		72				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: 15-0133	Period: From 03/01/2023 To 02/29/2024	Worksheet S-3 Part I Date/Time Prepared: 7/30/2024 1:58 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)	2,134	212	8,493			1.00
2.00	HMO and other (see instructions)	4,430	1,467				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	80	0	170			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)	2,214	212	8,663			7.00
8.00	INTENSIVE CARE UNIT	354	11	1,597			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		512	765			13.00
14.00	Total (see instructions)	2,568	735	11,025	0.00	376.04	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)			17			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	376.04	27.00
28.00	Observation Bed Days		0	2,348			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			142			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	162	278			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: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet S-3 Part I | Date/Time Prepared: 7/30/2024 1:58 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	685	599	3,060	1.00
2.00	HMO and other (see instructions)			1,072	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	685	599	3,060	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	30,578,203	0	30,578,203	782,173.00	39.09	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		0	0	0	0.00	0.00	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,830,846	0	1,830,846	18,768.00	97.55	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		122,646	0	122,646	872.00	140.65	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		4,443,177	0	4,443,177	123,054.00	36.11	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)		8,518,503	0	8,518,503			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		0	0	0			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		1,058,211	0	1,058,211			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

		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	158,490	0	158,490	4,019.00	39.44	26.00
27.00	Administrative & General	5.00	4,409,990	-257,400	4,152,590	116,500.00	35.64	27.00
28.00	Administrative & General under contract (see inst.)		70,099	0	70,099	2,241.00	31.28	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	814,090	0	814,090	26,916.00	30.25	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	666,875	0	666,875	30,099.00	22.16	32.00
33.00	Housekeeping under contract (see instructions)		46,873	0	46,873	1,129.00	41.52	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		1,070,647	0	1,070,647	44,114.00	24.27	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,636,839	257,400	1,894,239	40,114.00	47.22	38.00
39.00	Central Services and Supply	14.00	374,199	0	374,199	15,319.00	24.43	39.00
40.00	Pharmacy	15.00	1,064,420	0	1,064,420	20,591.00	51.69	40.00
41.00	Medical Records & Medical Records Library	16.00	275,379	0	275,379	9,439.00	29.17	41.00
42.00	Social Service	17.00	458,838	0	458,838	12,058.00	38.05	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet S-3 Part III | Date/Time Prepared: 7/30/2024 1:58 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)		31,765,822	0	31,765,822	829,657.00	38.29	1.00
2.00	Excluded area salaries (see instructions)		0	0	0	0.00	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)		31,765,822	0	31,765,822	829,657.00	38.29	3.00
4.00	Subtotal other wages & related costs (see inst.)		6,396,669	0	6,396,669	142,694.00	44.83	4.00
5.00	Subtotal wage-related costs (see inst.)		9,576,714	0	9,576,714	0.00	30.15	5.00
6.00	Total (sum of lines 3 thru 5)		47,739,205	0	47,739,205	972,351.00	49.10	6.00
7.00	Total overhead cost (see instructions)		11,046,739	0	11,046,739	322,539.00	34.25	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0133	Period: From 03/01/2023 To 02/29/2024	Worksheet S-3 Part IV Date/Time Prepared: 7/30/2024 1:58 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	566,948	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)	5,514,521	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	8,107	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	22,785	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	25,339	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	185,373	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	1,729,184	17.00
18.00	Medicare Taxes - Employers Portion Only	404,406	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	61,839	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)	8,518,502	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: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet S-3 Part V | Date/Time Prepared: 7/30/2024 1:58 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	1,830,846	8,518,502	1.00
2.00	Hospital	1,830,846	8,518,502	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet S-10 Parts I & II Date/Time Prepared: 7/30/2024 1:58 pm

		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)	0.106475	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	18,163,066	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?	N	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	129,942,110	6.00
7.00	Medicaid cost (line 1 times line 6)	13,835,586	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

		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)	11,164,363	10,978	11,175,341	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,188,726	10,978	1,199,704	21.00
22.00	Payments received from patients for amounts previously written off as charity care	1,311	0	1,311	22.00
23.00	Cost of charity care (see instructions)	1,187,415	10,978	1,198,393	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)	4,459,291	26.00
27.00	Medicare reimbursable bad debts (see instructions)	53,381	27.00
27.01	Medicare allowable bad debts (see instructions)	82,125	27.01
28.00	Non-Medicare bad debt amount (see instructions)	4,377,166	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	494,803	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	1,693,196	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,693,196	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet S-10 Parts I & II | Date/Time Prepared: 7/30/2024 1:58 pm

		1.00	
	PART II - HOSPITAL DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.106475	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)	11,164,363	10,978	11,175,341	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,188,726	10,978	1,199,704	21.00
22.00	Payments received from patients for amounts previously written off as charity care	1,311	0	1,311	22.00
23.00	Cost of charity care (see instructions)	1,187,415	10,978	1,198,393	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)	4,459,291	26.00
27.00	Medicare reimbursable bad debts (see instructions)	53,381	27.00
27.01	Medicare allowable bad debts (see instructions)	82,125	27.01
28.00	Non-Medicare bad debt amount (see instructions)	4,377,166	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	494,803	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	1,693,196	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,693,196	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet A | Date/Time Prepared: 7/30/2024 1:58 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		773,071	773,071	3,990,450	4,763,521	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,990,957	3,990,957	85,755	4,076,712	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	158,490	311,641	470,131	6,540,883	7,011,014	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,409,990	32,506,934	36,916,924	-9,779,761	27,137,163	5.00
7.00	00700	OPERATION OF PLANT	814,090	2,536,469	3,350,559	1,652,434	5,002,993	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	360,552	360,552	-48,285	312,267	8.00
9.00	00900	HOUSEKEEPING	666,875	472,828	1,139,703	-87,409	1,052,294	9.00
10.00	01000	DIETARY	0	1,646,717	1,646,717	-1,299,163	347,554	10.00
11.00	01100	CAFETERIA	0	0	0	1,298,878	1,298,878	11.00
13.00	01300	NURSING ADMINISTRATION	1,636,839	632,563	2,269,402	254,436	2,523,838	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	374,199	1,575,227	1,949,426	-1,018,513	930,913	14.00
15.00	01500	PHARMACY	1,064,420	10,622,757	11,687,177	-10,252,933	1,434,244	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	275,379	572,147	847,526	-6,886	840,640	16.00
17.00	01700	SOCIAL SERVICE	458,838	121,103	579,941	-1,810	578,131	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,737,807	2,692,424	8,430,231	-1,092,191	7,338,040	30.00
31.00	03100	INTENSIVE CARE UNIT	1,313,964	620,084	1,934,048	-5,737	1,928,311	31.00
43.00	04300	NURSERY	0	0	0	245,181	245,181	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,814,939	4,212,496	6,027,435	-2,016,005	4,011,430	50.00
51.00	05100	RECOVERY ROOM	1,002,360	251,259	1,253,619	-19,648	1,233,971	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	825,841	825,841	52.00
53.00	05300	ANESTHESIOLOGY	0	1,289,912	1,289,912	-13,425	1,276,487	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,759,471	3,704,825	6,464,296	-3,370,333	3,093,963	54.00
54.01	05401	ULTRASOUND	447,884	306,204	754,088	-754,088	0	54.01
54.02	05402	ONCOLOGY	0	0	0	2,924,440	2,924,440	54.02
56.00	05600	RADIOISOTOPE	253,897	246,365	500,262	-40,062	460,200	56.00
57.00	05700	CT SCAN	395,809	334,632	730,441	-57,062	673,379	57.00
58.00	05800	MRI	241,397	127,317	368,714	-75,833	292,881	58.00
60.00	06000	LABORATORY	2,324,473	2,565,066	4,889,539	-196,442	4,693,097	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	643,378	217,536	860,914	204,606	1,065,520	65.00
66.00	06600	PHYSICAL THERAPY	264,604	1,252,315	1,516,919	-3,343	1,513,576	66.00
67.00	06700	OCCUPATIONAL THERAPY	22,708	149,798	172,506	-888	171,618	67.00
68.00	06800	SPEECH PATHOLOGY	0	10,156	10,156	0	10,156	68.00
69.00	06900	ELECTROCARDIOLOGY	480,302	863,159	1,343,461	-67,150	1,276,311	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	691,629	691,629	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,810,823	1,810,823	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,894,418	9,894,418	73.00
76.00	03950	ANCILLARY SERVICE COST	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	132,962	74,084	207,046	-207,046	0	76.01
76.03	03951	WOUND CARE	222,440	87,875	310,315	-310,315	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	528,546	-52,813	475,733	307,510	783,243	90.00
91.00	09100	EMERGENCY	2,132,142	3,027,476	5,159,618	-2,956	5,156,662	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,578,203	78,103,136	108,681,339	0	108,681,339	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	384	384	0	384	192.00
194.00	07950	NON ALLOWABLE MEALS	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	30,578,203	78,103,520	108,681,723	0	108,681,723	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet A | Date/Time Prepared: 7/30/2024 1:58 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	1,078,551	5,842,072	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	128,967	4,205,679	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	7,011,014	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,248,073	23,889,090	5.00
7.00	00700	OPERATION OF PLANT	-10,194	4,992,799	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	312,267	8.00
9.00	00900	HOUSEKEEPING	0	1,052,294	9.00
10.00	01000	DIETARY	0	347,554	10.00
11.00	01100	CAFETERIA	-240,899	1,057,979	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,523,838	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	930,913	14.00
15.00	01500	PHARMACY	0	1,434,244	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-132	840,508	16.00
17.00	01700	SOCIAL SERVICE	0	578,131	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,045,005	6,293,035	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,928,311	31.00
43.00	04300	NURSERY	0	245,181	43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-65,507	3,945,923	50.00
51.00	05100	RECOVERY ROOM	0	1,233,971	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	825,841	52.00
53.00	05300	ANESTHESIOLOGY	-1,276,487	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,812,795	1,281,168	54.00
54.01	05401	ULTRASOUND	0	0	54.01
54.02	05402	ONCOLOGY	0	2,924,440	54.02
56.00	05600	RADIOISOTOPE	0	460,200	56.00
57.00	05700	CT SCAN	-9,793	663,586	57.00
58.00	05800	MRI	0	292,881	58.00
60.00	06000	LABORATORY	4,062	4,697,159	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	1,065,520	65.00
66.00	06600	PHYSICAL THERAPY	0	1,513,576	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	171,618	67.00
68.00	06800	SPEECH PATHOLOGY	0	10,156	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,276,311	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	691,629	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,810,823	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,894,418	73.00
76.00	03950	ANCILLARY SERVICE COST	0	0	76.00
76.01	03610	SLEEP LAB	0	0	76.01
76.03	03951	WOUND CARE	0	0	76.03
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	783,243	90.00
91.00	09100	EMERGENCY	-2,467,872	2,688,790	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
	SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-8,965,177	99,716,162	118.00
	NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	384	192.00
194.00	07950	NON ALLOWABLE MEALS	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-8,965,177	99,716,546	200.00

RECLASSIFICATIONS	Provider CCN: 15-0133	Period: From 03/01/2023 To 02/29/2024	Worksheet A-6 Date/Time Prepared: 7/30/2024 1:58 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6,541,529	1.00
	0		0	6,541,529	
	B - LEASE AND RENTAL				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,437,195	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	77,929	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
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
	0		0	1,515,124	
	C - OTHER CAPITAL				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	324,665	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	511,166	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	7,826	3.00
	0		0	843,657	
	D - REPAIRS & MAINT				
1.00	OPERATION OF PLANT	7.00	0	1,515,676	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
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
22.00		0.00	0	0	22.00
	0		0	1,515,676	
	E - CNO COST				
1.00	NURSING ADMINISTRATION	13.00	257,400	0	1.00
	0		257,400	0	
	F - CHARGABLE SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	691,629	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,810,823	2.00
3.00		0.00	0	0	3.00
	0		0	2,502,452	
	G - DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	9,894,418	1.00
	0		0	9,894,418	
	H - LABOR AND DELIVERY				
1.00	NURSERY	43.00	204,869	40,312	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	690,058	135,783	2.00
	0		894,927	176,095	

RECLASSIFICATIONS | Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet A-6 | Date/Time Prepared: 7/30/2024 1:58 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	I - MISC DEPARTMENTS				
1.00	OPERATING ROOM	50.00	0	13,425	1.00
2.00	RESPIRATORY THERAPY	65.00	132,962	73,576	2.00
3.00	CLINIC	90.00	222,440	87,538	3.00
	0		355,402	174,539	
	J - RADIOLOGY				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	447,884	234,911	1.00
2.00	ONCOLOGY	54.02	1,593,986	1,330,454	2.00
	0		2,041,870	1,565,365	
	K - DIETARY				
1.00	CAFETERIA	11.00	0	1,298,878	1.00
	0		0	1,298,878	
	L - UTILITIES				
1.00	OPERATION OF PLANT	7.00	0	85,531	1.00
2.00		0.00	0	0	2.00
	0		0	85,531	
	M - NONCAPITALIZED EQUIP				
1.00	OPERATION OF PLANT	7.00	0	53,809	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
	0		0	53,809	
	N - CAPITAL RELATED RENT				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,718,893	1.00
	TOTALS		0	1,718,893	
	O - INTEREST EXPENSE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,469	1.00
	TOTALS		0	1,469	
500.00	Grand Total: Increases		3,549,599	27,887,435	500.00

RECLASSIFICATIONS | Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet A-6 | Date/Time Prepared: 7/30/2024 1:58 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - EMPLOYEE BENEFITS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6,541,529	0	1.00
	0		0	6,541,529		
	B - LEASE AND RENTAL					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	646	10	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	129,194	10	2.00
3.00	OPERATION OF PLANT	7.00	0	368	0	3.00
4.00	DIETARY	10.00	0	285	0	4.00
5.00	NURSING ADMINISTRATION	13.00	0	2,580	0	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	46,754	0	6.00
7.00	PHARMACY	15.00	0	302,686	0	7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,140	0	8.00
9.00	SOCIAL SERVICE	17.00	0	1,364	0	9.00
10.00	ADULTS & PEDIATRICS	30.00	0	3,872	0	10.00
11.00	INTENSIVE CARE UNIT	31.00	0	1,136	0	11.00
12.00	OPERATING ROOM	50.00	0	327,784	0	12.00
13.00	RECOVERY ROOM	51.00	0	1,682	0	13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	468,356	0	14.00
15.00	ULTRASOUND	54.01	0	36,624	0	15.00
16.00	LABORATORY	60.00	0	182,905	0	16.00
17.00	RESPIRATORY THERAPY	65.00	0	508	0	17.00
18.00	PHYSICAL THERAPY	66.00	0	3,343	0	18.00
19.00	OCCUPATIONAL THERAPY	67.00	0	544	0	19.00
20.00	SLEEP LAB	76.01	0	508	0	20.00
21.00	WOUND CARE	76.03	0	337	0	21.00
22.00	CLINIC	90.00	0	221	0	22.00
23.00	EMERGENCY	91.00	0	1,287	0	23.00
	0		0	1,515,124		
	C - OTHER CAPITAL					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	843,657	12	1.00
2.00		0.00	0	0	13	2.00
3.00		0.00	0	0	12	3.00
	0		0	843,657		
	D - REPAIRS & MAINT					
1.00	OPERATION OF PLANT	7.00	0	2,214	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	274,675	0	2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	48,285	0	3.00
4.00	HOUSEKEEPING	9.00	0	12,792	0	4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	35,656	0	5.00
6.00	PHARMACY	15.00	0	55,829	0	6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	4,746	0	7.00
8.00	ADULTS & PEDIATRICS	30.00	0	16,858	0	8.00
9.00	INTENSIVE CARE UNIT	31.00	0	4,601	0	9.00
10.00	OPERATING ROOM	50.00	0	173,217	0	10.00
11.00	RECOVERY ROOM	51.00	0	2,844	0	11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	659,688	0	12.00
13.00	ULTRASOUND	54.01	0	34,669	0	13.00
14.00	RADIOISOTOPE	56.00	0	40,062	0	14.00
15.00	CT SCAN	57.00	0	56,579	0	15.00
16.00	MRI	58.00	0	75,833	0	16.00
17.00	LABORATORY	60.00	0	11,737	0	17.00
18.00	RESPIRATORY THERAPY	65.00	0	1,424	0	18.00
19.00	OCCUPATIONAL THERAPY	67.00	0	320	0	19.00
20.00	ELECTROCARDIOLOGY	69.00	0	103	0	20.00
21.00	CLINIC	90.00	0	2,113	0	21.00
22.00	EMERGENCY	91.00	0	1,431	0	22.00
	0		0	1,515,676		
	E - CNO COST					
1.00	ADMINISTRATIVE & GENERAL	5.00	257,400	0	0	1.00
	0		257,400	0		
	F - CHARGABLE SUPPLIES					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	920,520	0	1.00
2.00	OPERATING ROOM	50.00	0	1,519,057	0	2.00
3.00	ELECTROCARDIOLOGY	69.00	0	62,875	0	3.00
	0		0	2,502,452		
	G - DRUGS					
1.00	PHARMACY	15.00	0	9,894,418	0	1.00
	0		0	9,894,418		
	H - LABOR AND DELIVERY					
1.00	ADULTS & PEDIATRICS	30.00	894,927	176,095	0	1.00
2.00		0.00	0	0	0	2.00
	0		894,927	176,095		

RECLASSIFICATIONS | Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet A-6 | Date/Time Prepared: 7/30/2024 1:58 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	I - MISC DEPARTMENTS						
1.00	ANESTHESIOLOGY	53.00	0	13,425	0		1.00
2.00	SLEEP LAB	76.01	132,962	73,576	0		2.00
3.00	WOUND CARE	76.03	222,440	87,538	0		3.00
	0		355,402	174,539			
	J - RADIOLOGY						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	1,593,986	1,330,454	0		1.00
2.00	ULTRASOUND	54.01	447,884	234,911	0		2.00
	0		2,041,870	1,565,365			
	K - DIETARY						
1.00	DIETARY	10.00	0	1,298,878	0		1.00
	0		0	1,298,878			
	L - UTILITIES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	11,472	0		1.00
2.00	HOUSEKEEPING	9.00	0	74,059	0		2.00
	0		0	85,531			
	M - NONCAPITALIZED EQUIP						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,410	0		1.00
2.00	HOUSEKEEPING	9.00	0	558	0		2.00
3.00	NURSING ADMINISTRATION	13.00	0	384	0		3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	15,583	0		4.00
5.00	SOCIAL SERVICE	17.00	0	446	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	439	0		6.00
7.00	RECOVERY ROOM	51.00	0	15,122	0		7.00
8.00	OPERATING ROOM	50.00	0	9,372	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	644	0		9.00
10.00	OCCUPATIONAL THERAPY	67.00	0	24	0		10.00
11.00	CT SCAN	57.00	0	483	0		11.00
12.00	LABORATORY	60.00	0	1,800	0		12.00
13.00	ELECTROCARDIOLOGY	69.00	0	4,172	0		13.00
14.00	CLINIC	90.00	0	134	0		14.00
15.00	EMERGENCY	91.00	0	238	0		15.00
	0		0	53,809			
	N - CAPITAL RELATED RENT						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,718,893	10		1.00
	TOTALS		0	1,718,893			
	O - INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,469	11		1.00
	TOTALS		0	1,469			
500.00	Grand Total: Decreases		3,549,599	27,887,435			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet A-7 Part I | Date/Time Prepared: 7/30/2024 1:58 pm

		Beginning Balances	Acquisitions Purchases	Acquisitions Donation	Acquisitions 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	2,282,645	0	0	0	0	1.00
2.00	Land Improvements	998,012	0	0	0	6,450	2.00
3.00	Buildings and Fixtures	25,274,254	17,533	0	17,533	0	3.00
4.00	Building Improvements	24,596,210	3,727,495	0	3,727,495	66,229	4.00
5.00	Fixed Equipment	4,183,819	564,705	0	564,705	0	5.00
6.00	Movable Equipment	33,182,446	0	0	0	698,141	6.00
7.00	HIT designated Assets	123,305	0	0	0	62,632	7.00
8.00	Subtotal (sum of lines 1-7)	90,640,691	4,309,733	0	4,309,733	833,452	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	90,640,691	4,309,733	0	4,309,733	833,452	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,282,645	0	1.00
2.00	Land Improvements	991,562	0	2.00
3.00	Buildings and Fixtures	25,291,787	0	3.00
4.00	Building Improvements	28,257,476	0	4.00
5.00	Fixed Equipment	4,748,524	0	5.00
6.00	Movable Equipment	32,484,305	0	6.00
7.00	HIT designated Assets	60,673	0	7.00
8.00	Subtotal (sum of lines 1-7)	94,116,972	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	94,116,972	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet A-7 Part II Date/Time Prepared: 7/30/2024 1:58 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	773,071	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,990,957	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,764,028	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	773,071	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,990,957	2.00
3.00	Total (sum of lines 1-2)	0	4,764,028	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet A-7 Part III Date/Time Prepared: 7/30/2024 1:58 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	61,571,993	0	61,571,993	0.654207	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	32,544,978	0	32,544,978	0.345793	0	2.00
3.00	Total (sum of lines 1-2)	94,116,971	0	94,116,971	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	773,071	3,155,932	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,990,943	77,929	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,764,014	3,233,861	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	984,295	324,665	511,166	92,943	5,842,072	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	7,826	0	128,981	4,205,679	2.00
3.00	Total (sum of lines 1-2)	984,295	332,491	511,166	221,924	10,047,751	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet A-8 | Date/Time Prepared: 7/30/2024 1:58 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	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-10,194	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	-6,664,022			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-1,223,456			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-240,899	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	-132	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	B	0	CAFETERIA	11.00	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	-29,249	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	RENTAL INCOME	B	-156	CAP REL COSTS-BLDG & FIXT	1.00	10	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet A-8 | Date/Time Prepared: 7/30/2024 1:58 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	
34.00	MISC INCOME	B	-31,423	ADMINISTRATIVE & GENERAL	5.00	0	34.00
38.00	PATIENT TV - DEPRECIATION	A	-14	CAP REL COSTS-MVBLE EQUIP	2.00	9	38.00
39.00	MARKETING	A	-474,007	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	PHYSICIAN RECRUITING	A	-215,249	ADMINISTRATIVE & GENERAL	5.00	0	40.00
42.00	LOBBYING EXPENSE IN ASSOCIATION DUES	A	-25,023	ADMINISTRATIVE & GENERAL	5.00	0	42.00
44.00	LEGAL FEES	A	-5,512	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.01	CONTRIBUTIONS	A	-38,069	ADMINISTRATIVE & GENERAL	5.00	0	45.01
45.04	ALCOHOLIC BEVERAGES	A	-3,408	ADMINISTRATIVE & GENERAL	5.00	0	45.04
45.06	LOBBYING EXPENSE	A	-4,364	ADMINISTRATIVE & GENERAL	5.00	0	45.06
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,965,177				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: 15-0133	Period: From 03/01/2023 To 02/29/2024	Worksheet A-8-1 Date/Time Prepared: 7/30/2024 1:58 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		DIRECT ALLOCATION - CAPITAL-	0	0	1.00
2.00	0.00		PASI CAPITAL COSTS - BLDG &	0	0	2.00
3.00	0.00		PASI CAPITAL COSTS - MOVEABL	0	0	3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT	Capital-Related Interest	985,764	0	4.00
4.01	1.00	CAP REL COSTS-BLDG & FIXT	PASI Capital Costs - Bldg &	803	0	4.01
4.02	2.00	CAP REL COSTS-MVBLE EQUIP	PASI Capital Costs - Moveabl	1,720	0	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	PASI Operating Costs	504,875	474,698	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	Shared Service Center Alloca	2,646,116	1,910,937	4.04
4.05	1.00	CAP REL COSTS-BLDG & FIXT	New Capital - Building & Fix	92,140	0	4.05
4.06	2.00	CAP REL COSTS-MVBLE EQUIP	New Capital - Movable Equipm	127,261	0	4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	Non-Capital Home Office Cost	3,452,394	0	4.07
4.08	5.00	ADMINISTRATIVE & GENERAL	Malpractice Costs	175,907	775,247	4.08
4.09	5.00	ADMINISTRATIVE & GENERAL	Management Fees	0	3,050,058	4.09
4.10	5.00	ADMINISTRATIVE & GENERAL	401K Fees	0	4,942	4.10
4.11	5.00	ADMINISTRATIVE & GENERAL	Audit Fees	0	104,634	4.11
4.12	5.00	ADMINISTRATIVE & GENERAL	Corporate Overhead Allocatio	0	2,193,434	4.12
4.13	5.00	ADMINISTRATIVE & GENERAL	HIIM Allocation	0	518,827	4.13
4.14	5.00	ADMINISTRATIVE & GENERAL	Contract Management	0	154,545	4.14
4.15	5.00	ADMINISTRATIVE & GENERAL	PASI Lien Unit Collection Fe	0	23,114	4.15
4.26	0.00			0	0	4.26
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			7,986,980	9,210,436	5.00

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

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

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

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

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	B		0.00	COMMUNITY HEALTH SYSTEMS	100.00	6.00
7.00	C		0.00	HOSPITAL LAUNDR	20.00	7.00
8.00	C		0.00	PASI	100.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0133	Period: From 03/01/2023 To 02/29/2024	Worksheet A-8-1 Date/Time Prepared: 7/30/2024 1:58 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	985,764	11	4.00
4.01	803	14	4.01
4.02	1,720	14	4.02
4.03	30,177	0	4.03
4.04	735,179	0	4.04
4.05	92,140	14	4.05
4.06	127,261	14	4.06
4.07	3,452,394	0	4.07
4.08	-599,340	0	4.08
4.09	-3,050,058	0	4.09
4.10	-4,942	0	4.10
4.11	-104,634	0	4.11
4.12	-2,193,434	0	4.12
4.13	-518,827	0	4.13
4.14	-154,545	0	4.14
4.15	-23,114	0	4.15
4.26	0	9	4.26
5.00	-1,223,456		5.00

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

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

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

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

6.00	HOSPITAL MANAGEMENT		6.00
7.00	LAUNDRY SERVICES		7.00
8.00	DEBT COLLECTION		8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet A-8-2 | Date/Time Prepared: 7/30/2024 1:58 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	5.00	ADMINISTRATIVE & GENERAL	19,874	19,874	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,015,756	1,015,756	0	0	0	2.00
3.00	50.00	OPERATING ROOM	65,507	65,507	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	1,276,487	1,276,487	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	1,812,795	1,812,795	0	0	0	5.00
6.00	57.00	CT SCAN	9,793	9,793	0	0	0	6.00
7.00	60.00	LABORATORY	-4,062	-4,062	0	0	0	7.00
8.00	91.00	EMERGENCY	2,467,872	2,467,872	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			6,664,022	6,664,022	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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	57.00	CT SCAN	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	19,874		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,015,756		2.00
3.00	50.00	OPERATING ROOM	0	0	0	65,507		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	1,276,487		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,812,795		5.00
6.00	57.00	CT SCAN	0	0	0	9,793		6.00
7.00	60.00	LABORATORY	0	0	0	-4,062		7.00
8.00	91.00	EMERGENCY	0	0	0	2,467,872		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	6,664,022		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet B Part I | Date/Time Prepared: 7/30/2024 1:58 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	5,842,072	5,842,072				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	4,205,679		4,205,679			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,011,014	26,236	18,887	7,056,137		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	23,889,090	1,017,337	732,376	963,231	26,602,034	5.00
7.00	00700	OPERATION OF PLANT	4,992,799	621,928	447,723	188,836	6,251,286	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	312,267	16,279	11,719	0	340,265	8.00
9.00	00900	HOUSEKEEPING	1,052,294	34,348	24,727	154,688	1,266,057	9.00
10.00	01000	DIETARY	347,554	94,362	67,931	0	509,847	10.00
11.00	01100	CAFETERIA	1,057,979	79,277	57,071	0	1,194,327	11.00
13.00	01300	NURSING ADMINISTRATION	2,523,838	20,538	14,785	439,386	2,998,547	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	930,913	54,534	39,258	86,799	1,111,504	14.00
15.00	01500	PHARMACY	1,434,244	53,611	38,594	246,902	1,773,351	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	840,508	75,153	54,103	63,877	1,033,641	16.00
17.00	01700	SOCIAL SERVICE	578,131	0	0	106,432	684,563	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,293,035	1,141,083	821,460	1,123,361	9,378,939	30.00
31.00	03100	INTENSIVE CARE UNIT	1,928,311	255,060	183,616	304,786	2,671,773	31.00
43.00	04300	NURSERY	245,181	24,418	17,578	47,521	334,698	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,945,923	474,931	341,901	420,991	5,183,746	50.00
51.00	05100	RECOVERY ROOM	1,233,971	22,383	16,114	232,506	1,504,974	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	825,841	93,385	67,228	160,065	1,146,519	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,281,168	353,736	254,653	374,235	2,263,792	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	ONCOLOGY	2,924,440	304,140	218,949	369,739	3,817,268	54.02
56.00	05600	RADIOISOTOPE	460,200	13,864	9,981	58,894	542,939	56.00
57.00	05700	CT SCAN	663,586	68,560	49,356	91,811	873,313	57.00
58.00	05800	MRI	292,881	90,944	65,470	55,994	505,289	58.00
60.00	06000	LABORATORY	4,697,159	165,364	119,045	539,182	5,520,750	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,065,520	82,018	59,044	180,079	1,386,661	65.00
66.00	06600	PHYSICAL THERAPY	1,513,576	173,667	125,022	61,377	1,873,642	66.00
67.00	06700	OCCUPATIONAL THERAPY	171,618	0	0	5,267	176,885	67.00
68.00	06800	SPEECH PATHOLOGY	10,156	2,713	1,953	0	14,822	68.00
69.00	06900	ELECTROCARDIOLOGY	1,276,311	1,357	977	111,410	1,390,055	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	691,629	0	0	0	691,629	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,810,823	0	0	0	1,810,823	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,894,418	0	0	0	9,894,418	73.00
76.00	03950	ANCILLARY SERVICE COST	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	783,243	100,602	72,423	174,198	1,130,466	90.00
91.00	09100	EMERGENCY	2,688,790	363,558	261,723	494,570	3,808,641	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	99,716,162	5,825,386	4,193,667	7,056,137	99,687,464	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,686	12,012	0	28,698	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	384	0	0	0	384	192.00
194.00	07950	NON ALLOWABLE MEALS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	99,716,546	5,842,072	4,205,679	7,056,137	99,716,546	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet B Part I | Date/Time Prepared: 7/30/2024 1:58 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	26,602,034					5.00
7.00	00700	OPERATION OF PLANT	2,274,474	8,525,760				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	123,802	33,230	497,297			8.00
9.00	00900	HOUSEKEEPING	460,643	70,116	0	1,796,816		9.00
10.00	01000	DIETARY	185,503	192,624	0	43,583	931,557	10.00
11.00	01100	CAFETERIA	434,545	161,831	0	36,615	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,090,994	41,925	0	9,486	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	404,411	111,321	17,392	25,187	0	14.00
15.00	01500	PHARMACY	645,218	109,438	0	24,761	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	376,081	153,413	0	34,711	0	16.00
17.00	01700	SOCIAL SERVICE	249,072	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,412,443	2,329,326	121,745	527,027	446,199	30.00
31.00	03100	INTENSIVE CARE UNIT	972,101	520,662	30,437	117,804	67,145	31.00
43.00	04300	NURSERY	121,777	49,845	0	11,278	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,886,059	969,491	110,877	219,355	39,321	50.00
51.00	05100	RECOVERY ROOM	547,571	45,692	0	10,338	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	417,151	190,631	52,177	43,132	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	823,660	722,092	48,336	163,379	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	ONCOLOGY	1,388,879	620,851	0	140,472	0	54.02
56.00	05600	RADIOISOTOPE	197,543	28,301	0	6,403	0	56.00
57.00	05700	CT SCAN	317,747	139,954	0	24,272	0	57.00
58.00	05800	MRI	183,845	185,646	0	29,573	0	58.00
60.00	06000	LABORATORY	2,008,675	337,563	0	52,317	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	504,524	167,425	0	37,881	0	65.00
66.00	06600	PHYSICAL THERAPY	681,708	354,511	32,572	16,528	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	64,358	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,393	5,538	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	505,759	2,769	0	627	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	251,643	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	658,852	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,599,971	0	0	0	0	73.00
76.00	03950	ANCILLARY SERVICE COST	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	411,310	205,363	15,556	46,465	0	90.00
91.00	09100	EMERGENCY	1,385,740	742,141	60,873	167,915	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,591,452	8,491,699	489,965	1,789,109	552,665	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,442	34,061	0	7,707	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	140	0	7,332	0	0	192.00
194.00	07950	NON ALLOWABLE MEALS	0	0	0	0	378,892	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	26,602,034	8,525,760	497,297	1,796,816	931,557	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet B Part I | Date/Time Prepared: 7/30/2024 1:58 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,827,318					11.00
13.00	01300	NURSING ADMINISTRATION	123,555	4,264,507				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	49,719	0	1,719,534			14.00
15.00	01500	PHARMACY	66,878	0	0	2,619,646		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	30,669	0	233	0	1,628,748	16.00
17.00	01700	SOCIAL SERVICE	39,181	0	179	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	360,397	1,732,130	111,710	0	77,774	30.00
31.00	03100	INTENSIVE CARE UNIT	86,063	426,691	30,879	0	14,967	31.00
43.00	04300	NURSERY	12,497	0	0	0	2,859	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	132,945	494,743	492,956	0	195,696	50.00
51.00	05100	RECOVERY ROOM	76,133	357,416	33,934	0	28,370	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	42,086	0	0	0	5,408	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	122,136	290,890	70,817	0	58,015	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	ONCOLOGY	137,133	0	0	0	43,268	54.02
56.00	05600	RADIOISOTOPE	17,631	16,794	34,733	0	21,698	56.00
57.00	05700	CT SCAN	29,859	291	14,916	0	183,329	57.00
58.00	05800	MRI	15,943	0	706	0	43,018	58.00
60.00	06000	LABORATORY	278,455	7,478	223,263	0	193,635	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	54,245	0	16,518	0	36,331	65.00
66.00	06600	PHYSICAL THERAPY	40,262	0	7,317	0	15,760	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,851	0	551	0	1,871	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	277	68.00
69.00	06900	ELECTROCARDIOLOGY	36,614	91,637	133,934	0	71,826	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	10,801	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	453,639	0	58,469	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,619,646	488,049	73.00
76.00	03950	ANCILLARY SERVICE COST	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	71,066	155,217	22,056	0	4,809	90.00
91.00	09100	EMERGENCY	0	691,220	71,193	0	72,518	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,827,318	4,264,507	1,719,534	2,619,646	1,628,748	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NON ALLOWABLE MEALS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,827,318	4,264,507	1,719,534	2,619,646	1,628,748	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet B Part I | Date/Time Prepared: 7/30/2024 1:58 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	972,995					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	761,276	19,258,966	0	19,258,966		30.00
31.00	03100	INTENSIVE CARE UNIT	143,148	5,081,670	0	5,081,670		31.00
43.00	04300	NURSERY	68,571	601,525	0	601,525		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	9,725,189	0	9,725,189		50.00
51.00	05100	RECOVERY ROOM	0	2,604,428	0	2,604,428		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,897,104	0	1,897,104		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,563,117	0	4,563,117		54.00
54.01	05401	ULTRASOUND	0	0	0	0		54.01
54.02	05402	ONCOLOGY	0	6,147,871	0	6,147,871		54.02
56.00	05600	RADIOISOTOPE	0	866,042	0	866,042		56.00
57.00	05700	CT SCAN	0	1,583,681	0	1,583,681		57.00
58.00	05800	MRI	0	964,020	0	964,020		58.00
60.00	06000	LABORATORY	0	8,622,136	0	8,622,136		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	2,203,585	0	2,203,585		65.00
66.00	06600	PHYSICAL THERAPY	0	3,022,300	0	3,022,300		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	247,516	0	247,516		67.00
68.00	06800	SPEECH PATHOLOGY	0	26,030	0	26,030		68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,233,221	0	2,233,221		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	954,073	0	954,073		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,981,783	0	2,981,783		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,602,084	0	16,602,084		73.00
76.00	03950	ANCILLARY SERVICE COST	0	0	0	0		76.00
76.01	03610	SLEEP LAB	0	0	0	0		76.01
76.03	03951	WOUND CARE	0	0	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,062,308	0	2,062,308		90.00
91.00	09100	EMERGENCY	0	7,000,241	0	7,000,241		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	972,995	99,248,890	0	99,248,890		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	80,908	0	80,908		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,856	0	7,856		192.00
194.00	07950	NON ALLOWABLE MEALS	0	378,892	0	378,892		194.00
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	972,995	99,716,546	0	99,716,546		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet B Part II | Date/Time Prepared: 7/30/2024 1:58 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	26,236	18,887	45,123	45,123	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	1,017,337	732,376	1,749,713	6,158	5.00
7.00	00700	OPERATION OF PLANT	0	621,928	447,723	1,069,651	1,207	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	16,279	11,719	27,998	0	8.00
9.00	00900	HOUSEKEEPING	0	34,348	24,727	59,075	989	9.00
10.00	01000	DIETARY	0	94,362	67,931	162,293	0	10.00
11.00	01100	CAFETERIA	0	79,277	57,071	136,348	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	20,538	14,785	35,323	2,809	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	54,534	39,258	93,792	555	14.00
15.00	01500	PHARMACY	0	53,611	38,594	92,205	1,579	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	75,153	54,103	129,256	408	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	680	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,141,083	821,460	1,962,543	7,193	30.00
31.00	03100	INTENSIVE CARE UNIT	0	255,060	183,616	438,676	1,949	31.00
43.00	04300	NURSERY	0	24,418	17,578	41,996	304	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	474,931	341,901	816,832	2,692	50.00
51.00	05100	RECOVERY ROOM	0	22,383	16,114	38,497	1,486	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	93,385	67,228	160,613	1,023	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	353,736	254,653	608,389	2,393	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	ONCOLOGY	0	304,140	218,949	523,089	2,364	54.02
56.00	05600	RADIOISOTOPE	0	13,864	9,981	23,845	377	56.00
57.00	05700	CT SCAN	0	68,560	49,356	117,916	587	57.00
58.00	05800	MRI	0	90,944	65,470	156,414	358	58.00
60.00	06000	LABORATORY	0	165,364	119,045	284,409	3,447	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	82,018	59,044	141,062	1,151	65.00
66.00	06600	PHYSICAL THERAPY	0	173,667	125,022	298,689	392	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	34	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,713	1,953	4,666	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,357	977	2,334	712	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
76.00	03950	ANCILLARY SERVICE COST	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	100,602	72,423	173,025	1,114	90.00
91.00	09100	EMERGENCY	0	363,558	261,723	625,281	3,162	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	5,825,386	4,193,667	10,019,053	45,123	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,686	12,012	28,698	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NON ALLOWABLE MEALS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	5,842,072	4,205,679	10,047,751	45,123	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet B Part II | Date/Time Prepared: 7/30/2024 1:58 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,755,871					5.00
7.00	00700	OPERATION OF PLANT	150,125	1,220,983				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,171	4,759	40,928			8.00
9.00	00900	HOUSEKEEPING	30,404	10,041	0	100,509		9.00
10.00	01000	DIETARY	12,244	27,586	0	2,438	204,561	10.00
11.00	01100	CAFETERIA	28,682	23,176	0	2,048	0	11.00
13.00	01300	NURSING ADMINISTRATION	72,010	6,004	0	531	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	26,693	15,942	1,431	1,409	0	14.00
15.00	01500	PHARMACY	42,587	15,673	0	1,385	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	24,823	21,970	0	1,942	0	16.00
17.00	01700	SOCIAL SERVICE	16,440	0	0	0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	225,235	333,584	10,021	29,479	97,982	30.00
31.00	03100	INTENSIVE CARE UNIT	64,163	74,565	2,505	6,590	14,744	31.00
43.00	04300	NURSERY	8,038	7,138	0	631	0	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	124,488	138,842	9,125	12,270	8,634	50.00
51.00	05100	RECOVERY ROOM	36,142	6,544	0	578	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	27,534	27,300	4,294	2,413	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54,365	103,412	3,978	9,139	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	ONCOLOGY	91,672	88,913	0	7,858	0	54.02
56.00	05600	RADIOISOTOPE	13,039	4,053	0	358	0	56.00
57.00	05700	CT SCAN	20,973	20,043	0	1,358	0	57.00
58.00	05800	MRI	12,135	26,587	0	1,654	0	58.00
60.00	06000	LABORATORY	132,581	48,343	0	2,926	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	33,301	23,977	0	2,119	0	65.00
66.00	06600	PHYSICAL THERAPY	44,996	50,770	2,681	925	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,248	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	356	793	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	33,382	397	0	35	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16,609	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	43,487	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	237,637	0	0	0	0	73.00
76.00	03950	ANCILLARY SERVICE COST	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	27,148	29,410	1,280	2,599	0	90.00
91.00	09100	EMERGENCY	91,465	106,283	5,010	9,393	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,755,173	1,216,105	40,325	100,078	121,360	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	689	4,878	0	431	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9	0	603	0	0	192.00
194.00	07950	NON ALLOWABLE MEALS	0	0	0	0	83,201	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,755,871	1,220,983	40,928	100,509	204,561	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet B Part II | Date/Time Prepared: 7/30/2024 1:58 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	190,254					11.00
13.00	01300	NURSING ADMINISTRATION	12,864	129,541				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,177	0	144,999			14.00
15.00	01500	PHARMACY	6,963	0	0	160,392		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,193	0	20	0	181,612	16.00
17.00	01700	SOCIAL SERVICE	4,079	0	15	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	37,522	52,617	9,420	0	8,681	30.00
31.00	03100	INTENSIVE CARE UNIT	8,961	12,961	2,604	0	1,671	31.00
43.00	04300	NURSERY	1,301	0	0	0	319	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,842	15,028	41,565	0	21,844	50.00
51.00	05100	RECOVERY ROOM	7,927	10,857	2,862	0	3,167	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,382	0	0	0	604	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,716	8,836	5,972	0	6,476	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	ONCOLOGY	14,278	0	0	0	4,830	54.02
56.00	05600	RADIOISOTOPE	1,836	510	2,929	0	2,422	56.00
57.00	05700	CT SCAN	3,109	9	1,258	0	20,463	57.00
58.00	05800	MRI	1,660	0	60	0	4,802	58.00
60.00	06000	LABORATORY	28,992	227	18,827	0	21,614	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	5,648	0	1,393	0	4,055	65.00
66.00	06600	PHYSICAL THERAPY	4,192	0	617	0	1,759	66.00
67.00	06700	OCCUPATIONAL THERAPY	401	0	46	0	209	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	31	68.00
69.00	06900	ELECTROCARDIOLOGY	3,812	2,784	11,294	0	8,017	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,206	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	38,254	0	6,526	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	160,392	54,285	73.00
76.00	03950	ANCILLARY SERVICE COST	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,399	4,715	1,860	0	537	90.00
91.00	09100	EMERGENCY	0	20,997	6,003	0	8,094	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	190,254	129,541	144,999	160,392	181,612	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NON ALLOWABLE MEALS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	190,254	129,541	144,999	160,392	181,612	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet B Part II | Date/Time Prepared: 7/30/2024 1:58 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	21,214					17.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	16,598	2,790,875	0	2,790,875		30.00
31.00	03100	INTENSIVE CARE UNIT	3,121	632,510	0	632,510		31.00
43.00	04300	NURSERY	1,495	61,222	0	61,222		43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,205,162	0	1,205,162		50.00
51.00	05100	RECOVERY ROOM	0	108,060	0	108,060		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	228,163	0	228,163		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	815,676	0	815,676		54.00
54.01	05401	ULTRASOUND	0	0	0	0		54.01
54.02	05402	ONCOLOGY	0	733,004	0	733,004		54.02
56.00	05600	RADIOISOTOPE	0	49,369	0	49,369		56.00
57.00	05700	CT SCAN	0	185,716	0	185,716		57.00
58.00	05800	MRI	0	203,670	0	203,670		58.00
60.00	06000	LABORATORY	0	541,366	0	541,366		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	212,706	0	212,706		65.00
66.00	06600	PHYSICAL THERAPY	0	405,021	0	405,021		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,938	0	4,938		67.00
68.00	06800	SPEECH PATHOLOGY	0	5,846	0	5,846		68.00
69.00	06900	ELECTROCARDIOLOGY	0	62,767	0	62,767		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	17,815	0	17,815		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	88,267	0	88,267		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	452,314	0	452,314		73.00
76.00	03950	ANCILLARY SERVICE COST	0	0	0	0		76.00
76.01	03610	SLEEP LAB	0	0	0	0		76.01
76.03	03951	WOUND CARE	0	0	0	0		76.03
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	249,087	0	249,087		90.00
91.00	09100	EMERGENCY	0	875,688	0	875,688		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,214	9,929,242	0	9,929,242		118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	34,696	0	34,696		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	612	0	612		192.00
194.00	07950	NON ALLOWABLE MEALS	0	83,201	0	83,201		194.00
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	21,214	10,047,751	0	10,047,751		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet B-1 | Date/Time Prepared: 7/30/2024 1:58 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	215,327					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		215,327				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	967	967	30,419,713			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	37,497	37,497	4,152,590	-26,602,034	73,114,512	5.00
7.00	00700	OPERATION OF PLANT	22,923	22,923	814,090	0	6,251,286	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	600	600	0	0	340,265	8.00
9.00	00900	HOUSEKEEPING	1,266	1,266	666,875	0	1,266,057	9.00
10.00	01000	DIETARY	3,478	3,478	0	0	509,847	10.00
11.00	01100	CAFETERIA	2,922	2,922	0	0	1,194,327	11.00
13.00	01300	NURSING ADMINISTRATION	757	757	1,894,239	0	2,998,547	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,010	2,010	374,199	0	1,111,504	14.00
15.00	01500	PHARMACY	1,976	1,976	1,064,420	0	1,773,351	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,770	2,770	275,379	0	1,033,641	16.00
17.00	01700	SOCIAL SERVICE	0	0	458,838	0	684,563	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	42,058	42,058	4,842,880	0	9,378,939	30.00
31.00	03100	INTENSIVE CARE UNIT	9,401	9,401	1,313,964	0	2,671,773	31.00
43.00	04300	NURSERY	900	900	204,869	0	334,698	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,505	17,505	1,814,939	0	5,183,746	50.00
51.00	05100	RECOVERY ROOM	825	825	1,002,360	0	1,504,974	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,442	3,442	690,058	0	1,146,519	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,038	13,038	1,613,369	0	2,263,792	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	ONCOLOGY	11,210	11,210	1,593,986	0	3,817,268	54.02
56.00	05600	RADIOISOTOPE	511	511	253,897	0	542,939	56.00
57.00	05700	CT SCAN	2,527	2,527	395,809	0	873,313	57.00
58.00	05800	MRI	3,352	3,352	241,397	0	505,289	58.00
60.00	06000	LABORATORY	6,095	6,095	2,324,473	0	5,520,750	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	3,023	3,023	776,340	0	1,386,661	65.00
66.00	06600	PHYSICAL THERAPY	6,401	6,401	264,604	0	1,873,642	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	22,708	0	176,885	67.00
68.00	06800	SPEECH PATHOLOGY	100	100	0	0	14,822	68.00
69.00	06900	ELECTROCARDIOLOGY	50	50	480,302	0	1,390,055	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	691,629	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,810,823	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	9,894,418	73.00
76.00	03950	ANCILLARY SERVICE COST	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,708	3,708	750,986	0	1,130,466	90.00
91.00	09100	EMERGENCY	13,400	13,400	2,132,142	0	3,808,641	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	214,712	214,712	30,419,713	-26,602,034	73,085,430	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	615	615	0	0	28,698	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	384	192.00
194.00	07950	NON ALLOWABLE MEALS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,842,072	4,205,679	7,056,137		26,602,034	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.131163	19.531591	0.231959		0.363841	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			45,123		1,755,871	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001483		0.024015	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: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet B-1 | Date/Time Prepared: 7/30/2024 1:58 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	153,940					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	600	463,072				8.00
9.00	00900	HOUSEKEEPING	1,266	0	143,390			9.00
10.00	01000	DIETARY	3,478	0	3,478	56,883		10.00
11.00	01100	CAFETERIA	2,922	0	2,922	0	27,050	11.00
13.00	01300	NURSING ADMINISTRATION	757	0	757	0	1,829	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,010	16,195	2,010	0	736	14.00
15.00	01500	PHARMACY	1,976	0	1,976	0	990	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,770	0	2,770	0	454	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	580	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	42,058	113,368	42,058	27,246	5,335	30.00
31.00	03100	INTENSIVE CARE UNIT	9,401	28,342	9,401	4,100	1,274	31.00
43.00	04300	NURSERY	900	0	900	0	185	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,505	103,246	17,505	2,401	1,968	50.00
51.00	05100	RECOVERY ROOM	825	0	825	0	1,127	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,442	48,586	3,442	0	623	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,038	45,009	13,038	0	1,808	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	ONCOLOGY	11,210	0	11,210	0	2,030	54.02
56.00	05600	RADIOISOTOPE	511	0	511	0	261	56.00
57.00	05700	CT SCAN	2,527	0	1,937	0	442	57.00
58.00	05800	MRI	3,352	0	2,360	0	236	58.00
60.00	06000	LABORATORY	6,095	0	4,175	0	4,122	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	3,023	0	3,023	0	803	65.00
66.00	06600	PHYSICAL THERAPY	6,401	30,330	1,319	0	596	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	57	67.00
68.00	06800	SPEECH PATHOLOGY	100	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	50	0	50	0	542	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
76.00	03950	ANCILLARY SERVICE COST	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,708	14,485	3,708	0	1,052	90.00
91.00	09100	EMERGENCY	13,400	56,684	13,400	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	153,325	456,245	142,775	33,747	27,050	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	615	0	615	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,827	0	0	0	192.00
194.00	07950	NON ALLOWABLE MEALS	0	0	0	23,136	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	8,525,760	497,297	1,796,816	931,557	1,827,318	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	55.383656	1.073909	12.530971	16.376721	67.553346	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,220,983	40,928	100,509	204,561	190,254	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.931551	0.088384	0.700948	3.596171	7.033420	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: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet B-1 | Date/Time Prepared: 7/30/2024 1:58 pm

		Cost Center Description	NURSING ADMINISTRATION (NURSING SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	11,529,955					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	8,209,361				14.00
15.00	01500	PHARMACY	0	0	10,132,581			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,113	0	932,133,447		16.00
17.00	01700	SOCIAL SERVICE	0	853	0	0	10,855	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,683,159	533,326	0	44,518,437	8,493	30.00
31.00	03100	INTENSIVE CARE UNIT	1,153,646	147,420	0	8,567,542	1,597	31.00
43.00	04300	NURSERY	0	0	0	1,636,700	765	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,337,639	2,353,458	0	112,018,208	0	50.00
51.00	05100	RECOVERY ROOM	966,346	162,008	0	16,239,550	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,095,608	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	786,480	338,094	0	33,208,197	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	ONCOLOGY	0	0	0	24,766,861	0	54.02
56.00	05600	RADIOISOTOPE	45,407	165,821	0	12,420,045	0	56.00
57.00	05700	CT SCAN	788	71,211	0	104,939,481	0	57.00
58.00	05800	MRI	0	3,371	0	24,624,072	0	58.00
60.00	06000	LABORATORY	20,219	1,065,899	0	110,838,639	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	78,859	0	20,796,018	0	65.00
66.00	06600	PHYSICAL THERAPY	0	34,932	0	9,021,264	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,632	0	1,071,221	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	158,819	0	68.00
69.00	06900	ELECTROCARDIOLOGY	247,758	639,424	0	41,113,994	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	6,182,314	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,165,755	0	33,468,327	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	10,132,581	279,185,459	0	73.00
76.00	03950	ANCILLARY SERVICE COST	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	419,660	105,297	0	2,752,643	0	90.00
91.00	09100	EMERGENCY	1,868,853	339,888	0	41,510,048	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,529,955	8,209,361	10,132,581	932,133,447	10,855	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NON ALLOWABLE MEALS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,264,507	1,719,534	2,619,646	1,628,748	972,995	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.369863	0.209460	0.258537	0.001747	89.635652	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	129,541	144,999	160,392	181,612	21,214	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.011235	0.017663	0.015829	0.000195	1.954307	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: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet C Part I | Date/Time Prepared: 7/30/2024 1:58 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,258,966		19,258,966	0	19,258,966	30.00
31.00	03100	INTENSIVE CARE UNIT	5,081,670		5,081,670	0	5,081,670	31.00
43.00	04300	NURSERY	601,525		601,525	0	601,525	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,725,189		9,725,189	0	9,725,189	50.00
51.00	05100	RECOVERY ROOM	2,604,428		2,604,428	0	2,604,428	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,897,104		1,897,104	0	1,897,104	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,563,117		4,563,117	0	4,563,117	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
54.02	05402	ONCOLOGY	6,147,871		6,147,871	0	6,147,871	54.02
56.00	05600	RADIOISOTOPE	866,042		866,042	0	866,042	56.00
57.00	05700	CT SCAN	1,583,681		1,583,681	0	1,583,681	57.00
58.00	05800	MRI	964,020		964,020	0	964,020	58.00
60.00	06000	LABORATORY	8,622,136		8,622,136	0	8,622,136	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	2,203,585	0	2,203,585	0	2,203,585	65.00
66.00	06600	PHYSICAL THERAPY	3,022,300	0	3,022,300	0	3,022,300	66.00
67.00	06700	OCCUPATIONAL THERAPY	247,516	0	247,516	0	247,516	67.00
68.00	06800	SPEECH PATHOLOGY	26,030	0	26,030	0	26,030	68.00
69.00	06900	ELECTROCARDIOLOGY	2,233,221		2,233,221	0	2,233,221	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	954,073		954,073	0	954,073	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,981,783		2,981,783	0	2,981,783	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,602,084		16,602,084	0	16,602,084	73.00
76.00	03950	ANCILLARY SERVICE COST	0		0	0	0	76.00
76.01	03610	SLEEP LAB	0		0	0	0	76.01
76.03	03951	WOUND CARE	0		0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,062,308		2,062,308	0	2,062,308	90.00
91.00	09100	EMERGENCY	7,000,241		7,000,241	0	7,000,241	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,171,199		4,171,199		4,171,199	92.00
200.00		Subtotal (see instructions)	103,420,089	0	103,420,089	0	103,420,089	200.00
201.00		Less Observation Beds	4,171,199		4,171,199		4,171,199	201.00
202.00		Total (see instructions)	99,248,890	0	99,248,890	0	99,248,890	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet C Part I Date/Time Prepared: 7/30/2024 1:58 pm

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		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	34,346,159		34,346,159			30.00
31.00	03100	INTENSIVE CARE UNIT	8,567,542		8,567,542			31.00
43.00	04300	NURSERY	1,636,700		1,636,700			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,673,980	84,344,228	112,018,208	0.086818	0.000000	50.00
51.00	05100	RECOVERY ROOM	2,803,420	13,436,130	16,239,550	0.160376	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,049,562	46,046	3,095,608	0.612837	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,559,811	28,648,386	33,208,197	0.137409	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
54.02	05402	ONCOLOGY	168,710	24,598,151	24,766,861	0.248230	0.000000	54.02
56.00	05600	RADIOISOTOPE	880,894	11,539,151	12,420,045	0.069729	0.000000	56.00
57.00	05700	CT SCAN	23,977,876	80,961,605	104,939,481	0.015091	0.000000	57.00
58.00	05800	MRI	2,655,652	21,968,420	24,624,072	0.039149	0.000000	58.00
60.00	06000	LABORATORY	30,808,006	80,030,633	110,838,639	0.077790	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	14,015,921	6,780,097	20,796,018	0.105962	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,883,448	7,137,816	9,021,264	0.335020	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	181,063	890,158	1,071,221	0.231060	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	94,068	64,751	158,819	0.163897	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	11,874,524	29,239,470	41,113,994	0.054318	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,015,445	3,166,869	6,182,314	0.154323	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,116,156	25,352,171	33,468,327	0.089093	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	61,957,693	217,227,766	279,185,459	0.059466	0.000000	73.00
76.00	03950	ANCILLARY SERVICE COST	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.03	03951	WOUND CARE	0	0	0	0.000000	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,346	2,751,297	2,752,643	0.749210	0.000000	90.00
91.00	09100	EMERGENCY	10,102,533	31,407,515	41,510,048	0.168640	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,462,608	7,709,670	10,172,278	0.410056	0.000000	92.00
200.00		Subtotal (see instructions)	254,833,117	677,300,330	932,133,447			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	254,833,117	677,300,330	932,133,447			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-0133	Period: From 03/01/2023 To 02/29/2024	Worksheet C Part I Date/Time Prepared: 7/30/2024 1:58 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
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.086818	50.00
51.00	05100	RECOVERY ROOM	0.160376	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.612837	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.137409	54.00
54.01	05401	ULTRASOUND	0.000000	54.01
54.02	05402	ONCOLOGY	0.248230	54.02
56.00	05600	RADIOISOTOPE	0.069729	56.00
57.00	05700	CT SCAN	0.015091	57.00
58.00	05800	MRI	0.039149	58.00
60.00	06000	LABORATORY	0.077790	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0.105962	65.00
66.00	06600	PHYSICAL THERAPY	0.335020	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.231060	67.00
68.00	06800	SPEECH PATHOLOGY	0.163897	68.00
69.00	06900	ELECTROCARDIOLOGY	0.054318	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.154323	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.089093	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.059466	73.00
76.00	03950	ANCILLARY SERVICE COST	0.000000	76.00
76.01	03610	SLEEP LAB	0.000000	76.01
76.03	03951	WOUND CARE	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.749210	90.00
91.00	09100	EMERGENCY	0.168640	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.410056	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet C Part I | Date/Time Prepared: 7/30/2024 1:58 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,258,966		19,258,966	0	19,258,966	30.00
31.00	03100	INTENSIVE CARE UNIT	5,081,670		5,081,670	0	5,081,670	31.00
43.00	04300	NURSERY	601,525		601,525	0	601,525	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,725,189		9,725,189	0	9,725,189	50.00
51.00	05100	RECOVERY ROOM	2,604,428		2,604,428	0	2,604,428	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,897,104		1,897,104	0	1,897,104	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,563,117		4,563,117	0	4,563,117	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
54.02	05402	ONCOLOGY	6,147,871		6,147,871	0	6,147,871	54.02
56.00	05600	RADIOISOTOPE	866,042		866,042	0	866,042	56.00
57.00	05700	CT SCAN	1,583,681		1,583,681	0	1,583,681	57.00
58.00	05800	MRI	964,020		964,020	0	964,020	58.00
60.00	06000	LABORATORY	8,622,136		8,622,136	0	8,622,136	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	2,203,585	0	2,203,585	0	2,203,585	65.00
66.00	06600	PHYSICAL THERAPY	3,022,300	0	3,022,300	0	3,022,300	66.00
67.00	06700	OCCUPATIONAL THERAPY	247,516	0	247,516	0	247,516	67.00
68.00	06800	SPEECH PATHOLOGY	26,030	0	26,030	0	26,030	68.00
69.00	06900	ELECTROCARDIOLOGY	2,233,221		2,233,221	0	2,233,221	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	954,073		954,073	0	954,073	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,981,783		2,981,783	0	2,981,783	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,602,084		16,602,084	0	16,602,084	73.00
76.00	03950	ANCILLARY SERVICE COST	0		0	0	0	76.00
76.01	03610	SLEEP LAB	0		0	0	0	76.01
76.03	03951	WOUND CARE	0		0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,062,308		2,062,308	0	2,062,308	90.00
91.00	09100	EMERGENCY	7,000,241		7,000,241	0	7,000,241	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,171,199		4,171,199		4,171,199	92.00
200.00		Subtotal (see instructions)	103,420,089	0	103,420,089	0	103,420,089	200.00
201.00		Less Observation Beds	4,171,199		4,171,199		4,171,199	201.00
202.00		Total (see instructions)	99,248,890	0	99,248,890	0	99,248,890	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet C Part I Date/Time Prepared: 7/30/2024 1:58 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	34,346,159		34,346,159			30.00
31.00	03100	INTENSIVE CARE UNIT	8,567,542		8,567,542			31.00
43.00	04300	NURSERY	1,636,700		1,636,700			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,673,980	84,344,228	112,018,208	0.086818	0.000000	50.00
51.00	05100	RECOVERY ROOM	2,803,420	13,436,130	16,239,550	0.160376	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,049,562	46,046	3,095,608	0.612837	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,559,811	28,648,386	33,208,197	0.137409	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
54.02	05402	ONCOLOGY	168,710	24,598,151	24,766,861	0.248230	0.000000	54.02
56.00	05600	RADIOISOTOPE	880,894	11,539,151	12,420,045	0.069729	0.000000	56.00
57.00	05700	CT SCAN	23,977,876	80,961,605	104,939,481	0.015091	0.000000	57.00
58.00	05800	MRI	2,655,652	21,968,420	24,624,072	0.039149	0.000000	58.00
60.00	06000	LABORATORY	30,808,006	80,030,633	110,838,639	0.077790	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	14,015,921	6,780,097	20,796,018	0.105962	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,883,448	7,137,816	9,021,264	0.335020	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	181,063	890,158	1,071,221	0.231060	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	94,068	64,751	158,819	0.163897	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	11,874,524	29,239,470	41,113,994	0.054318	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,015,445	3,166,869	6,182,314	0.154323	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,116,156	25,352,171	33,468,327	0.089093	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	61,957,693	217,227,766	279,185,459	0.059466	0.000000	73.00
76.00	03950	ANCILLARY SERVICE COST	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.03	03951	WOUND CARE	0	0	0	0.000000	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,346	2,751,297	2,752,643	0.749210	0.000000	90.00
91.00	09100	EMERGENCY	10,102,533	31,407,515	41,510,048	0.168640	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,462,608	7,709,670	10,172,278	0.410056	0.000000	92.00
200.00		Subtotal (see instructions)	254,833,117	677,300,330	932,133,447			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	254,833,117	677,300,330	932,133,447			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet C Part I Date/Time Prepared: 7/30/2024 1:58 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
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.086818	50.00
51.00	05100	RECOVERY ROOM	0.160376	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.612837	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.137409	54.00
54.01	05401	ULTRASOUND	0.000000	54.01
54.02	05402	ONCOLOGY	0.248230	54.02
56.00	05600	RADIOISOTOPE	0.069729	56.00
57.00	05700	CT SCAN	0.015091	57.00
58.00	05800	MRI	0.039149	58.00
60.00	06000	LABORATORY	0.077790	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0.105962	65.00
66.00	06600	PHYSICAL THERAPY	0.335020	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.231060	67.00
68.00	06800	SPEECH PATHOLOGY	0.163897	68.00
69.00	06900	ELECTROCARDIOLOGY	0.054318	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.154323	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.089093	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.059466	73.00
76.00	03950	ANCILLARY SERVICE COST	0.000000	76.00
76.01	03610	SLEEP LAB	0.000000	76.01
76.03	03951	WOUND CARE	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.749210	90.00
91.00	09100	EMERGENCY	0.168640	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.410056	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet C Part II | Date/Time Prepared: 7/30/2024 1:58 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	9,725,189	1,205,162	8,520,027	0	0	50.00
51.00	05100	RECOVERY ROOM	2,604,428	108,060	2,496,368	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,897,104	228,163	1,668,941	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,563,117	815,676	3,747,441	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	ONCOLOGY	6,147,871	733,004	5,414,867	0	0	54.02
56.00	05600	RADIOISOTOPE	866,042	49,369	816,673	0	0	56.00
57.00	05700	CT SCAN	1,583,681	185,716	1,397,965	0	0	57.00
58.00	05800	MRI	964,020	203,670	760,350	0	0	58.00
60.00	06000	LABORATORY	8,622,136	541,366	8,080,770	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	2,203,585	212,706	1,990,879	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,022,300	405,021	2,617,279	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	247,516	4,938	242,578	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	26,030	5,846	20,184	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,233,221	62,767	2,170,454	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	954,073	17,815	936,258	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,981,783	88,267	2,893,516	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,602,084	452,314	16,149,770	0	0	73.00
76.00	03950	ANCILLARY SERVICE COST	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,062,308	249,087	1,813,221	0	0	90.00
91.00	09100	EMERGENCY	7,000,241	875,688	6,124,553	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,171,199	604,461	3,566,738	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	78,477,928	7,049,096	71,428,832	0	0	200.00
201.00		Less Observation Beds	4,171,199	604,461	3,566,738	0	0	201.00
202.00		Total (line 200 minus line 201)	74,306,729	6,444,635	67,862,094	0	0	202.00

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

Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet C Part II | Date/Time Prepared: 7/30/2024 1:58 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	9,725,189	112,018,208	0.086818	50.00
51.00	05100	RECOVERY ROOM	2,604,428	16,239,550	0.160376	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,897,104	3,095,608	0.612837	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,563,117	33,208,197	0.137409	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	54.01
54.02	05402	ONCOLOGY	6,147,871	24,766,861	0.248230	54.02
56.00	05600	RADIOISOTOPE	866,042	12,420,045	0.069729	56.00
57.00	05700	CT SCAN	1,583,681	104,939,481	0.015091	57.00
58.00	05800	MRI	964,020	24,624,072	0.039149	58.00
60.00	06000	LABORATORY	8,622,136	110,838,639	0.077790	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	2,203,585	20,796,018	0.105962	65.00
66.00	06600	PHYSICAL THERAPY	3,022,300	9,021,264	0.335020	66.00
67.00	06700	OCCUPATIONAL THERAPY	247,516	1,071,221	0.231060	67.00
68.00	06800	SPEECH PATHOLOGY	26,030	158,819	0.163897	68.00
69.00	06900	ELECTROCARDIOLOGY	2,233,221	41,113,994	0.054318	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	954,073	6,182,314	0.154323	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,981,783	33,468,327	0.089093	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,602,084	279,185,459	0.059466	73.00
76.00	03950	ANCILLARY SERVICE COST	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	76.01
76.03	03951	WOUND CARE	0	0	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2,062,308	2,752,643	0.749210	90.00
91.00	09100	EMERGENCY	7,000,241	41,510,048	0.168640	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,171,199	10,172,278	0.410056	92.00
200.00		Subtotal (sum of lines 50 thru 199)	78,477,928	887,583,046		200.00
201.00		Less Observation Beds	4,171,199	0		201.00
202.00		Total (line 200 minus line 201)	74,306,729	887,583,046		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet D Part I Date/Time Prepared: 7/30/2024 1:58 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	2,790,875	0	2,790,875	10,841	257.44	30.00
31.00	INTENSIVE CARE UNIT	632,510		632,510	1,597	396.06	31.00
43.00	NURSERY	61,222		61,222	765	80.03	43.00
200.00	Total (lines 30 through 199)	3,484,607		3,484,607	13,203		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	2,134	549,377	30.00
31.00	INTENSIVE CARE UNIT	354	140,205	31.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	2,488	689,582	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet D Part II Date/Time Prepared: 7/30/2024 1:58 pm

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		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,205,162	112,018,208	0.010759	4,745,024	51,052	50.00
51.00	05100	RECOVERY ROOM	108,060	16,239,550	0.006654	348,753	2,321	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	228,163	3,095,608	0.073705	5,205	384	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	815,676	33,208,197	0.024562	1,265,157	31,075	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
54.02	05402	ONCOLOGY	733,004	24,766,861	0.029596	37,953	1,123	54.02
56.00	05600	RADIOISOTOPE	49,369	12,420,045	0.003975	290,036	1,153	56.00
57.00	05700	CT SCAN	185,716	104,939,481	0.001770	5,713,495	10,113	57.00
58.00	05800	MRI	203,670	24,624,072	0.008271	690,262	5,709	58.00
60.00	06000	LABORATORY	541,366	110,838,639	0.004884	6,868,228	33,544	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	212,706	20,796,018	0.010228	3,714,225	37,989	65.00
66.00	06600	PHYSICAL THERAPY	405,021	9,021,264	0.044896	436,672	19,605	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,938	1,071,221	0.004610	35,880	165	67.00
68.00	06800	SPEECH PATHOLOGY	5,846	158,819	0.036809	35,303	1,299	68.00
69.00	06900	ELECTROCARDIOLOGY	62,767	41,113,994	0.001527	2,949,853	4,504	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,815	6,182,314	0.002882	689,178	1,986	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	88,267	33,468,327	0.002637	1,965,767	5,184	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	452,314	279,185,459	0.001620	13,645,804	22,106	73.00
76.00	03950	ANCILLARY SERVICE COST	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0	0	76.01
76.03	03951	WOUND CARE	0	0	0.000000	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	249,087	2,752,643	0.090490	0	0	90.00
91.00	09100	EMERGENCY	875,688	41,510,048	0.021096	2,219,780	46,828	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	604,461	10,172,278	0.059422	596,756	35,460	92.00
200.00		Total (lines 50 through 199)	7,049,096	887,583,046		46,253,331	311,600	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet D Part III Date/Time Prepared: 7/30/2024 1:58 pm

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		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
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	10,841	0.00	2,134	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,597	0.00	354	31.00
43.00	04300	NURSERY		0	765	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	13,203		2,488	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
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: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet D Part IV Date/Time Prepared: 7/30/2024 1:58 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	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	ONCOLOGY	0	0	0	0	0	54.02
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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	ANCILLARY SERVICE COST	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet D Part IV | Date/Time Prepared: 7/30/2024 1:58 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	112,018,208	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	16,239,550	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,095,608	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	33,208,197	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
54.02	05402	ONCOLOGY	0	0	0	24,766,861	0.000000	54.02
56.00	05600	RADIOISOTOPE	0	0	0	12,420,045	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	104,939,481	0.000000	57.00
58.00	05800	MRI	0	0	0	24,624,072	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	110,838,639	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	20,796,018	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	9,021,264	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,071,221	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	158,819	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	41,113,994	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	6,182,314	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	33,468,327	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	279,185,459	0.000000	73.00
76.00	03950	ANCILLARY SERVICE COST	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0.000000	76.01
76.03	03951	WOUND CARE	0	0	0	0	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	2,752,643	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	41,510,048	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	10,172,278	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	887,583,046		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet D Part IV | Date/Time Prepared: 7/30/2024 1:58 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	4,745,024	0	9,603,495	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	348,753	0	1,504,675	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	5,205	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,265,157	0	3,729,092	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
54.02	05402	ONCOLOGY	0.000000	37,953	0	5,904,758	0	54.02
56.00	05600	RADIOISOTOPE	0.000000	290,036	0	2,455,165	0	56.00
57.00	05700	CT SCAN	0.000000	5,713,495	0	11,376,224	0	57.00
58.00	05800	MRI	0.000000	690,262	0	3,101,760	0	58.00
60.00	06000	LABORATORY	0.000000	6,868,228	0	3,885,946	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	3,714,225	0	1,008,959	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	436,672	0	13,915	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	35,880	0	1,045	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	35,303	0	1,374	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	2,949,853	0	6,124,730	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	689,178	0	298,376	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,965,767	0	3,944,591	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	13,645,804	0	50,811,826	0	73.00
76.00	03950	ANCILLARY SERVICE COST	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03951	WOUND CARE	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	654,763	0	90.00
91.00	09100	EMERGENCY	0.000000	2,219,780	0	3,369,356	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	596,756	0	896,206	0	92.00
200.00		Total (lines 50 through 199)		46,253,331	0	108,686,256	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet D Part V Date/Time Prepared: 7/30/2024 1:58 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.086818	9,603,495	0	0	833,756	50.00
51.00	05100	RECOVERY ROOM	0.160376	1,504,675	0	0	241,314	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.612837	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.137409	3,729,092	0	0	512,411	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
54.02	05402	ONCOLOGY	0.248230	5,904,758	0	0	1,465,738	54.02
56.00	05600	RADIOISOTOPE	0.069729	2,455,165	0	0	171,196	56.00
57.00	05700	CT SCAN	0.015091	11,376,224	0	0	171,679	57.00
58.00	05800	MRI	0.039149	3,101,760	0	0	121,431	58.00
60.00	06000	LABORATORY	0.077790	3,885,946	0	0	302,288	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.105962	1,008,959	0	0	106,911	65.00
66.00	06600	PHYSICAL THERAPY	0.335020	13,915	0	0	4,662	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.231060	1,045	0	0	241	67.00
68.00	06800	SPEECH PATHOLOGY	0.163897	1,374	0	0	225	68.00
69.00	06900	ELECTROCARDIOLOGY	0.054318	6,124,730	0	0	332,683	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.154323	298,376	0	0	46,046	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.089093	3,944,591	0	0	351,435	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.059466	50,811,826	0	230	3,021,576	73.00
76.00	03950	ANCILLARY SERVICE COST	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03951	WOUND CARE	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.749210	654,763	0	0	490,555	90.00
91.00	09100	EMERGENCY	0.168640	3,369,356	0	0	568,208	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.410056	896,206	0	0	367,495	92.00
200.00		Subtotal (see instructions)		108,686,256	0	230	9,109,850	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		108,686,256	0	230	9,109,850	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet D Part V Date/Time Prepared: 7/30/2024 1:58 pm

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		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	ULTRASOUND	0	0	54.01
54.02	05402	ONCOLOGY	0	0	54.02
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	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	14	73.00
76.00	03950	ANCILLARY SERVICE COST	0	0	76.00
76.01	03610	SLEEP LAB	0	0	76.01
76.03	03951	WOUND CARE	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	14	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	14	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet D Part I Date/Time Prepared: 7/30/2024 1:58 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	2,790,875	0	2,790,875	10,841	257.44	30.00
31.00	INTENSIVE CARE UNIT	632,510		632,510	1,597	396.06	31.00
43.00	NURSERY	61,222		61,222	765	80.03	43.00
200.00	Total (lines 30 through 199)	3,484,607		3,484,607	13,203		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	212	54,577	30.00
31.00	INTENSIVE CARE UNIT	11	4,357	31.00
43.00	NURSERY	512	40,975	43.00
200.00	Total (lines 30 through 199)	735	99,909	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet D Part II Date/Time Prepared: 7/30/2024 1:58 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	1,205,162	112,018,208	0.010759	428,644	4,612	50.00
51.00	05100	RECOVERY ROOM	108,060	16,239,550	0.006654	71,342	475	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	228,163	3,095,608	0.073705	155,609	11,469	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	815,676	33,208,197	0.024562	87,785	2,156	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
54.02	05402	ONCOLOGY	733,004	24,766,861	0.029596	0	0	54.02
56.00	05600	RADIOISOTOPE	49,369	12,420,045	0.003975	31,638	126	56.00
57.00	05700	CT SCAN	185,716	104,939,481	0.001770	521,059	922	57.00
58.00	05800	MRI	203,670	24,624,072	0.008271	34,697	287	58.00
60.00	06000	LABORATORY	541,366	110,838,639	0.004884	642,561	3,138	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	212,706	20,796,018	0.010228	154,975	1,585	65.00
66.00	06600	PHYSICAL THERAPY	405,021	9,021,264	0.044896	38,441	1,726	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,938	1,071,221	0.004610	1,107	5	67.00
68.00	06800	SPEECH PATHOLOGY	5,846	158,819	0.036809	567	21	68.00
69.00	06900	ELECTROCARDIOLOGY	62,767	41,113,994	0.001527	155,410	237	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,815	6,182,314	0.002882	31,598	91	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	88,267	33,468,327	0.002637	22,120	58	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	452,314	279,185,459	0.001620	1,458,509	2,363	73.00
76.00	03950	ANCILLARY SERVICE COST	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0	0	76.01
76.03	03951	WOUND CARE	0	0	0.000000	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	249,087	2,752,643	0.090490	0	0	90.00
91.00	09100	EMERGENCY	875,688	41,510,048	0.021096	220,564	4,653	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	604,461	10,172,278	0.059422	54,927	3,264	92.00
200.00		Total (lines 50 through 199)	7,049,096	887,583,046		4,111,553	37,188	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet D Part III Date/Time Prepared: 7/30/2024 1:58 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
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	10,841	0.00	212	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,597	0.00	11	31.00
43.00	04300	NURSERY		0	765	0.00	512	43.00
200.00		Total (lines 30 through 199)		0	13,203		735	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
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: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet D Part IV Date/Time Prepared: 7/30/2024 1:58 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	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	ONCOLOGY	0	0	0	0	0	54.02
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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	ANCILLARY SERVICE COST	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet D Part IV | Date/Time Prepared: 7/30/2024 1:58 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	112,018,208	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	16,239,550	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,095,608	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	33,208,197	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
54.02	05402	ONCOLOGY	0	0	0	24,766,861	0.000000	54.02
56.00	05600	RADIOISOTOPE	0	0	0	12,420,045	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	104,939,481	0.000000	57.00
58.00	05800	MRI	0	0	0	24,624,072	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	110,838,639	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	20,796,018	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	9,021,264	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,071,221	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	158,819	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	41,113,994	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	6,182,314	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	33,468,327	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	279,185,459	0.000000	73.00
76.00	03950	ANCILLARY SERVICE COST	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0.000000	76.01
76.03	03951	WOUND CARE	0	0	0	0	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	2,752,643	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	41,510,048	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	10,172,278	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	887,583,046		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet D Part IV | Date/Time Prepared: 7/30/2024 1:58 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	428,644	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	71,342	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	155,609	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	87,785	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
54.02	05402	ONCOLOGY	0.000000	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0.000000	31,638	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	521,059	0	0	0	57.00
58.00	05800	MRI	0.000000	34,697	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	642,561	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	154,975	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	38,441	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,107	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	567	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	155,410	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	31,598	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	22,120	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,458,509	0	0	0	73.00
76.00	03950	ANCILLARY SERVICE COST	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03951	WOUND CARE	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	220,564	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	54,927	0	0	0	92.00
200.00		Total (lines 50 through 199)		4,111,553	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet D Part V Date/Time Prepared: 7/30/2024 1:58 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	0.086818	0	0	609,256	0	50.00
51.00	05100	RECOVERY ROOM	0.160376	0	0	102,471	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.612837	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.137409	0	0	396,820	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
54.02	05402	ONCOLOGY	0.248230	0	0	118,346	0	54.02
56.00	05600	RADIOISOTOPE	0.069729	0	0	39,281	0	56.00
57.00	05700	CT SCAN	0.015091	0	0	1,543,636	0	57.00
58.00	05800	MRI	0.039149	0	0	127,111	0	58.00
60.00	06000	LABORATORY	0.077790	0	0	880,186	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.105962	0	0	91,131	0	65.00
66.00	06600	PHYSICAL THERAPY	0.335020	0	0	46,444	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.231060	0	0	9,968	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.163897	0	0	4,335	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.054318	0	0	310,655	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.154323	0	0	18,301	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.089093	0	0	66,413	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.059466	0	0	1,824,158	0	73.00
76.00	03950	ANCILLARY SERVICE COST	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03951	WOUND CARE	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.749210	0	0	60,583	0	90.00
91.00	09100	EMERGENCY	0.168640	0	0	851,600	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.410056	0	0	91,822	0	92.00
200.00		Subtotal (see instructions)		0	0	7,192,517	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	7,192,517	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet D Part V Date/Time Prepared: 7/30/2024 1:58 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	52,894	50.00
51.00	05100	RECOVERY ROOM	0	16,434	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	54,527	54.00
54.01	05401	ULTRASOUND	0	0	54.01
54.02	05402	ONCOLOGY	0	29,377	54.02
56.00	05600	RADIOISOTOPE	0	2,739	56.00
57.00	05700	CT SCAN	0	23,295	57.00
58.00	05800	MRI	0	4,976	58.00
60.00	06000	LABORATORY	0	68,470	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	9,656	65.00
66.00	06600	PHYSICAL THERAPY	0	15,560	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,303	67.00
68.00	06800	SPEECH PATHOLOGY	0	710	68.00
69.00	06900	ELECTROCARDIOLOGY	0	16,874	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,824	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,917	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	108,475	73.00
76.00	03950	ANCILLARY SERVICE COST	0	0	76.00
76.01	03610	SLEEP LAB	0	0	76.01
76.03	03951	WOUND CARE	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	45,389	90.00
91.00	09100	EMERGENCY	0	143,614	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	37,652	92.00
200.00		Subtotal (see instructions)	0	641,686	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	641,686	202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0133	Period: From 03/01/2023 To 02/29/2024	Worksheet D-1 Date/Time Prepared: 7/30/2024 1:58 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)	11,011	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	10,841	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)	8,493	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)	170	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)	2,134	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)	80	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)	19,258,966	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)	19,258,966	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)	19,258,966	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,776.49	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,791,030	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3,791,030	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet D-1 | Date/Time Prepared: 7/30/2024 1:58 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	5,081,670	1,597	3,182.01	354	1,126,432	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	3,748,255	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)	8,665,717	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)	689,582	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	311,600	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,001,182	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	7,664,535	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)	2,348	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,776.49	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	4,171,199	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0133	Period: From 03/01/2023 To 02/29/2024	Worksheet D-1 Date/Time Prepared: 7/30/2024 1:58 pm
	Title XVIII	Hospital	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,790,875	19,258,966	0.144913	4,171,199	604,461	90.00
91.00	Nursing Program cost	0	19,258,966	0.000000	4,171,199	0	91.00
92.00	Allied health cost	0	19,258,966	0.000000	4,171,199	0	92.00
93.00	All other Medical Education	0	19,258,966	0.000000	4,171,199	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0133	Period: From 03/01/2023 To 02/29/2024	Worksheet D-1 Date/Time Prepared: 7/30/2024 1:58 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)	11,011	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	10,841	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)	8,493	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)	170	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)	212	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)	765	15.00
16.00	Nursery days (title V or XIX only)	512	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)	19,258,966	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)	19,258,966	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)	19,258,966	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,776.49	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	376,616	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)	376,616	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet D-1 | Date/Time Prepared: 7/30/2024 1:58 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)	601,525	765	786.31	512	402,591	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	5,081,670	1,597	3,182.01	11	35,002	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	408,882	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	1,223,091	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)	99,909	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	37,188	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	137,097	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,085,994	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)	2,348	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,776.49	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	4,171,199	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet D-1 | Date/Time Prepared: 7/30/2024 1:58 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,790,875	19,258,966	0.144913	4,171,199	604,461	90.00
91.00	Nursing Program cost	0	19,258,966	0.000000	4,171,199	0	91.00
92.00	Allied health cost	0	19,258,966	0.000000	4,171,199	0	92.00
93.00	All other Medical Education	0	19,258,966	0.000000	4,171,199	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0133	Period: From 03/01/2023 To 02/29/2024	Worksheet D-3 Date/Time Prepared: 7/30/2024 1:58 pm
	Title XVIII	Hospital	PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		7,665,601		30.00
31.00	03100	INTENSIVE CARE UNIT		1,840,498		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.086818	4,745,024	411,953	50.00
51.00	05100	RECOVERY ROOM	0.160376	348,753	55,932	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.612837	5,205	3,190	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.137409	1,265,157	173,844	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
54.02	05402	ONCOLOGY	0.248230	37,953	9,421	54.02
56.00	05600	RADIOISOTOPE	0.069729	290,036	20,224	56.00
57.00	05700	CT SCAN	0.015091	5,713,495	86,222	57.00
58.00	05800	MRI	0.039149	690,262	27,023	58.00
60.00	06000	LABORATORY	0.077790	6,868,228	534,279	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.105962	3,714,225	393,567	65.00
66.00	06600	PHYSICAL THERAPY	0.335020	436,672	146,294	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.231060	35,880	8,290	67.00
68.00	06800	SPEECH PATHOLOGY	0.163897	35,303	5,786	68.00
69.00	06900	ELECTROCARDIOLOGY	0.054318	2,949,853	160,230	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.154323	689,178	106,356	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.089093	1,965,767	175,136	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.059466	13,645,804	811,461	73.00
76.00	03950	ANCILLARY SERVICE COST	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	76.01
76.03	03951	WOUND CARE	0.000000	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.749210	0	0	90.00
91.00	09100	EMERGENCY	0.168640	2,219,780	374,344	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.410056	596,756	244,703	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		46,253,331	3,748,255	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)		46,253,331		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0133 | Component CCN: 15-U133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet D-3 | Date/Time Prepared: 7/30/2024 1:58 pm

Title XVIII | Swing Beds - SNF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.086818	0	0	50.00
51.00	05100	RECOVERY ROOM	0.160376	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.612837	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.137409	1,106	152	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
54.02	05402	ONCOLOGY	0.248230	0	0	54.02
56.00	05600	RADIOISOTOPE	0.069729	0	0	56.00
57.00	05700	CT SCAN	0.015091	0	0	57.00
58.00	05800	MRI	0.039149	0	0	58.00
60.00	06000	LABORATORY	0.077790	51,150	3,979	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.105962	78,318	8,299	65.00
66.00	06600	PHYSICAL THERAPY	0.335020	35,909	12,030	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.231060	20,123	4,650	67.00
68.00	06800	SPEECH PATHOLOGY	0.163897	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.054318	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.154323	9,637	1,487	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.089093	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.059466	110,849	6,592	73.00
76.00	03950	ANCILLARY SERVICE COST	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	76.01
76.03	03951	WOUND CARE	0.000000	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.749210	0	0	90.00
91.00	09100	EMERGENCY	0.168640	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.410056	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		307,092	37,189	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)		307,092		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0133	Period: From 03/01/2023 To 02/29/2024	Worksheet D-3 Date/Time Prepared: 7/30/2024 1:58 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		751,879		30.00
31.00	03100	INTENSIVE CARE UNIT		115,334		31.00
43.00	04300	NURSERY		128,985		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.086818	428,644	37,214	50.00
51.00	05100	RECOVERY ROOM	0.160376	71,342	11,442	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.612837	155,609	95,363	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.137409	87,785	12,062	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
54.02	05402	ONCOLOGY	0.248230	0	0	54.02
56.00	05600	RADIOISOTOPE	0.069729	31,638	2,206	56.00
57.00	05700	CT SCAN	0.015091	521,059	7,863	57.00
58.00	05800	MRI	0.039149	34,697	1,358	58.00
60.00	06000	LABORATORY	0.077790	642,561	49,985	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.105962	154,975	16,421	65.00
66.00	06600	PHYSICAL THERAPY	0.335020	38,441	12,879	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.231060	1,107	256	67.00
68.00	06800	SPEECH PATHOLOGY	0.163897	567	93	68.00
69.00	06900	ELECTROCARDIOLOGY	0.054318	155,410	8,442	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.154323	31,598	4,876	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.089093	22,120	1,971	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.059466	1,458,509	86,732	73.00
76.00	03950	ANCILLARY SERVICE COST	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	76.01
76.03	03951	WOUND CARE	0.000000	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.749210	0	0	90.00
91.00	09100	EMERGENCY	0.168640	220,564	37,196	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.410056	54,927	22,523	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,111,553	408,882	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		4,111,553		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0133 | Component CCN: 15-U133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet D-3 | Date/Time Prepared: 7/30/2024 1:58 pm

Title XIX | Swing Beds - SNF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.086818	0	0	50.00
51.00	05100	RECOVERY ROOM	0.160376	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.612837	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.137409	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
54.02	05402	ONCOLOGY	0.248230	0	0	54.02
56.00	05600	RADIOISOTOPE	0.069729	0	0	56.00
57.00	05700	CT SCAN	0.015091	0	0	57.00
58.00	05800	MRI	0.039149	0	0	58.00
60.00	06000	LABORATORY	0.077790	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.105962	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.335020	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.231060	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.163897	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.054318	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.154323	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.089093	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.059466	0	0	73.00
76.00	03950	ANCILLARY SERVICE COST	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	76.01
76.03	03951	WOUND CARE	0.000000	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.749210	0	0	90.00
91.00	09100	EMERGENCY	0.168640	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.410056	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	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)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0133	Period: From 03/01/2023 To 02/29/2024	Worksheet E Part A Date/Time Prepared: 7/30/2024 1:58 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)	3,116,016	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	2,453,658	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)	23,862	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	15,989	2.04
3.00	Managed Care Simulated Payments	9,382,387	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	65.07	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)	1.80	30.00
31.00	Percentage of Medicaid patient days (see instructions)	20.97	31.00
32.00	Sum of lines 30 and 31	22.77	32.00
33.00	Allowable disproportionate share percentage (see instructions)	8.00	33.00
34.00	Disproportionate share adjustment (see instructions)	111,393	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet E Part A | Date/Time Prepared: 7/30/2024 1:58 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)		6,874,403,459	0	35.00
35.01	Factor 3 (see instructions)		0.000050855	0.000000000	35.01
35.02	Hospital UCP, including supplemental UCP (see instructions)		349,598	300,629	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)		204,970	124,852	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)		329,822		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)		6,050,740		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		5,957,036		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	6,050,740	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	439,864	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	0	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
55.01	Cellular therapy acquisition cost (see instructions)	0	55.01
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	6,490,604	59.00
60.00	Primary payer payments	2,238	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	6,488,366	61.00
62.00	Deductibles billed to program beneficiaries	814,784	62.00
63.00	Coinsurance billed to program beneficiaries	0	63.00
64.00	Allowable bad debts (see instructions)	26,454	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	17,195	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	4,318	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	5,690,777	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)	14,576	70.93
70.94	HRR adjustment amount (see instructions)	-37,815	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0133	Period: From 03/01/2023 To 02/29/2024	Worksheet E Part A Date/Time Prepared: 7/30/2024 1:58 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)	2023	227,589	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)	2024	187,562	70.97
70.98	Low Volume Payment-3	0	0	70.98
70.99	HAC adjustment amount (see instructions)		30,042	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		6,052,647	71.00
71.01	Sequestration adjustment (see instructions)		121,053	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		6,025,451	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)		-93,857	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		1,413,420	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)	1.0000000000	1.0059408178	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)	0.9944	0.9917	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

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet E Part A Exhibit 4 | Date/Time Prepared: 7/30/2024 1:58 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	-1	1	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,116,016	0	3,116,016		3,116,016	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,453,658	0		2,453,658	2,453,658	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	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	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	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	23,862	0	23,862		23,862	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	15,989	0		0	15,989	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	9,382,387	0	9,382,387	0	9,382,387	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	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	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	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	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	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0800	0.0800	0.0800	0.0800		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	111,393	0	62,320	49,073	111,393	11.00
11.01	Uncompensated care payments	36.00	329,822	0	204,970	124,852	329,822	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	0	12.00
13.00	Subtotal (see instructions)	47.00	6,050,740	0	3,423,156	2,627,584	6,050,740	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	6,050,740	0	3,423,156	2,627,584	6,050,740	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	439,864	0	257,188	182,676	439,864	16.00

LOW VOLUME CALCULATION EXHIBIT 4	Provider CCN: 15-0133	Period: From 03/01/2023 To 02/29/2024	Worksheet E Part A Exhibit 4 Date/Time Prepared: 7/30/2024 1:58 pm
	Title XVIII	Hospital	PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	3,680,344	2,810,260	6,490,604	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	423,745	0	247,763	175,982	423,745	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	16,119	0	9,425	6,694	16,119	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	439,864	0	257,188	182,676	439,864	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.061839	0.066742		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			227,589		227,589	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				187,562	187,562	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 7/30/2024 1:58 pm

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		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	3,116,016	3,116,016		3,116,016	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,453,658		2,453,658	2,453,658	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	23,862	23,862		23,862	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	15,989		15,989	15,989	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	9,382,387	5,014,328	4,368,059	9,382,387	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	0.0800	0.0800	0.0800		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	111,393	62,320	49,073	111,393	11.00
11.01	Uncompensated care payments	36.00	329,822	204,970	124,852	329,822	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	6,050,740	3,407,168	2,643,572	6,050,740	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	6,050,740	3,407,168	2,643,572	6,050,740	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	439,864	257,188	182,676	439,864	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	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			3,664,356	2,826,248	6,490,604	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5	Provider CCN: 15-0133	Period: From 03/01/2023 To 02/29/2024	Worksheet E Part A Exhibit 5 Date/Time Prepared: 7/30/2024 1:58 pm
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		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	423,745	247,763	175,982	423,745	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	16,119	9,425	6,694	16,119	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	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	439,864	257,188	182,676	439,864	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	227,589	227,589		227,589	28.00
29.00	Low volume adjustment on or after October 1	70.97	187,562		187,562	187,562	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	14,576	8,523	6,053	14,576	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	-37,815	-22,110	-15,705	-37,815	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	30,042	30,042	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet E Part B Date/Time Prepared: 7/30/2024 1:58 pm

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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	14	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	9,109,850	2.00
3.00	OPPS or REH payments	8,057,125	3.00
4.00	Outlier payment (see instructions)	3,583	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)	14	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	230	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)	230	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)	230	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	216	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)	14	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)	8,060,708	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	9,835	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,389,107	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)	6,661,780	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)	6,661,780	30.00
31.00	Primary payer payments	2,030	31.00
32.00	Subtotal (line 30 minus line 31)	6,659,750	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)	55,671	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	36,186	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	37,549	36.00
37.00	Subtotal (see instructions)	6,695,936	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-555	38.00
39.00	OTHER ADJUSTMENTS	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)	6,696,491	40.00
40.01	Sequestration adjustment (see instructions)	133,930	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	6,527,125	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)	35,436	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: 15-0133	Period: From 03/01/2023 To 02/29/2024	Worksheet E Part B Date/Time Prepared: 7/30/2024 1:58 pm
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		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: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet E-1 Part I | Date/Time Prepared: 7/30/2024 1:58 pm

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		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		6,025,451		6,527,125	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)		6,025,451		6,527,125	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		35,436	6.01
6.02	SETTLEMENT TO PROGRAM		93,857		0	6.02
7.00	Total Medicare program liability (see instructions)		5,931,594		6,562,561	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CCN: 15-0133 Component CCN: 15-U133	Period: From 03/01/2023 To 02/29/2024	Worksheet E-1 Part I Date/Time Prepared: 7/30/2024 1:58 pm
	Title XVIII	Swing Beds - SNF	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		53,870		0	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)		53,870		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		53,870		0	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: 15-0133	Period: From 03/01/2023 To 02/29/2024	Worksheet E-1 Part II Date/Time Prepared: 7/30/2024 1:58 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 - SWING BEDS

Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet E-2

Component CCN: 15-U133 | Date/Time Prepared: 7/30/2024 1:58 pm

Title XVIII | Swing Beds - SNF | PPS

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	54,969	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	0	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	80	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	54,969	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	54,969	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	54,969	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	54,969	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	54,969	0	19.00
19.01	Sequestration adjustment (see instructions)	1,099	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	53,870	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	0	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	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 swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-0133 | Component CCN: 15-U133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet E-2 | Date/Time Prepared: 7/30/2024 1:58 pm

Title XIX | Swing Beds - SNF | PPS

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	0		3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)	0.00		4.00
5.00	Program days	0		5.00
6.00	Interns and residents not in approved teaching program (see instructions)	0		6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0		13.00
14.00	80% of Part B costs (line 12 x 80%)	0		14.00
15.00	Subtotal (see instructions)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)			16.55
16.99	Demonstration payment adjustment amount before sequestration	0		16.99
17.00	Allowable bad debts (see instructions)	0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		18.00
19.00	Total (see instructions)	0		19.00
19.01	Sequestration adjustment (see instructions)	0		19.01
19.02	Demonstration payment adjustment amount after sequestration)	0		19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0		19.25
20.00	Interim payments	0		20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0		21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	0		22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0		23.00
	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 swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet E-3 Part VII Date/Time Prepared: 7/30/2024 1:58 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		641,686	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	641,686	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	641,686	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	996,198		8.00
9.00	Ancillary service charges	4,111,553	7,192,517	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	5,107,751	7,192,517	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	5,107,751	7,192,517	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	5,107,751	6,550,831	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	641,686	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	641,686	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	641,686	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	641,686	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	641,686	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	641,686	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	641,686	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: 15-0133	Period: From 03/01/2023 To 02/29/2024	Worksheet E-5 Date/Time Prepared: 7/30/2024 1:58 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: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet G | Date/Time Prepared: 7/30/2024 1:58 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	-1,371,676	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	33,948,464	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-5,839,716	0	0	0	6.00
7.00	Inventory	2,755,948	0	0	0	7.00
8.00	Prepaid expenses	2,978,232	0	0	0	8.00
9.00	Other current assets	516,584	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)	32,987,836	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,282,645	0	0	0	12.00
13.00	Land improvements	991,562	0	0	0	13.00
14.00	Accumulated depreciation	-779,426	0	0	0	14.00
15.00	Buildings	25,387,327	0	0	0	15.00
16.00	Accumulated depreciation	-11,723,120	0	0	0	16.00
17.00	Leasehold improvements	28,408,722	0	0	0	17.00
18.00	Accumulated depreciation	-14,139,765	0	0	0	18.00
19.00	Fixed equipment	2,818,264	0	0	0	19.00
20.00	Accumulated depreciation	-2,527,927	0	0	0	20.00
21.00	Automobiles and trucks	131,426	0	0	0	21.00
22.00	Accumulated depreciation	-131,426	0	0	0	22.00
23.00	Major movable equipment	24,688,200	0	0	0	23.00
24.00	Accumulated depreciation	-21,750,375	0	0	0	24.00
25.00	Minor equipment depreciable	9,560,073	0	0	0	25.00
26.00	Accumulated depreciation	-7,312,845	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)	35,903,335	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	7,063,902	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	7,063,902	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	75,955,073	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,191,302	0	0	0	37.00
38.00	Salaries, wages, and fees payable	5,047,729	0	0	0	38.00
39.00	Payroll taxes payable	421,475	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,019,452	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	-540,278,008	0	0	0	43.00
44.00	Other current liabilities	1,021,303	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-530,576,747	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	3,287,918	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	3,287,918	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-527,288,829	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	603,243,902				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)	603,243,902	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	75,955,073	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0133

Period: From 03/01/2023 To 02/29/2024

Worksheet G-1

Date/Time Prepared: 7/30/2024 1:58 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		570,726,212		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		32,517,687				2.00
3.00	Total (sum of line 1 and line 2)		603,243,899		0		3.00
4.00	ROUNDING	3		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)		3		0		10.00
11.00	Subtotal (line 3 plus line 10)		603,243,902		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)		603,243,902		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	ROUNDING		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: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet G-2 Parts I & II | Date/Time Prepared: 7/30/2024 1:58 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	35,982,859		35,982,859	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)	35,982,859		35,982,859	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	8,567,542		8,567,542	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	8,567,542		8,567,542	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	44,550,401		44,550,401	17.00
18.00	Ancillary services	200,178,837	635,431,848	835,610,685	18.00
19.00	Outpatient services	10,103,879	41,868,482	51,972,361	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	IP CONTRACTED HOSPICE	352,343	0	352,343	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	255,185,460	677,300,330	932,485,790	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		108,681,723		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)		108,681,723		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0133	Period: From 03/01/2023 To 02/29/2024	Worksheet G-3 Date/Time Prepared: 7/30/2024 1:58 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	932,485,790	1.00
2.00	Less contractual allowances and discounts on patients' accounts	791,685,121	2.00
3.00	Net patient revenues (line 1 minus line 2)	140,800,669	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	108,681,723	4.00
5.00	Net income from service to patients (line 3 minus line 4)	32,118,946	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 INCOME	398,741	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	398,741	25.00
26.00	Total (line 5 plus line 25)	32,517,687	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)	32,517,687	29.00

CALCULATION OF CAPITAL PAYMENT | Provider CCN: 15-0133 | Period: From 03/01/2023 To 02/29/2024 | Worksheet L Parts I-III | Date/Time Prepared: 7/30/2024 1:58 pm

Title XVIII | Hospital | PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	423,745	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	16,119	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)	28.72	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)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	439,864	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