

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: 31-0041	Period: From 01/01/2024 To 12/31/2024	Worksheet S Parts I-III Date/Time Prepared: 5/28/2025 10:36 am
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report	Date: 5/28/2025	Time: 10:36 am
	2. <input type="checkbox"/> Manually prepared cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.		
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> 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 COMMUNITY MEDICAL CENTER (31-0041) for the cost reporting period beginning 01/01/2024 and ending 12/31/2024 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	Richard Henwood	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	Richard Henwood		2
3	Signatory Title	VP CORP REIMBURSEMENT		3
4	Date	(Dated when report is electronic)		4

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	-4, 118, 367	3, 471, 525	0	-1, 877, 224
2.00	SUBPROVIDER - IPF	0	0	0	0	0
3.00	SUBPROVIDER - IRF	0	0	0	0	0
5.00	SWING BED - SNF	0	0	0	0	0
6.00	SWING BED - NF	0			0	0
7.00	SKILLED NURSING FACILITY	0	481	0	0	0
200.00	TOTAL	0	-4, 117, 886	3, 471, 525	0	-1, 877, 224

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: 31-0041		Period: From 01/01/2024 To 12/31/2024		Worksheet S-2 Part I Date/Time Prepared: 5/28/2025 10:36 am		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 99 ROUTE 37S			PO Box:				1.00		
2.00	City: TOMS RIVER			State: NJ		Zip Code: 08755-6423		County: OCEAN		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	
								XIX		
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		COMMUNITY MEDICAL CENTER	310041	35154	1	07/01/1967	N	P	T
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF									
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF		COMMUNITY MEDICAL CENTER	315490	35154		02/10/2005	N	P	O
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC									
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2024	12/31/2024		
21.00	Type of Control (see instructions)						2			
							1.00	2.00		
							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			
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y			
22.02	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			
22.03	Did this hospital receive a geographic redesignation from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015 or FY2025? 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		
22.04	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.									
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.					1	Y			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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Period:
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		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.	2,420	827	6	53	11,378	315	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
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
						V	XVII	XIX
						1.00	2.00	3.00
	Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 412.320? (see instructions)					N	Y	N
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
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
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
	Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					Y	Y	
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.					Y		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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		V	XVIII	XIX		
		1.00	2.00	3.00		
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	
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.	Y	Y		60.00	
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1	60.01	
		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
61.01	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)					
61.02	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)					
61.03	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)					
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).					
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)					
61.06	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)					
		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
62.01	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
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

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			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)		1.80	55.63	0.031343	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)	INTERNAL MEDICINE	1400	0.71	34.86	0.019961	67.00

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			1.00		
68.00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?			68.00	
			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N	70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N	75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87.00
			Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
			1.00	2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.			N	0 88.00
			Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge
			1.00	2.00	3.00
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.			0.00	0 89.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y 90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	Y 91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N 92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N 93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	Y 94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	10.00 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	Y 96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00	5.80 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	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	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	Y	98.06
Rural Providers				
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00
107.01	If this facility is a REH (line 3, column 4, is "12"), is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no. (see instructions)			107.01
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00
		Physical 1.00	Occupational 2.00	Speech 3.00
		Respiratory 4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			109.00
				1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.		N	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		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 31-0041	Period: From 01/01/2024 To 12/31/2024	Worksheet S-2 Part I Date/Time Prepared: 5/28/2025 10:36 am
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	0	0	5,130,880
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	Y	N	123.00
124.00	Did the hospital incur cost, either directly or through a contract with an outside supplier, to establish and maintain access to no less than a 6-month buffer stock of one or more essential medicines according to 42 CFR 412.113(g)? Enter "Y" for yes or "N" for no.			124.00
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	H53560	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: RWJBARNABAS HEALTH	Contractor's Name: NOVITAS SOLUTIONS		Contractor's Number: 12001
142.00	Street: 95 OLD SHORT HILLS ROAD	PO Box:		
143.00	City: WEST ORANGE	State: NJ		Zip Code: 07052
				1.00
144.00	Are provider based physicians' costs included in Worksheet A?	Y		144.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 31-0041		Period: From 01/01/2024 To 12/31/2024		Worksheet S-2 Part I Date/Time Prepared: 5/28/2025 10:36 am	
		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.	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	
		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
		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				0171.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 31-0041	Period: From 01/01/2024 To 12/31/2024	Worksheet S-2 Part II Date/Time Prepared: 5/28/2025 10:36 am	
			Y/N	Date	
			1.00	2.00	
PART II - HOSPITAL AND HOSPITAL HEALTHCARE 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)	N			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	A	04/01/2025	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, in columns 2 and 4, from the PS&R used to prepare this cost report, enter the "Paid Claims Verified Current As Of" date, if present, or the paid-through date. (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, in columns 2 and 4, enter the "Paid Claims Verified Current As Of" date, if present, or the paid-through date. (see instructions)	Y	04/01/2025	Y	04/01/2025
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024Worksheet S-2
Part II
Date/Time Prepared:
5/28/2025 10:36 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				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.	RICHARD		HENWOOD	41.00
42.00	Enter the employer/company name of the cost report preparer.	RWJBARNABAS HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	732-923-8074		RICH.HENWOOD@RWJBH.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 31-0041	Period: From 01/01/2024 To 12/31/2024	Worksheet S-2 Part II Date/Time Prepared: 5/28/2025 10:36 am
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	VP OF CORPORATE REIMBURSEMENT		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: 31-0041

Period:
From 01/01/2024
To 12/31/2024Worksheet S-3
Part I
Date/Time Prepared:
5/28/2025 10:36 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
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	253	92,598	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)		253	92,598	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	165	60,390	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT	34.00	12	4,392	0.00	0	11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		430	157,380	0.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	25	9,150		0	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)		455				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024Worksheet S-3
Part I
Date/Time Prepared:
5/28/2025 10:36 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)	45,608	1,198	66,261			1.00
2.00	HMO and other (see instructions)	37,827	10,688				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)	45,608	1,198	66,261			7.00
8.00	INTENSIVE CARE UNIT	2,907	975	45,965			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT	1,556	0	3,574			11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		2,116	4,236			13.00
14.00	Total (see instructions)	50,071	4,289	120,036	93.01	2,007.96	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	4,056	0	6,859	0.00	36.78	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)				93.01	2,044.74	27.00
28.00	Observation Bed Days		0	83			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			1,165			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	22	1,059			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024Worksheet S-3
Part I
Date/Time Prepared:
5/28/2025 10:36 am

Component	Full Time Equivalents	Di scharges					
	Nonpai d Workers	Ti tle V	Ti tle XVIII	Ti tle XIX	Total All Pati ents		
	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	8,282	527	24,295	1.00
2.00	HMO and other (see instructions)			6,280	3,570		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	8,282	527	24,295	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024Worksheet S-3
Part II
Date/Time Prepared:
5/28/2025 10:36 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	196,762,298	-3,081,535	193,680,763	4,253,065.82	45.54 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		154,394	0	154,394	312.00	494.85 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		2,041,779	0	2,041,779	20,950.00	97.46 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	7,754,845	7,754,845	216,866.53	35.76 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	4,048,922	-18,273	4,030,649	77,437.23	52.05 9.00
10.00	Excluded area salaries (see instructions)		341,072	397,619	738,691	17,150.31	43.07 10.00
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		6,993,017	0	6,993,017	59,819.00	116.90 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		0	0	0	0.00	0.00 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		34,646,465	0	34,646,465	492,857.45	70.30 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
15.01	Home office Physicians Part A - Administrative		0	0	0	0.00	0.00 15.01
15.02	Home office contract Physicians Part A - Administrative		0	0	0	0.00	0.00 15.02
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)		51,878,288	0	51,878,288		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		1,200,292	0	1,200,292		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		1,121	0	1,121		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		111,240	0	111,240		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		779,411	0	779,411		
25.50	Home office wage-related (core)		7,630,301	0	7,630,301		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024Worksheet S-3
Part II
Date/Time Prepared:
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		Wkst. A Line Number	Amount Reported	Reclassifi- cation 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	
25.51	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
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	451,514	0	451,514	9,493.02	47.56	26.00
27.00	Administrative & General	5.00	13,286,588	-1,931,659	11,354,929	201,015.16	56.49	27.00
28.00	Administrative & General under contract (see inst.)		2,430,831	0	2,430,831	9,798.00	248.09	28.00
29.00	Maintenance & Repairs	6.00	279,530	0	279,530	6,176.60	45.26	29.00
30.00	Operation of Plant	7.00	4,529,802	0	4,529,802	147,717.16	30.67	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	3,363,188	0	3,363,188	169,946.71	19.79	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	3,874,356	-807,549	3,066,807	129,287.09	23.72	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	807,549	807,549	34,044.00	23.72	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	4,488,878	-9,442	4,479,436	69,699.66	64.27	38.00
39.00	Central Services and Supply	14.00	2,191,007	0	2,191,007	77,554.43	28.25	39.00
40.00	Pharmacy	15.00	6,578,326	-30,503	6,547,823	129,390.78	50.61	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	3,174,530	0	3,174,530	61,073.47	51.98	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024Worksheet S-3
Part III
Date/Time Prepared:
5/28/2025 10:36 am

	Worksheet A Line Number	Amount Reported	Reclassifi- cation 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)	197,151,350	-10,836,380	186,314,970	4,025,047.29	46.29	1.00
2.00	Excluded area salaries (see instructions)	4,389,994	379,346	4,769,340	94,587.54	50.42	2.00
3.00	Subtotal salaries (line 1 minus line 2)	192,761,356	-11,215,726	181,545,630	3,930,459.75	46.19	3.00
4.00	Subtotal other wages & related costs (see inst.)	41,639,482	0	41,639,482	552,676.45	75.34	4.00
5.00	Subtotal wage-related costs (see inst.)	59,509,710	0	59,509,710	0.00	32.78	5.00
6.00	Total (sum of lines 3 thru 5)	293,910,548	-11,215,726	282,694,822	4,483,136.20	63.06	6.00
7.00	Total overhead cost (see instructions)	44,648,550	-1,971,604	42,676,946	1,045,196.08	40.83	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024Worksheet S-3
Part IV
Date/Time Prepared:
5/28/2025 10:36 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	7,471,799	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	358,135	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	1,254,973	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	1,881,164	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)	24,988,006	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	418,021	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	156,206	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)	833,825	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	338,403	14.00
15.00	'Workers' Compensation Insurance	1,247,851	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	14,125,102	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	326,456	19.00
20.00	State or Federal Unemployment Taxes	0	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	570,413	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	53,970,354	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024Worksheet S-3
Part V
Date/Time Prepared:
5/28/2025 10:36 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	6,993,017	53,970,353	1.00
2.00	Hospital	6,993,017	53,970,353	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY	0	0	8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 31-0041	Period: From 01/01/2024 To 12/31/2024	Worksheet S-10 Parts I & II Date/Time Prepared: 5/28/2025 10:36 am
				1.00
PART I - HOSPITAL AND HOSPITAL COMPLEX DATA				
Uncompensated and Indigent Care Cost-to-Charge Ratio				
1.00	Cost to charge ratio (see instructions)		0.176082	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		44,282,794	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		3,239,484	5.00
6.00	Medicaid charges		333,689,828	6.00
7.00	Medicaid cost (line 1 times line 6)		58,756,772	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)		11,234,494	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		313,632	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		4,860,338	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		855,818	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)		542,186	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		11,776,680	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	74,568,621	799,570	75,368,191
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	13,130,192	799,570	13,929,762
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (see instructions)	13,130,192	799,570	13,929,762
				1.00
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
25.01	Charges for insured patients' liability (see instructions)		0	25.01
26.00	Bad debt amount (see instructions)		20,293,518	26.00
27.00	Medicare reimbursable bad debts (see instructions)		1,348,757	27.00
27.01	Medicare allowable bad debts (see instructions)		2,075,011	27.01
28.00	Non-Medicare bad debt amount (see instructions)		18,218,507	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)		3,934,205	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)		17,863,967	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		29,640,647	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 31-0041	Period: From 01/01/2024 To 12/31/2024	Worksheet S-10 Parts I & II Date/Time Prepared: 5/28/2025 10:36 am
				1.00
PART II - HOSPITAL DATA				
Uncompensated and Indigent Care Cost-to-Charge Ratio				
1.00	Cost to charge ratio (see instructions)			0.174383 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			5.00
6.00	Medicaid charges			6.00
7.00	Medicaid cost (line 1 times line 6)			7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)			8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP			9.00
10.00	Stand-alone CHIP charges			10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)			12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			14.00
15.00	State or local indigent care program cost (line 1 times line 14)			15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)			16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care			17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	74,568,571	798,804	75,367,375 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	13,003,491	798,804	13,802,295 21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0 22.00
23.00	Cost of charity care (see instructions)	13,003,491	798,804	13,802,295 23.00
				1.00
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N 24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0 25.00
25.01	Charges for insured patients' liability (see instructions)			0 25.01
26.00	Bad debt amount (see instructions)			20,275,052 26.00
27.00	Medicare reimbursable bad debts (see instructions)			1,348,757 27.00
27.01	Medicare allowable bad debts (see instructions)			2,075,011 27.01
28.00	Non-Medicare bad debt amount (see instructions)			18,200,041 28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)			3,900,032 29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)			17,702,327 30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			17,702,327 31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024

Worksheet A

Date/Time Prepared:
5/28/2025 10:36 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification (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		13,100,283	13,100,283	2,311,716	15,411,999	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		11,341,453	11,341,453	1,914,079	13,255,532	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	451,514	31,925,904	32,377,418	3,546,440	35,923,858	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,286,588	108,716,416	122,003,004	-2,339,934	119,663,070	5.00
6.00	00600	MAINTENANCE & REPAIRS	279,530	466,275	745,805	0	745,805	6.00
7.00	00700	OPERATION OF PLANT	4,529,802	8,773,533	13,303,335	-40,417	13,262,918	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	1,410,819	1,410,819	8.00
9.00	00900	HOUSEKEEPING	3,363,188	3,004,986	6,368,174	-131,260	6,236,914	9.00
10.00	01000	DIETARY	3,874,356	3,788,508	7,662,864	-1,628,931	6,033,933	10.00
11.00	01100	CAFETERIA	0	0	0	1,596,407	1,596,407	11.00
13.00	01300	NURSING ADMINISTRATION	4,488,878	507,144	4,996,022	-947	4,995,075	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,191,007	3,021,181	5,212,188	-792,844	4,419,344	14.00
15.00	01500	PHARMACY	6,578,326	47,759,516	54,337,842	-47,443,415	6,894,427	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	3,174,530	2,341,301	5,515,831	0	5,515,831	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	7,754,845	7,754,845	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	9,868,310	3,860,489	13,728,799	-9,248,808	4,479,991	22.00
23.00	02300	PARAMEDICAL PRGM-(SPECIFY)	91,272	21,760	113,032	30,503	143,535	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	38,237,894	12,981,586	51,219,480	-4,603,679	46,615,801	30.00
31.00	03100	INTENSIVE CARE UNIT	26,666,430	4,331,436	30,997,866	-1,885,166	29,112,700	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	3,568,185	560,712	4,128,897	-237,511	3,891,386	34.00
43.00	04300	NURSERY	1,052,335	64,204	1,116,539	2,323,274	3,439,813	43.00
44.00	04400	SKILLED NURSING FACILITY	4,048,922	1,672,607	5,721,529	-1,119,444	4,602,085	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	10,655,293	32,273,628	42,928,921	-27,621,849	15,307,072	50.00
51.00	05100	RECOVERY ROOM	1,691,197	153,787	1,844,984	-6,379	1,838,605	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,983,000	649,616	4,632,616	-621,633	4,010,983	52.00
52.01	03190	OP INFUSION	1,760,787	325,044	2,085,831	-212,000	1,873,831	52.01
53.00	05300	ANESTHESIOLOGY	116,657	3,316,819	3,433,476	-553,337	2,880,139	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,879,713	6,903,982	14,783,695	-2,686,436	12,097,259	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,202,656	1,177,980	5,380,636	632,913	6,013,549	55.00
56.00	05600	RADIOISOTOPE	555,035	827,916	1,382,951	55,341	1,438,292	56.00
57.00	05700	CT SCAN	2,407,215	873,471	3,280,686	220,796	3,501,482	57.00
58.00	05800	MRI	919,397	226,210	1,145,607	107,174	1,252,781	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,910,359	7,637,108	11,547,467	-6,819,666	4,727,801	59.00
60.00	06000	LABORATORY	0	19,339,404	19,339,404	224,596	19,564,000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	3,922,027	1,236,983	5,159,010	-357,711	4,801,299	65.00
66.00	06600	PHYSICAL THERAPY	2,219,068	63,719	2,282,787	-15,378	2,267,409	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,334,036	1,138	1,335,174	19,844	1,355,018	67.00
68.00	06800	SPEECH PATHOLOGY	387,387	461	387,848	3,090	390,938	68.00
69.00	06900	ELECTROCARDIOLOGY	2,746,492	891,927	3,638,419	-208,820	3,429,599	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,456,239	494,781	1,951,020	3,408	1,954,428	70.00
70.01	07001	SLEEP LAB	20,833	0	20,833	37,756	58,589	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	24,575,434	24,575,434	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	21,515,000	21,515,000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	47,420,332	47,420,332	73.00
76.97	07697	CARDIAC REHABILITATION	720,733	22,805	743,538	-6,803	736,735	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	287,635	287,635	-22,198	265,437	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	331,655	933,022	1,264,677	-489,659	775,018	90.00
91.00	09100	EMERGENCY	16,325,541	6,887,283	23,212,824	-2,491,700	20,721,124	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	3,216,111	344,998	3,561,109	-218,789	3,342,320	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		3,899,053	3,899,053	-3,899,053	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	196,512,498	347,008,064	543,520,562	0	543,520,562	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	MISCELLANEOUS	0	0	0	0	0	194.00
194.01	07951	PUBLIC RELATIONS	0	546	546	0	546	194.01
194.03	07952	LIGHTHOUSE	56,030	616	56,646	0	56,646	194.03
194.04	07953	KIDS & FAMILY	0	0	0	0	0	194.04
194.05	07954	OTHER NON REIMBURABLE	193,770	368,535	562,305	0	562,305	194.05
194.06	07955	GRANTS/TRIALS	0	7,061	7,061	0	7,061	194.06

Health Financial Systems			COMMUNITY MEDICAL CENTER			In Lieu of Form CMS-2552-10	
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 31-0041		Period: From 01/01/2024 To 12/31/2024	Worksheet A Date/Time Prepared: 5/28/2025 10:36 am
Cost Center Description				Salaries	Other	Total (col . 1 + col . 2)	Recl assi fi cati ons (See A-6)
				1.00	2.00	3.00	4.00
							5.00
194.07	07956	RETAIL PHARMACY		0	0	0	0
200.00		TOTAL (SUM OF LINES 118 through 199)		196,762,298	347,384,822	544,147,120	0
							544,147,120
							194.07
							200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024Worksheet A
Date/Time Prepared:
5/28/2025 10:36 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	-49,268	15,362,731	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-42,653	13,212,879	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,817,032	37,740,890	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-5,389,758	114,273,312	5.00
6.00	00600	MAINTENANCE & REPAIRS	-170,408	575,397	6.00
7.00	00700	OPERATION OF PLANT	-86,135	13,176,783	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,410,819	8.00
9.00	00900	HOUSEKEEPING	0	6,236,914	9.00
10.00	01000	DIETARY	-72,295	5,961,638	10.00
11.00	01100	CAFETERIA	-1,508,938	87,469	11.00
13.00	01300	NURSING ADMINISTRATION	-28,680	4,966,395	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-263,430	4,155,914	14.00
15.00	01500	PHARMACY	-66,352	6,828,075	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	16.00
17.00	01700	SOCIAL SERVICE	-25,674	5,490,157	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	7,754,845	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	-66,855	4,413,136	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	-4,016	139,519	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,976,822	43,638,979	30.00
31.00	03100	INTENSIVE CARE UNIT	-14,804	29,097,896	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	-703	3,890,683	34.00
43.00	04300	NURSERY	-676	3,439,137	43.00
44.00	04400	SKILLED NURSING FACILITY	-43,889	4,558,196	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-300,139	15,006,933	50.00
51.00	05100	RECOVERY ROOM	-1,756	1,836,849	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-20,400	3,990,583	52.00
52.01	03190	OP INFUSION	-942	1,872,889	52.01
53.00	05300	ANESTHESIOLOGY	-2,124,058	756,081	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,892,320	10,204,939	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-104,436	5,909,113	55.00
56.00	05600	RADIOISOTOPE	-390	1,437,902	56.00
57.00	05700	CT SCAN	-5,133	3,496,349	57.00
58.00	05800	MRI	-3,167	1,249,614	58.00
59.00	05900	CARDIAC CATHETERIZATION	-127,537	4,600,264	59.00
60.00	06000	LABORATORY	-625,551	18,938,449	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	-15,298	4,786,001	65.00
66.00	06600	PHYSICAL THERAPY	-1,570	2,265,839	66.00
67.00	06700	OCCUPATIONAL THERAPY	-247	1,354,771	67.00
68.00	06800	SPEECH PATHOLOGY	-113	390,825	68.00
69.00	06900	ELECTROCARDIOLOGY	-24,755	3,404,844	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-261,206	1,693,222	70.00
70.01	07001	SLEEP LAB	-58,589	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-1,459	24,573,975	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	-1,411	21,513,589	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-4,704	47,415,628	73.00
76.97	07697	CARDIAC REHABILITATION	-154	736,581	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	265,437	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	78.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-74,047	700,971	90.00
91.00	09100	EMERGENCY	-705,324	20,015,800	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	-2,657	3,339,663	92.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-15,351,687	528,168,875	118.00
NONREIMBURSABLE COST CENTERS					
194.00	07950	MISCELLANEOUS	0	0	194.00
194.01	07951	PUBLIC RELATIONS	0	546	194.01
194.03	07952	LIGHTHOUSE	0	56,646	194.03
194.04	07953	KIDS & FAMILY	0	0	194.04
194.05	07954	OTHER NON REIMBURABLE	0	562,305	194.05
194.06	07955	GRANTS/TRIALS	0	7,061	194.06
194.07	07956	RETAIL PHARMACY	0	0	194.07
200.00		TOTAL (SUM OF LINES 118 through 199)	-15,351,687	528,795,433	200.00

RECLASSIFICATIONS

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024

Worksheet A-6

Date/Time Prepared:
5/28/2025 10:36 am

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - MEDICAL SURGICAL SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	24,575,434		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
0			0	24,575,434		
B - IMPLANTABLES						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	21,515,000		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
0			0	21,515,000		
C - DRUGS AND IV SOLUTIONS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	47,420,332		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00			0	0		4.00
5.00			0	0		5.00
6.00			0	0		6.00
7.00			0	0		7.00
8.00			0	0		8.00
9.00			0	0		9.00
10.00			0	0		10.00
11.00			0	0		11.00
0			0	47,420,332		
D - BLOOD						
1.00	LABORATORY	60.00		225,597		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00

RECLASSIFICATIONS

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024

Worksheet A-6

Date/Time Prepared:
5/28/2025 10:36 am

Increases					
Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00		
0		0	225,597		
E - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,089,814	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,809,239	2.00
0		0	3,899,053		
F - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00		221,902	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00		104,840	2.00
0		0	326,742		
G - RADIOLOGY RNS					
1.00	RADIOLOGY-THERAPEUTIC	55.00	666,939	0	1.00
2.00	RADIOISOTOPE	56.00	68,771	0	2.00
0			735,710	0	
H - DIETARY					
1.00	CAFETERIA	11.00	807,549	788,858	1.00
0			807,549	788,858	
J - LINEN					
1.00	LAUNDRY & LINEN SERVICE	8.00		1,410,819	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00		134,866	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
0			0	1,545,685	
K - MOTHER BABY					
1.00	NURSERY	43.00	2,046,883	275,872	1.00
0			2,046,883	275,872	
M - MALPRACTICE					
1.00	SKILLED NURSING FACILITY	44.00		24,137	1.00
2.00	CARDIAC CATHETERIZATION	59.00		54,368	2.00
3.00	RESPIRATORY THERAPY	65.00		6,803	3.00
4.00	ELECTROCARDIOLOGY	69.00		75,806	4.00
5.00	ELECTROENCEPHALOGRAPHY	70.00		58,252	5.00
6.00	SLEEP LAB	70.01		37,756	6.00
7.00	CLINIC	90.00		18,641	7.00
0			0	275,763	
N - BENEFITS DIRECTLY ASSIGNED					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,546,440	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
0			0	3,546,440	
Q - TRANSPORT					
1.00	ADULTS & PEDIATRICS	30.00	71,668	885	1.00
2.00	INTENSIVE CARE UNIT	31.00	50,328	621	2.00
3.00	SURGICAL INTENSIVE CARE UNIT	34.00	5,796	72	3.00
4.00	NURSERY	43.00	513	6	4.00
5.00	SKILLED NURSING FACILITY	44.00	17,737	219	5.00
6.00	OPERATING ROOM	50.00	215,967	2,666	6.00
7.00	RECOVERY ROOM	51.00	78,754	972	7.00
8.00	DELIVERY ROOM & LABOR ROOM	52.00	23,497	290	8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	79,849	986	9.00
10.00	RADIOLOGY-THERAPEUTIC	55.00	557	7	10.00
11.00	RADIOISOTOPE	56.00	998	12	11.00

RECLASSIFICATIONS

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024

Worksheet A-6

Date/Time Prepared:
5/28/2025 10:36 am

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
12.00	CT SCAN	57.00	384,110	4,742		12.00
13.00	MRI	58.00	131,890	1,628		13.00
14.00	CARDIAC CATHETERIZATION	59.00	54,855	677		14.00
15.00	RESPIRATORY THERAPY	65.00	57,779	713		15.00
16.00	PHYSICAL THERAPY	66.00	26,395	326		16.00
17.00	OCCUPATIONAL THERAPY	67.00	19,602	242		17.00
18.00	SPEECH PATHOLOGY	68.00	3,052	38		18.00
19.00	ELECTROCARDIOLOGY	69.00	17,082	211		19.00
20.00	ELECTROENCEPHALOGRAPHY	70.00	915	11		20.00
21.00	CARDIAC REHABILITATION	76.97	2	0		21.00
22.00	CLINIC	90.00	38	0		22.00
23.00	EMERGENCY	91.00	52,730	651		23.00
			1,294,114	15,975		
R - PHARMACY RESIDENTS						
1.00	PARAMED ED PRGM-(SPECFY)	23.00	30,503	0		1.00
			30,503	0		
W - WAGE INDEX						
1.00	ADMINISTRATIVE & GENERAL	5.00		349,433		1.00
2.00	NURSING ADMINISTRATION	13.00		9,442		2.00
3.00	I&R SERVICES-OTHER PRGM.	22.00		1,479,026		3.00
	COSTS APPRVD					
4.00	ADULTS & PEDIATRICS	30.00		399,437		4.00
5.00	INTENSIVE CARE UNIT	31.00		234,887		5.00
6.00	SURGICAL INTENSIVE CARE UNIT	34.00		80,290		6.00
7.00	SKILLED NURSING FACILITY	44.00		36,010		7.00
8.00	OPERATING ROOM	50.00		10,204		8.00
9.00	DELIVERY ROOM & LABOR ROOM	52.00		23,994		9.00
10.00	OP INFUSION	52.01		97,186		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00		204,042		11.00
12.00	RADIOLOGY-THERAPEUTIC	55.00		120,555		12.00
13.00	CT SCAN	57.00		1,631		13.00
14.00	CARDIAC CATHETERIZATION	59.00		41,106		14.00
15.00	RESPIRATORY THERAPY	65.00		18,057		15.00
16.00	CARDIAC REHABILITATION	76.97		42,667		16.00
17.00	EMERGENCY	91.00		299,094		17.00
18.00	OBSERVATION BEDS-DISTINCT	92.01		1,590		18.00
19.00	OTHER NON REIMBURABLE	194.05	367,116			19.00
			367,116	3,448,651		
X - OB SUPPORT						
1.00	ADULTS & PEDIATRICS	30.00	210,918	4,434		1.00
			210,918	4,434		
Y - INTERN & RESIDENT SALARY RECLASS						
1.00	I&R SERVICES-SALARY & FRINGES APPRVD	21.00	7,754,845	0		1.00
			7,754,845	0		
Z - COVID-19- CONTRACT LABOR						
1.00	ADULTS & PEDIATRICS	30.00	0	0		1.00
			0	0		
AA - CONTRACT LABOR						
1.00	ADULTS & PEDIATRICS	30.00	0	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	0		2.00
3.00	LABORATORY	60.00	0	0		3.00
			0	0		
AB - HBP TEACH PART A						
1.00	I&R SERVICES-OTHER PRGM.	22.00	906,999	10,495		1.00
	COSTS APPRVD					
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
			906,999	10,495		
AC - RESIDENT MALPRACTICE						
1.00	I&R SERVICES-OTHER PRGM.	22.00	0	8,632		1.00
	COSTS APPRVD					
			0	8,632		
500.00	Grand Total: Increases		14,154,637	107,882,963		500.00

RECLASSIFICATIONS

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024

Worksheet A-6

Date/Time Prepared:
5/28/2025 10:36 am

		Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
	A - MEDICAL SURGICAL SUPPLIES							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	58,927	0		1.00	
2.00	OPERATION OF PLANT	7.00	0	40,417	0		2.00	
3.00	HOUSEKEEPING	9.00	0	127,699	0		3.00	
4.00	DIETARY	10.00	0	3,826	0		4.00	
5.00	NURSING ADMINISTRATION	13.00	0	947	0		5.00	
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	914,306	0		6.00	
7.00	PHARMACY	15.00	0	49,951	0		7.00	
8.00	I&R SERVICES-OTHER PRGM.	22.00	0	2,741	0		8.00	
	COSTS APPRVD							
9.00	ADULTS & PEDIATRICS	30.00	0	1,880,488	0		9.00	
10.00	INTENSIVE CARE UNIT	31.00	0	1,630,071	0		10.00	
11.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	211,028	0		11.00	
12.00	SKILLED NURSING FACILITY	44.00	0	118,891	0		12.00	
13.00	OPERATING ROOM	50.00	0	11,422,179	0		13.00	
14.00	RECOVERY ROOM	51.00	0	67,478	0		14.00	
15.00	DELIVERY ROOM & LABOR ROOM	52.00	0	380,992	0		15.00	
16.00	OP INFUSION	52.01	0	127,605	0		16.00	
17.00	ANESTHESIOLOGY	53.00	0	549,273	0		17.00	
18.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,334,256	0		18.00	
19.00	RADIOLOGY-THERAPEUTIC	55.00	0	33,220	0		19.00	
20.00	RADIOISOTOPE	56.00	0	1,294	0		20.00	
21.00	CT SCAN	57.00	0	168,056	0		21.00	
22.00	MRI	58.00	0	13,993	0		22.00	
23.00	CARDIAC CATHETERIZATION	59.00	0	2,497,475	0		23.00	
24.00	RESPIRATORY THERAPY	65.00	0	421,224	0		24.00	
25.00	PHYSICAL THERAPY	66.00	0	28,431	0		25.00	
26.00	ELECTROCARDIOLOGY	69.00	0	221,808	0		26.00	
27.00	ELECTROENCEPHALOGRAPHY	70.00	0	46,342	0		27.00	
28.00	CARDIAC REHABILITATION	76.97	0	6,805	0		28.00	
29.00	CLINIC	90.00	0	267,454	0		29.00	
30.00	EMERGENCY	91.00	0	1,778,462	0		30.00	
31.00	OBSERVATION BEDS-DISTINCT	92.01	0	169,795	0		31.00	
	0		0	24,575,434				
B - IMPLANTABLES								
1.00	ADMINISTRATIVE & GENERAL	5.00		4,136	0		1.00	
2.00	CENTRAL SERVICES & SUPPLY	14.00		13,404	0		2.00	
3.00	I&R SERVICES-OTHER PRGM.	22.00		11,439	0		3.00	
	COSTS APPRVD							
4.00	ADULTS & PEDIATRICS	30.00		10,122	0		4.00	
5.00	INTENSIVE CARE UNIT	31.00		2,977	0		5.00	
6.00	SURGICAL INTENSIVE CARE UNIT	34.00		5,105	0		6.00	
7.00	OPERATING ROOM	50.00		16,167,415	0		7.00	
8.00	RECOVERY ROOM	51.00		28	0		8.00	
9.00	ANESTHESIOLOGY	53.00		4,064	0		9.00	
10.00	RADIOLOGY-DIAGNOSTIC	54.00		616,976	0		10.00	
11.00	CARDIAC CATHETERIZATION	59.00		4,418,195	0		11.00	
12.00	ELECTROCARDIOLOGY	69.00		12,618	0		12.00	
13.00	CLINIC	90.00		240,884	0		13.00	
14.00	EMERGENCY	91.00		7,637	0		14.00	
	0		0	21,515,000				
C - DRUGS AND IV SOLUTIONS								
1.00	PHARMACY	15.00		47,361,062	0		1.00	
2.00	ADULTS & PEDIATRICS	30.00		313	0		2.00	
3.00	INTENSIVE CARE UNIT	31.00		131	0		3.00	
4.00	SKILLED NURSING FACILITY	44.00		3,246	0		4.00	
5.00	OPERATING ROOM	50.00		370	0		5.00	
6.00	RECOVERY ROOM	51.00		46	0		6.00	
7.00	RADIOLOGY-DIAGNOSTIC	54.00		1,998	0		7.00	
8.00	RESPIRATORY THERAPY	65.00		1,782	0		8.00	
9.00	ELECTROCARDIOLOGY	69.00		50,577	0		9.00	
10.00	EMERGENCY	91.00		696	0		10.00	
11.00	OBSERVATION BEDS-DISTINCT	92.01		111	0		11.00	
	0		0	47,420,332				
D - BLOOD								
1.00	ADMINISTRATIVE & GENERAL	5.00		26	0		1.00	
2.00	PHARMACY	15.00		212	0		2.00	
3.00	ADULTS & PEDIATRICS	30.00		722	0		3.00	
4.00	INTENSIVE CARE UNIT	31.00		774	0		4.00	
5.00	OPERATING ROOM	50.00		154,306	0		5.00	
6.00	OP INFUSION	52.01		68,061	0		6.00	
7.00	RADIOLOGY-THERAPEUTIC	55.00		1,365	0		7.00	
8.00	CARDIAC CATHETERIZATION	59.00		105	0		8.00	
9.00	EMERGENCY	91.00		26	0		9.00	

RECLASSIFICATIONS

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024

Worksheet A-6

Date/Time Prepared:
5/28/2025 10:36 am

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
	0		0	225,597			
E - INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	3,899,053	11		1.00
2.00		0.00	0	0	11		2.00
	0		0	3,899,053			
F - PROPERTY INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00		326,742	12		1.00
2.00			0	326,742	12		2.00
	0		0	326,742			
G - RADIOLOGY RNS							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	735,710	0	0		1.00
2.00		0.00	0	0	0		2.00
	0		735,710	0			
H - DIETARY							
1.00	DIETARY	10.00	807,549	788,858	0		1.00
	0		807,549	788,858			
J - LINEN							
1.00	ADMINISTRATIVE & GENERAL	5.00		83	0		1.00
2.00	HOUSEKEEPING	9.00		3,561	0		2.00
3.00	DIETARY	10.00		28,698	0		3.00
4.00	PHARMACY	15.00		1,687	0		4.00
5.00	I&R SERVICES-OTHER PRGM.	22.00		45	0		5.00
	COSTS APPRVD						
6.00	ADULTS & PEDIATRICS	30.00		408,142	0		6.00
7.00	INTENSIVE CARE UNIT	31.00		302,162	0		7.00
8.00	SURGICAL INTENSIVE CARE UNIT	34.00		27,246	0		8.00
9.00	SKILLED NURSING FACILITY	44.00		27,324	0		9.00
10.00	OPERATING ROOM	50.00		96,212	0		10.00
11.00	RECOVERY ROOM	51.00		18,553	0		11.00
12.00	DELIVERY ROOM & LABOR ROOM	52.00		49,076	0		12.00
13.00	OP INFUSION	52.01		16,334	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00		78,331	0		14.00
15.00	RADIOLOGY-THERAPEUTIC	55.00		5	0		15.00
16.00	RADIOISOTOPE	56.00		13,146	0		16.00
17.00	MRI	58.00		12,351	0		17.00
18.00	CARDIAC CATHETERIZATION	59.00		13,791	0		18.00
19.00	LABORATORY	60.00		1,001	0		19.00
20.00	PHYSICAL THERAPY	66.00		13,668	0		20.00
21.00	ELECTROCARDIOLOGY	69.00		16,916	0		21.00
22.00	ELECTROENCEPHALOGRAPHY	70.00		9,428	0		22.00
23.00	HYPERBARIC OXYGEN THERAPY	76.98		22,198	0		23.00
24.00	EMERGENCY	91.00		336,844	0		24.00
25.00	OBSERVATION BEDS-DISTINCT	92.01		48,883	0		25.00
	0		0	1,545,685			
K - MOTHER BABY							
1.00	ADULTS & PEDIATRICS	30.00	2,046,883	275,872	0		1.00
	0		2,046,883	275,872			
M - MALPRACTICE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	275,763	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
	0		0	275,763			
N - BENEFITS DIRECTLY ASSIGNED							
1.00	ADMINISTRATIVE & GENERAL	5.00		56,929	0		1.00
2.00	I&R SERVICES-OTHER PRGM.	22.00		2,405,864	0		2.00
	COSTS APPRVD						
3.00	ADULTS & PEDIATRICS	30.00		64,071	0		3.00
4.00	SKILLED NURSING FACILITY	44.00		1,012,076	0		4.00
5.00	EMERGENCY	91.00		7,500	0		5.00
	0		0	3,546,440			
Q - TRANSPORT							
1.00	ADMINISTRATIVE & GENERAL	5.00	1,294,114	15,975	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00

RECLASSIFICATIONS

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024

Worksheet A-6

Date/Time Prepared:
5/28/2025 10:36 am

	Decreases				Wkst. A-7 Ref.		
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00	10.00		
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
	0		1,294,114	15,975			
	R - PHARMACY RESIDENTS						
1.00	PHARMACY	15.00	30,503	0	0		1.00
	0		30,503	0			
	W - WAGE INDEX						
1.00	ADMINISTRATIVE & GENERAL	5.00	349,433		0		1.00
2.00	NURSING ADMINISTRATION	13.00	9,442		0		2.00
3.00	I&R SERVICES-OTHER PRGM.	22.00	1,479,026		0		3.00
	COSTS APPRVD						
4.00	ADULTS & PEDIATRICS	30.00	399,437		0		4.00
5.00	INTENSIVE CARE UNIT	31.00	234,887		0		5.00
6.00	SURGICAL INTENSIVE CARE UNIT	34.00	80,290		0		6.00
7.00	SKILLED NURSING FACILITY	44.00	36,010		0		7.00
8.00	OPERATING ROOM	50.00	10,204		0		8.00
9.00	DELIVERY ROOM & LABOR ROOM	52.00	23,994		0		9.00
10.00	OP INFUSION	52.01	97,186		0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	204,042		0		11.00
12.00	RADIOLOGY-THERAPEUTIC	55.00	120,555		0		12.00
13.00	CT SCAN	57.00	1,631		0		13.00
14.00	CARDIAC CATHETERIZATION	59.00	41,106		0		14.00
15.00	RESPIRATORY THERAPY	65.00	18,057		0		15.00
16.00	CARDIAC REHABILITATION	76.97	42,667		0		16.00
17.00	EMERGENCY	91.00	299,094		0		17.00
18.00	OBSERVATION BEDS-DISTINCT	92.01	1,590		0		18.00
19.00	OTHER NON REIMBURABLE	194.05		367,116	0		19.00
	0		3,448,651	367,116			
	X - OB SUPPORT						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	210,918	4,434	0		1.00
	0		210,918	4,434			
	Y - INTERN & RESIDENT SALARY RECLASS						
1.00	I&R SERVICES-OTHER PRGM.	22.00	7,754,845	0	0		1.00
	COSTS APPRVD						
	0		7,754,845	0			
	Z - COVID-19- CONTRACT LABOR						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	0	0		1.00
	0		0	0			
	AA - CONTRACT LABOR						
1.00	SOCIAL SERVICE	17.00	0	0	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		0	0			
	AB - HBP TEACH PART A						
1.00	ADMINISTRATIVE & GENERAL	5.00	288,112	10,495	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	204,971	0	0		2.00
3.00	EMERGENCY	91.00	413,916	0	0		3.00
	0		906,999	10,495			
	AC - RESIDENT MALPRACTICE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	8,632	0		1.00
	0		0	8,632			
500.00	Grand Total: Decreases		17,236,172	104,801,428			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024Worksheet A-7
Part I
Date/Time Prepared:
5/28/2025 10:36 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	198,713	1,139,748	0	1,139,748	0	1.00
2.00	Land Improvements	3,070,069	0	0	0	0	2.00
3.00	Buildings and Fixtures	310,465,785	53,679,562	0	53,679,562	139,706	3.00
4.00	Building Improvements	17,860,652	0	0	0	0	4.00
5.00	Fixed Equipment	79,638,021	0	0	0	0	5.00
6.00	Movable Equipment	215,944,398	3,549,353	0	3,549,353	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	627,177,638	58,368,663	0	58,368,663	139,706	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	627,177,638	58,368,663	0	58,368,663	139,706	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,338,461	0				1.00
2.00	Land Improvements	3,070,069	2,157,470				2.00
3.00	Buildings and Fixtures	364,005,641	57,892,997				3.00
4.00	Building Improvements	17,860,652	5,183,612				4.00
5.00	Fixed Equipment	79,638,021	68,619,001				5.00
6.00	Movable Equipment	219,493,751	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	685,406,595	133,853,080				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	685,406,595	133,853,080				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024Worksheet A-7
Part II
Date/Time Prepared:
5/28/2025 10:36 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	13,100,283	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	11,341,453	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	24,441,736	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of col.s. 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	13,100,283				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	11,341,453				2.00
3.00	Total (sum of lines 1-2)	0	24,441,736				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024Worksheet A-7
Part III
Date/Time Prepared:
5/28/2025 10:36 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	465,912,844	0	465,912,844	0.679761	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	219,493,750	0	219,493,750	0.320239	0	2.00
3.00	Total (sum of lines 1-2)	685,406,594	0	685,406,594	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital -Related Costs	Total (sum of col.s. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	13,100,283	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	11,341,453	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	24,441,736	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital -Related Costs (see instructions)	Total (2) (sum of col.s. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	2,040,546	221,902	0	0	15,362,731	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,766,586	104,840	0	0	13,212,879	2.00
3.00	Total (sum of lines 1-2)	3,807,132	326,742	0	0	28,575,610	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024

Worksheet A-8

Date/Time Prepared:
5/28/2025 10:36 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-49,268	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-42,653	CAP REL COSTS-MVBLE EQUIP	2.00	11	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)	B	-61,010	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	B	-35,847	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-11,373,133			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	11,314,230			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-1,508,938	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,287	ADMINISTRATIVE & GENERAL	5.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-40,023	OPERATION OF PLANT	7.00	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	MED & DENTAL STAFF OTHER REV	B	-263,430	CENTRAL SERVICES & SUPPLY	14.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024

Worksheet A-8

Date/Time Prepared:
5/28/2025 10:36 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.01	GARNISHEE SERVICE CHARGE REV	B	-4,025	EMPLOYEE BENEFITS DEPARTMENT	4.00		0 33.01
33.02	OUTREACH LAB	B	-415,190	LABORATORY	60.00		0 33.02
33.03	MEDICAL EDUCATION	B	-6,000	I&R SERVICES-OTHER PRGM.	22.00		0 33.03
				COSTS APPRVD			
33.04	OTHER MISCELLANEOUS REVENUE	B	-76,894	ADMINISTRATIVE & GENERAL	5.00		0 33.04
33.05	OTHER MISCELLANEOUS REVENUE	B	-152,000	MAINTENANCE & REPAIRS	6.00		0 33.05
33.06	OTHER MISCELLANEOUS REVENUE	B	-65	OPERATION OF PLANT	7.00		0 33.06
33.07	OTHER MISCELLANEOUS REVENUE	B	-63,909	PHARMACY	15.00		0 33.07
33.08	OTHER MISCELLANEOUS REVENUE	B	-10,250	ADULTS & PEDIATRICS	30.00		0 33.08
33.09	OTHER MISCELLANEOUS REVENUE	B	-102,016	OPERATING ROOM	50.00		0 33.09
33.10	OTHER MISCELLANEOUS REVENUE	B	-4,000	RADIOLOGY-THERAPEUTIC	55.00		0 33.10
33.11	OTHER MISCELLANEOUS REVENUE	B	-289,776	LABORATORY	60.00		0 33.11
33.12	EMPLOYEE - HEALTH PAYMENTS	B	-12,654	ADULTS & PEDIATRICS	30.00		0 33.12
33.13	EMPLOYEE - HEALTH PAYMENTS	B	-5,901	INTENSIVE CARE UNIT	31.00		0 33.13
33.14	EMPLOYEE - HEALTH PAYMENTS	B	-473	SURGICAL INTENSIVE CARE UNIT	34.00		0 33.14
33.15	EMPLOYEE - HEALTH PAYMENTS	B	-676	NURSERY	43.00		0 33.15
33.16	EMPLOYEE - HEALTH PAYMENTS	B	-170	SKILLED NURSING FACILITY	44.00		0 33.16
33.17	EMPLOYEE - HEALTH PAYMENTS	B	-7,119	OPERATING ROOM	50.00		0 33.17
33.18	EMPLOYEE - HEALTH PAYMENTS	B	-1,426	RECOVERY ROOM	51.00		0 33.18
33.19	EMPLOYEE - HEALTH PAYMENTS	B	-3,587	DELIVERY ROOM & LABOR ROOM	52.00		0 33.19
33.20	EMPLOYEE - HEALTH PAYMENTS	B	-772	OP INFUSION	52.01		0 33.20
33.21	EMPLOYEE - HEALTH PAYMENTS	B	-1,668	ANESTHESIOLOGY	53.00		0 33.21
33.22	EMPLOYEE - HEALTH PAYMENTS	B	-6,275	RADIOLOGY-DIAGNOSTIC	54.00		0 33.22
33.23	EMPLOYEE - HEALTH PAYMENTS	B	-2,963	RADIOLOGY-THERAPEUTIC	55.00		0 33.23
33.24	EMPLOYEE - HEALTH PAYMENTS	B	-390	RADIOISOTOPE	56.00		0 33.24
33.25	EMPLOYEE - HEALTH PAYMENTS	B	-4,882	CT SCAN	57.00		0 33.25
33.26	EMPLOYEE - HEALTH PAYMENTS	B	-3,167	MRI	58.00		0 33.26
33.27	EMPLOYEE - HEALTH PAYMENTS	B	-1,963	CARDIAC CATHETERIZATION	59.00		0 33.27
33.28	EMPLOYEE - HEALTH PAYMENTS	B	-11,347	LABORATORY	60.00		0 33.28
33.29	EMPLOYEE - HEALTH PAYMENTS	B	-402	RESPIRATORY THERAPY	65.00		0 33.29
33.30	EMPLOYEE - HEALTH PAYMENTS	B	-227	PHYSICAL THERAPY	66.00		0 33.30
33.31	EMPLOYEE - HEALTH PAYMENTS	B	-247	OCCUPATIONAL THERAPY	67.00		0 33.31
33.32	EMPLOYEE - HEALTH PAYMENTS	B	-62	SPEECH PATHOLOGY	68.00		0 33.32
33.33	EMPLOYEE - HEALTH PAYMENTS	B	-4,077	ELECTROCARDIOLOGY	69.00		0 33.33
33.34	EMPLOYEE - HEALTH PAYMENTS	B	-770	ELECTROENCEPHALOGRAPHY	70.00		0 33.34
33.35	EMPLOYEE - HEALTH PAYMENTS	B	-1,459	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00		0 33.35
33.36	EMPLOYEE - HEALTH PAYMENTS	B	-1,411	IMPL. DEV. CHARGED TO PATIENTS	72.00		0 33.36
33.37	EMPLOYEE - HEALTH PAYMENTS	B	-4,704	DRUGS CHARGED TO PATIENTS	73.00		0 33.37
33.38	EMPLOYEE - HEALTH PAYMENTS	B	-154	CARDIAC REHABILITATION	76.97		0 33.38
33.39	EMPLOYEE - HEALTH PAYMENTS	B	-168	CLINIC	90.00		0 33.39
33.40	EMPLOYEE - HEALTH PAYMENTS	B	-13,799	EMERGENCY	91.00		0 33.40
33.41	EMPLOYEE - HEALTH PAYMENTS	B	-47	OBSERVATION BEDS-DISTINCT	92.01		0 33.41
33.42	EMPLOYEE - HEALTH PAYMENTS	B	-2,081	OBSERVATION BEDS-DISTINCT	92.01		0 33.42
33.43	RENTAL INCOME	B	-602,661	ADMINISTRATIVE & GENERAL	5.00		0 33.43
33.44	RENTAL INCOME	B	-1,665	RADIOLOGY-DIAGNOSTIC	54.00		0 33.44
33.45	FOUNDATION SUBSIDY	B	-60,107	EMPLOYEE BENEFITS DEPARTMENT	4.00		0 33.45
33.46	FOUNDATION SUBSIDY	B	-3,798	ADMINISTRATIVE & GENERAL	5.00		0 33.46
33.47	FOUNDATION SUBSIDY	B	-17,908	MAINTENANCE & REPAIRS	6.00		0 33.47
33.48	FOUNDATION SUBSIDY	B	-9,818	OPERATION OF PLANT	7.00		0 33.48
33.49	FOUNDATION SUBSIDY	B	-72,129	DIETARY	10.00		0 33.49
33.50	FOUNDATION SUBSIDY	B	-28,093	NURSING ADMINISTRATION	13.00		0 33.50
33.51	FOUNDATION SUBSIDY	B	-626	PHARMACY	15.00		0 33.51
33.52	FOUNDATION SUBSIDY	B	-500	SOCIAL SERVICE	17.00		0 33.52
33.53	FOUNDATION SUBSIDY	B	-44,651	I&R SERVICES-OTHER PRGM.	22.00		0 33.53
				COSTS APPRVD			
33.54	FOUNDATION SUBSIDY	B	-2,665	PARAMEDICAL PRGM-(SPECIFY)	23.00		0 33.54
33.55	FOUNDATION SUBSIDY	B	-60,681	ADULTS & PEDIATRICS	30.00		0 33.55
33.56	FOUNDATION SUBSIDY	B	-6,185	INTENSIVE CARE UNIT	31.00		0 33.56
33.57	FOUNDATION SUBSIDY	B	-10	SURGICAL INTENSIVE CARE UNIT	34.00		0 33.57
33.58	FOUNDATION SUBSIDY	B	-5,033	SKILLED NURSING FACILITY	44.00		0 33.58
33.59	FOUNDATION SUBSIDY	B	-324,120	OPERATING ROOM	50.00		0 33.59
33.60	FOUNDATION SUBSIDY	B	-330	RECOVERY ROOM	51.00		0 33.60
33.61	FOUNDATION SUBSIDY	B	-16,813	DELIVERY ROOM & LABOR ROOM	52.00		0 33.61
33.62	FOUNDATION SUBSIDY	B	-170	OP INFUSION	52.01		0 33.62
33.63	FOUNDATION SUBSIDY	B	-2,500	ANESTHESIOLOGY	53.00		0 33.63
33.64	FOUNDATION SUBSIDY	B	-99,504	RADIOLOGY-THERAPEUTIC	55.00		0 33.64
33.65	FOUNDATION SUBSIDY	B	-251	CT SCAN	57.00		0 33.65

ADJUSTMENTS TO EXPENSES

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024

Worksheet A-8

Date/Time Prepared:
5/28/2025 10:36 am

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
Cost Center Description	Basis/Code (2)	Amount	Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00			
33.66 FOUNDATION SUBSIDY	B	-4,339		RESPIRATORY THERAPY	65.00	0	33.66
33.67 FOUNDATION SUBSIDY	B	-749		PHYSICAL THERAPY	66.00	0	33.67
33.68 FOUNDATION SUBSIDY	B	-169,691		ELECTROENCEPHALOGRAPHY	70.00	0	33.68
33.69 FOUNDATION SUBSIDY	B	-44,952		CLINIC	90.00	0	33.69
33.70 FOUNDATION SUBSIDY	B	-480		EMERGENCY	91.00	0	33.70
33.71 INTERCOMPANY RENTAL INCOME	B	-1,939,077		ADMINISTRATIVE & GENERAL	5.00	0	33.71
33.72 INTERCOMPANY RENTAL INCOME	A	-231,086		RADIOLOGY-DIAGNOSTIC	54.00	0	33.72
33.73 NON ALLOWABLE ENTERTAINMENT	A	-13,851		ADMINISTRATIVE & GENERAL	5.00	0	33.73
33.74 NON ALLOWABLE ENTERTAINMENT	A	-500		MAINTENANCE & REPAIRS	6.00	0	33.74
33.75 NON ALLOWABLE ENTERTAINMENT	A	-250		OPERATION OF PLANT	7.00	0	33.75
33.76 NON ALLOWABLE ENTERTAINMENT	A	-166		DIETARY	10.00	0	33.76
33.77 NON ALLOWABLE ENTERTAINMENT	A	-587		NURSING ADMINISTRATION	13.00	0	33.77
33.78 NON ALLOWABLE ENTERTAINMENT	A	-1,817		PHARMACY	15.00	0	33.78
33.79 NON ALLOWABLE ENTERTAINMENT	A	-2,009		SOCIAL SERVICE	17.00	0	33.79
33.80 NON ALLOWABLE ENTERTAINMENT	A	-16,204		I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00	0	33.80
33.81 NON ALLOWABLE ENTERTAINMENT	A	-1,351		PARAMEDICAL PRGM-(SPECIFY)	23.00	0	33.81
33.82 NON ALLOWABLE ENTERTAINMENT	A	-5,571		ADULTS & PEDIATRICS	30.00	0	33.82
33.83 NON ALLOWABLE ENTERTAINMENT	A	-2,718		INTENSIVE CARE UNIT	31.00	0	33.83
33.84 NON ALLOWABLE ENTERTAINMENT	A	-220		SURGICAL INTENSIVE CARE UNIT	34.00	0	33.84
33.85 NON ALLOWABLE ENTERTAINMENT	A	-1,230		SKILLED NURSING FACILITY	44.00	0	33.85
33.86 NON ALLOWABLE ENTERTAINMENT	A	-1,050		OPERATING ROOM	50.00	0	33.86
33.87 NON ALLOWABLE ENTERTAINMENT	A	-362		RADIOLOGY-THERAPEUTIC	55.00	0	33.87
33.88 NON ALLOWABLE ENTERTAINMENT	A	-100		CARDIAC CATHETERIZATION	59.00	0	33.88
33.89 NON ALLOWABLE ENTERTAINMENT	A	-594		PHYSICAL THERAPY	66.00	0	33.89
33.90 NON ALLOWABLE ENTERTAINMENT	A	-51		SPEECH PATHOLOGY	68.00	0	33.90
33.91 NON ALLOWABLE ENTERTAINMENT	A	-1,533		ELECTROENCEPHALOGRAPHY	70.00	0	33.91
33.92 NON ALLOWABLE ENTERTAINMENT	A	-138		EMERGENCY	91.00	0	33.92
33.93 NON ALLOWABLE ENTERTAINMENT	A	-529		OBSERVATION BEDS-DISTINCT	92.01	0	33.93
33.94 COMMUNITY BENEFIT	A	-252		ADMINISTRATIVE & GENERAL	5.00	0	33.94
33.95 COMMUNITY BENEFIT	A	-132		OPERATION OF PLANT	7.00	0	33.95
33.96 COMMUNITY BENEFIT	A	-23,165		SOCIAL SERVICE	17.00	0	33.96
33.97 FQHC	A	-1,150,000		ADMINISTRATIVE & GENERAL	5.00	0	33.97
33.98 LOBBYING EXPENSE	A	-31,614		ADMINISTRATIVE & GENERAL	5.00	0	33.98
33.99 BHM/MGM	A	-9,326,515		ADMINISTRATIVE & GENERAL	5.00	0	33.99
34.00 NURSE PRACTITIONERS (INCLUDES FRI NGES)	A	172,910		ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01 NURSE PRACTITIONERS (INCLUDES FRI NGES)	A	152,166		OPERATING ROOM	50.00	0	34.01
34.02 PENSION ADMINISTRATION COSTS	A	1,881,164		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.02
34.03 HBP	A			DIETARY	10.00	0	34.03
34.04 HBP	A	-37,456		SKILLED NURSING FACILITY	44.00	0	34.04
34.05 HBP	A	2,393		RADIOLOGY-THERAPEUTIC	55.00	0	34.05
34.06 HBP	A	90,762		LABORATORY	60.00	0	34.06
34.07 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.07
34.08 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.08
34.09 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.09
34.10 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.10
34.11 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.11
34.12 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.12
34.13 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.13
34.14 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.14
34.15 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.15
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-15,351,687					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.

			Provider CCN: 31-0041	Period: From 01/01/2024 To 12/31/2024	Worksheet A-8 Date/Time Prepared: 5/28/2025 10:36 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 #		
	1.00	2.00	3.00	4.00	5.00	

(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: 31-0041

Period:
From 01/01/2024
To 12/31/2024

Worksheet A-8-1

Date/Time Prepared:
5/28/2025 10:36 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	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	83,203,141	71,888,911	1.00
2.00	0.00			0	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	COMMUNITY MEDICAL CENTER AUX	7,256	7,256	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	COMMUNITY MEDICAL CENTER FOU	108,714	108,714	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	SAINT BARNABAS CORPORATION	570,882	570,882	3.02
3.03	0.00			0	0	3.03
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.			83,889,993	72,575,763	5.00

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

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
	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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	A		0.00	RWJ BARNABAS HEALTH	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: 31-0041

Period:
From 01/01/2024
To 12/31/2024

Worksheet A-8-1

Date/Time Prepared:
5/28/2025 10:36 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	11,314,230	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
3.01	0	0		3.01
3.02	0	0		3.02
3.03	0	0		3.03
4.00	0	0		4.00
5.00	11,314,230			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 requested 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: 31-0041

Period:
From 01/01/2024
To 12/31/2024

Worksheet A-8-2

Date/Time Prepared:
5/28/2025 10:36 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	4,571,036	3,669,939	901,097	211,500	8,966	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	3,803,857	2,887,655	916,202	197,500	9,649	2.00
3.00	50.00	AGGREGATE-OPERATING ROOM	18,000	18,000	0	0	0	3.00
4.00	53.00	AGGREGATE-ANESTHESIOLOGY	2,687,178	2,119,885	567,293	211,500	5,579	4.00
5.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	2,078,269	1,653,269	425,000	271,900	3,251	5.00
6.00	59.00	AGGREGATE-CARDIAC CATHETERIZATION	125,474	125,474	0	0	0	6.00
7.00	65.00	AGGREGATE-RESPIRATORY THERAPY	10,557	10,557	0	0	0	7.00
8.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	117,634	0	117,634	211,500	208	8.00
9.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY	89,212	89,212	0	0	0	9.00
10.00	70.01	AGGREGATE-SLEEP LAB	58,589	58,589	0	0	0	10.00
11.00	90.00	AGGREGATE-CLINIC	28,927	28,927	0	0	0	11.00
12.00	91.00	AGGREGATE-EMERGENCY	2,536,040	690,907	1,845,133	211,500	18,146	12.00
200.00			16,124,773	11,352,414	4,772,359		45,799	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	911,687	45,584	0	0	918,780	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	916,191	45,810	0	0	0	2.00
3.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	3.00
4.00	53.00	AGGREGATE-ANESTHESIOLOGY	567,288	28,364	0	0	0	4.00
5.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	424,975	21,249	0	0	0	5.00
6.00	59.00	AGGREGATE-CARDIAC CATHETERIZATION	0	0	0	0	54,368	6.00
7.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	0	6,803	7.00
8.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	21,150	1,058	0	0	75,806	8.00
9.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY	0	0	0	0	58,252	9.00
10.00	70.01	AGGREGATE-SLEEP LAB	0	0	0	0	37,756	10.00
11.00	90.00	AGGREGATE-CLINIC	0	0	0	0	18,641	11.00
12.00	91.00	AGGREGATE-EMERGENCY	1,845,134	92,257	0	0	0	12.00
200.00			4,686,425	234,322	0	0	1,170,406	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	181,121	1,092,808	0	3,669,939		1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	916,191	11	2,887,666		2.00
3.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	18,000		3.00
4.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	567,288	5	2,119,890		4.00
5.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	424,975	25	1,653,294		5.00
6.00	59.00	AGGREGATE-CARDIAC CATHETERIZATION	0	0	0	125,474		6.00
7.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	10,557		7.00
8.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	75,806	96,956	20,678	20,678		8.00
9.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY	0	0	0	89,212		9.00
10.00	70.01	AGGREGATE-SLEEP LAB	0	0	0	58,589		10.00
11.00	90.00	AGGREGATE-CLINIC	0	0	0	28,927		11.00
12.00	91.00	AGGREGATE-EMERGENCY	0	1,845,134	0	690,907		12.00
200.00			256,927	4,943,352	20,719	11,373,133		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024Worksheet B
Part I
Date/Time Prepared:
5/28/2025 10:36 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	15,362,731	15,362,731				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	13,212,879		13,212,879			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	37,740,890	154,957	0	37,895,847		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	114,273,312	1,001,988	5,893,371	2,226,917	123,395,588	5.00
6.00	00600	MAINTENANCE & REPAIRS	575,397	47,695	4,500	54,821	682,413	6.00
7.00	00700	OPERATION OF PLANT	13,176,783	238,530	865,268	888,380	15,168,961	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,410,819	0	0	0	1,410,819	8.00
9.00	00900	HOUSEKEEPING	6,236,914	175,033	11,684	659,585	7,083,216	9.00
10.00	01000	DIETARY	5,961,638	310,775	72,998	601,459	6,946,870	10.00
11.00	01100	CAFETERIA	87,469	258,635	4,687	158,376	509,167	11.00
13.00	01300	NURSING ADMINISTRATION	4,966,395	126,507	696,923	878,503	6,668,328	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,155,914	594,533	327,320	429,698	5,507,465	14.00
15.00	01500	PHARMACY	6,828,075	155,215	164,852	1,284,152	8,432,294	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	5,490,157	0	0	622,586	6,112,743	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	7,754,845	0	0	1,520,872	9,275,717	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	4,413,136	352,992	0	302,305	5,068,433	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	139,519	0	0	23,882	163,401	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	43,638,979	3,207,466	93,668	7,034,552	53,974,665	30.00
31.00	03100	INTENSIVE CARE UNIT	29,097,896	1,766,277	96,315	5,193,598	36,154,086	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	3,890,683	136,201	8,827	685,179	4,720,890	34.00
43.00	04300	NURSERY	3,439,137	191,553	8,059	607,916	4,246,665	43.00
44.00	04400	SKILLED NURSING FACILITY	4,558,196	247,564	1,208	790,487	5,597,455	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	15,006,933	976,778	1,679,969	2,130,059	19,793,739	50.00
51.00	05100	RECOVERY ROOM	1,836,849	139,384	7,043	347,121	2,330,397	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,990,583	448,840	56,590	739,679	5,235,692	52.00
52.01	03190	OP INFUSION	1,872,889	239,763	5,984	326,264	2,444,900	52.01
53.00	05300	ANESTHESIOLOGY	756,081	28,680	0	22,879	807,640	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,204,939	622,238	709,338	1,376,718	12,913,233	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,909,113	415,972	687,465	931,486	7,944,036	55.00
56.00	05600	RADIOISOTOPE	1,437,902	14,340	44,693	122,536	1,619,471	56.00
57.00	05700	CT SCAN	3,496,349	21,510	0	547,112	4,064,971	57.00
58.00	05800	MRI	1,249,614	85,064	188,759	206,177	1,729,614	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,600,264	605,317	342,121	769,592	6,317,294	59.00
60.00	06000	LABORATORY	18,938,449	381,614	378,122	0	19,698,185	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	4,786,001	53,975	304,975	776,974	5,921,925	65.00
66.00	06600	PHYSICAL THERAPY	2,265,839	153,581	20,051	440,378	2,879,849	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,354,771	7,686	0	265,474	1,627,931	67.00
68.00	06800	SPEECH PATHOLOGY	390,825	24,034	0	76,573	491,432	68.00
69.00	06900	ELECTROCARDIOLOGY	3,404,844	127,482	112,309	541,989	4,186,624	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,693,222	266,149	153,989	285,776	2,399,136	70.00
70.01	07001	SLEEP LAB	0	0	0	4,086	4,086	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	24,573,975	0	0	0	24,573,975	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,513,589	0	0	0	21,513,589	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	47,415,628	0	0	0	47,415,628	73.00
76.97	07697	CARDIAC REHABILITATION	736,581	70,151	2,272	132,982	941,986	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	265,437	74,568	0	0	340,005	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	700,971	0	0	65,051	766,022	90.00
91.00	09100	EMERGENCY	20,015,800	1,639,684	214,238	3,072,255	24,941,977	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	3,339,663	0	0	630,429	3,970,092	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	528,168,875	15,362,731	13,157,598	37,774,858	527,992,605	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	MISCELLANEOUS	0	0	0	0	0	194.00
194.01	07951	PUBLIC RELATIONS	546	0	0	0	546	194.01
194.03	07952	LIGHTHOUSE	56,646	0	0	10,989	67,635	194.03
194.04	07953	KIDS & FAMILY	0	0	0	0	0	194.04

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024Worksheet B
Part I
Date/Time Prepared:
5/28/2025 10:36 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
194.05	07954	OTHER NON REIMBURABLE	562,305	0	55,281	110,000	727,586	194.05
194.06	07955	GRANTS/TRIALS	7,061	0	0	0	7,061	194.06
194.07	07956	RETAIL PHARMACY	0	0	0	0	0	194.07
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)	528,795,433	15,362,731	13,212,879	37,895,847	528,795,433	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024Worksheet B
Part I
Date/Time Prepared:
5/28/2025 10:36 am

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	123,395,588					5.00
6.00	00600	MAINTENANCE & REPAIRS	207,713	890,126				6.00
7.00	00700	OPERATION OF PLANT	4,617,128	14,997	19,801,086			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	429,425	0	0	1,840,244		8.00
9.00	00900	HOUSEKEEPING	2,155,989	11,004	248,991	0	9,499,200	9.00
10.00	01000	DIETARY	2,114,488	19,539	442,089	18,398	0	10.00
11.00	01100	CAFETERIA	154,980	16,261	367,918	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,029,706	7,954	179,961	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,676,362	37,379	845,745	21,572	350,325	14.00
15.00	01500	PHARMACY	2,566,622	9,758	220,799	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,860,597	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	2,823,343	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	1,542,730	22,193	502,143	0	161,689	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	49,736	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	16,428,788	201,654	4,562,739	493,373	4,446,432	30.00
31.00	03100	INTENSIVE CARE UNIT	11,004,581	111,047	2,512,594	366,151	1,320,456	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,436,944	8,563	193,750	33,017	0	34.00
43.00	04300	NURSERY	1,292,600	12,043	272,491	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,703,753	15,564	352,169	33,081	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,024,818	61,411	1,389,503	113,252	134,740	50.00
51.00	05100	RECOVERY ROOM	709,326	8,763	198,279	22,482	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,593,640	28,219	638,491	58,662	350,325	52.00
52.01	03190	OP INFUSION	744,179	15,074	341,072	19,793	0	52.01
53.00	05300	ANESTHESIOLOGY	245,829	1,803	40,798	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,930,530	39,120	885,156	71,624	161,689	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,418,006	26,152	591,736	0	161,689	55.00
56.00	05600	RADIOISOTOPE	492,935	902	20,399	15,931	0	56.00
57.00	05700	CT SCAN	1,237,296	1,352	30,599	0	0	57.00
58.00	05800	MRI	526,460	5,348	121,007	14,867	161,689	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,922,858	38,057	861,085	16,711	336,851	59.00
60.00	06000	LABORATORY	5,995,734	23,992	542,860	3,059	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,802,516	3,393	76,782	0	0	65.00
66.00	06600	PHYSICAL THERAPY	876,568	9,656	218,474	16,562	161,689	66.00
67.00	06700	OCCUPATIONAL THERAPY	495,510	483	10,934	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	149,582	1,511	34,189	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,274,325	8,015	181,348	16,871	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	730,249	16,733	378,607	11,424	0	70.00
70.01	07001	SLEEP LAB	1,244	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,479,827	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,548,306	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,432,369	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	286,722	4,410	99,792	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	103,491	4,688	106,075	26,012	0	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	233,162	0	0	0	0	90.00
91.00	09100	EMERGENCY	7,591,839	103,088	2,332,511	467,402	1,751,626	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	1,208,417	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	123,151,223	890,126	19,801,086	1,840,244	9,499,200	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	MISCELLANEOUS	0	0	0	0	0	194.00
194.01	07951	PUBLIC RELATIONS	166	0	0	0	0	194.01
194.03	07952	LIGHTHOUSE	20,587	0	0	0	0	194.03
194.04	07953	KIDS & FAMILY	0	0	0	0	0	194.04
194.05	07954	OTHER NON REIMBURABLE	221,463	0	0	0	0	194.05
194.06	07955	GRANTS/TRIALS	2,149	0	0	0	0	194.06
194.07	07956	RETAIL PHARMACY	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

Health Financial Systems		COMMUNITY MEDICAL CENTER			In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 31-0041	Period: From 01/01/2024 To 12/31/2024	Worksheet B Part I Date/Time Prepared: 5/28/2025 10:36 am	
Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
202.00	TOTAL (sum lines 118 through 201)	123,395,588	890,126	19,801,086	1,840,244	9,499,200	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 31-0041

Period:
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	9,541,384					10.00
11.00	01100	CAFETERIA	0	1,048,326				11.00
13.00	01300	NURSING ADMINISTRATION	0	21,267	8,907,216			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	23,143	0	8,461,991		14.00
15.00	01500	PHARMACY	0	38,781	0	36,711	11,304,965	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	18,139	200,128	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	68,804	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	1,251	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,176,677	248,322	3,015,276	35,432	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,560,062	157,624	2,002,492	34,481	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	275,863	18,765	285,355	5,045	0	34.00
43.00	04300	NURSERY	0	4,378	75,609	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	528,782	23,143	165,696	2,810	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	64,426	706,304	38,107	0	50.00
51.00	05100	RECOVERY ROOM	0	7,506	143,114	236	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	21,892	294,155	8,412	0	52.00
52.01	03190	OP INFUSION	0	11,259	111,471	1,551	0	52.01
53.00	05300	ANESTHESIOLOGY	0	1,251	0	72	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	47,537	92,723	8,577	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	20,641	71,333	121	0	55.00
56.00	05600	RADIOISOTOPE	0	2,502	0	86	0	56.00
57.00	05700	CT SCAN	0	12,510	0	0	0	57.00
58.00	05800	MRI	0	5,004	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	18,139	245,520	7,266	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	23,143	0	483	0	65.00
66.00	06600	PHYSICAL THERAPY	0	12,510	0	121	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,506	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,502	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	16,888	86,304	1,200	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	8,757	0	13,812	0	70.00
70.01	07001	SLEEP LAB	0	0	28,554	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,580,505	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,642,231	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	11,304,965	73.00
76.97	07697	CARDIAC REHABILITATION	0	3,753	50,949	46	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	1,876	17,434	831	0	90.00
91.00	09100	EMERGENCY	0	110,087	1,057,451	38,818	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0	21,267	255,381	5,037	0	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,541,384	1,044,573	8,905,249	8,461,991	11,304,965	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	MISCELLANEOUS	0	0	0	0	0	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0	0	194.01
194.03	07952	LIGHTHOUSE	0	0	0	0	0	194.03
194.04	07953	KIDS & FAMILY	0	0	0	0	0	194.04
194.05	07954	OTHER NON REIMBURABLE	0	3,753	0	0	0	194.05
194.06	07955	GRANTS/TRIALS	0	0	1,967	0	0	194.06
194.07	07956	RETAIL PHARMACY	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments						200.00

Health Financial Systems			COMMUNITY MEDICAL CENTER			In Lieu of Form CMS-2552-10	
COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 31-0041			Period: From 01/01/2024 To 12/31/2024	Worksheet B Part I Date/Time Prepared: 5/28/2025 10:36 am
Cost Center Description			DI ETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY
			10.00	11.00	13.00	14.00	15.00
201.00	Negative Cost Centers		0	0	0	0	0
202.00	TOTAL (sum lines 118 through 201)		9,541,384	1,048,326	8,907,216	8,461,991	11,304,965

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 31-0041

Period:
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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		PARAMED PRGM	
					SERVICES-SALARIES & FRINGES	SERVICES-OTHER PRGM. COSTS		
			16.00	17.00	21.00	22.00	23.00	
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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0					16.00
17.00	01700	SOCIAL SERVICE	0	8,191,607				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	12,099,060			21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	235,109		7,601,101		22.00
23.00	02300	PARAMED PRGM-(SPECIFY)	0	0			214,388	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	2,136,320	5,563,242	3,495,046	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,176,421	1,039,022	652,754	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	90,716	0	0	0	34.00
43.00	04300	NURSERY	0	127,583	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	164,889	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	650,579	1,044,352	656,103	0	50.00
51.00	05100	RECOVERY ROOM	0	92,836	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	298,948	0	0	0	52.00
52.01	03190	OP INFUSION	0	159,693	27,717	17,413	0	52.01
53.00	05300	ANESTHESIOLOGY	0	19,102	198,637	124,791	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	414,439	156,351	98,226	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	277,057	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	9,551	0	0	0	56.00
57.00	05700	CT SCAN	0	14,327	0	0	0	57.00
58.00	05800	MRI	0	56,657	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	403,169	0	0	0	59.00
60.00	06000	LABORATORY	0	254,172	37,311	23,440	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	35,950	115,131	72,330	0	65.00
66.00	06600	PHYSICAL THERAPY	0	102,292	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,119	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	16,008	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	84,909	127,923	80,366	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	177,267	0	0	0	70.00
70.01	07001	SLEEP LAB	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	214,388	73.00
76.97	07697	CARDIAC REHABILITATION	0	46,724	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	49,665	0	0	0	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	1,090,902	685,347	0	90.00
91.00	09100	EMERGENCY	0	1,092,105	2,698,472	1,695,285	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	8,191,607	12,099,060	7,601,101	214,388	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	MISCELLANEOUS	0	0	0	0	0	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0	0	194.01
194.03	07952	LIGHTHOUSE	0	0	0	0	0	194.03
194.04	07953	KIDS & FAMILY	0	0	0	0	0	194.04
194.05	07954	OTHER NON REIMBURABLE	0	0	0	0	0	194.05
194.06	07955	GRANTS/TRIALS	0	0	0	0	0	194.06

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		PARAMED ED PRGM	
					SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM. COSTS		
194.07	07956	RETAIL PHARMACY	16.00	17.00	21.00	22.00	23.00	
			0	0	0	0	0	194.07
200.00		Cross Foot Adjustments			0	0		0200.00
201.00		Negative Cost Centers	0	0	0	0		0201.00
202.00		TOTAL (sum lines 118 through 201)	0	8,191,607	12,099,060	7,601,101	214,388	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD				21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)				23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	99,777,966	-9,058,288	90,719,678	30.00
31.00	03100	INTENSIVE CARE UNIT	60,091,771	-1,691,776	58,399,995	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	7,068,908	0	7,068,908	34.00
43.00	04300	NURSERY	6,031,369	0	6,031,369	43.00
44.00	04400	SKILLED NURSING FACILITY	8,587,342	0	8,587,342	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	30,677,334	-1,700,455	28,976,879	50.00
51.00	05100	RECOVERY ROOM	3,512,939	0	3,512,939	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,528,436	0	8,528,436	52.00
52.01	03190	OP INFUSION	3,894,122	-45,130	3,848,992	52.01
53.00	05300	ANESTHESIOLOGY	1,439,923	-323,428	1,116,495	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,819,205	-254,577	18,564,628	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	11,510,771	0	11,510,771	55.00
56.00	05600	RADIOISOTOPE	2,161,777	0	2,161,777	56.00
57.00	05700	CT SCAN	5,361,055	0	5,361,055	57.00
58.00	05800	MRI	2,620,646	0	2,620,646	58.00
59.00	05900	CARDIAC CATHETERIZATION	10,166,950	0	10,166,950	59.00
60.00	06000	LABORATORY	26,578,753	-60,751	26,518,002	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	8,051,653	-187,461	7,864,192	65.00
66.00	06600	PHYSICAL THERAPY	4,277,721	0	4,277,721	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,147,483	0	2,147,483	67.00
68.00	06800	SPEECH PATHOLOGY	695,224	0	695,224	68.00
69.00	06900	ELECTROCARDIOLOGY	6,064,773	-208,289	5,856,484	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,735,985	0	3,735,985	70.00
70.01	07001	SLEEP LAB	33,884	0	33,884	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	36,634,307	0	36,634,307	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	31,704,126	0	31,704,126	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73,367,350	0	73,367,350	73.00
76.97	07697	CARDIAC REHABILITATION	1,434,382	0	1,434,382	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	629,936	0	629,936	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,795,574	-1,776,249	1,019,325	90.00
91.00	09100	EMERGENCY	43,880,661	-4,393,757	39,486,904	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	5,460,194	0	5,460,194	92.01
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	527,742,520	-19,700,161	508,042,359	118.00
NONREIMBURSABLE COST CENTERS						
194.00	07950	MISCELLANEOUS	0	0	0	194.00
194.01	07951	PUBLIC RELATIONS	712	0	712	194.01
194.03	07952	LIGHTHOUSE	88,222	0	88,222	194.03
194.04	07953	KIDS & FAMILY	0	0	0	194.04
194.05	07954	OTHER NON REIMBURABLE	952,802	0	952,802	194.05
194.06	07955	GRANTS/TRIALS	11,177	0	11,177	194.06

Health Financial Systems			COMMUNITY MEDICAL CENTER			In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 31-0041		Period: From 01/01/2024 To 12/31/2024		Worksheet B Part I Date/Time Prepared: 5/28/2025 10:36 am
Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total			
			24.00	25.00	26.00			
194.07	07956	RETAIL PHARMACY	0	0	0			194.07
200.00		Cross Foot Adjustments	0	0	0			200.00
201.00		Negative Cost Centers	0	0	0			201.00
202.00		TOTAL (sum lines 118 through 201)	528,795,433	-19,700,161	509,095,272			202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-0041

Period:
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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MOVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	154,957	0	154,957	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	28,913	1,001,988	5,893,371	6,924,272	5.00
6.00	00600	MAINTENANCE & REPAIRS	5,389	47,695	4,500	57,584	6.00
7.00	00700	OPERATION OF PLANT	32,783	238,530	865,268	1,136,581	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	175,033	11,684	186,717	9.00
10.00	01000	DIETARY	19,003	310,775	72,998	402,776	10.00
11.00	01100	CAFETERIA	0	258,635	4,687	263,322	11.00
13.00	01300	NURSING ADMINISTRATION	919	126,507	696,923	824,349	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	236,125	594,533	327,320	1,157,978	14.00
15.00	01500	PHARMACY	8,658	155,215	164,852	328,725	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	2,546	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	6,219	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	830	352,992	0	353,822	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	98	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	39,989	3,207,466	93,668	3,341,123	30.00
31.00	03100	INTENSIVE CARE UNIT	28,229	1,766,277	96,315	1,890,821	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,655	136,201	8,827	146,683	34.00
43.00	04300	NURSERY	0	191,553	8,059	199,612	43.00
44.00	04400	SKILLED NURSING FACILITY	5,404	247,564	1,208	254,176	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,155,825	976,778	1,679,969	3,812,572	50.00
51.00	05100	RECOVERY ROOM	6,772	139,384	7,043	153,199	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,779	448,840	56,590	515,209	52.00
52.01	03190	OP INFUSION	2,856	239,763	5,984	248,603	52.01
53.00	05300	ANESTHESIOLOGY	10,239	28,680	0	38,919	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	72,917	622,238	709,338	1,404,493	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	591	415,972	687,465	1,104,028	55.00
56.00	05600	RADIOISOTOPE	3,508	14,340	44,693	62,541	56.00
57.00	05700	CT SCAN	8,608	21,510	0	30,118	57.00
58.00	05800	MRI	7,646	85,064	188,759	281,469	58.00
59.00	05900	CARDIAC CATHETERIZATION	41,985	605,317	342,121	989,423	59.00
60.00	06000	LABORATORY	0	381,614	378,122	759,736	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	62,630	53,975	304,975	421,580	65.00
66.00	06600	PHYSICAL THERAPY	4,523	153,581	20,051	178,155	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,686	0	7,686	67.00
68.00	06800	SPEECH PATHOLOGY	0	24,034	0	24,034	68.00
69.00	06900	ELECTROCARDIOLOGY	42,049	127,482	112,309	281,840	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	14,664	266,149	153,989	434,802	70.00
70.01	07001	SLEEP LAB	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	538	70,151	2,272	72,961	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	74,568	0	74,568	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	266	90.00
91.00	09100	EMERGENCY	55,611	1,639,684	214,238	1,909,533	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	5,943	0	0	5,943	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,914,581	15,362,731	13,157,598	30,434,910	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	MISCELLANEOUS	0	0	0	0	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0	194.01
194.03	07952	LIGHTHOUSE	0	0	0	45	194.03
194.04	07953	KIDS & FAMILY	0	0	0	0	194.04
194.05	07954	OTHER NON REIMBURABLE	0	0	55,281	55,281	194.05

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 31-0041		Period: From 01/01/2024 To 12/31/2024	Worksheet B Part II Date/Time Prepared: 5/28/2025 10:36 am	
Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT
				BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
194.06	07955	GRANTS/TRIALS	1,388	0	0	1,388	0
194.07	07956	RETAIL PHARMACY	0	0	0	0	0
200.00		Cross Foot Adjustments				0	
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	1,915,969	15,362,731	13,212,879	30,491,579	154,957

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024Worksheet B
Part II
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,933,379					5.00
6.00	00600	MAINTENANCE & REPAIRS	11,671	69,479				6.00
7.00	00700	OPERATION OF PLANT	259,435	1,171	1,400,820			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	24,129	0	0	24,129		8.00
9.00	00900	HOUSEKEEPING	121,144	859	17,615	0	329,032	9.00
10.00	01000	DIETARY	118,812	1,525	31,275	241	0	10.00
11.00	01100	CAFETERIA	8,708	1,269	26,028	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	114,048	621	12,731	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	94,194	2,918	59,832	283	12,135	14.00
15.00	01500	PHARMACY	144,218	762	15,620	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	104,546	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	158,643	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	86,685	1,732	35,524	0	5,601	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	2,795	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	922,955	15,737	322,790	6,469	154,011	30.00
31.00	03100	INTENSIVE CARE UNIT	618,343	8,668	177,752	4,801	45,738	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	80,741	668	13,707	433	0	34.00
43.00	04300	NURSERY	72,631	940	19,277	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	95,733	1,215	24,914	434	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	338,532	4,793	98,300	1,485	4,667	50.00
51.00	05100	RECOVERY ROOM	39,857	684	14,027	295	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	89,546	2,203	45,170	769	12,135	52.00
52.01	03190	OP INFUSION	41,815	1,177	24,129	260	0	52.01
53.00	05300	ANESTHESIOLOGY	13,813	141	2,886	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	220,855	3,054	62,620	939	5,601	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	135,867	2,041	41,862	0	5,601	55.00
56.00	05600	RADIOISOTOPE	27,698	70	1,443	209	0	56.00
57.00	05700	CT SCAN	69,523	106	2,165	0	0	57.00
58.00	05800	MRI	29,582	417	8,561	195	5,601	58.00
59.00	05900	CARDIAC CATHETERIZATION	108,045	2,971	60,917	219	11,668	59.00
60.00	06000	LABORATORY	336,898	1,873	38,404	40	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	101,283	265	5,432	0	0	65.00
66.00	06600	PHYSICAL THERAPY	49,254	754	15,456	217	5,601	66.00
67.00	06700	OCCUPATIONAL THERAPY	27,843	38	774	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,405	118	2,419	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	71,604	626	12,829	221	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	41,032	1,306	26,784	150	0	70.00
70.01	07001	SLEEP LAB	70	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	420,289	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	367,947	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	810,949	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	16,111	344	7,060	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	5,815	366	7,504	341	0	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	13,101	0	0	0	0	90.00
91.00	09100	EMERGENCY	426,583	8,047	165,013	6,128	60,673	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	67,900	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,919,648	69,479	1,400,820	24,129	329,032	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	MISCELLANEOUS	0	0	0	0	0	194.00
194.01	07951	PUBLIC RELATIONS	9	0	0	0	0	194.01
194.03	07952	LIGHTHOUSE	1,157	0	0	0	0	194.03
194.04	07953	KIDS & FAMILY	0	0	0	0	0	194.04
194.05	07954	OTHER NON REIMBURABLE	12,444	0	0	0	0	194.05
194.06	07955	GRANTS/TRIALS	121	0	0	0	0	194.06
194.07	07956	RETAIL PHARMACY	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

Health Financial Systems		COMMUNITY MEDICAL CENTER			In Lieu of Form CMS-2552-10		
ALLOCATION OF CAPITAL RELATED COSTS				Provider CCN: 31-0041	Period: From 01/01/2024 To 12/31/2024	Worksheet B Part II Date/Time Prepared: 5/28/2025 10:36 am	
Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
202.00	TOTAL (sum lines 118 through 201)	6,933,379	69,479	1,400,820	24,129	329,032	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-0041

Period:
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	557,089					10.00
11.00	01100	CAFETERIA	0	299,975				11.00
13.00	01300	NURSING ADMINISTRATION	0	6,085	961,427			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,622	0	1,335,719		14.00
15.00	01500	PHARMACY	0	11,097	0	5,795	511,468	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	5,190	21,601	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	19,688	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	358	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	302,248	71,057	325,465	5,593	0	30.00
31.00	03100	INTENSIVE CARE UNIT	207,860	45,104	216,145	5,443	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	16,107	5,369	30,801	796	0	34.00
43.00	04300	NURSERY	0	1,253	8,161	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	30,874	6,622	17,885	444	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	18,435	76,237	6,015	0	50.00
51.00	05100	RECOVERY ROOM	0	2,148	15,447	37	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,264	31,750	1,328	0	52.00
52.01	03190	OP INFUSION	0	3,222	12,032	245	0	52.01
53.00	05300	ANESTHESIOLOGY	0	358	0	11	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,603	10,008	1,354	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	5,906	7,700	19	0	55.00
56.00	05600	RADIOISOTOPE	0	716	0	14	0	56.00
57.00	05700	CT SCAN	0	3,580	0	0	0	57.00
58.00	05800	MRI	0	1,432	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	5,190	26,501	1,147	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	6,622	0	76	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3,580	0	19	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,148	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	716	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,833	9,315	189	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,506	0	2,180	0	70.00
70.01	07001	SLEEP LAB	0	0	3,082	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	723,025	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	574,929	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	511,468	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,074	5,499	7	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	537	1,882	131	0	90.00
91.00	09100	EMERGENCY	0	31,501	114,139	6,127	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0	6,085	27,565	795	0	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	557,089	298,901	961,215	1,335,719	511,468	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	MISCELLANEOUS	0	0	0	0	0	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0	0	194.01
194.03	07952	LIGHTHOUSE	0	0	0	0	0	194.03
194.04	07953	KIDS & FAMILY	0	0	0	0	0	194.04
194.05	07954	OTHER NON REIMBURABLE	0	1,074	0	0	0	194.05
194.06	07955	GRANTS/TRIALS	0	0	212	0	0	194.06
194.07	07956	RETAIL PHARMACY	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments						200.00

Health Financial Systems			COMMUNITY MEDICAL CENTER			In Lieu of Form CMS-2552-10	
ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 31-0041			Period: From 01/01/2024 To 12/31/2024	Worksheet B Part II Date/Time Prepared: 5/28/2025 10:36 am
Cost Center Description			DI ETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	13.00	14.00	15.00
201.00	Negative Cost Centers	0	0	0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	557,089	299,975	961,427	1,335,719	511,468	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024Worksheet B
Part II
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Cost Center Description		INTERNS & RESIDENTS				PARAMED ED PRGM	
		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM. COSTS		
				16.00	17.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0				16.00
17.00	01700	SOCIAL SERVICE	0	133,883			17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	164,862		21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	3,843		508,131	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	34,915			30.00
31.00	03100	INTENSIVE CARE UNIT	0	19,227			31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	1,483			34.00
43.00	04300	NURSERY	0	2,085			43.00
44.00	04400	SKILLED NURSING FACILITY	0	2,695			44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	10,633			50.00
51.00	05100	RECOVERY ROOM	0	1,517			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,886			52.00
52.01	03190	OP INFUSION	0	2,610			52.01
53.00	05300	ANESTHESIOLOGY	0	312			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,774			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	4,528			55.00
56.00	05600	RADIOISOTOPE	0	156			56.00
57.00	05700	CT SCAN	0	234			57.00
58.00	05800	MRI	0	926			58.00
59.00	05900	CARDIAC CATHETERIZATION	0	6,589			59.00
60.00	06000	LABORATORY	0	4,154			60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0			63.00
65.00	06500	RESPIRATORY THERAPY	0	588			65.00
66.00	06600	PHYSICAL THERAPY	0	1,672			66.00
67.00	06700	OCCUPATIONAL THERAPY	0	84			67.00
68.00	06800	SPEECH PATHOLOGY	0	262			68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,388			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,897			70.00
70.01	07001	SLEEP LAB	0	0			70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0			73.00
76.97	07697	CARDIAC REHABILITATION	0	764			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	812			76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0			77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0			78.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0			90.00
91.00	09100	EMERGENCY	0	17,849			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0	0			92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0			95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0			102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	133,883	0	0	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	MISCELLANEOUS	0	0			194.00
194.01	07951	PUBLIC RELATIONS	0	0			194.01
194.03	07952	LIGHTHOUSE	0	0			194.03
194.04	07953	KIDS & FAMILY	0	0			194.04
194.05	07954	OTHER NON REIMBURABLE	0	0			194.05
194.06	07955	GRANTS/TRIALS	0	0			194.06

ALLOCATION OF CAPITAL RELATED COSTS				Provider CCN: 31-0041		Period: From 01/01/2024 To 12/31/2024		Worksheet B Part II Date/Time Prepared: 5/28/2025 10:36 am	
Cost Center Description				MEDICAL RECORDS & LIBRARY	SOCIAL SERVICES	INTERNS & RESIDENTS		PARAMEDICAL PRGM	
						SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM. COSTS		
						16.00	17.00		
194.07	07956	RETAIL PHARMACY		0	0				194.07
200.00		Cross Foot Adjustments				164,862	508,131	3,251	200.00
201.00		Negative Cost Centers		0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)		0	133,883	164,862	508,131	3,251	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD				21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD				22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)				23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,531,115	0	5,531,115	30.00
31.00	03100	INTENSIVE CARE UNIT	3,261,140	0	3,261,140	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	299,590	0	299,590	34.00
43.00	04300	NURSERY	306,445	0	306,445	43.00
44.00	04400	SKILLED NURSING FACILITY	438,225	0	438,225	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,380,380	0	4,380,380	50.00
51.00	05100	RECOVERY ROOM	228,631	0	228,631	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	712,285	0	712,285	52.00
52.01	03190	OP INFUSION	335,427	0	335,427	52.01
53.00	05300	ANESTHESIOLOGY	56,534	0	56,534	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,734,931	0	1,734,931	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,311,361	0	1,311,361	55.00
56.00	05600	RADIOISOTOPE	93,348	0	93,348	56.00
57.00	05700	CT SCAN	107,963	0	107,963	57.00
58.00	05800	MRI	329,026	0	329,026	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,215,817	0	1,215,817	59.00
60.00	06000	LABORATORY	1,141,105	0	1,141,105	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	539,023	0	539,023	65.00
66.00	06600	PHYSICAL THERAPY	256,509	0	256,509	66.00
67.00	06700	OCCUPATIONAL THERAPY	39,659	0	39,659	67.00
68.00	06800	SPEECH PATHOLOGY	36,267	0	36,267	68.00
69.00	06900	ELECTROCARDIOLOGY	385,061	0	385,061	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	512,826	0	512,826	70.00
70.01	07001	SLEEP LAB	3,169	0	3,169	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,143,314	0	1,143,314	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	942,876	0	942,876	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,322,417	0	1,322,417	73.00
76.97	07697	CARDIAC REHABILITATION	104,364	0	104,364	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	89,406	0	89,406	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	15,917	0	15,917	90.00
91.00	09100	EMERGENCY	2,758,157	0	2,758,157	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	110,866	0	110,866	92.01
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,743,154	0	29,743,154	118.00
NONREIMBURSABLE COST CENTERS						
194.00	07950	MISCELLANEOUS	0	0	0	194.00
194.01	07951	PUBLIC RELATIONS	9	0	9	194.01
194.03	07952	LIGHTHOUSE	1,202	0	1,202	194.03
194.04	07953	KIDS & FAMILY	0	0	0	194.04
194.05	07954	OTHER NON REIMBURABLE	69,249	0	69,249	194.05
194.06	07955	GRANTS/TRIALS	1,721	0	1,721	194.06

ALLOCATION OF CAPITAL RELATED COSTS				Provider CCN: 31-0041		Period: From 01/01/2024 To 12/31/2024	Worksheet B Part II Date/Time Prepared: 5/28/2025 10:36 am
Cost Center Description				Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
				24.00	25.00	26.00	
194.07	07956	RETAIL PHARMACY		0	0	0	194.07
200.00		Cross Foot Adjustments		676,244	0	676,244	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)		30,491,579	0	30,491,579	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	535,663					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		9,350,751				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,403	0	193,229,249			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	34,937	4,170,737	11,354,929	-123,395,588	405,399,845	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,663	3,185	279,530	0	682,413	6.00
7.00	00700	OPERATION OF PLANT	8,317	612,350	4,529,802	0	15,168,961	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	1,410,819	8.00
9.00	00900	HOUSEKEEPING	6,103	8,269	3,363,188	0	7,083,216	9.00
10.00	01000	DIETARY	10,836	51,661	3,066,807	0	6,946,870	10.00
11.00	01100	CAFETERIA	9,018	3,317	807,549	0	509,167	11.00
13.00	01300	NURSING ADMINISTRATION	4,411	493,212	4,479,436	0	6,668,328	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	20,730	231,644	2,191,007	0	5,507,465	14.00
15.00	01500	PHARMACY	5,412	116,666	6,547,823	0	8,432,294	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	3,174,530	0	6,112,743	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	7,754,845	0	9,275,717	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	12,308	0	1,541,438	0	5,068,433	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	121,775	0	163,401	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	111,837	66,289	35,869,189	0	53,974,665	30.00
31.00	03100	INTENSIVE CARE UNIT	61,586	68,162	26,481,871	0	36,154,086	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	4,749	6,247	3,493,691	0	4,720,890	34.00
43.00	04300	NURSERY	6,679	5,703	3,099,731	0	4,246,665	43.00
44.00	04400	SKILLED NURSING FACILITY	8,632	855	4,030,649	0	5,597,455	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	34,058	1,188,913	10,861,056	0	19,793,739	50.00
51.00	05100	RECOVERY ROOM	4,860	4,984	1,769,951	0	2,330,397	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,650	40,049	3,771,585	0	5,235,692	52.00
52.01	03190	OP INFUSION	8,360	4,235	1,663,601	0	2,444,900	52.01
53.00	05300	ANESTHESIOLOGY	1,000	0	116,657	0	807,640	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,696	501,998	7,019,810	0	12,913,233	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	14,504	486,519	4,749,597	0	7,944,036	55.00
56.00	05600	RADIOISOTOPE	500	31,629	624,804	0	1,619,471	56.00
57.00	05700	CT SCAN	750	0	2,789,694	0	4,064,971	57.00
58.00	05800	MRI	2,966	133,585	1,051,287	0	1,729,614	58.00
59.00	05900	CARDIAC CATHETERIZATION	21,106	242,119	3,924,108	0	6,317,294	59.00
60.00	06000	LABORATORY	13,306	267,597	0	0	19,698,185	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,882	215,831	3,961,749	0	5,921,925	65.00
66.00	06600	PHYSICAL THERAPY	5,355	14,190	2,245,463	0	2,879,849	66.00
67.00	06700	OCCUPATIONAL THERAPY	268	0	1,353,638	0	1,627,931	67.00
68.00	06800	SPEECH PATHOLOGY	838	0	390,439	0	491,432	68.00
69.00	06900	ELECTROCARDIOLOGY	4,445	79,481	2,763,574	0	4,186,624	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	9,280	108,978	1,457,154	0	2,399,136	70.00
70.01	07001	SLEEP LAB	0	0	20,833	0	4,086	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	24,573,975	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	21,513,589	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	47,415,628	73.00
76.97	07697	CARDIAC REHABILITATION	2,446	1,608	678,068	0	941,986	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	2,600	0	0	0	340,005	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	331,693	0	766,022	90.00
91.00	09100	EMERGENCY	57,172	151,616	15,665,261	0	24,941,977	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0	0	3,214,521	0	3,970,092	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	535,663	9,311,629	192,612,333	-123,395,588	404,597,017	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	MISCELLANEOUS	0	0	0	0	0	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0	546	194.01
194.03	07952	LIGHTHOUSE	0	0	56,030	0	67,635	194.03
194.04	07953	KIDS & FAMILY	0	0	0	0	0	194.04

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024

Worksheet B-1

Date/Time Prepared:
5/28/2025 10:36 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
194.05	07954	OTHER NON REIMBURABLE	0	39,122	560,886	0	727,586	194.05
194.06	07955	GRANTS/TRIALS	0	0	0	0	7,061	194.06
194.07	07956	RETAIL PHARMACY	0	0	0	0	0	194.07
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)	15,362,731	13,212,879	37,895,847		123,395,588	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.679843	1.413029	0.196119		0.304380	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			154,957		6,933,379	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000802		0.017103	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: 31-0041

Period:
From 01/01/2024
To 12/31/2024

Worksheet B-1

Date/Time Prepared:
5/28/2025 10:36 am

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			6.00	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						5.00
6.00	00600	MAINTENANCE & REPAIRS	493,660					6.00
7.00	00700	OPERATION OF PLANT	8,317	485,343				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	2,082,875			8.00
9.00	00900	HOUSEKEEPING	6,103	6,103	0	2,820		9.00
10.00	01000	DIETARY	10,836	10,836	20,824	0	471,564	10.00
11.00	01100	CAFETERIA	9,018	9,018	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	4,411	4,411	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	20,730	20,730	24,416	104	0	14.00
15.00	01500	PHARMACY	5,412	5,412	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	12,308	12,308	0	48	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	111,837	111,837	558,423	1,320	255,847	30.00
31.00	03100	INTENSIVE CARE UNIT	61,586	61,586	414,427	392	175,949	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	4,749	4,749	37,370	0	13,634	34.00
43.00	04300	NURSERY	6,679	6,679	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	8,632	8,632	37,443	0	26,134	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	34,058	34,058	128,184	40	0	50.00
51.00	05100	RECOVERY ROOM	4,860	4,860	25,446	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,650	15,650	66,396	104	0	52.00
52.01	03190	OP INFUSION	8,360	8,360	22,403	0	0	52.01
53.00	05300	ANESTHESIOLOGY	1,000	1,000	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,696	21,696	81,068	48	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	14,504	14,504	0	48	0	55.00
56.00	05600	RADIOISOTOPE	500	500	18,031	0	0	56.00
57.00	05700	CT SCAN	750	750	0	0	0	57.00
58.00	05800	MRI	2,966	2,966	16,827	48	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	21,106	21,106	18,914	100	0	59.00
60.00	06000	LABORATORY	13,306	13,306	3,462	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,882	1,882	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5,355	5,355	18,746	48	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	268	268	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	838	838	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,445	4,445	19,095	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	9,280	9,280	12,930	0	0	70.00
70.01	07001	SLEEP LAB	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	2,446	2,446	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	2,600	2,600	29,442	0	0	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	57,172	57,172	529,028	520	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	493,660	485,343	2,082,875	2,820	471,564	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	MISCELLANEOUS	0	0	0	0	0	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0	0	194.01
194.03	07952	LIGHTHOUSE	0	0	0	0	0	194.03
194.04	07953	KIDS & FAMILY	0	0	0	0	0	194.04
194.05	07954	OTHER NON REIMBURABLE	0	0	0	0	0	194.05
194.06	07955	GRANTS/TRIALS	0	0	0	0	0	194.06
194.07	07956	RETAIL PHARMACY	0	0	0	0	0	194.07

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024

Worksheet B-1

Date/Time Prepared:
5/28/2025 10:36 am

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	890,126	19,801,086	1,840,244	9,499,200	9,541,384	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.803116	40.798128	0.883511	3,368.510638	20.233487	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	69,479	1,400,820	24,129	329,032	557,089	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.140743	2.886247	0.011584	116.678014	1.181365	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: 31-0041

Period:
From 01/01/2024
To 12/31/2024

Worksheet B-1

Date/Time Prepared:

5/28/2025 10:36 am

Cost Center Description			CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,676					11.00
13.00	01300	NURSING ADMINISTRATION	34	1,612,419				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	37	0	45,400,541			14.00
15.00	01500	PHARMACY	62	0	196,965	50,581,492		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	29	36,228	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	110	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	2	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	397	545,837	190,101	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	252	362,499	184,999	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	30	51,656	27,068	0	0	34.00
43.00	04300	NURSERY	7	13,687	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	37	29,995	15,077	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	103	127,858	204,455	0	0	50.00
51.00	05100	RECOVERY ROOM	12	25,907	1,266	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	35	53,249	45,133	0	0	52.00
52.01	03190	OP INFUSION	18	20,179	8,324	0	0	52.01
53.00	05300	ANESTHESIOLOGY	2	0	388	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	76	16,785	46,017	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	33	12,913	649	0	0	55.00
56.00	05600	RADIOISOTOPE	4	0	462	0	0	56.00
57.00	05700	CT SCAN	20	0	0	0	0	57.00
58.00	05800	MRI	8	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	29	44,445	38,984	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	37	0	2,593	0	0	65.00
66.00	06600	PHYSICAL THERAPY	20	0	647	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	12	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	4	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	27	15,623	6,438	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	14	0	74,107	0	0	70.00
70.01	07001	SLEEP LAB	0	5,169	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	24,575,433	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	19,541,437	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	50,581,492	0	73.00
76.97	07697	CARDIAC REHABILITATION	6	9,223	246	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3	3,156	4,459	0	0	90.00
91.00	09100	EMERGENCY	176	191,424	208,267	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	34	46,230	27,026	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,670	1,612,063	45,400,541	50,581,492	0	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	MISCELLANEOUS	0	0	0	0	0	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0	0	194.01
194.03	07952	LIGHTHOUSE	0	0	0	0	0	194.03
194.04	07953	KIDS & FAMILY	0	0	0	0	0	194.04
194.05	07954	OTHER NON REIMBURABLE	6	0	0	0	0	194.05
194.06	07955	GRANTS/TRIALS	0	356	0	0	0	194.06

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024

Worksheet B-1

Date/Time Prepared:
5/28/2025 10:36 am

Cost Center Description			CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			11.00	13.00	14.00	15.00	16.00	
194.07	07956	RETAIL PHARMACY	0	0	0	0	0	194.07
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)	1,048,326	8,907,216	8,461,991	11,304,965	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	625.492840	5.524132	0.186385	0.223500	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	299,975	961,427	1,335,719	511,468	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	178.982697	0.596264	0.029421	0.010112	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: 31-0041

Period:
From 01/01/2024
To 12/31/2024

Worksheet B-1

Date/Time Prepared:
5/28/2025 10:36 am

Cost Center Description			SOCIAL SERVICE (SQUARE FEET)	INTERNS & RESIDENTS		PARAMED PRGM (ASSIGNED TIME)		
				SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)			
				17.00	21.00			
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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	428,833					17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	272,392				21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	12,308		272,392			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0			499		23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	111,837	125,248	125,248	0		30.00
31.00	03100	INTENSIVE CARE UNIT	61,586	23,392	23,392	0		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	4,749	0	0	0		34.00
43.00	04300	NURSERY	6,679	0	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	8,632	0	0	0		44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	34,058	23,512	23,512	0		50.00
51.00	05100	RECOVERY ROOM	4,860	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,650	0	0	0		52.00
52.01	03190	OP INFUSION	8,360	624	624	0		52.01
53.00	05300	ANESTHESIOLOGY	1,000	4,472	4,472	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,696	3,520	3,520	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	14,504	0	0	0		55.00
56.00	05600	RADIOISOTOPE	500	0	0	0		56.00
57.00	05700	CT SCAN	750	0	0	0		57.00
58.00	05800	MRI	2,966	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	21,106	0	0	0		59.00
60.00	06000	LABORATORY	13,306	840	840	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	1,882	2,592	2,592	0		65.00
66.00	06600	PHYSICAL THERAPY	5,355	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	268	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	838	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	4,445	2,880	2,880	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	9,280	0	0	0		70.00
70.01	07001	SLEEP LAB	0	0	0	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	499		73.00
76.97	07697	CARDIAC REHABILITATION	2,446	0	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	2,600	0	0	0		76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0		78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	24,560	24,560	0		90.00
91.00	09100	EMERGENCY	57,172	60,752	60,752	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0	0	0	0		92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0		102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	428,833	272,392	272,392	499		118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	MISCELLANEOUS	0	0	0	0		194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0		194.01
194.03	07952	LIGHTHOUSE	0	0	0	0		194.03
194.04	07953	KIDS & FAMILY	0	0	0	0		194.04
194.05	07954	OTHER NON REIMBURABLE	0	0	0	0		194.05

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024

Worksheet B-1

Date/Time Prepared:
5/28/2025 10:36 am

Cost Center Description			INTERNS & RESIDENTS			PARAMETERED PRGM (ASSIGNED TIME)	
			SOCIAL SERVICES (SQUARE FEET)	SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)		
				21.00	22.00		
194.06	07955	GRANTS/TRIALS	0	0	0	0	194.06
194.07	07956	RETAIL PHARMACY	0	0	0	0	194.07
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	8,191,607	12,099,060	7,601,101	214,388	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	19.102091	44.417824	27.905008	429.635271	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	133,883	164,862	508,131	3,251	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.312203	0.605238	1.865440	6.515030	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000	207.00

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MCRI F32 - 23.3.179.2

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024Worksheet C
Part I
Date/Time Prepared:
5/28/2025 10:36 am

			Title XVIII			Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	563,635,386		563,635,386			30.00
31.00	03100	INTENSIVE CARE UNIT	474,363,055		474,363,055			31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	47,891,546		47,891,546			34.00
43.00	04300	NURSERY	23,052,464		23,052,464			43.00
44.00	04400	SKILLED NURSING FACILITY	21,136,957		21,136,957			44.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	57,312,544	56,985,997	114,298,541	0.253519	0.000000	50.00
51.00	05100	RECOVERY ROOM	9,499,974	11,250,874	20,750,848	0.169291	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	20,703,222	6,685,698	27,388,920	0.311383	0.000000	52.00
52.01	03190	OP INFUSION	55,318	20,943,398	20,998,716	0.183297	0.000000	52.01
53.00	05300	ANESTHESIOLOGY	13,601,696	10,917,599	24,519,295	0.045535	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	34,578,759	50,867,224	85,445,983	0.217267	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,877,124	87,807,282	91,684,406	0.125548	0.000000	55.00
56.00	05600	RADIOISOTOPE	2,599,303	3,496,032	6,095,335	0.354661	0.000000	56.00
57.00	05700	CT SCAN	75,949,941	68,756,757	144,706,698	0.037048	0.000000	57.00
58.00	05800	MRI	22,353,241	16,074,364	38,427,605	0.068197	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	41,095,951	41,054,332	82,150,283	0.123760	0.000000	59.00
60.00	06000	LABORATORY	137,097,902	82,501,071	219,598,973	0.120756	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	58,205,053	1,313,131	59,518,184	0.132131	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	15,786,695	1,547,858	17,334,553	0.246774	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	12,140,735	587,865	12,728,600	0.168713	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	3,723,735	854,330	4,578,065	0.151860	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	36,563,114	62,902,983	99,466,097	0.058879	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,531,554	8,025,462	11,557,016	0.323266	0.000000	70.00
70.01	07001	SLEEP LAB	0	0	0	0.000000	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,435,333	12,265,950	29,701,283	1.233425	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,556,710	18,987,409	43,544,119	0.728092	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,768,978	78,686,379	102,455,357	0.716091	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	2,015	4,040,966	4,042,981	0.354783	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	95,000	4,644,862	4,739,862	0.132902	0.000000	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0.000000	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	131,633	15,451,276	15,582,909	0.065413	0.000000	90.00
91.00	09100	EMERGENCY	140,905,583	267,504,572	408,410,155	0.096684	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	365,100	315,600	680,700	0.166733	0.000000	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	21,805,490	42,968,315	64,773,805	0.084296	0.000000	92.01
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	1,907,821,111	977,437,586	2,885,258,697			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	1,907,821,111	977,437,586	2,885,258,697			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024Worksheet C
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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT			34.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.253519		50.00
51.00	05100	RECOVERY ROOM	0.169291		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.311383		52.00
52.01	03190	OP INFUSION	0.183297		52.01
53.00	05300	ANESTHESIOLOGY	0.045536		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.217268		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.125548		55.00
56.00	05600	RADIOISOTOPE	0.354661		56.00
57.00	05700	CT SCAN	0.037048		57.00
58.00	05800	MRI	0.068197		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.123760		59.00
60.00	06000	LABORATORY	0.120756		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	0.132131		65.00
66.00	06600	PHYSICAL THERAPY	0.246774		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.168713		67.00
68.00	06800	SPEECH PATHOLOGY	0.151860		68.00
69.00	06900	ELECTROCARDIOLOGY	0.059087		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.323266		70.00
70.01	07001	SLEEP LAB	0.000000		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.233425		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.728092		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.716091		73.00
76.97	07697	CARDIAC REHABILITATION	0.354783		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.132902		76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000		78.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.065413		90.00
91.00	09100	EMERGENCY	0.096684		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.166733		92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0.084296		92.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
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: 31-0041

Period:
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				Title XIX		Hospital		TEFRA	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs			
						RCE	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	90,719,678		90,719,678	11	90,719,689	30.00	
31.00	03100	INTENSIVE CARE UNIT	58,399,995		58,399,995	0	58,399,995	31.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	7,068,908		7,068,908	0	7,068,908	34.00	
43.00	04300	NURSERY	6,031,369		6,031,369	0	6,031,369	43.00	
44.00	04400	SKILLED NURSING FACILITY	8,587,342		8,587,342	0	8,587,342	44.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	28,976,879		28,976,879	0	28,976,879	50.00	
51.00	05100	RECOVERY ROOM	3,512,939		3,512,939	0	3,512,939	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,528,436		8,528,436	0	8,528,436	52.00	
52.01	03190	OP INFUSION	3,848,992		3,848,992	0	3,848,992	52.01	
53.00	05300	ANESTHESIOLOGY	1,116,495		1,116,495	5	1,116,500	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,564,628		18,564,628	25	18,564,653	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	11,510,771		11,510,771	0	11,510,771	55.00	
56.00	05600	RADIOISOTOPE	2,161,777		2,161,777	0	2,161,777	56.00	
57.00	05700	CT SCAN	5,361,055		5,361,055	0	5,361,055	57.00	
58.00	05800	MRI	2,620,646		2,620,646	0	2,620,646	58.00	
59.00	05900	CARDIAC CATHETERIZATION	10,166,950		10,166,950	0	10,166,950	59.00	
60.00	06000	LABORATORY	26,518,002		26,518,002	0	26,518,002	60.00	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00	
65.00	06500	RESPIRATORY THERAPY	7,864,192	0	7,864,192	0	7,864,192	65.00	
66.00	06600	PHYSICAL THERAPY	4,277,721	0	4,277,721	0	4,277,721	66.00	
67.00	06700	OCCUPATIONAL THERAPY	2,147,483	0	2,147,483	0	2,147,483	67.00	
68.00	06800	SPEECH PATHOLOGY	695,224	0	695,224	0	695,224	68.00	
69.00	06900	ELECTROCARDIOLOGY	5,856,484		5,856,484	20,678	5,877,162	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	3,735,985		3,735,985	0	3,735,985	70.00	
70.01	07001	SLEEP LAB	33,884		33,884	0	33,884	70.01	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	36,634,307		36,634,307	0	36,634,307	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	31,704,126		31,704,126	0	31,704,126	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	73,367,350		73,367,350	0	73,367,350	73.00	
76.97	07697	CARDIAC REHABILITATION	1,434,382		1,434,382	0	1,434,382	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	629,936		629,936	0	629,936	76.98	
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0		0	0	0	77.00	
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,019,325		1,019,325	0	1,019,325	90.00	
91.00	09100	EMERGENCY	39,486,904		39,486,904	0	39,486,904	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	113,495		113,495		113,495	92.00	
92.01	09201	OBSERVATION BEDS-DISTINCT	5,460,194		5,460,194	0	5,460,194	92.01	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00	
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	508,155,854	0	508,155,854	20,719	508,176,573	200.00	
201.00		Less Observation Beds	113,495		113,495		113,495	201.00	
202.00		Total (see instructions)	508,042,359	0	508,042,359	20,719	508,063,078	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 31-0041

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			Title XIX			Hospital	TEFRA	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00		9.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	563,635,386		563,635,386			30.00
31.00	03100	INTENSIVE CARE UNIT	474,363,055		474,363,055			31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	47,891,546		47,891,546			34.00
43.00	04300	NURSERY	23,052,464		23,052,464			43.00
44.00	04400	SKILLED NURSING FACILITY	21,136,957		21,136,957			44.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	57,312,544	56,985,997	114,298,541	0.253519	0.253519	50.00
51.00	05100	RECOVERY ROOM	9,499,974	11,250,874	20,750,848	0.169291	0.169291	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	20,703,222	6,685,698	27,388,920	0.311383	0.311383	52.00
52.01	03190	OP INFUSION	55,318	20,943,398	20,998,716	0.183297	0.183297	52.01
53.00	05300	ANESTHESIOLOGY	13,601,696	10,917,599	24,519,295	0.045535	0.045535	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	34,578,759	50,867,224	85,445,983	0.217267	0.217267	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,877,124	87,807,282	91,684,406	0.125548	0.125548	55.00
56.00	05600	RADIOISOTOPE	2,599,303	3,496,032	6,095,335	0.354661	0.354661	56.00
57.00	05700	CT SCAN	75,949,941	68,756,757	144,706,698	0.037048	0.037048	57.00
58.00	05800	MRI	22,353,241	16,074,364	38,427,605	0.068197	0.068197	58.00
59.00	05900	CARDIAC CATHETERIZATION	41,095,951	41,054,332	82,150,283	0.123760	0.123760	59.00
60.00	06000	LABORATORY	137,097,902	82,501,071	219,598,973	0.120756	0.120756	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	58,205,053	1,313,131	59,518,184	0.132131	0.132131	65.00
66.00	06600	PHYSICAL THERAPY	15,786,695	1,547,858	17,334,553	0.246774	0.246774	66.00
67.00	06700	OCCUPATIONAL THERAPY	12,140,735	587,865	12,728,600	0.168713	0.168713	67.00
68.00	06800	SPEECH PATHOLOGY	3,723,735	854,330	4,578,065	0.151860	0.151860	68.00
69.00	06900	ELECTROCARDIOLOGY	36,563,114	62,902,983	99,466,097	0.058879	0.058879	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,531,554	8,025,462	11,557,016	0.323266	0.323266	70.00
70.01	07001	SLEEP LAB	0	0	0	0.000000	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,435,333	12,265,950	29,701,283	1.233425	1.233425	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,556,710	18,987,409	43,544,119	0.728092	0.728092	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,768,978	78,686,379	102,455,357	0.716091	0.716091	73.00
76.97	07697	CARDIAC REHABILITATION	2,015	4,040,966	4,042,981	0.354783	0.354783	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	95,000	4,644,862	4,739,862	0.132902	0.132902	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0.000000	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	131,633	15,451,276	15,582,909	0.065413	0.065413	90.00
91.00	09100	EMERGENCY	140,905,583	267,504,572	408,410,155	0.096684	0.096684	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	365,100	315,600	680,700	0.166733	0.166733	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	21,805,490	42,968,315	64,773,805	0.084296	0.084296	92.01
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	1,907,821,111	977,437,586	2,885,258,697			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	1,907,821,111	977,437,586	2,885,258,697			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 31-0041

Period:
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Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	TEFRA
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT			34.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
52.01	03190	OP INFUSION	0.000000		52.01
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
70.01	07001	SLEEP LAB	0.000000		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000		78.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0.000000		92.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
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: 31-0041

Period:
From 01/01/2024
To 12/31/2024Worksheet C
Part II
Date/Time Prepared:
5/28/2025 10:36 am

			Title XIX			Hospital		TEFRA	
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	28,976,879	4,380,380	24,596,499	438,038	1,426,597	50.00	
51.00	05100	RECOVERY ROOM	3,512,939	228,631	3,284,308	22,863	190,490	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,528,436	712,285	7,816,151	71,229	453,337	52.00	
52.01	03190	OP INFUSION	3,848,992	335,427	3,513,565	33,543	203,787	52.01	
53.00	05300	ANESTHESIOLOGY	1,116,495	56,534	1,059,961	5,653	61,478	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,564,628	1,734,931	16,829,697	173,493	976,122	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	11,510,771	1,311,361	10,199,410	131,136	591,566	55.00	
56.00	05600	RADIOISOTOPE	2,161,777	93,348	2,068,429	9,335	119,969	56.00	
57.00	05700	CT SCAN	5,361,055	107,963	5,253,092	10,796	304,679	57.00	
58.00	05800	MRI	2,620,646	329,026	2,291,620	32,903	132,914	58.00	
59.00	05900	CARDIAC CATHETERIZATION	10,166,950	1,215,817	8,951,133	121,582	519,166	59.00	
60.00	06000	LABORATORY	26,518,002	1,141,105	25,376,897	114,111	1,471,860	60.00	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00	
65.00	06500	RESPIRATORY THERAPY	7,864,192	539,023	7,325,169	53,902	424,860	65.00	
66.00	06600	PHYSICAL THERAPY	4,277,721	256,509	4,021,212	25,651	233,230	66.00	
67.00	06700	OCCUPATIONAL THERAPY	2,147,483	39,659	2,107,824	3,966	122,254	67.00	
68.00	06800	SPEECH PATHOLOGY	695,224	36,267	658,957	3,627	38,220	68.00	
69.00	06900	ELECTROCARDIOLOGY	5,856,484	385,061	5,471,423	38,506	317,343	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	3,735,985	512,826	3,223,159	51,283	186,943	70.00	
70.01	07001	SLEEP LAB	33,884	3,169	30,715	317	1,781	70.01	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	36,634,307	1,143,314	35,490,993	114,331	2,058,478	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	31,704,126	942,876	30,761,250	94,288	1,784,153	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	73,367,350	1,322,417	72,044,933	132,242	4,178,606	73.00	
76.97	07697	CARDIAC REHABILITATION	1,434,382	104,364	1,330,018	10,436	77,141	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	629,936	89,406	540,530	8,941	31,351	76.98	
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00	
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,019,325	15,917	1,003,408	1,592	58,198	90.00	
91.00	09100	EMERGENCY	39,486,904	2,758,157	36,728,747	275,816	2,130,267	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	113,495	6,920	106,575	692	6,181	92.00	
92.01	09201	OBSERVATION BEDS-DISTINCT	5,460,194	110,866	5,349,328	11,087	310,261	92.01	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00	
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (sum of lines 50 thru 199)	337,348,562	19,913,559	317,435,003	1,991,359	18,411,232	200.00	
201.00		Less Observation Beds	113,495	6,920	106,575	692	6,181	201.00	
202.00		Total (line 200 minus line 201)	337,235,067	19,906,639	317,328,428	1,990,667	18,405,051	202.00	

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

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024Worksheet C
Part II
Date/Time Prepared:
5/28/2025 10:36 am

Cost Center Description			Title XIX		Hospital	TEFRA
			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	27,112,244	114,298,541	0.237206	50.00
51.00	05100	RECOVERY ROOM	3,299,586	20,750,848	0.159010	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,003,870	27,388,920	0.292230	52.00
52.01	03190	OP INFUSION	3,611,662	20,998,716	0.171994	52.01
53.00	05300	ANESTHESIOLOGY	1,049,364	24,519,295	0.042797	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,415,013	85,445,983	0.203813	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	10,788,069	91,684,406	0.117665	55.00
56.00	05600	RADIOISOTOPE	2,032,473	6,095,335	0.333447	56.00
57.00	05700	CT SCAN	5,045,580	144,706,698	0.034868	57.00
58.00	05800	MRI	2,454,829	38,427,605	0.063882	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,526,202	82,150,283	0.115961	59.00
60.00	06000	LABORATORY	24,932,031	219,598,973	0.113534	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	7,385,430	59,518,184	0.124087	65.00
66.00	06600	PHYSICAL THERAPY	4,018,840	17,334,553	0.231840	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,021,263	12,728,600	0.158797	67.00
68.00	06800	SPEECH PATHOLOGY	653,377	4,578,065	0.142719	68.00
69.00	06900	ELECTROCARDIOLOGY	5,500,635	99,466,097	0.055302	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,497,759	11,557,016	0.302652	70.00
70.01	07001	SLEEP LAB	31,786	0	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	34,461,498	29,701,283	1.160270	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	29,825,685	43,544,119	0.684953	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	69,056,502	102,455,357	0.674016	73.00
76.97	07697	CARDIAC REHABILITATION	1,346,805	4,042,981	0.333122	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	589,644	4,739,862	0.124401	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	959,535	15,582,909	0.061576	90.00
91.00	09100	EMERGENCY	37,080,821	408,410,155	0.090793	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	106,622	680,700	0.156636	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	5,138,846	64,773,805	0.079335	92.01
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0.000000	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0.000000	102.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (sum of lines 50 thru 199)	316,945,971	1,755,179,289		200.00
201.00		Less Observation Beds	106,622	0		201.00
202.00		Total (line 200 minus line 201)	316,839,349	1,755,179,289		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024Worksheet D
Part I
Date/Time Prepared:
5/28/2025 10:36 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	5,531,115	0	5,531,115	66,344	83.37	30.00
31.00	INTENSIVE CARE UNIT	3,261,140		3,261,140	45,965	70.95	31.00
34.00	SURGICAL INTENSIVE CARE UNIT	299,590		299,590	3,574	83.82	34.00
43.00	NURSERY	306,445		306,445	4,236	72.34	43.00
44.00	SKILLED NURSING FACILITY	438,225		438,225	6,859	63.89	44.00
200.00	Total (lines 30 through 199)	9,836,515		9,836,515	126,978		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	45,608	3,802,339				30.00
31.00	INTENSIVE CARE UNIT	2,907	206,252				31.00
34.00	SURGICAL INTENSIVE CARE UNIT	1,556	130,424				34.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	4,056	259,138				44.00
200.00	Total (lines 30 through 199)	54,127	4,398,153				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024Worksheet D
Part II
Date/Time Prepared:
5/28/2025 10:36 am

Cost Center Description		Title XVIII			Hospital		PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,380,380	114,298,541	0.038324	21,505,566	824,179	50.00
51.00	05100	RECOVERY ROOM	228,631	20,750,848	0.011018	3,564,718	39,276	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	712,285	27,388,920	0.026006	51,923	1,350	52.00
52.01	03190	OP INFUSION	335,427	20,998,716	0.015974	40,327	644	52.01
53.00	05300	ANESTHESIOLOGY	56,534	24,519,295	0.002306	4,151,116	9,572	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,734,931	85,445,983	0.020304	15,280,323	310,252	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,311,361	91,684,406	0.014303	1,447,256	20,700	55.00
56.00	05600	RADIOISOTOPE	93,348	6,095,335	0.015315	1,088,570	16,671	56.00
57.00	05700	CT SCAN	107,963	144,706,698	0.000746	32,605,101	24,323	57.00
58.00	05800	MRI	329,026	38,427,605	0.008562	8,847,870	75,755	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,215,817	82,150,283	0.014800	15,110,134	223,630	59.00
60.00	06000	LABORATORY	1,141,105	219,598,973	0.005196	56,754,741	294,898	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	539,023	59,518,184	0.009056	26,746,273	242,214	65.00
66.00	06600	PHYSICAL THERAPY	256,509	17,334,553	0.014798	7,398,938	109,489	66.00
67.00	06700	OCCUPATIONAL THERAPY	39,659	12,728,600	0.003116	5,329,227	16,606	67.00
68.00	06800	SPEECH PATHOLOGY	36,267	4,578,065	0.007922	1,832,439	14,517	68.00
69.00	06900	ELECTROCARDIOLOGY	385,061	99,466,097	0.003871	15,986,046	61,882	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	512,826	11,557,016	0.044374	1,332,892	59,146	70.00
70.01	07001	SLEEP LAB	3,169	0	0.000000	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,143,314	29,701,283	0.038494	6,710,528	258,315	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	942,876	43,544,119	0.021653	10,087,369	218,422	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,322,417	102,455,357	0.012907	11,356,741	146,581	73.00
76.97	07697	CARDIAC REHABILITATION	104,364	4,042,981	0.025814	1,137	29	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	89,406	4,739,862	0.018863	5,288	100	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	15,917	15,582,909	0.001021	126,399	129	90.00
91.00	09100	EMERGENCY	2,758,157	408,410,155	0.006753	58,733,924	396,630	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,920	680,700	0.010166	111,754	1,136	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	110,866	64,773,805	0.001712	8,461,581	14,486	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	19,913,559	1,755,179,289		314,668,181	3,380,932	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 31-0041		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part III Date/Time Prepared: 5/28/2025 10:36 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	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	0	31.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	0	0	34.00	
43.00	04300	NURSERY	0	0	0	0	0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	0	44.00	
200.00		Total (lines 30 through 199)	0	0	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	66,344	0.00	45,608	30.00			
31.00	03100	INTENSIVE CARE UNIT	0	0	45,965	0.00	2,907	31.00			
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	3,574	0.00	1,556	34.00			
43.00	04300	NURSERY	0	0	4,236	0.00	0	43.00			
44.00	04400	SKILLED NURSING FACILITY	0	0	6,859	0.00	4,056	44.00			
200.00		Total (lines 30 through 199)	0	0	126,978		54,127	200.00			
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
	INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0						30.00		
31.00	03100	INTENSIVE CARE UNIT	0						31.00		
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0						34.00		
43.00	04300	NURSERY	0						43.00		
44.00	04400	SKILLED NURSING FACILITY	0						44.00		
200.00		Total (lines 30 through 199)	0						200.00		

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024Worksheet D
Part IV
Date/Time Prepared:
5/28/2025 10:36 am

			Title XVIII			Hospital	PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	03190	OP INFUSION	0	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	SLEEP LAB	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	214,388	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0	0	0	0	0	92.01
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	0	0	0	0	214,388	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024Worksheet D
Part IV
Date/Time Prepared:
5/28/2025 10:36 am

Cost Center Description		Title XVIII			Hospital		PPS	
		All Other Medical Education Cost	Total Cost (sum of col. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	114,298,541	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	20,750,848	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	27,388,920	0.000000	52.00
52.01	03190	OP INFUSION	0	0	0	20,998,716	0.000000	52.01
53.00	05300	ANESTHESIOLOGY	0	0	0	24,519,295	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	85,445,983	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	91,684,406	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	6,095,335	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	144,706,698	0.000000	57.00
58.00	05800	MRI	0	0	0	38,427,605	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	82,150,283	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	219,598,973	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	59,518,184	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	17,334,553	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	12,728,600	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	4,578,065	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	99,466,097	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	11,557,016	0.000000	70.00
70.01	07001	SLEEP LAB	0	0	0	0	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	29,701,283	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	43,544,119	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	214,388	214,388	102,455,357	0.002093	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	4,042,981	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	4,739,862	0.000000	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	15,582,909	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	408,410,155	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	680,700	0.000000	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0	0	0	64,773,805	0.000000	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0.000000	95.00
200.00		Total (lines 50 through 199)	0	214,388	214,388	1,755,179,289		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 31-0041		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part IV Date/Time Prepared: 5/28/2025 10:36 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	21,505,566	0	15,943,618	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	3,564,718	0	2,978,600	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	51,923	0	7,272	0	52.00
52.01	03190	OP INFUSION		0.000000	40,327	0	7,524,455	0	52.01
53.00	05300	ANESTHESIOLOGY		0.000000	4,151,116	0	3,084,204	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	15,280,323	0	9,984,463	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	1,447,256	0	34,760,876	0	55.00
56.00	05600	RADIOISOTOPE		0.000000	1,088,570	0	1,050,871	0	56.00
57.00	05700	CT SCAN		0.000000	32,605,101	0	20,389,223	0	57.00
58.00	05800	MRI		0.000000	8,847,870	0	4,362,672	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	15,110,134	0	16,598,802	0	59.00
60.00	06000	LABORATORY		0.000000	56,754,741	0	14,148,660	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY		0.000000	26,746,273	0	446,381	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	7,398,938	0	150,700	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	5,329,227	0	39,617	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	1,832,439	0	6,671	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	15,986,046	0	22,779,257	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	1,332,892	0	2,104,379	0	70.00
70.01	07001	SLEEP LAB		0.000000	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	6,710,528	0	3,833,760	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	10,087,369	0	7,209,480	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.002093	11,356,741	23,770	34,398,049	71,995	73.00
76.97	07697	CARDIAC REHABILITATION		0.000000	1,137	0	1,742,775	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0.000000	5,288	0	2,369,430	0	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION		0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY		0.000000	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	126,399	0	8,954,636	0	90.00
91.00	09100	EMERGENCY		0.000000	58,733,924	0	54,402,016	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	111,754	0	158,670	0	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT		0.000000	8,461,581	0	15,102,638	0	92.01
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)			314,668,181	23,770	284,532,175	71,995	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024Worksheet D
Part V
Date/Time Prepared:
5/28/2025 10:36 am

			Title XVIII		Hospital		PPS	
	Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00			
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.253519	15,943,618	0	0	4,042,010	50.00
51.00	05100	RECOVERY ROOM	0.169291	2,978,600	0	0	504,250	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.311383	7,272	0	0	2,264	52.00
52.01	03190	OP INFUSION	0.183297	7,524,455	0	0	1,379,210	52.01
53.00	05300	ANESTHESIOLOGY	0.045535	3,084,204	0	0	140,439	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.217267	9,984,463	0	0	2,169,294	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.125548	34,760,876	0	0	4,364,158	55.00
56.00	05600	RADIOISOTOPE	0.354661	1,050,871	0	0	372,703	56.00
57.00	05700	CT SCAN	0.037048	20,389,223	0	0	755,380	57.00
58.00	05800	MRI	0.068197	4,362,672	0	0	297,521	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.123760	16,598,802	0	0	2,054,268	59.00
60.00	06000	LABORATORY	0.120756	14,148,660	0	0	1,708,536	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.132131	446,381	0	0	58,981	65.00
66.00	06600	PHYSICAL THERAPY	0.246774	150,700	0	0	37,189	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.168713	39,617	0	0	6,684	67.00
68.00	06800	SPEECH PATHOLOGY	0.151860	6,671	0	0	1,013	68.00
69.00	06900	ELECTROCARDIOLOGY	0.058879	22,779,257	0	0	1,341,220	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.323266	2,104,379	0	0	680,274	70.00
70.01	07001	SLEEP LAB	0.000000	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.233425	3,833,760	0	0	4,728,655	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.728092	7,209,480	0	0	5,249,165	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.716091	34,398,049	0	25,937	24,632,133	73.00
76.97	07697	CARDIAC REHABILITATION	0.354783	1,742,775	0	0	618,307	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.132902	2,369,430	0	0	314,902	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.065413	8,954,636	0	228	585,750	90.00
91.00	09100	EMERGENCY	0.096684	54,402,016	0	0	5,259,805	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.166733	158,670	0	0	26,456	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0.084296	15,102,638	0	0	1,273,092	92.01
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		284,532,175	0	26,165	62,603,659	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		284,532,175	0	26,165	62,603,659	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024Worksheet D
Part V
Date/Time Prepared:
5/28/2025 10:36 am

			Title XVIII		Hospital		PPS	
	Cost Center Description		Costs					
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
			6.00	7.00				
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0			50.00	
51.00	05100	RECOVERY ROOM	0	0			51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0			52.00	
52.01	03190	OP INFUSION	0	0			52.01	
53.00	05300	ANESTHESIOLOGY	0	0			53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0			54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0			55.00	
56.00	05600	RADIOISOTOPE	0	0			56.00	
57.00	05700	CT SCAN	0	0			57.00	
58.00	05800	MRI	0	0			58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0			59.00	
60.00	06000	LABORATORY	0	0			60.00	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0			63.00	
65.00	06500	RESPIRATORY THERAPY	0	0			65.00	
66.00	06600	PHYSICAL THERAPY	0	0			66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0			67.00	
68.00	06800	SPEECH PATHOLOGY	0	0			68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0			69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0			70.00	
70.01	07001	SLEEP LAB	0	0			70.01	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	18,573			73.00	
76.97	07697	CARDIAC REHABILITATION	0	0			76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0			76.98	
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0			77.00	
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0			78.00	
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	15			90.00	
91.00	09100	EMERGENCY	0	0			91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0			92.00	
92.01	09201	OBSERVATION BEDS-DISTINCT	0	0			92.01	
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0				95.00	
200.00		Subtotal (see instructions)	0	18,588			200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0				201.00	
202.00		Net Charges (line 200 - line 201)	0	18,588			202.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 31-0041 Component CCN: 31-5490		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part IV Date/Time Prepared: 5/28/2025 10:36 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
52.01	03190	OP INFUSION		0	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0	0	0	0	0	63.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
70.01	07001	SLEEP LAB		0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	214,388	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION		0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY		0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT		0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES		0	0	0	0	0	95.00
200.00		Total (lines 50 through 199)		0	0	0	0	214,388	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 31-0041 Component CCN: 31-5490		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part IV Date/Time Prepared: 5/28/2025 10:36 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of col.s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col.s. 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	114,298,541	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	20,750,848	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	27,388,920	0.000000	52.00
52.01	03190	OP INFUSION		0	0	0	20,998,716	0.000000	52.01
53.00	05300	ANESTHESIOLOGY		0	0	0	24,519,295	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	85,445,983	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	91,684,406	0.000000	55.00
56.00	05600	RADIOISOTOPE		0	0	0	6,095,335	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	144,706,698	0.000000	57.00
58.00	05800	MRI		0	0	0	38,427,605	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	82,150,283	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	219,598,973	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0	0	0	0	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	59,518,184	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	17,334,553	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	12,728,600	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	4,578,065	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	99,466,097	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	11,557,016	0.000000	70.00
70.01	07001	SLEEP LAB		0	0	0	0	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	29,701,283	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	43,544,119	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	214,388	214,388	102,455,357	0.002093	73.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	4,042,981	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	4,739,862	0.000000	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION		0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY		0	0	0	0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	15,582,909	0.000000	90.00
91.00	09100	EMERGENCY		0	0	0	408,410,155	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	680,700	0.000000	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT		0	0	0	64,773,805	0.000000	92.01
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES		0	214,388	214,388	1,755,179,289		95.00
200.00		Total (lines 50 through 199)		0	214,388	214,388	1,755,179,289		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 31-0041 Component CCN: 31-5490	Period: From 01/01/2024 To 12/31/2024	Worksheet D Part IV Date/Time Prepared: 5/28/2025 10:36 am	
				Title XVIII	Skilled Nursing Facility	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	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
52.01	03190	OP INFUSION	0.000000	6,002	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	65,204	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	2,390	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	905,545	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	89,188	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	10,142	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	134,250	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	22,617	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	15,101	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	2,283	0	0	70.00
70.01	07001	SLEEP LAB	0.000000	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,331	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.002093	229,805	481	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0.000000	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)		1,483,858	481	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024Worksheet D
Part I
Date/Time Prepared:
5/28/2025 10:36 am

			Title XIX		Hospital	TEFRA		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	5,531,115	0	5,531,115	66,344	83.37	30.00	
31.00	INTENSIVE CARE UNIT	3,261,140		3,261,140	45,965	70.95	31.00	
34.00	SURGICAL INTENSIVE CARE UNIT	299,590		299,590	3,574	83.82	34.00	
43.00	NURSERY	306,445		306,445	4,236	72.34	43.00	
44.00	SKILLED NURSING FACILITY	438,225		438,225	6,859	63.89	44.00	
200.00	Total (lines 30 through 199)	9,836,515		9,836,515	126,978		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,198	99,877					30.00
31.00	INTENSIVE CARE UNIT	975	69,176					31.00
34.00	SURGICAL INTENSIVE CARE UNIT	0	0					34.00
43.00	NURSERY	2,116	153,071					43.00
44.00	SKILLED NURSING FACILITY	0	0					44.00
200.00	Total (lines 30 through 199)	4,289	322,124					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024Worksheet D
Part II
Date/Time Prepared:
5/28/2025 10:36 am

Cost Center Description		Title XIX		Hospital		TEFRA	
		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	4,380,380	114,298,541	0.038324	791,699	30,341 50.00
51.00	05100	RECOVERY ROOM	228,631	20,750,848	0.011018	143,194	1,578 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	712,285	27,388,920	0.026006	461,875	12,012 52.00
52.01	03190	OP INFUSION	335,427	20,998,716	0.015974	0	0 52.01
53.00	05300	ANESTHESIOLOGY	56,534	24,519,295	0.002306	241,694	557 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,734,931	85,445,983	0.020304	581,768	11,812 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,311,361	91,684,406	0.014303	66,342	949 55.00
56.00	05600	RADIOISOTOPE	93,348	6,095,335	0.015315	66,777	1,023 56.00
57.00	05700	CT SCAN	107,963	144,706,698	0.000746	1,469,803	1,096 57.00
58.00	05800	MRI	329,026	38,427,605	0.008562	561,229	4,805 58.00
59.00	05900	CARDIAC CATHETERIZATION	1,215,817	82,150,283	0.014800	800,905	11,853 59.00
60.00	06000	LABORATORY	1,141,105	219,598,973	0.005196	2,764,780	14,366 60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0 63.00
65.00	06500	RESPIRATORY THERAPY	539,023	59,518,184	0.009056	1,162,848	10,531 65.00
66.00	06600	PHYSICAL THERAPY	256,509	17,334,553	0.014798	177,953	2,633 66.00
67.00	06700	OCCUPATIONAL THERAPY	39,659	12,728,600	0.003116	132,098	412 67.00
68.00	06800	SPEECH PATHOLOGY	36,267	4,578,065	0.007922	76,656	607 68.00
69.00	06900	ELECTROCARDIOLOGY	385,061	99,466,097	0.003871	659,156	2,552 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	512,826	11,557,016	0.044374	100,913	4,478 70.00
70.01	07001	SLEEP LAB	3,169	0	0.000000	0	0 70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,143,314	29,701,283	0.038494	179,088	6,894 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	942,876	43,544,119	0.021653	141,436	3,063 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,322,417	102,455,357	0.012907	776,223	10,019 73.00
76.97	07697	CARDIAC REHABILITATION	104,364	4,042,981	0.025814	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	89,406	4,739,862	0.018863	0	0 76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000	0	0 77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0 78.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	15,917	15,582,909	0.001021	1,710	2 90.00
91.00	09100	EMERGENCY	2,758,157	408,410,155	0.006753	1,995,590	13,476 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,920	680,700	0.010166	0	0 92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	110,866	64,773,805	0.001712	205,262	351 92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)	19,913,559	1,755,179,289		13,558,999	145,410 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provi der CCN: 31-0041		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part III Date/Time Prepared: 5/28/2025 10:36 am	
					Ti tle XIX		Hospi tal		TEFRA	
Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1. 00	2A	2. 00	3. 00			
	INPATIENT ROUTINE SERVICE COST CENTERS									
30. 00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30. 00		
31. 00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31. 00		
34. 00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34. 00		
43. 00	04300	NURSERY	0	0	0	0	0	43. 00		
44. 00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44. 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	66,344	0. 00	1,198	30. 00		
31. 00	03100	INTENSIVE CARE UNIT		0	45,965	0. 00	975	31. 00		
34. 00	03400	SURGICAL INTENSIVE CARE UNIT		0	3,574	0. 00	0	34. 00		
43. 00	04300	NURSERY		0	4,236	0. 00	2,116	43. 00		
44. 00	04400	SKILLED NURSING FACILITY		0	6,859	0. 00	0	44. 00		
200. 00		Total (lines 30 through 199)		0	126,978		4,289	200. 00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)							
			9. 00							
	INPATIENT ROUTINE SERVICE COST CENTERS									
30. 00	03000	ADULTS & PEDIATRICS	0						30. 00	
31. 00	03100	INTENSIVE CARE UNIT	0						31. 00	
34. 00	03400	SURGICAL INTENSIVE CARE UNIT	0						34. 00	
43. 00	04300	NURSERY	0						43. 00	
44. 00	04400	SKILLED NURSING FACILITY	0						44. 00	
200. 00		Total (lines 30 through 199)	0						200. 00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 31-0041		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part IV Date/Time Prepared: 5/28/2025 10:36 am	
				Title XIX		Hospital		TEFRA	
Cost Center Description				Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
52.01	03190	OP INFUSION		0	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0	0	0	0	0	63.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
70.01	07001	SLEEP LAB		0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	214,388	73.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION		0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY		0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT		0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES		0	0	0	0	0	95.00
200.00		Total (lines 50 through 199)		0	0	0	0	214,388	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024Worksheet D
Part IV
Date/Time Prepared:
5/28/2025 10:36 am

				Title XIX		Hospital	TEFRA	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of col.s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col.s. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	114,298,541	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	20,750,848	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	27,388,920	0.000000	52.00
52.01	03190	OP INFUSION	0	0	0	20,998,716	0.000000	52.01
53.00	05300	ANESTHESIOLOGY	0	0	0	24,519,295	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	85,445,983	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	91,684,406	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	6,095,335	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	144,706,698	0.000000	57.00
58.00	05800	MRI	0	0	0	38,427,605	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	82,150,283	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	219,598,973	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	59,518,184	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	17,334,553	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	12,728,600	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	4,578,065	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	99,466,097	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	11,557,016	0.000000	70.00
70.01	07001	SLEEP LAB	0	0	0	0	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	29,701,283	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	43,544,119	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	214,388	214,388	102,455,357	0.002093	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	4,042,981	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	4,739,862	0.000000	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	15,582,909	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	408,410,155	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	680,700	0.000000	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0	0	0	64,773,805	0.000000	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0.000000	95.00
200.00		Total (lines 50 through 199)	0	214,388	214,388	1,755,179,289		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 31-0041		Period: From 01/01/2024 To 12/31/2024		Worksheet D Part IV Date/Time Prepared: 5/28/2025 10:36 am	
				Title XIX		Hospital		TEFRA	
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	791,699	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	143,194	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	461,875	0	0	0	52.00
52.01	03190	OP INFUSION		0.000000	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY		0.000000	241,694	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	581,768	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	66,342	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0.000000	66,777	0	0	0	56.00
57.00	05700	CT SCAN		0.000000	1,469,803	0	0	0	57.00
58.00	05800	MRI		0.000000	561,229	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	800,905	0	0	0	59.00
60.00	06000	LABORATORY		0.000000	2,764,780	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY		0.000000	1,162,848	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	177,953	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	132,098	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	76,656	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	659,156	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	100,913	0	0	0	70.00
70.01	07001	SLEEP LAB		0.000000	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	179,088	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	141,436	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.002093	776,223	1,625	0	0	73.00
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0.000000	0	0	0	0	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION		0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY		0.000000	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	1,710	0	0	0	90.00
91.00	09100	EMERGENCY		0.000000	1,995,590	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT		0.000000	205,262	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)			13,558,999	1,625	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024Worksheet D
Part V
Date/Time Prepared:
5/28/2025 10:36 am

			Title XIX		Hospital		TEFRA	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.237206	0	0	111,562	0	50.00
51.00	05100	RECOVERY ROOM	0.159010	0	0	34,096	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.292230	0	0	717,084	0	52.00
52.01	03190	OP INFUSION	0.171994	0	0	51,363	0	52.01
53.00	05300	ANESTHESIOLOGY	0.042797	0	0	26,453	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.203813	0	0	585,346	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.117665	0	0	245,047	0	55.00
56.00	05600	RADIOISOTOPE	0.333447	0	0	10,066	0	56.00
57.00	05700	CT SCAN	0.034868	0	0	1,015,553	0	57.00
58.00	05800	MRI	0.063882	0	0	128,267	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.115961	0	0	0	0	59.00
60.00	06000	LABORATORY	0.113534	0	0	2,179	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.124087	0	0	3,291	0	65.00
66.00	06600	PHYSICAL THERAPY	0.231840	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.158797	0	0	456	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.142719	0	0	3,999	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.055302	0	0	156,532	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.302652	0	0	10,444	0	70.00
70.01	07001	SLEEP LAB	0.000000	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.160270	0	0	7,374	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.684953	0	0	9,774	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.674016	0	0	138,638	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.333122	0	0	39	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.124401	0	0	0	0	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.061576	0	0	59,115	0	90.00
91.00	09100	EMERGENCY	0.090793	0	0	7,829,926	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.156636	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0.079335	0	0	856,332	0	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.000000	0	0	0	0	95.00
200.00		Subtotal (see instructions)		0	0	12,002,936	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	12,002,936	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024Worksheet D
Part V
Date/Time Prepared:
5/28/2025 10:36 am

			Title XIX		Hospital	TEFRA
	Cost Center Description	Costs				
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		6.00	7.00			
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	26,463		50.00
51.00	05100	RECOVERY ROOM	0	5,422		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	209,553		52.00
52.01	03190	OP INFUSION	0	8,834		52.01
53.00	05300	ANESTHESIOLOGY	0	1,132		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	119,301		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	28,833		55.00
56.00	05600	RADIOISOTOPE	0	3,356		56.00
57.00	05700	CT SCAN	0	35,410		57.00
58.00	05800	MRI	0	8,194		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	247		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	408		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	72		67.00
68.00	06800	SPEECH PATHOLOGY	0	571		68.00
69.00	06900	ELECTROCARDIOLOGY	0	8,657		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,161		70.00
70.01	07001	SLEEP LAB	0	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	8,556		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,695		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	93,444		73.00
76.97	07697	CARDIAC REHABILITATION	0	13		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	3,640		90.00
91.00	09100	EMERGENCY	0	710,902		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0	67,937		92.01
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	1,350,801		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	1,350,801		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 31-0041	Period: From 01/01/2024 To 12/31/2024	Worksheet D-1 Date/Time Prepared: 5/28/2025 10:36 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)		66,344	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		66,344	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)		66,261	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)		45,608	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)		90,719,689	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)		90,719,689	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)		90,719,689	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)		1,367.41	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		62,364,835	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)		62,364,835	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024

Worksheet D-1

Date/Time Prepared:

5/28/2025 10:36 am

Cost Center Description		Title XVIII			Hospital		PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
	Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	58,399,995	45,965	1,270.53	2,907	3,693,431		43.00
44.00	CORONARY CARE UNIT							44.00
45.00	BURN INTENSIVE CARE UNIT							45.00
46.00	SURGICAL INTENSIVE CARE UNIT	7,068,908	3,574	1,977.87	1,556	3,077,566		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)					58,777,236		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)					127,913,068		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)					4,139,015		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					3,404,702		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					7,543,717		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					120,369,351		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0		54.00
55.00	Target amount per discharge					0.00		55.00
55.01	Permanent adjustment amount per discharge					0.00		55.01
55.02	Adjustment amount per discharge (contractor use only)					0.00		55.02
55.03	CAR T-cell amount paid as an interim payment					0		55.03
56.00	Target amount ((line 54 x sum of lines 55, 55.01, and 55.02) plus line 55.03)					0		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00	Bonus payment (see instructions)					0		58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00		59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00		60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0		61.00
62.00	Relief payment (see instructions)					0		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					0		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00	Program capital-related costs (line 9 x line 76)							77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)						83	87.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 31-0041		Period: From 01/01/2024 To 12/31/2024		Worksheet D-1 Date/Time Prepared: 5/28/2025 10:36 am	
				Title XVIII		Hospital		PPS	
Cost Center Description								1.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)							1,367.41	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)							113,495	89.00
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)			
		1.00	2.00	3.00	4.00	5.00			
COMPUTATION OF OBSERVATION BED PASS THROUGH COST									
90.00	Capital-related cost	5,531,115	90,719,689	0.060969	113,495	6,920	90.00		
91.00	Nursing Program cost	0	90,719,689	0.000000	113,495	0	91.00		
92.00	Allied health cost	0	90,719,689	0.000000	113,495	0	92.00		
93.00	All other Medical Education	0	90,719,689	0.000000	113,495	0	93.00		

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 31-0041 Component CCN: 31-5490	Period: From 01/01/2024 To 12/31/2024	Worksheet D-1 Date/Time Prepared: 5/28/2025 10:36 am
		Title XVIII	Skilled Nursing Facility	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)		6,859	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,859	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)		6,859	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		4,056	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)		8,587,342	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)		8,587,342	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)		8,587,342	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)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 31-0041	Period: From 01/01/2024 To 12/31/2024	Worksheet D-1	
				Component CCN: 31-5490		Date/Time Prepared: 5/28/2025 10:36 am	
				Title XVIII	Skilled Nursing Facility	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)						48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)						48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)						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)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
55.01	Permanent adjustment amount per discharge						55.01
55.02	Adjustment amount per discharge (contractor use only)						55.02
55.03	CAR T-cell amount paid as an interim payment						55.03
56.00	Target amount ((line 54 x sum of lines 55, 55.01, and 55.02) plus line 55.03)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						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)						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)						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)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						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)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions						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)						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)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						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)					8,587,342	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					1,251.98	71.00
72.00	Program routine service cost (line 9 x line 71)					5,078,031	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					5,078,031	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)					0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00	Inpatient routine service cost per diem limitation					0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)					5,078,031	83.00
84.00	Program inpatient ancillary services (see instructions)					333,670	84.00
85.00	Utilization review - physician compensation (see instructions)					0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					5,411,701	86.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 31-0041 Component CCN: 31-5490		Period: From 01/01/2024 To 12/31/2024		Worksheet D-1 Date/Time Prepared: 5/28/2025 10:36 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description								1.00	
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
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	0	0	0.000000	0	0			
91.00	Nursing Program cost	0	0	0.000000	0	0			
92.00	Allied health cost	0	0	0.000000	0	0			
93.00	All other Medical Education	0	0	0.000000	0	0			

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 31-0041	Period: From 01/01/2024 To 12/31/2024	Worksheet D-1 Date/Time Prepared: 5/28/2025 10:36 am
		Title XIX	Hospital	TEFRA
Cost Center Description				
PART I - ALL PROVIDER COMPONENTS				1.00
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		66,344	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		66,344	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)		66,261	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,198	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)		4,236	15.00
16.00	Nursery days (title V or XIX only)		2,116	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)		90,719,678	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)		90,719,678	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)		90,719,678	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)		1,367.41	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,638,157	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,638,157	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024

Worksheet D-1

Date/Time Prepared:

5/28/2025 10:36 am

Cost Center Description		Title XIX		Hospital		TEFRA	
		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)	6,031,369	4,236	1,423.84	2,116	3,012,845	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	58,399,995	45,965	1,270.53	975	1,238,767	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT	7,068,908	3,574	1,977.87	0	0	46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,456,895	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					8,346,664	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)					322,124	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					147,035	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					469,159	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					7,877,505	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					527	54.00
55.00	Target amount per discharge					4,731.79	55.00
55.01	Permanent adjustment amount per discharge					0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)					0.00	55.02
55.03	CAR T-cell amount paid as an interim payment					0	55.03
56.00	Target amount ((line 54 x sum of lines 55, 55.01, and 55.02) plus line 55.03)					2,493,653	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					-5,383,852	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)					249,365	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					3,212,177	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)					83	87.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 31-0041	Period: From 01/01/2024 To 12/31/2024	Worksheet D-1 Date/Time Prepared: 5/28/2025 10:36 am			
				Title XIX		Hospital		TEFRA	
Cost Center Description								1.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)							1,367.41	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)							113,495	89.00
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)			
		1.00	2.00	3.00	4.00	5.00			
COMPUTATION OF OBSERVATION BED PASS THROUGH COST									
90.00	Capital-related cost	5,531,115	90,719,678	0.060969	113,495	6,920		90.00	
91.00	Nursing Program cost	0	90,719,678	0.000000	113,495	0		91.00	
92.00	Allied health cost	0	90,719,678	0.000000	113,495	0		92.00	
93.00	All other Medical Education	0	90,719,678	0.000000	113,495	0		93.00	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 31-0041	Period: From 01/01/2024 To 12/31/2024	Worksheet D-3 Date/Time Prepared: 5/28/2025 10:36 am	
Cost Center Description		Title XVIII	Hospital	PPS	
		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		237,681,268	30.00
31.00	03100	INTENSIVE CARE UNIT		214,996,644	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		20,453,045	34.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.253519	21,505,566	50.00
51.00	05100	RECOVERY ROOM	0.169291	3,564,718	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.311383	51,923	52.00
52.01	03190	OP INFUSION	0.183297	40,327	52.01
53.00	05300	ANESTHESIOLOGY	0.045536	4,151,116	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.217268	15,280,323	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.125548	1,447,256	55.00
56.00	05600	RADIOISOTOPE	0.354661	1,088,570	56.00
57.00	05700	CT SCAN	0.037048	32,605,101	57.00
58.00	05800	MRI	0.068197	8,847,870	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.123760	15,110,134	59.00
60.00	06000	LABORATORY	0.120756	56,754,741	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.132131	26,746,273	65.00
66.00	06600	PHYSICAL THERAPY	0.246774	7,398,938	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.168713	5,329,227	67.00
68.00	06800	SPEECH PATHOLOGY	0.151860	1,832,439	68.00
69.00	06900	ELECTROCARDIOLOGY	0.059087	15,986,046	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.323266	1,332,892	70.00
70.01	07001	SLEEP LAB	0.000000	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.233425	6,710,528	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.728092	10,087,369	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.716091	11,356,741	73.00
76.97	07697	CARDIAC REHABILITATION	0.354783	1,137	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.132902	5,288	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	78.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.065413	126,399	90.00
91.00	09100	EMERGENCY	0.096684	58,733,924	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.166733	111,754	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0.084296	8,461,581	92.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		314,668,181	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)		314,668,181	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 31-0041 Component CCN: 31-5490	Period: From 01/01/2024 To 12/31/2024	Worksheet D-3 Date/Time Prepared: 5/28/2025 10:36 am	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT				34.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.253519	0	0	50.00
51.00	05100 RECOVERY ROOM	0.169291	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.311383	0	0	52.00
52.01	03190 OP INFUSION	0.183297	6,002	1,100	52.01
53.00	05300 ANESTHESIOLOGY	0.045536	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.217268	65,204	14,167	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.125548	0	0	55.00
56.00	05600 RADIOISOTOPE	0.354661	2,390	848	56.00
57.00	05700 CT SCAN	0.037048	0	0	57.00
58.00	05800 MRI	0.068197	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.123760	0	0	59.00
60.00	06000 LABORATORY	0.120756	905,545	109,350	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.132131	89,188	11,784	65.00
66.00	06600 PHYSICAL THERAPY	0.246774	10,142	2,503	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.168713	134,250	22,650	67.00
68.00	06800 SPEECH PATHOLOGY	0.151860	22,617	3,435	68.00
69.00	06900 ELECTROCARDIOLOGY	0.059087	15,101	892	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.323266	2,283	738	70.00
70.01	07001 SLEEP LAB	0.000000	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.233425	1,331	1,642	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.728092	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.716091	229,805	164,561	73.00
76.97	07697 CARDIAC REHABILITATION	0.354783	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.132902	0	0	76.98
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.065413	0	0	90.00
91.00	09100 EMERGENCY	0.096684	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.166733	0	0	92.00
92.01	09201 OBSERVATION BEDS-DISTINCT	0.084296	0	0	92.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,483,858	333,670	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)		1,483,858		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 31-0041	Period: From 01/01/2024 To 12/31/2024	Worksheet D-3 Date/Time Prepared: 5/28/2025 10:36 am	
Cost Center Description		Title XIX	Hospital	TEFRA	
		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		9,689,570	30.00
31.00	03100	INTENSIVE CARE UNIT		10,772,547	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		23,147	34.00
43.00	04300	NURSERY		1,140,487	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.253519	791,699	50.00
51.00	05100	RECOVERY ROOM	0.169291	143,194	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.311383	461,875	52.00
52.01	03190	OP INFUSION	0.183297	0	52.01
53.00	05300	ANESTHESIOLOGY	0.045535	241,694	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.217267	581,768	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.125548	66,342	55.00
56.00	05600	RADIOISOTOPE	0.354661	66,777	56.00
57.00	05700	CT SCAN	0.037048	1,469,803	57.00
58.00	05800	MRI	0.068197	561,229	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.123760	800,905	59.00
60.00	06000	LABORATORY	0.120756	2,764,780	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.132131	1,162,848	65.00
66.00	06600	PHYSICAL THERAPY	0.246774	177,953	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.168713	132,098	67.00
68.00	06800	SPEECH PATHOLOGY	0.151860	76,656	68.00
69.00	06900	ELECTROCARDIOLOGY	0.058879	659,156	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.323266	100,913	70.00
70.01	07001	SLEEP LAB	0.000000	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.233425	179,088	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.728092	141,436	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.716091	776,223	73.00
76.97	07697	CARDIAC REHABILITATION	0.354783	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.132902	0	76.98
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	78.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.065413	1,710	90.00
91.00	09100	EMERGENCY	0.096684	1,995,590	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.166733	0	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0.084296	205,262	92.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		13,558,999	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)		13,558,999	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 31-0041	Period: From 01/01/2024 To 12/31/2024	Worksheet E Part A Date/Time Prepared: 5/28/2025 10:36 am
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		73,369,057	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		24,223,350	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		369,805	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		5,687	2.04
3.00	Managed Care Simulated Payments		72,815,118	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		429.77	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
5.01	FTE cap adjustment for qualifying hospitals under §131 of the CAA 2021 (see instructions)		0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)		0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)		0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)		0.00	8.21
8.28	The amount of increase if the hospital was awarded FTE cap slots under §4122 of the CAA 2023 (see instructions)			8.28
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.28 (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		8.47	11.00
12.00	Current year allowable FTE (see instructions)		8.47	12.00
13.00	Total allowable FTE count for the prior year.		7.11	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		4.43	14.00
15.00	Sum of lines 12 through 14 divided by 3.		6.67	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)		84.54	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		91.21	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.212230	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.224094	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.212230	21.00
22.00	IME payment adjustment (see instructions)		10,680,318	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		7,968,741	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		10,680,318	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		7,968,741	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		1.62	30.00
31.00	Percentage of Medicaid patient days (see instructions)		12.27	31.00
32.00	Sum of lines 30 and 31		13.89	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 31-0041	Period: From 01/01/2024 To 12/31/2024	Worksheet E Part A Date/Time Prepared: 5/28/2025 10:36 am	
		Title XVIII	Hospital	PPS	
			1.00		
33.00	Allowable disproportionate share percentage (see instructions)		0.00		33.00
34.00	Disproportionate share adjustment (see instructions)		0		34.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
	Uncompensated Care Payment Adjustment				
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)		0.000000000	0.000000000	35.01
35.02	Hospital UCP, including supplemental UCP (see instructions)		0	0	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)		0	0	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)		0		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		108,648,217		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)		116,616,958		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		8,405,393		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		6,395,745		52.00
53.00	Nursing and Allied Health Managed Care payment		78,594		53.00
54.00	Special add-on payments for new technologies		11,372		54.00
54.01	Islet isolation add-on payment		0		54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
55.01	Cellular therapy acquisition cost (see instructions)		0		55.01
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		23,770		58.00
59.00	Total (sum of amounts on lines 49 through 58)		131,531,832		59.00
60.00	Primary payer payments		28,618		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		131,503,214		61.00
62.00	Deductibles billed to program beneficiaries		9,213,088		62.00
63.00	Coinsurance billed to program beneficiaries		536,512		63.00
64.00	Allowable bad debts (see instructions)		1,288,996		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		837,847		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		446,910		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		122,591,461		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0		70.50
70.75	N95 respirator payment adjustment amount (see instructions)		0		70.75
70.76	Essential medicines payment adjustment amount (see instructions)				70.76
70.87	Demonstration payment adjustment amount before sequestration		0		70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0		70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)				70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		-601,968		70.93
70.94	HRR adjustment amount (see instructions)		-1,963,623		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 31-0041	Period: From 01/01/2024 To 12/31/2024	Worksheet E Part A Date/Time Prepared: 5/28/2025 10:36 am
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3	0	0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		120,025,870	71.00
71.01	Sequestration adjustment (see instructions)		2,400,517	71.01
71.02	Demonstration payment adjustment amount after sequestration		337,997	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		121,405,723	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-4,118,367	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		8,575,815	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/28/2025 10:36 am

					Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)			
		0	1.00	2.00	3.00	4.00	5.00			
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00		
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	73,369,057	0	73,369,057		73,369,057	1.01		
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	24,223,350	0		24,223,350	24,223,350	1.02		
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03		
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04		
2.00	Outlier payments for discharges (see instructions)	2.00						2.00		
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01		
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	369,805	0	369,805		369,805	2.02		
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	5,687	0		5,687	5,687	2.03		
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00		
4.00	Managed care simulated payments	3.00	72,815,118	0	54,965,948	17,849,170	72,815,118	4.00		
Indirect Medical Education Adjustment										
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.212230	0.212230	0.212230	0.212230		5.00		
6.00	IME payment adjustment (see instructions)	22.00	10,680,318	0	8,029,363	2,650,955	10,680,318	6.00		
6.01	IME payment adjustment for managed care (see instructions)	22.01	7,968,741	0	6,015,364	1,953,377	7,968,741	6.01		
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA										
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00		
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00		
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01		
9.00	Total IME payment (sum of lines 6 and 8)	29.00	10,680,318	0	8,029,363	2,650,955	10,680,318	9.00		
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	7,968,741	0	6,015,364	1,953,377	7,968,741	9.01		
Disproportionate Share Adjustment										
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000	0.0000		10.00		
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	0	11.00		
11.01	Uncompensated care payments	36.00	0	0	0	0	0	11.01		
Additional payment for high percentage of ESRD beneficiary discharges										
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00		
13.00	Subtotal (see instructions)	47.00	108,648,217	0	81,768,225	26,879,992	108,648,217	13.00		
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00		
15.00	Total payment for inpatient operating costs (see instructions)	49.00	116,616,958	0	87,783,589	28,833,369	116,616,958	15.00		
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	8,405,393	0	6,325,618	2,079,775	8,405,393	16.00		

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/28/2025 10:36 am

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	11,372	0	11,372	0	11,372	17.00
17.01	Net organ acquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	94,120,579	30,913,144	125,033,723	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	7,549,847	0	5,678,873	1,870,974	7,549,847	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	12,983	0	12,983	0	12,983	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0831	0.0831	0.0831	0.0831		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	627,392	0	471,914	155,478	627,392	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0285	0.0285	0.0285	0.0285		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	215,171	0	161,848	53,323	215,171	25.00
26.00	Total prospective capital payments (see instructions)	12.00	8,405,393	0	6,325,618	2,079,775	8,405,393	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024Worksheet E
Part A Exhibit 5
Date/Time Prepared:
5/28/2025 10:36 am

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (col s. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	73,369,057	73,369,057		73,369,057	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	24,223,350		24,223,350	24,223,350	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	369,805	369,805		369,805	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	5,687		5,687	5,687	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	72,815,118	54,965,947	17,849,170	72,815,117	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.212230	0.212230	0.212230		5.00
6.00	IME payment adjustment (see instructions)	22.00	10,680,318	8,029,363	2,650,955	10,680,318	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	7,968,741	6,015,364	1,953,377	7,968,741	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	10,680,318	8,029,363	2,650,955	10,680,318	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	7,968,741	6,015,364	1,953,377	7,968,741	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	108,648,217	81,768,225	26,879,992	108,648,217	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	116,616,958	87,783,589	28,833,369	116,616,958	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	8,405,393	6,325,618	2,079,775	8,405,393	16.00
17.00	Special add-on payments for new technologies	54.00	11,372	11,372	0	11,372	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			94,120,579	30,913,144	125,033,723	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024Worksheet E
Part A Exhibit 5
Date/Time Prepared:
5/28/2025 10:36 am

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	7,549,847	5,678,873	1,870,974	7,549,847	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	12,983	12,983	0	12,983	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0831	0.0831	0.0831		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	627,392	471,914	155,478	627,392	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0285	0.0285	0.0285		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	215,171	161,848	53,323	215,171	25.00
26.00	Total prospective capital payments (see instructions)	12.00	8,405,393	6,325,618	2,079,775	8,405,393	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-601,968	-475,210	-126,758	-601,968	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-1,963,623	-1,408,909	-554,714	-1,963,623	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 31-0041	Period: From 01/01/2024 To 12/31/2024	Worksheet E Part B Date/Time Prepared: 5/28/2025 10:36 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		18,588	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		62,531,664	2.00
3.00	OPPS or REH payments		53,677,368	3.00
4.00	Outlier payment (see instructions)		37,251	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200		71,995	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		18,588	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		26,165	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		26,165	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		26,165	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		7,577	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		18,588	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		53,786,614	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		9,554,471	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		44,250,731	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		2,943,290	28.00
28.50	REH facility payment amount (see instructions)			28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)		47,194,021	30.00
31.00	Primary payer payments		31,226	31.00
32.00	Subtotal (line 30 minus line 31)		47,162,795	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		786,015	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		510,910	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		454,608	36.00
37.00	Subtotal (see instructions)		47,673,705	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-522	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.75	N95 respirator payment adjustment amount (see instructions)		0	39.75
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		47,674,227	40.00
40.01	Sequestration adjustment (see instructions)		953,485	40.01
40.02	Demonstration payment adjustment amount after sequestration		180,074	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00	Interim payments		43,069,143	41.00
41.01	Interim payments-PARHM			41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)			42.01
43.00	Balance due provider/program (see instructions)		3,471,525	43.00
43.01	Balance due provider/program-PARHM (see instructions)			43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00

MCRI F32 - 23. 3. 179. 2

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024Worksheet E-1
Part I
Date/Time Prepared:
5/28/2025 10:36 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		118,242,349		43,069,143	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	06/04/2024	2,313,220		0	3.01
3.02		10/23/2024	850,154		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		3,163,374		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)		121,405,723		43,069,143	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		3,471,525	6.01
6.02	SETTLEMENT TO PROGRAM		4,118,367		0	6.02
7.00	Total Medicare program liability (see instructions)		117,287,356		46,540,668	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

 Provider CCN: 31-0041
 Component CCN: 31-5490

 Period:
 From 01/01/2024
 To 12/31/2024

 Worksheet E-1
 Part I
 Date/Time Prepared:
 5/28/2025 10:36 am

		Title XVIII		Skilled Nursing Facility		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				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		2,945,290		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,945,290		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		481		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,945,771		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: 31-0041 Component CCN: 31-5490	Period: From 01/01/2024 To 12/31/2024	Worksheet E-3 Part VI Date/Time Prepared: 5/28/2025 10:36 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)			3,046,606 1.00
2.00	Routine service other pass through costs			0 2.00
3.00	Ancillary service other pass through costs			481 3.00
4.00	Subtotal (sum of lines 1 through 3)			3,047,087 4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible			0 6.00
7.00	Coinsurance			41,208 7.00
8.00	Allowable bad debts (see instructions)			0 8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0 9.00
10.00	Adjusted reimbursable bad debts (see instructions)			0 10.00
11.00	Utilization review			0 11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)			3,005,879 12.00
13.00	Inpatient primary payer payments			0 13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 14.50
14.98	Recovery of accelerated depreciation.			0 14.98
14.99	Demonstration payment adjustment amount before sequestration			0 14.99
15.00	Subtotal (see instructions)			3,005,879 15.00
15.01	Sequestration adjustment (see instructions)			60,108 15.01
15.02	Demonstration payment adjustment amount after sequestration			0 15.02
15.75	Sequestration for non-claims based amounts (see instructions)			0 15.75
16.00	Interim payments			2,945,290 16.00
17.00	Tentative settlement (for contractor use only)			0 17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)			481 18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2			0 19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 31-0041	Period: From 01/01/2024 To 12/31/2024	Worksheet E-3 Part VII Date/Time Prepared: 5/28/2025 10:36 am
		Title XIX	Hospital	TEFRA
			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	3,212,177		1.00
2.00	Medical and other services		1,350,801	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	3,212,177	1,350,801	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)	3,212,177	1,350,801	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	21,625,751		8.00
9.00	Ancillary service charges	13,558,999	12,002,936	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)	35,184,750	12,002,936	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)	35,184,750	12,002,936	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	31,972,573	10,652,135	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)	3,212,177	1,350,801	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)	3,212,177	1,350,801	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)	3,212,177	1,350,801	31.00
32.00	Deductibles	0		32.00
33.00	Coinurance	0		33.00
34.00	Allowable bad debts (see instructions)	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)	3,212,177	1,350,801	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	3,212,177	1,350,801	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)	3,212,177	1,350,801	40.00
41.00	Interim payments	4,937,152	1,503,050	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-1,724,975	-152,249	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0		43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 31-0041 Component CCN: 31-5490	Period: From 01/01/2024 To 12/31/2024	Worksheet E-3 Part VII Date/Time Prepared: 5/28/2025 10:36 am
		Title XIX	Skilled Nursing Facility	Cost
		Inpatient 1.00	Outpatient 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	0	24.00
25.00	Capital exception payments (see instructions)	0	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	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	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	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 31-0041	Period: From 01/01/2024 To 12/31/2024	Worksheet E-4 Date/Time Prepared: 5/28/2025 10:36 am	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
1.01	FTE cap adjustment under §131 of the CAA 2021 (see instructions)			0.00	1.01
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
2.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)			0.00	2.26
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
3.02	Adjustment (increase or decrease) to the hospital's rural track FTE limitation(s) for rural track programs with a rural track Medicare GME affiliation agreement in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)			0.00	3.02
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
4.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)			0.00	4.21
4.28	The amount of increase if the hospital was awarded FTE cap slots under §4122 of the CAA 2023 (see instructions)				4.28
5.00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lines 2.26 through 2.49, minus lines 3 and 3.01, plus or minus line 3.02, plus or minus line 4, plus lines 4.01 through 4.28)			0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.00	6.00
7.00	Enter the lesser of line 5 or line 6			0.00	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	0.00	0.00	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6. For cost reporting periods beginning on or after October 1, 2022, or if Worksheet S-2, Part I, line 68, is "Y", see instructions.	0.00	0.00	0.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		8.47		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		8.47		10.01
11.00	Total weighted FTE count	0.00	8.47		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	7.11		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	4.43		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	6.67		14.00
15.00	Adjustment for residents in initial years of new programs	35.78	48.77		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	35.78	48.77		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	35.78	55.44		17.00
18.00	Per resident amount	0.00	0.00		18.00
18.01	Per resident amount under §131 of the CAA 2021	137,735.60	137,735.60		18.01
19.00	Approved amount for resident costs	4,928,180	7,636,062	12,564,242	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			12,564,242	25.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 31-0041	Period: From 01/01/2024 To 12/31/2024	Worksheet E-4 Date/Time Prepared: 5/28/2025 10:36 am	
		Title XVIII	Hospital	PPS	
		Inpatient Part A	Managed Care	Total	
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	50,071	37,827		26.00
27.00	Total Inpatient Days (see instructions)	116,859	116,859		27.00
28.00	Ratio of inpatient days to total inpatient days	0.428474	0.323698		28.00
29.00	Program direct GME amount	5,383,451	4,067,020	9,450,471	29.00
29.01	Percent reduction for MA DGME		2.74		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		111,436	111,436	30.00
31.00	Net Program direct GME amount			9,339,035	31.00
				1.00	
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS)					
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)				0 32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)				0 33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)				0.000000 34.00
35.00	Medicare outpatient ESRD charges (see instructions)				0 35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)				0 36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY					
Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)				136,038,186 37.00
38.00	Organ acquisition and HSCT acquisition costs (see instructions)				0 38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)				0 39.00
40.00	Primary payer payments (see instructions)				28,618 40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)				136,009,568 41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)				62,622,247 42.00
43.00	Primary payer payments (see instructions)				31,226 43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)				62,591,021 44.00
45.00	Total reasonable cost (sum of lines 41 and 44)				198,600,589 45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)				0.684840 46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)				0.315160 47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)				9,339,035 48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)				6,395,745 49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)				2,943,290 50.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT		Provider CCN: 31-0041	Period: From 01/01/2024 To 12/31/2024	Worksheet E-5 Date/Time Prepared: 5/28/2025 10:36 am
Title XVIII			PPS	
				1.00
TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)			0 1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2			0 2.00
3.00	Operating outlier reconciliation adjustment amount (see instructions)			0 3.00
4.00	Capital outlier reconciliation adjustment amount (see instructions)			0 4.00
5.00	The rate used to calculate the time value of money (see instructions)			0.00 5.00
6.00	Time value of money for operating expenses (see instructions)			0 6.00
7.00	Time value of money for capital related expenses (see instructions)			0 7.00

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

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024

Worksheet G

Date/Time Prepared:
5/28/2025 10:36 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	10,025	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	66,583,534	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-14,616,903	0	0	0	6.00
7.00	Inventory	10,767,804	0	0	0	7.00
8.00	Prepaid expenses	4,436,276	0	0	0	8.00
9.00	Other current assets	16,108,057	0	0	0	9.00
10.00	Due from other funds	264,788,835	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	348,077,628	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,338,461	0	0	0	12.00
13.00	Land improvements	3,070,069	0	0	0	13.00
14.00	Accumulated depreciation	-2,445,633	0	0	0	14.00
15.00	Buildings	364,005,641	0	0	0	15.00
16.00	Accumulated depreciation	-157,735,905	0	0	0	16.00
17.00	Leasehold improvements	17,860,652	0	0	0	17.00
18.00	Accumulated depreciation	-6,451,316	0	0	0	18.00
19.00	Fixed equipment	79,638,022	0	0	0	19.00
20.00	Accumulated depreciation	-74,520,468	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	219,493,750	0	0	0	23.00
24.00	Accumulated depreciation	-134,369,970	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)	309,883,303	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	500	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	31,836,789	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	31,837,289	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	689,798,220	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	20,309,052	0	0	0	37.00
38.00	Salaries, wages, and fees payable	21,187,007	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	102,867	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	28,796,314	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	70,395,240	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	166,882,142	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	166,882,142	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	237,277,382	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	452,520,838	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	452,520,838	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	689,798,220	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024

Worksheet G-1

Date/Time Prepared:
5/28/2025 10:36 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		407,968,902		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		42,515,265				2.00
3.00	Total (sum of line 1 and line 2)		450,484,167		0		3.00
4.00	OTHER CHANGES IN NET ASSETS	2,036,671		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		2,036,671		0		10.00
11.00	Subtotal (line 3 plus line 10)		452,520,838		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		452,520,838		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	OTHER CHANGES IN NET ASSETS		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024Worksheet G-2
Parts I & II
Date/Time Prepared:
5/28/2025 10:36 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	592,990,861		592,990,861	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	21,217,350		21,217,350	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)	614,208,211		614,208,211	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	477,153,272		477,153,272	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT	48,115,328		48,115,328	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	525,268,600		525,268,600	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,139,476,811		1,139,476,811	17.00
18.00	Ancillary services	620,927,147	672,734,675	1,293,661,822	18.00
19.00	Outpatient services	164,298,391	332,759,354	497,057,745	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	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)	1,924,702,349	1,005,494,029	2,930,196,378	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		544,147,120		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		544,147,120		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 31-0041

Period:
From 01/01/2024
To 12/31/2024

Worksheet G-3

Date/Time Prepared:
5/28/2025 10:36 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	2,930,196,378	1.00
2.00	Less contractual allowances and discounts on patients' accounts	2,356,778,024	2.00
3.00	Net patient revenues (line 1 minus line 2)	573,418,354	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	544,147,120	4.00
5.00	Net income from service to patients (line 3 minus line 4)	29,271,234	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	11,042,314	24.00
24.01	FEMA C-19	2,201,717	24.01
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	13,244,031	25.00
26.00	Total (line 5 plus line 25)	42,515,265	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	42,515,265	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 31-0041	Period: From 01/01/2024 To 12/31/2024	Worksheet L Parts I-III Date/Time Prepared: 5/28/2025 10:36 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		7,549,847	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		12,983	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		322.47	3.00
4.00	Number of interns & residents (see instructions)		91.21	4.00
5.00	Indirect medical education percentage (see instructions)		8.31	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		627,392	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		1.62	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		12.27	8.00
9.00	Sum of lines 7 and 8		13.89	9.00
10.00	Allowable disproportionate share percentage (see instructions)		2.85	10.00
11.00	Disproportionate share adjustment (see instructions)		215,171	11.00
12.00	Total prospective capital payments (see instructions)		8,405,393	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00