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: 15-2024	Period: From 02/01/2023 To 01/31/2024	Worksheet S Parts I-III Date/Time Prepared: 6/3/2024 8:32 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 6/3/2024 Time: 8:32 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

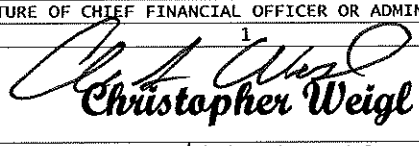
5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12.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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by RH OF NORTHWEST INDIANA, LLC (15-2024) for the cost reporting period beginning 02/01/2023 and ending 01/31/2024 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1			Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Christopher Weigl			2
3	Signatory Title	SENIOR VICE PRESIDENT			3
4	Date	06/03/2024 05:37:52 AM (PT)			4

Encryption Information
ECR: Date: 6/3/2024 Time: 8:32 am
SOMfNPxvSnP91L3ywKepsV.uzEdV30
Q4hv:0J2AM26or9IG6nOxCxz78Q1B7
LgcO0nBRMGOC9NFJ

		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	692,066	0	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	692,066	0	0	0	200.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-2024	Period: From 02/01/2023 To 01/31/2024	Worksheet S Parts I-III Date/Time Prepared: 6/3/2024 8:32 am

PART I - COST REPORT STATUS

Provider use only

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2. [ ] Manually prepared cost report
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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
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   (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)

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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 RH OF NORTHWEST INDIANA, LLC (15-2024) for the cost reporting period beginning 02/01/2023 and ending 01/31/2024 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	Christopher Weigl		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Christopher Weigl			2
3	Signatory Title	SENIOR VICE PRESIDENT			3
4	Date	(Dated when report is electronica			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	692,066	0	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	692,066	0	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet S-2 Part I Date/Time Prepared: 6/3/2024 8:32 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 4321 FIR STREET, 4TH FLOOR	PO Box:			1.00
2.00	City: EAST CHICAGO	State: IN	Zip Code: 46312	County: LAKE	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	RH OF NORTHWEST INDIANA, LLC	152024	23844	2	02/01/2004	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	02/01/2023	01/31/2024	20.00
21.00	Type of Control (see instructions)	4		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	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	N		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: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet S-2 Part I | Date/Time Prepared: 6/3/2024 8:32 am

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

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	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: 15-2024	Period: From 02/01/2023 To 01/31/2024	Worksheet S-2 Part I Date/Time Prepared: 6/3/2024 8:32 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-2024	Period: From 02/01/2023 To 01/31/2024	Worksheet S-2 Part I Date/Time Prepared: 6/3/2024 8:32 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-2024	Period: From 02/01/2023 To 01/31/2024	Worksheet S-2 Part I Date/Time Prepared: 6/3/2024 8:32 am

		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.	Y	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.	Y	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	N	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00

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

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

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

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

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

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	178,110	0	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.	N		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	HB0312	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: NAME: SELECT MEDICAL	Contractor's Name: NOVITAS SOLUTIONS INC.	Contractor's Number: 12001	141.00
142.00	Street: STREET: 4714 GETTYSBURG ROAD	PO Box:		142.00
143.00	City: CITY: MECHANICSBURG	State: PA	Zip Code: 17055	143.00

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

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y	N	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

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					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.		N	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)		0.00	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: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet S-2 Part II | Date/Time Prepared: 6/3/2024 8:32 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C		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)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	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

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		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.	Y		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		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
	Provider-Based Physicians		
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?			36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ANDREW	BUTZ	41.00
42.00	Enter the employer/company name of the cost report preparer.	SELECT MEDICAL		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	717-972-1391	APBUTZ@SELECTMEDICAL.COM	43.00

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		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.	SR REIMBURSEMENT ANALYST		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: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet S-3 Part I | Date/Time Prepared: 6/3/2024 8:32 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	61	22,265	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)		61	22,265	0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		61	22,265	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)		61				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: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet S-3 Part I | Date/Time Prepared: 6/3/2024 8:32 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	6,546	0	12,644			1.00
2.00	HMO and other (see instructions)	2,607	1,450				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	6,546	0	12,644			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)	6,546	0	12,644	0.00	135.10	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)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	135.10	27.00
28.00	Observation Bed Days		0	0			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	2					33.00
33.01	LTCH site neutral days and discharges	18					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: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet S-3 Part I | Date/Time Prepared: 6/3/2024 8:32 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	264	0	494	1.00
2.00	HMO and other (see instructions)			90	56		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	264	0	494	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			1			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet S-3 Part II Date/Time Prepared: 6/3/2024 8:32 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	12,042,032	0	12,042,032	280,999.16	42.85	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	56,563	56,563	1,638.22	34.53	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,304,732	0	1,304,732	17,391.40	75.02	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		170,014	0	170,014	1,107.91	153.45	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		1,087,930	0	1,087,930	21,492.00	50.62	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)		1,975,098	0	1,975,098			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		16,484	0	16,484			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)		119,280	0	119,280			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet S-3 Part II | Date/Time Prepared: 6/3/2024 8:32 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	61,930	0	61,930	1,251.95	49.47	26.00
27.00	Administrative & General	5.00	2,015,559	-56,563	1,958,996	25,471.39	76.91	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	88,779	0	88,779	2,612.88	33.98	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	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	1,213,781	0	1,213,781	17,647.15	68.78	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	139,715	0	139,715	5,639.47	24.77	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet S-3 Part III Date/Time Prepared: 6/3/2024 8:32 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		12,042,032	0	12,042,032	280,999.16	42.85	1.00
2.00	Excluded area salaries (see instructions)		0	56,563	56,563	1,638.22	34.53	2.00
3.00	Subtotal salaries (line 1 minus line 2)		12,042,032	-56,563	11,985,469	279,360.94	42.90	3.00
4.00	Subtotal other wages & related costs (see inst.)		2,562,676	0	2,562,676	39,991.31	64.08	4.00
5.00	Subtotal wage-related costs (see inst.)		2,094,378	0	2,094,378	0.00	17.47	5.00
6.00	Total (sum of lines 3 thru 5)		16,699,086	-56,563	16,642,523	319,352.25	52.11	6.00
7.00	Total overhead cost (see instructions)		3,519,764	-56,563	3,463,201	52,622.84	65.81	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet S-3 Part IV Date/Time Prepared: 6/3/2024 8:32 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	68,369	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)	745,506	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	13,300	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	27,905	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)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	174,173	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	868,879	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	34,101	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	42,865	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	1,975,098	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet A | Date/Time Prepared: 6/3/2024 8:32 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	1,154,562	1,154,562	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,706,237	1,706,237	-1,353,222	353,015	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	61,930	12,781	74,711	27,905	102,616	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,015,559	2,297,717	4,313,276	83,347	4,396,623	5.00
7.00	00700	OPERATION OF PLANT	0	3,571	3,571	0	3,571	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	102,517	102,517	0	102,517	8.00
9.00	00900	HOUSEKEEPING	0	5,057	5,057	0	5,057	9.00
10.00	01000	DIETARY	88,779	228,922	317,701	0	317,701	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,213,781	202,722	1,416,503	0	1,416,503	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	139,715	25,114	164,829	0	164,829	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,403,763	2,570,901	7,974,664	4,811	7,979,475	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,345	465,048	481,393	-97,741	383,652	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	361,525	361,525	97,741	459,266	54.00
60.00	06000	LABORATORY	0	1,203,354	1,203,354	0	1,203,354	60.00
65.00	06500	RESPIRATORY THERAPY	1,601,614	318,097	1,919,711	-49,673	1,870,038	65.00
66.00	06600	PHYSICAL THERAPY	354,804	68,161	422,965	0	422,965	66.00
67.00	06700	OCCUPATIONAL THERAPY	215,110	24,458	239,568	0	239,568	67.00
68.00	06800	SPEECH PATHOLOGY	106,765	35,209	141,974	0	141,974	68.00
69.00	06900	ELECTROCARDIOLOGY	0	38,342	38,342	0	38,342	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	153,444	1,479,010	1,632,454	44,862	1,677,316	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	670,423	1,053,514	1,723,937	0	1,723,937	73.00
74.00	07400	RENAL DIALYSIS	0	725,488	725,488	0	725,488	74.00
76.00	03950	WOUND CARE	0	0	0	0	0	76.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,042,032	12,927,745	24,969,777	-87,408	24,882,369	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PROVIDER RELATIONS NRCC	0	0	0	87,408	87,408	194.00
194.01	07951	NRCC SUBLEASED SPACE	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	12,042,032	12,927,745	24,969,777	0	24,969,777	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet A | Date/Time Prepared: 6/3/2024 8:32 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	1,154,562		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	71,837	424,852		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	102,616		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	829,064	5,225,687		5.00
7.00	00700	OPERATION OF PLANT	0	3,571		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	102,517		8.00
9.00	00900	HOUSEKEEPING	0	5,057		9.00
10.00	01000	DIETARY	0	317,701		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	1,416,503		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-132	164,697		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-27,702	7,951,773		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	383,652		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	459,266		54.00
60.00	06000	LABORATORY	0	1,203,354		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,870,038		65.00
66.00	06600	PHYSICAL THERAPY	0	422,965		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	239,568		67.00
68.00	06800	SPEECH PATHOLOGY	0	141,974		68.00
69.00	06900	ELECTROCARDIOLOGY	0	38,342		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,677,316		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,723,937		73.00
74.00	07400	RENAL DIALYSIS	0	725,488		74.00
76.00	03950	WOUND CARE	0	0		76.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	873,067	25,755,436		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07950	PROVIDER RELATIONS NRCC	0	87,408		194.00
194.01	07951	NRCC SUBLEASED SPACE	0	0		194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	873,067	25,842,844		200.00

RECLASSIFICATIONS | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet A-6 | Date/Time Prepared: 6/3/2024 8:32 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - FACILITY RENT					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,154,562		1.00
	TOTALS		0	1,154,562		
	B - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	27,905		1.00
	TOTALS		0	27,905		
	C - CAPITAL RECONCILIATION					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	198,660		1.00
	TOTALS		0	198,660		
	D - PROVIDER RELATIONS NRCC					
1.00	PROVIDER RELATIONS NRCC	194.00	56,563	30,845		1.00
	TOTALS		56,563	30,845		
	E - PICC LINE RECLASS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	97,741		1.00
	TOTALS		0	97,741		
	F - OXYGEN TANK RENTAL					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	44,862		1.00
	TOTALS		0	44,862		
	G - SITTER FEES					
1.00	ADULTS & PEDIATRICS	30.00	0	4,811		1.00
	TOTALS		0	4,811		
500.00	Grand Total: Increases		56,563	1,559,386		500.00

RECLASSIFICATIONS | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet A-6 | Date/Time Prepared: 6/3/2024 8:32 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - FACILITY RENT						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,154,562	10		1.00
	TOTALS		0	1,154,562			
	B - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	27,905	0		1.00
	TOTALS		0	27,905			
	C - CAPITAL RECONCILIATION						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	198,660	12		1.00
	TOTALS		0	198,660			
	D - PROVIDER RELATIONS NRCC						
1.00	ADMINISTRATIVE & GENERAL	5.00	56,563	30,845	0		1.00
	TOTALS		56,563	30,845			
	E - PICC LINE RECLASS						
1.00	OPERATING ROOM	50.00	0	97,741	0		1.00
	TOTALS		0	97,741			
	F - OXYGEN TANK RENTAL						
1.00	RESPIRATORY THERAPY	65.00	0	44,862	0		1.00
	TOTALS		0	44,862			
	G - SITTER FEES						
1.00	RESPIRATORY THERAPY	65.00	0	4,811	0		1.00
	TOTALS		0	4,811			
500.00	Grand Total: Decreases		56,563	1,559,386			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet A-7 Part I | Date/Time Prepared: 6/3/2024 8:32 am

		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	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	426,711	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	3,917,965	921,818	0	921,818	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	4,344,676	921,818	0	921,818	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	4,344,676	921,818	0	921,818	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	426,711	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	4,839,783	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	5,266,494	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	5,266,494	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet A-7 Part II | Date/Time Prepared: 6/3/2024 8:32 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	364,767	1,095,902	1,776	229,476	14,316	2.00
3.00	Total (sum of lines 1-2)	364,767	1,095,902	1,776	229,476	14,316	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	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,706,237		2.00
3.00	Total (sum of lines 1-2)	0	1,706,237		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet A-7 Part III Date/Time Prepared: 6/3/2024 8:32 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	426,711	0	426,711	0.081024	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,839,783	0	4,839,783	0.918976	0	2.00
3.00	Total (sum of lines 1-2)	5,266,494	0	5,266,494	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,154,562	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	436,604	-58,660	2.00
3.00	Total (sum of lines 1-2)	0	0	0	436,604	1,095,902	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,154,562	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,776	30,816	14,316	0	424,852	2.00
3.00	Total (sum of lines 1-2)	1,776	30,816	14,316	0	1,579,414	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet A-8 | Date/Time Prepared: 6/3/2024 8:32 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-27,702			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	939,789			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	GIFTS	A	0	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet A-8 | Date/Time Prepared: 6/3/2024 8:32 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
35.00	OTHER PERSONNAL EXPENSE	A	-37,075	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	AHA DUES	A	-1,096	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	MEDICAL RECORDS INCOME	B	-132	MEDICAL RECORDS & LIBRARY	16.00	0	37.00
38.00	NON-ALLOWABLE TRANSPORTATION	A	-717	ADMINISTRATIVE & GENERAL	5.00	0	38.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		873,067				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: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet A-8-1 | Date/Time Prepared: 6/3/2024 8:32 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE CAPITAL	71,837	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ADMIN	1,655,647	787,695	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,727,484	787,695	5.00

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

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

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

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

6.00	B		0.00	SELECT MEDICAL	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					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: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet A-8-1 | Date/Time Prepared: 6/3/2024 8:32 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	71,837	9		1.00
2.00	867,952	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	939,789			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	HEALTHCARE		6.00
7.00			7.00
8.00			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: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet A-8-2 | Date/Time Prepared: 6/3/2024 8:32 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	DR. A	10,179	0	10,179	211,500	62	1.00
2.00	30.00	DR. B	11,894	0	11,894	211,500	88	2.00
3.00	30.00	DR. C	10,500	0	10,500	211,500	70	3.00
4.00	30.00	DR. D	14,400	0	14,400	211,500	96	4.00
5.00	30.00	DR. E	15,000	0	15,000	211,500	120	5.00
6.00	30.00	DR. F	15,000	0	15,000	211,500	120	6.00
7.00	30.00	DR. G	600	0	600	211,500	4	7.00
8.00	30.00	DR. H	12,880	0	12,880	211,500	103	8.00
9.00	30.00	DR. I	12,800	0	12,800	211,500	80	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			103,253	0	103,253		743	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	30.00	DR. A	6,304	315	0	0	0	1.00
2.00	30.00	DR. B	8,948	447	0	0	0	2.00
3.00	30.00	DR. C	7,118	356	0	0	0	3.00
4.00	30.00	DR. D	9,762	488	0	0	0	4.00
5.00	30.00	DR. E	12,202	610	0	0	0	5.00
6.00	30.00	DR. F	12,202	610	0	0	0	6.00
7.00	30.00	DR. G	407	20	0	0	0	7.00
8.00	30.00	DR. H	10,473	524	0	0	0	8.00
9.00	30.00	DR. I	8,135	407	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			75,551	3,777	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	30.00	DR. A	0	6,304	3,875	3,875		1.00
2.00	30.00	DR. B	0	8,948	2,946	2,946		2.00
3.00	30.00	DR. C	0	7,118	3,382	3,382		3.00
4.00	30.00	DR. D	0	9,762	4,638	4,638		4.00
5.00	30.00	DR. E	0	12,202	2,798	2,798		5.00
6.00	30.00	DR. F	0	12,202	2,798	2,798		6.00
7.00	30.00	DR. G	0	407	193	193		7.00
8.00	30.00	DR. H	0	10,473	2,407	2,407		8.00
9.00	30.00	DR. I	0	8,135	4,665	4,665		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	75,551	27,702	27,702		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet B Part I Date/Time Prepared: 6/3/2024 8:32 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,154,562	1,154,562				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	424,852		424,852			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	102,616	5,806	2,136	110,558		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,225,687	153,237	56,388	18,078	5,453,390	5.00
7.00	00700	OPERATION OF PLANT	3,571	345,954	127,303	0	476,828	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	102,517	18,192	6,694	0	127,403	8.00
9.00	00900	HOUSEKEEPING	5,057	10,567	3,888	0	19,512	9.00
10.00	01000	DIETARY	317,701	9,019	3,319	819	330,858	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,416,503	9,947	3,660	11,201	1,441,311	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	164,697	6,232	2,293	1,289	174,511	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,951,773	495,977	182,508	49,871	8,680,129	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	383,652	0	0	151	383,803	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	459,266	0	0	0	459,266	54.00
60.00	06000	LABORATORY	1,203,354	6,774	2,493	0	1,212,621	60.00
65.00	06500	RESPIRATORY THERAPY	1,870,038	14,515	5,341	14,780	1,904,674	65.00
66.00	06600	PHYSICAL THERAPY	422,965	8,090	2,977	3,274	437,306	66.00
67.00	06700	OCCUPATIONAL THERAPY	239,568	8,090	2,977	1,985	252,620	67.00
68.00	06800	SPEECH PATHOLOGY	141,974	3,677	1,353	985	147,989	68.00
69.00	06900	ELECTROCARDIOLOGY	38,342	0	0	0	38,342	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,677,316	28,488	10,483	1,416	1,717,703	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,723,937	27,675	10,184	6,187	1,767,983	73.00
74.00	07400	RENAL DIALYSIS	725,488	0	0	0	725,488	74.00
76.00	03950	WOUND CARE	0	0	0	0	0	76.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,755,436	1,152,240	423,997	110,036	25,751,737	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PROVIDER RELATIONS NRCC	87,408	2,322	855	522	91,107	194.00
194.01	07951	NRCC SUBLEASED SPACE	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	25,842,844	1,154,562	424,852	110,558	25,842,844	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet B Part I Date/Time Prepared: 6/3/2024 8:32 am

		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	5,453,390					5.00
7.00	00700	OPERATION OF PLANT	127,533	604,361				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	34,075	16,926	178,404			8.00
9.00	00900	HOUSEKEEPING	5,219	9,831	0	34,562		9.00
10.00	01000	DIETARY	88,492	8,391	0	502	428,243	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	385,494	9,255	0	554	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	46,675	5,798	0	347	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,321,601	461,463	178,404	27,613	428,243	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	102,652	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	122,836	0	0	0	0	54.00
60.00	06000	LABORATORY	324,329	6,302	0	377	0	60.00
65.00	06500	RESPIRATORY THERAPY	509,426	13,505	0	808	0	65.00
66.00	06600	PHYSICAL THERAPY	116,962	7,527	0	450	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	67,566	7,527	0	450	0	67.00
68.00	06800	SPEECH PATHOLOGY	39,581	3,421	0	205	0	68.00
69.00	06900	ELECTROCARDIOLOGY	10,255	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	459,419	26,505	0	1,586	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	472,867	25,749	0	1,541	0	73.00
74.00	07400	RENAL DIALYSIS	194,040	0	0	0	0	74.00
76.00	03950	WOUND CARE	0	0	0	0	0	76.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,429,022	602,200	178,404	34,433	428,243	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PROVIDER RELATIONS NRCC	24,368	2,161	0	129	0	194.00
194.01	07951	NRCC SUBLEASED SPACE	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,453,390	604,361	178,404	34,562	428,243	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet B Part I Date/Time Prepared: 6/3/2024 8:32 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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	0					11.00
13.00	01300	NURSING ADMINISTRATION	0	1,836,614				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	227,331			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,836,614	61,134	13,995,201	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	938	487,393	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	5,327	587,429	0	54.00
60.00	06000	LABORATORY	0	0	11,730	1,555,359	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	104,163	2,532,576	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,938	565,183	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	2,260	330,423	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	765	191,961	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	6,487	55,084	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	15,821	2,221,034	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	9,878	2,278,018	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	5,890	925,418	0	74.00
76.00	03950	WOUND CARE	0	0	0	0	0	76.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,836,614	227,331	25,725,079	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PROVIDER RELATIONS NRCC	0	0	0	117,765	0	194.00
194.01	07951	NRCC SUBLEASED SPACE	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,836,614	227,331	25,842,844	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet B Part I Date/Time Prepared: 6/3/2024 8:32 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	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
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	13,995,201		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	487,393		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	587,429		54.00
60.00	06000	LABORATORY	1,555,359		60.00
65.00	06500	RESPIRATORY THERAPY	2,532,576		65.00
66.00	06600	PHYSICAL THERAPY	565,183		66.00
67.00	06700	OCCUPATIONAL THERAPY	330,423		67.00
68.00	06800	SPEECH PATHOLOGY	191,961		68.00
69.00	06900	ELECTROCARDIOLOGY	55,084		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,221,034		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,278,018		73.00
74.00	07400	RENAL DIALYSIS	925,418		74.00
76.00	03950	WOUND CARE	0		76.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,725,079		118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	PROVIDER RELATIONS NRCC	117,765		194.00
194.01	07951	NRCC SUBLEASED SPACE	0		194.01
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	25,842,844		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet B Part II Date/Time Prepared: 6/3/2024 8:32 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,806	2,136	7,942	7,942	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	153	153,237	56,388	209,778	1,299	5.00
7.00	00700	OPERATION OF PLANT	0	345,954	127,303	473,257	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	18,192	6,694	24,886	0	8.00
9.00	00900	HOUSEKEEPING	0	10,567	3,888	14,455	0	9.00
10.00	01000	DIETARY	0	9,019	3,319	12,338	59	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	9,947	3,660	13,607	805	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,232	2,293	8,525	93	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	495,977	182,508	678,485	3,580	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	11	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	6,774	2,493	9,267	0	60.00
65.00	06500	RESPIRATORY THERAPY	44,862	14,515	5,341	64,718	1,062	65.00
66.00	06600	PHYSICAL THERAPY	0	8,090	2,977	11,067	235	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,090	2,977	11,067	143	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,677	1,353	5,030	71	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	264,336	28,488	10,483	303,307	102	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	27,675	10,184	37,859	444	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	WOUND CARE	0	0	0	0	0	76.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	309,351	1,152,240	423,997	1,885,588	7,904	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PROVIDER RELATIONS NRCC	0	2,322	855	3,177	38	194.00
194.01	07951	NRCC SUBLEASED SPACE	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	309,351	1,154,562	424,852	1,888,765	7,942	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet B Part II | Date/Time Prepared: 6/3/2024 8:32 am

		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	211,077					5.00
7.00	00700	OPERATION OF PLANT	4,936	478,193				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,319	13,392	39,597			8.00
9.00	00900	HOUSEKEEPING	202	7,779	0	22,436		9.00
10.00	01000	DIETARY	3,425	6,639	0	326	22,787	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	14,920	7,323	0	360	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,807	4,588	0	225	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	89,863	365,128	39,597	17,924	22,787	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,973	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,754	0	0	0	0	54.00
60.00	06000	LABORATORY	12,553	4,987	0	245	0	60.00
65.00	06500	RESPIRATORY THERAPY	19,717	10,685	0	525	0	65.00
66.00	06600	PHYSICAL THERAPY	4,527	5,955	0	292	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,615	5,955	0	292	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,532	2,707	0	133	0	68.00
69.00	06900	ELECTROCARDIOLOGY	397	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,782	20,972	0	1,030	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,302	20,373	0	1,000	0	73.00
74.00	07400	RENAL DIALYSIS	7,510	0	0	0	0	74.00
76.00	03950	WOUND CARE	0	0	0	0	0	76.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	210,134	476,483	39,597	22,352	22,787	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PROVIDER RELATIONS NRCC	943	1,710	0	84	0	194.00
194.01	07951	NRCC SUBLEASED SPACE	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	211,077	478,193	39,597	22,436	22,787	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet B Part II Date/Time Prepared: 6/3/2024 8:32 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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	0					11.00
13.00	01300	NURSING ADMINISTRATION	0	37,015				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	15,238			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	37,015	4,107	1,258,486	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	63	4,047	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	358	5,112	0	54.00
60.00	06000	LABORATORY	0	0	788	27,840	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	6,963	103,670	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	197	22,273	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	152	20,224	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	51	9,524	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	436	833	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,063	344,256	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	664	78,642	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	396	7,906	0	74.00
76.00	03950	WOUND CARE	0	0	0	0	0	76.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	37,015	15,238	1,882,813	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PROVIDER RELATIONS NRCC	0	0	0	5,952	0	194.00
194.01	07951	NRCC SUBLEASED SPACE	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	37,015	15,238	1,888,765	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet B Part II Date/Time Prepared: 6/3/2024 8:32 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	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
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	1,258,486		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	4,047		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,112		54.00
60.00	06000	LABORATORY	27,840		60.00
65.00	06500	RESPIRATORY THERAPY	103,670		65.00
66.00	06600	PHYSICAL THERAPY	22,273		66.00
67.00	06700	OCCUPATIONAL THERAPY	20,224		67.00
68.00	06800	SPEECH PATHOLOGY	9,524		68.00
69.00	06900	ELECTROCARDIOLOGY	833		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	344,256		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	78,642		73.00
74.00	07400	RENAL DIALYSIS	7,906		74.00
76.00	03950	WOUND CARE	0		76.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,882,813		118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	PROVIDER RELATIONS NRCC	5,952		194.00
194.01	07951	NRCC SUBLEASED SPACE	0		194.01
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,888,765		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet B-1 | Date/Time Prepared: 6/3/2024 8:32 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS 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	29,829					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		29,829				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	150	150	11,980,102			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,959	3,959	1,958,996	-5,453,390	20,389,454	5.00
7.00	00700	OPERATION OF PLANT	8,938	8,938	0	0	476,828	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	470	470	0	0	127,403	8.00
9.00	00900	HOUSEKEEPING	273	273	0	0	19,512	9.00
10.00	01000	DIETARY	233	233	88,779	0	330,858	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	257	257	1,213,781	0	1,441,311	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	161	161	139,715	0	174,511	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,814	12,814	5,403,763	0	8,680,129	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	16,345	0	383,803	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	459,266	54.00
60.00	06000	LABORATORY	175	175	0	0	1,212,621	60.00
65.00	06500	RESPIRATORY THERAPY	375	375	1,601,614	0	1,904,674	65.00
66.00	06600	PHYSICAL THERAPY	209	209	354,804	0	437,306	66.00
67.00	06700	OCCUPATIONAL THERAPY	209	209	215,110	0	252,620	67.00
68.00	06800	SPEECH PATHOLOGY	95	95	106,765	0	147,989	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	38,342	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	736	736	153,444	0	1,717,703	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	715	715	670,423	0	1,767,983	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	725,488	74.00
76.00	03950	WOUND CARE	0	0	0	0	0	76.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,769	29,769	11,923,539	-5,453,390	20,298,347	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PROVIDER RELATIONS NRCC	60	60	56,563	0	91,107	194.00
194.01	07951	NRCC SUBLEASED SPACE	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,154,562	424,852	110,558		5,453,390	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	38.706024	14.242918	0.009228		0.267461	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			7,942		211,077	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000663		0.010352	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: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet B-1 | Date/Time Prepared: 6/3/2024 8:32 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MEALS SERVED)	
			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	16,782					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	470	12,644				8.00
9.00	00900	HOUSEKEEPING	273	0	16,039			9.00
10.00	01000	DIETARY	233	0	233	12,644		10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	257	0	257	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	161	0	161	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,814	12,644	12,814	12,644	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	175	0	175	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	375	0	375	0	0	65.00
66.00	06600	PHYSICAL THERAPY	209	0	209	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	209	0	209	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	95	0	95	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	736	0	736	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	715	0	715	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	WOUND CARE	0	0	0	0	0	76.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,722	12,644	15,979	12,644	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PROVIDER RELATIONS NRCC	60	0	60	0	0	194.00
194.01	07951	NRCC SUBLEASED SPACE	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	604,361	178,404	34,562	428,243	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	36.012454	14.109775	2.154872	33.869266	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	478,193	39,597	22,436	22,787	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	28.494399	3.131683	1.398840	1.802199	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet B-1 | Date/Time Prepared: 6/3/2024 8:32 am

		Cost Center Description	NURSING ADMINISTRATION (NURSING FTE'S)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)		
			13.00	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				11.00
13.00	01300	NURSING ADMINISTRATION	70			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	288,169,210		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	70	77,483,012		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,189,245		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,751,160		54.00
60.00	06000	LABORATORY	0	14,866,771		60.00
65.00	06500	RESPIRATORY THERAPY	0	132,063,799		65.00
66.00	06600	PHYSICAL THERAPY	0	3,723,763		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,863,784		67.00
68.00	06800	SPEECH PATHOLOGY	0	969,778		68.00
69.00	06900	ELECTROCARDIOLOGY	0	8,221,458		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	20,051,978		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,519,277		73.00
74.00	07400	RENAL DIALYSIS	0	7,465,185		74.00
76.00	03950	WOUND CARE	0	0		76.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	70	288,169,210		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07950	PROVIDER RELATIONS NRCC	0	0		194.00
194.01	07951	NRCC SUBLEASED SPACE	0	0		194.01
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,836,614	227,331		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	26,237.342857	0.000789		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	37,015	15,238		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	528.785714	0.000053		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: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet C Part I Date/Time Prepared: 6/3/2024 8:32 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,995,201		13,995,201	27,702	14,022,903	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	487,393		487,393	0	487,393	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	587,429		587,429	0	587,429	54.00
60.00	06000	LABORATORY	1,555,359		1,555,359	0	1,555,359	60.00
65.00	06500	RESPIRATORY THERAPY	2,532,576	0	2,532,576	0	2,532,576	65.00
66.00	06600	PHYSICAL THERAPY	565,183	0	565,183	0	565,183	66.00
67.00	06700	OCCUPATIONAL THERAPY	330,423	0	330,423	0	330,423	67.00
68.00	06800	SPEECH PATHOLOGY	191,961	0	191,961	0	191,961	68.00
69.00	06900	ELECTROCARDIOLOGY	55,084		55,084	0	55,084	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,221,034		2,221,034	0	2,221,034	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,278,018		2,278,018	0	2,278,018	73.00
74.00	07400	RENAL DIALYSIS	925,418		925,418	0	925,418	74.00
76.00	03950	WOUND CARE	0		0	0	0	76.00
200.00		Subtotal (see instructions)	25,725,079	0	25,725,079	27,702	25,752,781	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	25,725,079	0	25,725,079	27,702	25,752,781	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet C Part I Date/Time Prepared: 6/3/2024 8:32 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	77,483,012		77,483,012			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,189,245	0	1,189,245	0.409834	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,751,160	0	6,751,160	0.087012	0.000000	54.00
60.00	06000	LABORATORY	14,866,771	0	14,866,771	0.104620	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	132,063,799	0	132,063,799	0.019177	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,723,763	0	3,723,763	0.151777	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,863,784	0	2,863,784	0.115380	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	969,778	0	969,778	0.197943	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	8,221,458	0	8,221,458	0.006700	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20,051,978	0	20,051,978	0.110764	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,519,277	0	12,519,277	0.181961	0.000000	73.00
74.00	07400	RENAL DIALYSIS	7,465,185	0	7,465,185	0.123965	0.000000	74.00
76.00	03950	WOUND CARE	0	0	0	0.000000	0.000000	76.00
200.00		Subtotal (see instructions)	288,169,210	0	288,169,210			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	288,169,210	0	288,169,210			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet C Part I Date/Time Prepared: 6/3/2024 8:32 am

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		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.409834		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.087012		54.00
60.00	06000	LABORATORY	0.104620		60.00
65.00	06500	RESPIRATORY THERAPY	0.019177		65.00
66.00	06600	PHYSICAL THERAPY	0.151777		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.115380		67.00
68.00	06800	SPEECH PATHOLOGY	0.197943		68.00
69.00	06900	ELECTROCARDIOLOGY	0.006700		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.110764		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.181961		73.00
74.00	07400	RENAL DIALYSIS	0.123965		74.00
76.00	03950	WOUND CARE	0.000000		76.00
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: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet C Part I Date/Time Prepared: 6/3/2024 8:32 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,995,201		13,995,201	27,702	14,022,903	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	487,393		487,393	0	487,393	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	587,429		587,429	0	587,429	54.00
60.00	06000	LABORATORY	1,555,359		1,555,359	0	1,555,359	60.00
65.00	06500	RESPIRATORY THERAPY	2,532,576	0	2,532,576	0	2,532,576	65.00
66.00	06600	PHYSICAL THERAPY	565,183	0	565,183	0	565,183	66.00
67.00	06700	OCCUPATIONAL THERAPY	330,423	0	330,423	0	330,423	67.00
68.00	06800	SPEECH PATHOLOGY	191,961	0	191,961	0	191,961	68.00
69.00	06900	ELECTROCARDIOLOGY	55,084		55,084	0	55,084	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,221,034		2,221,034	0	2,221,034	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,278,018		2,278,018	0	2,278,018	73.00
74.00	07400	RENAL DIALYSIS	925,418		925,418	0	925,418	74.00
76.00	03950	WOUND CARE	0		0	0	0	76.00
200.00		Subtotal (see instructions)	25,725,079	0	25,725,079	27,702	25,752,781	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	25,725,079	0	25,725,079	27,702	25,752,781	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet C Part I Date/Time Prepared: 6/3/2024 8:32 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	77,483,012		77,483,012			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,189,245	0	1,189,245	0.409834	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,751,160	0	6,751,160	0.087012	0.000000	54.00
60.00	06000	LABORATORY	14,866,771	0	14,866,771	0.104620	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	132,063,799	0	132,063,799	0.019177	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,723,763	0	3,723,763	0.151777	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,863,784	0	2,863,784	0.115380	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	969,778	0	969,778	0.197943	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	8,221,458	0	8,221,458	0.006700	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20,051,978	0	20,051,978	0.110764	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,519,277	0	12,519,277	0.181961	0.000000	73.00
74.00	07400	RENAL DIALYSIS	7,465,185	0	7,465,185	0.123965	0.000000	74.00
76.00	03950	WOUND CARE	0	0	0	0.000000	0.000000	76.00
200.00		Subtotal (see instructions)	288,169,210	0	288,169,210			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	288,169,210	0	288,169,210			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet C Part I Date/Time Prepared: 6/3/2024 8:32 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.409834		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.087012		54.00
60.00	06000	LABORATORY	0.104620		60.00
65.00	06500	RESPIRATORY THERAPY	0.019177		65.00
66.00	06600	PHYSICAL THERAPY	0.151777		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.115380		67.00
68.00	06800	SPEECH PATHOLOGY	0.197943		68.00
69.00	06900	ELECTROCARDIOLOGY	0.006700		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.110764		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.181961		73.00
74.00	07400	RENAL DIALYSIS	0.123965		74.00
76.00	03950	WOUND CARE	0.000000		76.00
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: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet C Part II Date/Time Prepared: 6/3/2024 8:32 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	487,393	4,047	483,346	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	587,429	5,112	582,317	0	0	54.00
60.00	06000	LABORATORY	1,555,359	27,840	1,527,519	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,532,576	103,670	2,428,906	0	0	65.00
66.00	06600	PHYSICAL THERAPY	565,183	22,273	542,910	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	330,423	20,224	310,199	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	191,961	9,524	182,437	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	55,084	833	54,251	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,221,034	344,256	1,876,778	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,278,018	78,642	2,199,376	0	0	73.00
74.00	07400	RENAL DIALYSIS	925,418	7,906	917,512	0	0	74.00
76.00	03950	WOUND CARE	0	0	0	0	0	76.00
200.00		Subtotal (sum of lines 50 thru 199)	11,729,878	624,327	11,105,551	0	0	200.00
201.00		Less Observation Beds	0	0	0	0	0	201.00
202.00		Total (line 200 minus line 201)	11,729,878	624,327	11,105,551	0	0	202.00

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

Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet C Part II Date/Time Prepared: 6/3/2024 8:32 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	487,393	1,189,245	0.409834		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	587,429	6,751,160	0.087012		54.00
60.00	06000	LABORATORY	1,555,359	14,866,771	0.104620		60.00
65.00	06500	RESPIRATORY THERAPY	2,532,576	132,063,799	0.019177		65.00
66.00	06600	PHYSICAL THERAPY	565,183	3,723,763	0.151777		66.00
67.00	06700	OCCUPATIONAL THERAPY	330,423	2,863,784	0.115380		67.00
68.00	06800	SPEECH PATHOLOGY	191,961	969,778	0.197943		68.00
69.00	06900	ELECTROCARDIOLOGY	55,084	8,221,458	0.006700		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,221,034	20,051,978	0.110764		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,278,018	12,519,277	0.181961		73.00
74.00	07400	RENAL DIALYSIS	925,418	7,465,185	0.123965		74.00
76.00	03950	WOUND CARE	0	0	0.000000		76.00
200.00		Subtotal (sum of lines 50 thru 199)	11,729,878	210,686,198			200.00
201.00		Less Observation Beds	0	0			201.00
202.00		Total (line 200 minus line 201)	11,729,878	210,686,198			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet D Part I Date/Time Prepared: 6/3/2024 8:32 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,258,486	0	1,258,486	12,644	99.53	30.00
200.00	Total (lines 30 through 199)	1,258,486		1,258,486	12,644		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	6,546	651,523	30.00
200.00	Total (lines 30 through 199)	6,546	651,523	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet D Part II Date/Time Prepared: 6/3/2024 8:32 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,047	1,189,245	0.003403	621,070	2,114	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,112	6,751,160	0.000757	3,181,781	2,409	54.00
60.00	06000	LABORATORY	27,840	14,866,771	0.001873	7,672,923	14,371	60.00
65.00	06500	RESPIRATORY THERAPY	103,670	132,063,799	0.000785	60,667,567	47,624	65.00
66.00	06600	PHYSICAL THERAPY	22,273	3,723,763	0.005981	1,880,484	11,247	66.00
67.00	06700	OCCUPATIONAL THERAPY	20,224	2,863,784	0.007062	1,457,388	10,292	67.00
68.00	06800	SPEECH PATHOLOGY	9,524	969,778	0.009821	508,931	4,998	68.00
69.00	06900	ELECTROCARDIOLOGY	833	8,221,458	0.000101	4,147,632	419	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	344,256	20,051,978	0.017168	10,059,429	172,700	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	78,642	12,519,277	0.006282	6,506,436	40,873	73.00
74.00	07400	RENAL DIALYSIS	7,906	7,465,185	0.001059	4,351,210	4,608	74.00
76.00	03950	WOUND CARE	0	0	0.000000	0	0	76.00
200.00		Total (lines 50 through 199)	624,327	210,686,198		101,054,851	311,655	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet D Part III Date/Time Prepared: 6/3/2024 8:32 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
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	12,644	0.00	6,546	30.00
200.00		Total (lines 30 through 199)		0	12,644		6,546	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
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet D Part IV Date/Time Prepared: 6/3/2024 8:32 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	WOUND CARE	0	0	0	0	0	76.00
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: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet D Part IV Date/Time Prepared: 6/3/2024 8:32 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	1,189,245	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	6,751,160	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	14,866,771	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	132,063,799	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,723,763	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,863,784	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	969,778	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	8,221,458	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	20,051,978	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	12,519,277	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	7,465,185	0.000000	74.00
76.00	03950	WOUND CARE	0	0	0	0	0.000000	76.00
200.00		Total (lines 50 through 199)	0	0	0	210,686,198		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet D Part IV Date/Time Prepared: 6/3/2024 8:32 am

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	621,070	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	3,181,781	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	7,672,923	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	60,667,567	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,880,484	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,457,388	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	508,931	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	4,147,632	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	10,059,429	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	6,506,436	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	4,351,210	0	0	0	74.00
76.00	03950	WOUND CARE	0.000000	0	0	0	0	76.00
200.00		Total (lines 50 through 199)		101,054,851	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet D Part I Date/Time Prepared: 6/3/2024 8:32 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,258,486	0	1,258,486	12,644	99.53	30.00
200.00	Total (lines 30 through 199)	1,258,486		1,258,486	12,644		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	0	0	30.00
200.00	Total (lines 30 through 199)	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet D Part II Date/Time Prepared: 6/3/2024 8:32 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,047	1,189,245	0.003403	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,112	6,751,160	0.000757	0	0	54.00
60.00	06000	LABORATORY	27,840	14,866,771	0.001873	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	103,670	132,063,799	0.000785	0	0	65.00
66.00	06600	PHYSICAL THERAPY	22,273	3,723,763	0.005981	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	20,224	2,863,784	0.007062	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	9,524	969,778	0.009821	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	833	8,221,458	0.000101	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	344,256	20,051,978	0.017168	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	78,642	12,519,277	0.006282	0	0	73.00
74.00	07400	RENAL DIALYSIS	7,906	7,465,185	0.001059	0	0	74.00
76.00	03950	WOUND CARE	0	0	0.000000	0	0	76.00
200.00		Total (lines 50 through 199)	624,327	210,686,198		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet D Part III Date/Time Prepared: 6/3/2024 8:32 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
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	12,644	0.00	0	30.00
200.00		Total (lines 30 through 199)		0	12,644		0	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
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet D Part IV Date/Time Prepared: 6/3/2024 8:32 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	WOUND CARE	0	0	0	0	0	76.00
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: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet D Part IV Date/Time Prepared: 6/3/2024 8:32 am

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	1,189,245	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	6,751,160	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	14,866,771	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	132,063,799	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,723,763	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,863,784	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	969,778	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	8,221,458	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	20,051,978	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	12,519,277	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	7,465,185	0.000000	74.00
76.00	03950	WOUND CARE	0	0	0	0	0.000000	76.00
200.00		Total (lines 50 through 199)	0	0	0	210,686,198		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet D Part IV | Date/Time Prepared: 6/3/2024 8:32 am

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	WOUND CARE	0.000000	0	0	0	0	76.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-2024	Period: From 02/01/2023 To 01/31/2024	Worksheet D-1 Date/Time Prepared: 6/3/2024 8:32 am
	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)	12,644	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,644	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)	12,644	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	6,546	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	14,022,903	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)	14,022,903	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)	14,022,903	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)	1,109.06	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	7,259,907	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)	7,259,907	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet D-1 | Date/Time Prepared: 6/3/2024 8:32 am

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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	5,917,186	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)	13,177,093	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)	651,523	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	311,655	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	963,178	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	12,213,915	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet D-1 | Date/Time Prepared: 6/3/2024 8:32 am

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	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	1,258,486	14,022,903	0.089745	0	0	90.00
91.00	Nursing Program cost	0	14,022,903	0.000000	0	0	91.00
92.00	Allied health cost	0	14,022,903	0.000000	0	0	92.00
93.00	All other Medical Education	0	14,022,903	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-2024	Period: From 02/01/2023 To 01/31/2024	Worksheet D-1 Date/Time Prepared: 6/3/2024 8:32 am
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	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	12,644	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,644	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)	12,644	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	14,022,903	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)	14,022,903	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)	14,022,903	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)	1,109.06	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	0	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)	0	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet D-1 | Date/Time Prepared: 6/3/2024 8:32 am

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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)	0	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)	0	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)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet D-1 | Date/Time Prepared: 6/3/2024 8:32 am

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	1,258,486	14,022,903	0.089745	0	0	90.00
91.00	Nursing Program cost	0	14,022,903	0.000000	0	0	91.00
92.00	Allied health cost	0	14,022,903	0.000000	0	0	92.00
93.00	All other Medical Education	0	14,022,903	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet D-3 | Date/Time Prepared: 6/3/2024 8:32 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		38,787,617		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.409834	621,070	254,536	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.087012	3,181,781	276,853	54.00
60.00	06000	LABORATORY	0.104620	7,672,923	802,741	60.00
65.00	06500	RESPIRATORY THERAPY	0.019177	60,667,567	1,163,422	65.00
66.00	06600	PHYSICAL THERAPY	0.151777	1,880,484	285,414	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.115380	1,457,388	168,153	67.00
68.00	06800	SPEECH PATHOLOGY	0.197943	508,931	100,739	68.00
69.00	06900	ELECTROCARDIOLOGY	0.006700	4,147,632	27,789	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.110764	10,059,429	1,114,223	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.181961	6,506,436	1,183,918	73.00
74.00	07400	RENAL DIALYSIS	0.123965	4,351,210	539,398	74.00
76.00	03950	WOUND CARE	0.000000	0	0	76.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		101,054,851	5,917,186	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)		101,054,851		202.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet E-1 Part I | Date/Time Prepared: 6/3/2024 8:32 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		12,884,866		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	11/29/2023	825,339		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	08/29/2023	905,322		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)		-79,983		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)		12,804,883		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		692,066		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		13,496,949		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	Provider CCN: 15-2024	Period: From 02/01/2023 To 01/31/2024	Worksheet E-3 Part IV Date/Time Prepared: 6/3/2024 8:32 am
	Title XVIII	Hospital	PPS

		1.00	
	PART IV - MEDICARE PART A SERVICES - LTCH PPS		
1.00	Net Federal PPS Payments (see instructions)	11,766,629	1.00
1.01	Full standard payment amount	9,897,496	1.01
1.02	Short stay outlier standard payment amount	1,858,932	1.02
1.03	Site neutral payment amount - Cost	0	1.03
1.04	Site neutral payment amount - IPPS comparable	10,201	1.04
2.00	Outlier Payments	2,702,543	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)	14,469,172	3.00
4.00	Nursing and Allied Health Managed Care payments (see instructions)	0	4.00
5.00	Organ acquisition (DO NOT USE THIS LINE)		5.00
6.00	Cost of physicians' services in a teaching hospital (see instructions)	0	6.00
7.00	Subtotal (see instructions)	14,469,172	7.00
8.00	Primary payer payments	0	8.00
9.00	Subtotal (line 7 less line 8).	14,469,172	9.00
10.00	Deductibles	14,504	10.00
11.00	Subtotal (line 9 minus line 10)	14,454,668	11.00
12.00	Coinsurance	921,210	12.00
13.00	Subtotal (line 11 minus line 12)	13,533,458	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	367,599	14.00
15.00	Adjusted reimbursable bad debts (see instructions)	238,939	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	308,030	16.00
17.00	Subtotal (sum of lines 13 and 15)	13,772,397	17.00
18.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	18.00
19.00	Other pass through costs (see instructions)	0	19.00
20.00	Outlier payments reconciliation	0	20.00
21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	21.00
21.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	21.50
21.98	Recovery of accelerated depreciation.	0	21.98
21.99	Demonstration payment adjustment amount before sequestration	0	21.99
22.00	Total amount payable to the provider (see instructions)	13,772,397	22.00
22.01	Sequestration adjustment (see instructions)	275,448	22.01
22.02	Demonstration payment adjustment amount after sequestration	0	22.02
23.00	Interim payments	12,804,883	23.00
24.00	Tentative settlement (for contractor use only)	0	24.00
25.00	Balance due provider/program (line 22 minus lines 22.01, 22.02, 23 and 24)	692,066	25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	79,139	26.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions)	2,702,543	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money (see instructions)	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet E-3 Part VII Date/Time Prepared: 6/3/2024 8:32 am

Title XIX | Hospital | PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	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	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	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)	0	0	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)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	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	0	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	0	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	0	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	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet G | Date/Time Prepared: 6/3/2024 8:32 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	0	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,538,789	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	41,653	0	0	0	8.00
9.00	Other current assets	135,934	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)	4,716,376	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	426,711	0	0	0	15.00
16.00	Accumulated depreciation	-426,711	0	0	0	16.00
17.00	Leasehold improvements	603,487	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	4,839,783	0	0	0	23.00
24.00	Accumulated depreciation	-3,154,758	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	2,288,512	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	2,060,582	0	0	0	32.00
33.00	Due from owners/officers	18,154,063	0	0	0	33.00
34.00	Other assets	16,538,105	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	36,752,750	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	43,757,638	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,133,399	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,768,561	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,901,960	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,209,466	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	1,209,466	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	6,111,426	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	37,646,212				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)	37,646,212	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	43,757,638	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet G-1 | Date/Time Prepared: 6/3/2024 8:32 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		35,898,349		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,231,700				2.00
3.00	Total (sum of line 1 and line 2)		38,130,049		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	FUND BALANCE RECON	0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		38,130,049		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	ACCOUNT 62101 BAD DEBT REV DED	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)		38,130,049		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00	FUND BALANCE RECON		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	ACCOUNT 62101 BAD DEBT REV DED		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: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet G-2 Parts I & II Date/Time Prepared: 6/3/2024 8:32 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	77,483,012		77,483,012	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)	77,483,012		77,483,012	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	77,483,012		77,483,012	17.00
18.00	Ancillary services	210,686,197	0	210,686,197	18.00
19.00	Outpatient services	0	0	0	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	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	288,169,209	0	288,169,209	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		24,969,777		29.00
30.00	BAD DEBT ADDED INTO EXPENSE	0			30.00
31.00	ROUNDING	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	ROUNDING	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)		24,969,777		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-2024 | Period: From 02/01/2023 To 01/31/2024 | Worksheet G-3 | Date/Time Prepared: 6/3/2024 8:32 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	288,169,209	1.00
2.00	Less contractual allowances and discounts on patients' accounts	259,340,747	2.00
3.00	Net patient revenues (line 1 minus line 2)	28,828,462	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	24,969,777	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,858,685	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	132	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 REVENUE	0	24.00
24.01	PHYSICIAN REVENUE	0	24.01
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	132	25.00
26.00	Total (line 5 plus line 25)	3,858,817	26.00
27.00	MANAGEMENT FEE	1,097,611	27.00
27.01	INTERCOMPANY INTEREST	-467,285	27.01
27.02	TAXES	50,450	27.02
27.03	INTEREST EXPENSE	946,341	27.03
27.04	MEDICARE SPREAD PUSHDOWN	0	27.04
28.00	Total other expenses (sum of line 27 and subscripts)	1,627,117	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,231,700	29.00