

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet S Parts I-III Date/Time Prepared: 5/26/2023 8:03 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report	Date: 5/26/2023	Time: 8:03 pm
	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 checked="" type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.		
Contractor use only	5. <input checked="" 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 checked="" type="checkbox"/> Initial Report for this Provider CCN 9. <input checked="" 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 MEMORIAL HOSPITAL LOGANSPO RT (15-0072) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 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	David Ameen	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification to be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	David Ameen		2
3	Signatory Title	CEO		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	-178,257	4,293	0	-141,293 1.00
2.00	SUBPROVIDER - IPF	0	0	0	0	2.00
3.00	SUBPROVIDER - IRF	0	0	0	0	3.00
5.00	SWING BED - SNF	0	0	0	0	5.00
6.00	SWING BED - NF	0	0	0	0	6.00
10.00	EXPRESS MEDICAL CENTER I	0	0	84,342	0	10.00
10.01	FAMILY HEALTH CARE II	0	0	227,300	0	10.01
200.00	TOTAL	0	-178,257	315,935	0	-141,293 200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0072		Period: From 01/01/2022 To 12/31/2022		Worksheet S-2 Part I Date/Time Prepared: 5/26/2023 8:03 pm				
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1101 MICHIGAN AVENUE			PO Box:						1.00
2.00	City: LOGANSPORT			State: IN		Zip Code: 46947-		County: CASS		2.00
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	MEMORIAL HOSPITAL LOGANSPORT	150072	99915	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	SWING BED - SNF	15U072	99915		05/14/2008	N	P	P	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	LOGANSPORT MEMORIAL EXPRESS MEDICAL	158561	99915		05/25/2021	N	O	O	15.00
15.01	Hospital-Based Health Clinic - RHC II	LOGANSPORT FAMILY HEALTH CARE	158563	99915		05/19/2021	N	O	O	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:		To:		
						1.00		2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2022		12/31/2022		20.00
21.00	Type of Control (see instructions)					9				21.00
						1.00		2.00		3.00
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.				Y	N				22.00
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				Y	Y				22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.				N	N				22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				N	N		N		22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.									22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.				3	N				23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0072			Period: From 01/01/2022 To 12/31/2022		Worksheet S-2 Part I Date/Time Prepared: 5/26/2023 8:03 pm		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	267	0	0	0	1,593	0		24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0		25.00
						Urban/Rural	S	Date of Geogr	
						1.00		2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					1			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.					01/01/2022	12/31/2022		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)					Y	Y		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					Y	N		40.00
						V	XVIII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					N			56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.								57.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/26/2023 8:03 pm		
		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.	N				60.00
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)					61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)					61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)					61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).					61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)					61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)					61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20
						1.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)				N	63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 15-0072

Period:
From 01/01/2022
To 12/31/2022

Worksheet S-2
Part I
Date/Time Prepared:
5/26/2023 8:03 pm

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

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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)?		N		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.				0 88.00
			Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge
			1.00	2.00	3.00
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.		0.00		0 89.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N		Y 90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N		Y 91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N 92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N		N 93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N		N 94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00 95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N		N 96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00 97.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/26/2023 8:03 pm	
		V 1.00	XIX 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. 1, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. 1V, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. 1, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. 1 through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00	
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.	N	N	N	N
				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
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
113.00	Did this hospital participate in the Community Health Access and Rural Transformation (CHART) model for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no.				113.00
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			115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/26/2023 8:03 pm	
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	725,284	0	0	
		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	Y	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.				123.00
Certified Transplant Center Information					
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	Removed and reserved				133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		N		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:	Contractor's Name:	Contractor's Number:		141.00
142.00	Street:	PO Box:			142.00
143.00	City:	State:	Zip Code:		143.00
			1.00		
144.00	Are provider based physicians' costs included in Worksheet A?			Y	144.00
			1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N		146.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0072		Period: From 01/01/2022 To 12/31/2022		Worksheet S-2 Part I Date/Time Prepared: 5/26/2023 8:03 pm		
1.00								
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N	149.00
		Part A	Part B	Title V	Title XIX			
		1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital	N	N	N	N		155.00	
156.00	Subprovider - IPF	N	N	N	N		156.00	
157.00	Subprovider - IRF	N	N	N	N		157.00	
158.00	SUBPROVIDER						158.00	
159.00	SNF	N	N	N	N		159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N		160.00	
161.00	CMHC		N	N	N		161.00	
1.00								
Multi campus								
165.00	Is this hospital part of a Multi campus 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.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						9.99	169.00
		Beginning		Ending				
		1.00		2.00				
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							170.00
		1.00		2.00				
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, 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: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Prepared: 5/26/2023 8:03 pm	
			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		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
			1.00	2.00	3.00
					4.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	04/24/2023	Y	04/24/2023
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Prepared: 5/26/2023 8:03 pm	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N	N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		N		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		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.		N		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.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MICHAEL		ALESSANDRINI	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7959		MALESSANDRINI@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Prepared: 5/26/2023 8:03 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DI RECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0072

Period:
From 01/01/2022
To 12/31/2022

Worksheet S-3
Part I
Date/Time Prepared:
5/26/2023 8:03 pm

Component	Worksheet A Line No.	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps		
					Ti tle V		
	1.00	2.00	3.00	4.00	5.00		
PART I - STATISTICAL DATA							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	32	11,680	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)		32	11,680	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	5	1,825	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		37	13,505	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	EXPRESS MEDICAL CENTER	88.00				0	26.00
26.01	FAMILY HEALTH CARE	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		37				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)		5	1,825			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0072

Period:
From 01/01/2022
To 12/31/2022

Worksheet S-3
Part I
Date/Time Prepared:
5/26/2023 8:03 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,209	267	3,825		1.00
2.00	HMO and other (see instructions)	898	1,593			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	0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,209	267	3,825		7.00
8.00	INTENSIVE CARE UNIT	156	0	338		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		0	1,131		13.00
14.00	Total (see instructions)	1,365	267	5,294	0.00	538.12
15.00	CAH visits	0	0	0		15.00
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF					17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY					19.00
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE					21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE					24.00
24.10	HOSPICE (non-distinct part)			0		24.10
25.00	CMHC - CMHC					25.00
26.00	EXPRESS MEDICAL CENTER	1,097	2,108	12,111	0.00	13.64
26.01	FAMILY HEALTH CARE	1,517	1,150	5,677	0.00	42.22
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00
27.00	Total (sum of lines 14-26)				0.00	593.98
28.00	Observation Bed Days		25	921		28.00
29.00	Ambulance Trips	0				29.00
30.00	Employee discount days (see instruction)			0		30.00
31.00	Employee discount days - IRF			0		31.00
32.00	Labor & delivery days (see instructions)	0	0	429		32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		32.01
33.00	LTCH non-covered days	0				33.00
33.01	LTCH site neutral days and discharges	0				33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0		34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0072

Period:
From 01/01/2022
To 12/31/2022

Worksheet S-3
Part I
Date/Time Prepared:
5/26/2023 8:03 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
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	354	63	1,424	1.00
2.00	HMO and other (see instructions)			210	388		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	354	63	1,424	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	EXPRESS MEDICAL CENTER	0.00					26.00
26.01	FAMILY HEALTH CARE	0.00					26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0072

Period:
From 01/01/2022
To 12/31/2022

Worksheet S-3
Part II
Date/Time Prepared:
5/26/2023 8:03 pm

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	46,295,671	-271,798	46,023,873	1,212,696.00	37.95 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		35,125	0	35,125	1,743.00	20.15 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		8,049,803	0	8,049,803	50,029.00	160.90 5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		2,245,065	0	2,245,065	47,060.00	47.71 6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00 7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00 7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00 8.00
9.00	SNF	44.00	0	0	0	0.00	0.00 9.00
10.00	Excluded area salaries (see instructions)		4,743,518	3,051,841	7,795,359	165,931.00	46.98 10.00
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		2,751,206	0	2,751,206	24,778.00	111.03 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		78,133	0	78,133	521.00	149.97 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		0	0	0	0.00	0.00 14.01
14.02	Related organization salaries		0	0	0	0.00	0.00 14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00 15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00 16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.02
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		10,568,882	0	10,568,882		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		2,040,193	0	2,040,193		
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		32,518	0	32,518		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		882,424	0	882,424		
24.00	Wage-related costs (RHC/FQHC)		613,726	0	613,726		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0072

Period:
From 01/01/2022
To 12/31/2022

Worksheet S-3
Part II
Date/Time Prepared:
5/26/2023 8:03 pm

		Wkst. A Line Number	Amount Reported	Recl assi fi cat ion of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	355,790	0	355,790	10,837.00	32.83	26.00
27.00	Administrative & General	5.00	4,674,856	-37,554	4,637,302	170,925.00	27.13	27.00
28.00	Administrative & General under contract (see inst.)		834,961	0	834,961	8,934.00	93.46	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	914,049	0	914,049	27,463.00	33.28	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	759,508	-8,321	751,187	41,245.00	18.21	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	446,773	-384,675	62,098	3,758.00	16.52	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	381,902	381,902	22,126.00	17.26	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,052,689	0	1,052,689	19,078.00	55.18	38.00
39.00	Central Services and Supply	14.00	343,116	0	343,116	16,117.00	21.29	39.00
40.00	Pharmacy	15.00	740,953	-12,045	728,908	17,243.00	42.27	40.00
41.00	Medical Records & Medical Records Library	16.00	2,223,353	-15,048	2,208,305	83,594.00	26.42	41.00
42.00	Social Service	17.00	161,790	0	161,790	7,571.00	21.37	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0072

Period:
From 01/01/2022
To 12/31/2022

Worksheet S-3
Part III
Date/Time Prepared:
5/26/2023 8:03 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion 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)	36,835,764	-271,798	36,563,966	1,124,541.00	32.51	1.00
2.00	Excluded area salaries (see instructions)	4,743,518	3,051,841	7,795,359	165,931.00	46.98	2.00
3.00	Subtotal salaries (line 1 minus line 2)	32,092,246	-3,323,639	28,768,607	958,610.00	30.01	3.00
4.00	Subtotal other wages & related costs (see inst.)	2,829,339	0	2,829,339	25,299.00	111.84	4.00
5.00	Subtotal wage-related costs (see inst.)	10,601,400	0	10,601,400	0.00	36.85	5.00
6.00	Total (sum of lines 3 thru 5)	45,522,985	-3,323,639	42,199,346	983,909.00	42.89	6.00
7.00	Total overhead cost (see instructions)	12,507,838	-75,741	12,432,097	428,891.00	28.99	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part IV Date/Time Prepared: 5/26/2023 8:03 pm
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	451,604	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	8,979,415	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	611,167	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	34,059	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)	668,000	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	240,948	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	3,050,908	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	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	101,643	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	14,137,744	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part V Date/Time Prepared: 5/26/2023 8:03 pm
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	2,751,206	14,137,744	1.00
2.00	Hospital	2,751,206	14,137,744	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
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-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 15-0072 Component CCN: 15-8561		Period: From 01/01/2022 To 12/31/2022		Worksheet S-8 Date/Time Prepared: 5/26/2023 8:03 pm	
		RHC I		Cost			
				1.00			
1.00	Clinic Address and Identification Street	3400 E MARKET ST				1.00	
		City		State		ZIP Code	
		1.00		2.00		3.00	
2.00	City, State, ZIP Code, County	LOGANSPORT		IN		46947	
				1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0		3.00	
		Grant Award		Date			
		1.00		2.00			
4.00	Source of Federal Funds Community Health Center (Section 330(d), PHS Act)					4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00	
7.00	Appalachian Regional Commission					7.00	
8.00	Look-Alikes					8.00	
9.00	OTHER (SPECIFY)					9.00	
				1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0		10.00	
		Sunday		Monday		Tuesday	
		from to		from to		from	
		1.00 2.00		3.00 4.00		5.00	
11.00	Facility hours of operations (1) CLINIC	12:00	18:00	08:30	19:00	08:30	11.00
				1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	Y				12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0		13.00	
		Provider name		CCN			
		1.00		2.00			
14.00	RHC/FQHC name, CCN					14.00	
		Y/N		V		Total Visits	
		1.00		2.00		3.00 4.00 5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00	
		County		4.00			
2.00	City, State, ZIP Code, County	CASS				2.00	
		Tuesday		Wednesday		Thursday	
		to		from to		from to	
		6.00		7.00 8.00		9.00 10.00	
11.00	Facility hours of operations (1) CLINIC	19:00	08:30	19:00	08:30	19:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 15-0072 Component CCN: 15-8561		Period: From 01/01/2022 To 12/31/2022		Worksheet S-8 Date/Time Prepared: 5/26/2023 8:03 pm	
				RHC I		Cost	
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1) CLINIC	08:30	19:00	10:00	18:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 15-0072 Component CCN: 15-8563		Period: From 01/01/2022 To 12/31/2022		Worksheet S-8 Date/Time Prepared: 5/26/2023 8:03 pm	
		RHC II		Cost			
				1.00			
1.00	Clinic Address and Identification Street	1201 MICHIGAN AVE				1.00	
		City	State	ZIP Code			
		1.00	2.00	3.00			
2.00	City, State, ZIP Code, County	LOGANSPO RT IN		46947		2.00	
				1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0		3.00	
		Grant Award		Date			
		1.00		2.00			
4.00	Source of Federal Funds Community Health Center (Section 330(d), PHS Act)					4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00	
7.00	Appalachian Regional Commission					7.00	
8.00	Look-Alikes					8.00	
9.00	OTHER (SPECIFY)					9.00	
				1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0		10.00	
		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
11.00	Facility hours of operations (1) CLINIC	12:00	18:00	08:30	19:00	08:30	11.00
				1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	Y				12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0		13.00	
		Provider name		CCN			
		1.00		2.00			
14.00	RHC/FQHC name, CCN					14.00	
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00	
		County		4.00			
2.00	City, State, ZIP Code, County					2.00	
		Tuesday		Wednesday		Thursday	
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
11.00	Facility hours of operations (1) CLINIC	19:00	08:30	19:00	08:30	19:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 15-0072 Component CCN: 15-8563		Period: From 01/01/2022 To 12/31/2022		Worksheet S-8 Date/Time Prepared: 5/26/2023 8:03 pm	
				RHC II		Cost	
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1) CLINIC	08:30	19:00	10:00	18:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet S-10 Date/Time Prepared: 5/26/2023 8:03 pm
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.314849	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		9,580,351	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		61,761,694	6.00	
7.00	Medicaid cost (line 1 times line 6)		19,445,608	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		9,865,257	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 (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		9,865,257	19.00	
			Uninsured patients	Insured patients	Total (col. 1 + col. 2)
			1.00	2.00	3.00
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	900,487	664,104	1,564,591	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	283,517	664,104	947,621	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 (line 21 minus line 22)	283,517	664,104	947,621	23.00
			1.00		
24.00	Does the amount on line 20 column 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
26.00	Total bad debt expense for the entire hospital complex (see instructions)		10,546,885		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		108,824		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		167,421		27.01
28.00	Non-Medicare bad debt expense (see instructions)		10,379,464		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		3,326,561		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		4,274,182		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		14,139,439		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet A Date/Time Prepared: 5/26/2023 8:03 pm		
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified ions (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	NEW CAP REL COSTS-BLDG & FIXT		7,080,347	7,080,347	-1,096,302	5,984,045	1.00
1.01	00101	MOB		0	0	223,692	223,692	1.01
1.02	00102	OPS		0	0	147,326	147,326	1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	355,790	14,160,309	14,516,099	271,798	14,787,897	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,674,856	9,204,348	13,879,204	510,909	14,390,113	5.00
7.00	00700	OPERATION OF PLANT	914,049	1,841,332	2,755,381	266,572	3,021,953	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	215,780	215,780	0	215,780	8.00
9.00	00900	HOUSEKEEPING	759,508	198,260	957,768	-8,321	949,447	9.00
10.00	01000	DIETARY	446,773	416,115	862,888	-740,370	122,518	10.00
11.00	01100	CAFETERIA	0	0	0	737,597	737,597	11.00
13.00	01300	NURSING ADMINISTRATION	1,052,689	56,114	1,108,803	0	1,108,803	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	343,116	311,086	654,202	-64,757	589,445	14.00
15.00	01500	PHARMACY	740,953	909,140	1,650,093	-12,045	1,638,048	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,223,353	4,238,279	6,461,632	-15,728	6,445,904	16.00
17.00	01700	SOCIAL SERVICE	161,790	31,075	192,865	0	192,865	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,907,704	331,207	5,238,911	-1,249,096	3,989,815	30.00
31.00	03100	INTENSIVE CARE UNIT	914,508	50,485	964,993	-8,399	956,594	31.00
43.00	04300	NURSERY	0	149	149	462,055	462,204	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,965,566	2,053,803	8,019,369	-10,410	8,008,959	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	708,554	708,554	52.00
53.00	05300	ANESTHESIOLOGY	0	2,395,622	2,395,622	0	2,395,622	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,496,925	783,774	2,280,699	0	2,280,699	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (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	4,456,376	4,456,376	0	4,456,376	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	160,033	160,033	0	160,033	63.00
65.00	06500	RESPIRATORY THERAPY	841,407	515,434	1,356,841	-13,788	1,343,053	65.00
66.00	06600	PHYSICAL THERAPY	1,235,152	90,895	1,326,047	0	1,326,047	66.00
69.00	06900	ELECTROCARDIOLOGY	258,301	207,757	466,058	-11,324	454,734	69.00
69.01	06901	CARDIAC REHAB	327,633	18,813	346,446	0	346,446	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,701,920	4,701,920	-1,704,816	2,997,104	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,704,816	1,704,816	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27	12,562,469	12,562,496	0	12,562,496	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	326,510	442,507	769,017	-5,411	763,606	76.00
76.01	03480	ONCOLOGY	751,142	2,166,471	2,917,613	-3,538	2,914,075	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	EXPRESS MEDICAL CENTER	1,402,497	416,110	1,818,607	-152,398	1,666,209	88.00
88.01	08801	FAMILY HEALTH CARE	3,859,614	163,869	4,023,483	-3,068,625	954,858	88.01
90.00	09000	CLINIC	4,742,454	632,850	5,375,304	-31,955	5,343,349	90.00
90.01	09001	WOUND CARE	167,507	689,266	856,773	0	856,773	90.01
90.02	09002	INTERNAL MEDICINE	0	503,126	503,126	0	503,126	90.02
90.03	09003	PODIATRY CLINIC	615,436	243,632	859,068	-51,882	807,186	90.03
91.00	09100	EMERGENCY	2,066,893	1,143,368	3,210,261	-16,992	3,193,269	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	41,552,153	73,392,121	114,944,274	-3,232,838	111,711,436	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	FOUNDATION	0	4,200	4,200	0	4,200	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	481,681	147,494	629,175	-5,688	623,487	194.04
194.05	07955	PHYSICIANS OFFICE	3,322,222	1,690,020	5,012,242	3,239,971	8,252,213	194.05
194.06	07956	THE ARBORS	0	0	0	0	0	194.06
194.07	07957	PAIN MANAGEMENT	0	0	0	0	0	194.07
194.08	07958	OPS	0	0	0	0	0	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	620,640	54,969	675,609	0	675,609	194.09
194.10	07961	RHEUMATOLOGY	0	0	0	0	0	194.10
194.11	07960	SPORTS HEALTH	273,380	33,301	306,681	-1,445	305,236	194.11
194.12	07962	BEHAVIORAL HEALTH CLINIC	45,595	12,991	58,586	0	58,586	194.12
200.00		TOTAL (SUM OF LINES 118 through 199)	46,295,671	75,335,096	121,630,767	0	121,630,767	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0072

Period:
From 01/01/2022
To 12/31/2022

Worksheet A
Date/Time Prepared:
5/26/2023 8:03 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-134,945	5,849,100	1.00
1.01	00101	MOB	0	223,692	1.01
1.02	00102	OPS	0	147,326	1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-18,614	14,769,283	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-5,562,953	8,827,160	5.00
7.00	00700	OPERATION OF PLANT	-10,851	3,011,102	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	215,780	8.00
9.00	00900	HOUSEKEEPING	0	949,447	9.00
10.00	01000	DIETARY	-39,776	82,742	10.00
11.00	01100	CAFETERIA	-4,670	732,927	11.00
13.00	01300	NURSING ADMINISTRATION	-1,425	1,107,378	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-117,180	472,265	14.00
15.00	01500	PHARMACY	0	1,638,048	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-30,660	6,415,244	16.00
17.00	01700	SOCIAL SERVICE	-2,899	189,966	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,177,506	2,812,309	30.00
31.00	03100	INTENSIVE CARE UNIT	0	956,594	31.00
43.00	04300	NURSERY	0	462,204	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-4,200,163	3,808,796	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	708,554	52.00
53.00	05300	ANESTHESIOLOGY	-2,392,325	3,297	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-15,205	2,265,494	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	4,456,376	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	160,033	63.00
65.00	06500	RESPIRATORY THERAPY	0	1,343,053	65.00
66.00	06600	PHYSICAL THERAPY	0	1,326,047	66.00
69.00	06900	ELECTROCARDIOLOGY	0	454,734	69.00
69.01	06901	CARDIAC REHAB	0	346,446	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,997,104	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,704,816	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-433,712	12,128,784	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	763,606	76.00
76.01	03480	ONCOLOGY	-1,759,548	1,154,527	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	EXPRESS MEDICAL CENTER	0	1,666,209	88.00
88.01	08801	FAMILY HEALTH CARE	0	954,858	88.01
90.00	09000	CLINIC	-4,675,652	667,697	90.00
90.01	09001	WOUND CARE	-656,928	199,845	90.01
90.02	09002	INTERNAL MEDICINE	-499,626	3,500	90.02
90.03	09003	PODIATRY CLINIC	-712,222	94,964	90.03
91.00	09100	EMERGENCY	-959,268	2,234,001	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-23,406,128	88,305,308	118.00
NONREIMBURSABLE COST CENTERS					
194.00	07950	FOUNDATION	0	4,200	194.00
194.01	07951	MOB	0	0	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	194.02
194.03	07953	PIH	0	0	194.03
194.04	07954	HEALTH COMPANIES	-30,621	592,866	194.04
194.05	07955	PHYSICIANS OFFICE	-3,175,462	5,076,751	194.05
194.06	07956	THE ARBORS	0	0	194.06
194.07	07957	PAIN MANAGEMENT	0	0	194.07
194.08	07958	OPS	0	0	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	-287,155	388,454	194.09
194.10	07961	RHEUMATOLOGY	0	0	194.10
194.11	07960	SPORTS HEALTH	-10,000	295,236	194.11
194.12	07962	BEHAVIORAL HEALTH CLINIC	0	58,586	194.12
200.00		TOTAL (SUM OF LINES 118 through 199)	-26,909,366	94,721,401	200.00

RECLASSIFICATIONS

Provider CCN: 15-0072

Period:
From 01/01/2022
To 12/31/2022

Worksheet A-6

Date/Time Prepared:
5/26/2023 8:03 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	381,902	355,695	1.00
	O		381,902	355,695	
B - OB RECLASS					
1.00	NURSERY	43.00	426,839	35,216	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	654,340	54,214	2.00
	O		1,081,179	89,430	
C - MALPRACTICE INS. RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	725,284	1.00
	O		0	725,284	
D - IMPLANT EXPENSE RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	1,704,816	1.00
	O		0	1,704,816	
E - UTILITIES RECLASS					
1.00	OPERATION OF PLANT	7.00	0	266,572	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
	O		0	266,572	
F - DEPRECIATION RECLASS					
1.00	MOB	1.01	0	223,692	1.00
2.00	OPS	1.02	0	147,326	2.00
	O		0	371,018	
G - SHORT TERM DISABILITY RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	271,798	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
	O		0	271,798	
H - RHC EXPENSE ALLOCATION RECLASS					
1.00	PHYSICIANS OFFICE	194.05	3,122,153	180,997	1.00
2.00		0.00	0	0	2.00
	TOTALS		3,122,153	180,997	
I - RHC PRACTITIONER RECLASS					
1.00	EXPRESS MEDICAL CENTER	88.00	132,732	0	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	TOTALS		132,732	0	
500.00	Grand Total: Increases		4,717,966	3,965,610	500.00

RECLASSIFICATIONS

Provider CCN: 15-0072

Period:
From 01/01/2022
To 12/31/2022

Worksheet A-6
Date/Time Prepared:
5/26/2023 8:03 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA RECLASS							
1.00	DIETARY	10.00	381,902	355,695	0		1.00
	O		381,902	355,695			
B - OB RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	1,081,179	89,430	0		1.00
2.00	O	0.00	0	0	0		2.00
	O		1,081,179	89,430			
C - MALPRACTICE INS. RECLASS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	725,284	12		1.00
	O		0	725,284			
D - IMPLANT EXPENSE RECLASS							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,704,816	0		1.00
	O		0	1,704,816			
E - UTILITIES RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00		176,821	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00		64,757	0		2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00		680	0		3.00
4.00	OPERATING ROOM	50.00		1,334	0		4.00
5.00	EXPRESS MEDICAL CENTER	88.00		22,980	0		5.00
	O		0	266,572			
F - DEPRECIATION RECLASS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	371,018	9		1.00
2.00	O	0.00	0	0	9		2.00
	O		0	371,018			
G - SHORT TERM DISABILITY RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	37,554	0	0		1.00
2.00	HOUSEKEEPING	9.00	8,321	0	0		2.00
3.00	DIETARY	10.00	2,773	0	0		3.00
4.00	PHARMACY	15.00	12,045	0	0		4.00
5.00	MEDICAL RECORDS & LIBRARY	16.00	15,048	0	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	40,484	0	0		6.00
7.00	INTENSIVE CARE UNIT	31.00	8,399	0	0		7.00
8.00	OPERATING ROOM	50.00	9,076	0	0		8.00
9.00	RESPIRATORY THERAPY	65.00	13,788	0	0		9.00
10.00	ELECTROCARDIOLOGY	69.00	11,324	0	0		10.00
11.00	NUCLEAR MEDICINE - DIAGNOSTIC	76.00	5,411	0	0		11.00
12.00	ONCOLOGY	76.01	3,538	0	0		12.00
13.00	EXPRESS MEDICAL CENTER	88.00	1,415	0	0		13.00
14.00	FAMILY HEALTH CARE	88.01	26,210	0	0		14.00
15.00	CLINIC	90.00	31,955	0	0		15.00
16.00	PODIATRY CLINIC	90.03	664	0	0		16.00
17.00	EMERGENCY	91.00	16,992	0	0		17.00
18.00	HEALTH COMPANIES	194.04	5,688	0	0		18.00
19.00	PHYSICIANS OFFICE	194.05	19,668	0	0		19.00
20.00	SPORTS HEALTH	194.11	1,445	0	0		20.00
	O		271,798	0			
H - RHC EXPENSE ALLOCATION RECLASS							
1.00	EXPRESS MEDICAL CENTER	88.00	203,650	57,085	0		1.00
2.00	FAMILY HEALTH CARE	88.01	2,918,503	123,912	0		2.00
	TOTALS		3,122,153	180,997			
I - RHC PRACTITIONER RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	38,003	0	0		1.00
2.00	PODIATRY CLINIC	90.03	51,218	0	0		2.00
3.00	PHYSICIANS OFFICE	194.05	43,511	0	0		3.00
	TOTALS		132,732	0			
500.00	Grand Total: Decreases		4,989,764	3,693,812			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0072

Period:
From 01/01/2022
To 12/31/2022

Worksheet A-7
Part I
Date/Time Prepared:
5/26/2023 8:03 pm

	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	205,783	0	0	0	1.00
2.00	Land Improvements	838,517	38,500	0	38,500	2.00
3.00	Buildings and Fixtures	71,692,889	38,133	0	38,133	3.00
4.00	Building Improvements	0	3,937,902	0	3,937,902	4.00
5.00	Fixed Equipment	8,229,054	0	0	0	5.00
6.00	Movable Equipment	46,665,751	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	127,631,994	4,014,535	0	4,014,535	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	127,631,994	4,014,535	0	4,014,535	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	205,783	0			1.00
2.00	Land Improvements	877,017	0			2.00
3.00	Buildings and Fixtures	71,731,022	0			3.00
4.00	Building Improvements	3,937,902	0			4.00
5.00	Fixed Equipment	7,812,025	0			5.00
6.00	Movable Equipment	36,264,848	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	120,828,597	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	120,828,597	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0072

Period:
From 01/01/2022
To 12/31/2022

Worksheet A-7
Part II
Date/Time Prepared:
5/26/2023 8:03 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	5,522,374	0	694,540	863,433	0	1.00
1.01	MOB	0	0	0	0	0	1.01
1.02	OPS	0	0	0	0	0	1.02
3.00	Total (sum of lines 1-2)	5,522,374	0	694,540	863,433	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	7,080,347				1.00
1.01	MOB	0	0				1.01
1.02	OPS	0	0				1.02
3.00	Total (sum of lines 1-2)	0	7,080,347				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0072

Period:
From 01/01/2022
To 12/31/2022

Worksheet A-7
Part III
Date/Time Prepared:
5/26/2023 8:03 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	120,828,597	0	120,828,597	1.000000	0	1.00
1.01	MOB	0	0	0	0.000000	0	1.01
1.02	OPS	0	0	0	0.000000	0	1.02
3.00	Total (sum of lines 1-2)	120,828,597	0	120,828,597	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	5,134,360	0	1.00
1.01	MOB	0	0	0	223,692	0	1.01
1.02	OPS	0	0	0	147,326	0	1.02
3.00	Total (sum of lines 1-2)	0	0	0	5,505,378	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 cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	576,591	138,149	0	0	5,849,100	1.00
1.01	MOB	0	0	0	0	223,692	1.01
1.02	OPS	0	0	0	0	147,326	1.02
3.00	Total (sum of lines 1-2)	576,591	138,149	0	0	6,220,118	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0072

Period:
From 01/01/2022
To 12/31/2022

Worksheet A-8

Date/Time Prepared:
5/26/2023 8:03 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst. A-7 Ref.	
			3.00	4.00	5.00	
1.00	2.00	3.00	4.00	5.00		
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			ONEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01 Investment income - MOB (chapter 2)			OMOB	1.01	0	1.01
1.02 Investment income - OPS (chapter 2)			OOPS	1.02	0	1.02
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0*** Cost Center Deleted ***	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0	0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0	0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)	B	-117,180	CENTRAL SERVICES & SUPPLY	14.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0	0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0	0.00	0	7.00
8.00 Television and radio service (chapter 21)			0	0.00	0	8.00
9.00 Parking lot (chapter 21)			0	0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-16,985,540			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		0		0	12.00
13.00 Laundry and linen service			0	0.00	0	13.00
14.00 Cafeteria-employees and guests	A	-4,670	CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employees and others			0	0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0	0.00	0	16.00
17.00 Sale of drugs to other than patients			0	0.00	0	17.00
18.00 Sale of medical records and abstracts			0	0.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)			0	0.00	0	19.00
20.00 Vending machines			0	0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0	0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0	0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		ORESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			ONEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01 Depreciation - MOB			OMOB	1.01	0	26.01
26.02 Depreciation - OPS			OOPS	1.02	0	26.02
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0*** Cost Center Deleted ***	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

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	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	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	*** Cost Center Deleted ***	68.00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0 32.00
33.00	OTHER REVENUE - MISCELLANEOUS	B	-103,281	ADMINISTRATIVE & GENERAL	5.00	0 33.00
34.00	OTHER REVENUE - CPR TRAINING	B	-1,425	NURSING ADMINISTRATION	13.00	0 34.00
35.00	HIM MEDICAL RECORDS FEES	B	-30,660	MEDICAL RECORDS & LIBRARY	16.00	0 35.00
37.00	INTEREST INCOME	B	-117,949	NEW CAP REL COSTS-BLDG & FI XT	1.00	11 37.00
38.00	DIETARY REVENUE	B	-39,776	DIETARY	10.00	0 38.00
39.00	PATIENT TELEVISIONS	A	-1,511	OPERATION OF PLANT	7.00	0 39.00
40.00	PATIENT TELEPHONES	A	-3,660	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 40.00
41.00	PATIENT TELEPHONES	A	-2,138	NEW CAP REL COSTS-BLDG & FI XT	1.00	9 41.00
45.00	PATIENT TELEPHONES	A	-1,597	ADMINISTRATIVE & GENERAL	5.00	0 45.00
45.01	IHA & AHA LOBBYING FEES	A	-8,944	ADMINISTRATIVE & GENERAL	5.00	0 45.01
45.02	GIFT SHOP	A	-14,858	NEW CAP REL COSTS-BLDG & FI XT	1.00	9 45.02
45.03	GIFT SHOP	A	-9,340	OPERATION OF PLANT	7.00	0 45.03
45.04	ADVERTISING	A	-794,019	ADMINISTRATIVE & GENERAL	5.00	0 45.04
45.05	TAXES	A	-49,243	ADMINISTRATIVE & GENERAL	5.00	0 45.05
45.06	DONATION EXPENSE	A	-115,520	ADMINISTRATIVE & GENERAL	5.00	0 45.06
45.07	PHYSICIAN RECRUITMENT	A	-151,667	ADMINISTRATIVE & GENERAL	5.00	0 45.07
45.08	HOSPITAL ASSESSMENT FEE OFFSET	A	-4,331,629	ADMINISTRATIVE & GENERAL	5.00	0 45.08
45.09	HOSPITALIST OFFSET	A	-72,855	ADULTS & PEDIATRICS	30.00	0 45.09
45.10	HOSPITALIST OFFSET	A	-14,954	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 45.10
45.12	340B OFFSET	A	-433,712	DRUGS CHARGED TO PATIENTS	73.00	0 45.12
45.13	PROFESSIONAL OFFSET	A	-30,621	HEALTH COMPANIES	194.04	0 45.13
45.14	PROFESSIONAL OFFSET	A	-3,175,462	PHYSICIANS OFFICE	194.05	0 45.14
45.15	PROFESSIONAL OFFSET	A	-287,155	MHL ROCHESTER HEALTH CENTER	194.09	0 45.15
45.16	PROFESSIONAL OFFSET	A	-10,000	SPORTS HEALTH	194.11	0 45.16
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-26,909,366			50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0072

Period:
From 01/01/2022
To 12/31/2022

Worksheet A-8-2

Date/Time Prepared:
5/26/2023 8:03 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	22,000	0	22,000	211,500	147	1.00
2.00	17.00	SOCIAL SERVICE	9,000	0	9,000	211,500	60	2.00
3.00	30.00	ADULTS & PEDIATRICS	1,104,651	1,104,651	0	211,500	0	3.00
4.00	50.00	OPERATING ROOM	4,339,592	4,008,424	331,168	246,400	1,177	4.00
5.00	53.00	ANESTHESIOLOGY	2,392,325	2,392,325	0	211,500	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	47,133	0	47,133	211,500	314	6.00
7.00	76.01	ONCOLOGY	1,759,548	1,759,548	0	211,500	0	7.00
8.00	90.00	CLINIC	4,733,204	4,639,192	94,012	211,500	566	8.00
9.00	90.01	WOUND CARE	656,928	656,928	0	211,500	0	9.00
10.00	90.02	INTERNAL MEDICINE	499,626	499,626	0	211,500	0	10.00
11.00	90.03	PODIATRY CLINIC	712,222	712,222	0	211,500	0	11.00
12.00	91.00	EMERGENCY	959,268	959,268	0	211,500	0	12.00
200.00			17,235,497	16,732,184	503,313		2,264	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	14,947	747	0	0	0	1.00
2.00	17.00	SOCIAL SERVICE	6,101	305	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	139,429	6,971	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	31,928	1,596	0	0	0	6.00
7.00	76.01	ONCOLOGY	0	0	0	0	0	7.00
8.00	90.00	CLINIC	57,552	2,878	0	0	0	8.00
9.00	90.01	WOUND CARE	0	0	0	0	0	9.00
10.00	90.02	INTERNAL MEDICINE	0	0	0	0	0	10.00
11.00	90.03	PODIATRY CLINIC	0	0	0	0	0	11.00
12.00	91.00	EMERGENCY	0	0	0	0	0	12.00
200.00			249,957	12,497	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	14,947	7,053	7,053	1.00
2.00	17.00	SOCIAL SERVICE	0	6,101	2,899	2,899	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,104,651	3.00
4.00	50.00	OPERATING ROOM	0	139,429	191,739	4,200,163	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	2,392,325	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	31,928	15,205	15,205	6.00
7.00	76.01	ONCOLOGY	0	0	0	1,759,548	7.00
8.00	90.00	CLINIC	0	57,552	36,460	4,675,652	8.00
9.00	90.01	WOUND CARE	0	0	0	656,928	9.00
10.00	90.02	INTERNAL MEDICINE	0	0	0	499,626	10.00
11.00	90.03	PODIATRY CLINIC	0	0	0	712,222	11.00
12.00	91.00	EMERGENCY	0	0	0	959,268	12.00
200.00			0	249,957	253,356	16,985,540	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0072

Period:
From 01/01/2022
To 12/31/2022

Worksheet B
Part I
Date/Time Prepared:
5/26/2023 8:03 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT		
		NEW BLDG & FIXT	MOB	OPS			
		1.00	1.01	1.02			4.00
GENERAL SERVICE COST CENTERS							
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	5,849,100	5,849,100				1.00	
1.01 00101 MOB	223,692	0	223,692			1.01	
1.02 00102 OPS	147,326	0	0	147,326		1.02	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	14,769,283	36,758	6,105	0	14,812,146	4.00	
5.00 00500 ADMINISTRATIVE & GENERAL	8,827,160	467,702	19,343	0	1,504,081	5.00	
7.00 00700 OPERATION OF PLANT	3,011,102	1,065,849	1,322	11,704	296,466	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	215,780	18,678	0	0	0	8.00	
9.00 00900 HOUSEKEEPING	949,447	41,816	12,264	432	243,643	9.00	
10.00 01000 DIETARY	82,742	176,993	0	0	20,141	10.00	
11.00 01100 CAFETERIA	732,927	85,548	0	0	123,868	11.00	
13.00 01300 NURSING ADMINISTRATION	1,107,378	66,361	0	0	341,433	13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY	472,265	123,533	0	0	111,288	14.00	
15.00 01500 PHARMACY	1,638,048	62,949	0	0	236,417	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	6,415,244	222,851	0	0	716,250	16.00	
17.00 01700 SOCIAL SERVICE	189,966	37,177	0	0	52,476	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	2,812,309	1,042,863	0	0	1,215,654	30.00	
31.00 03100 INTENSIVE CARE UNIT	956,594	158,136	0	0	293,891	31.00	
43.00 04300 NURSERY	462,204	7,783	0	0	138,443	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	3,808,796	583,303	0	33,560	1,931,952	50.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	708,554	127,604	0	0	212,231	52.00	
53.00 05300 ANESTHESIOLOGY	3,297	61,572	0	0	0	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	2,265,494	270,234	0	8,309	485,519	54.00	
57.00 05700 CT SCAN	0	0	0	0	0	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00	
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00	
60.00 06000 LABORATORY	4,456,376	144,785	6,686	3,875	0	60.00	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	160,033	0	0	0	0	63.00	
65.00 06500 RESPIRATORY THERAPY	1,343,053	10,297	0	0	268,433	65.00	
66.00 06600 PHYSICAL THERAPY	1,326,047	165,409	0	0	400,614	66.00	
69.00 06900 ELECTROCARDIOLOGY	454,734	14,338	14,069	0	80,106	69.00	
69.01 06901 CARDIAC REHAB	346,446	166,517	0	0	106,266	69.01	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,997,104	0	0	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	1,704,816	0	0	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	12,128,784	0	0	0	9	73.00	
76.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	763,606	21,941	0	0	104,147	76.00	
76.01 03480 ONCOLOGY	1,154,527	0	0	48,216	242,481	76.01	
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 EXPRESS MEDICAL CENTER	1,666,209	0	0	0	431,431	88.00	
88.01 08801 FAMILY HEALTH CARE	954,858	0	13,701	0	296,743	88.01	
90.00 09000 CLINIC	667,697	6,286	50,682	0	1,527,822	90.00	
90.01 09001 WOUND CARE	199,845	0	13,611	0	54,330	90.01	
90.02 09002 INTERNAL MEDICINE	3,500	0	0	0	0	90.02	
90.03 09003 PODIATRY CLINIC	94,964	0	10,708	0	182,785	90.03	
91.00 09100 EMERGENCY	2,234,001	458,602	0	0	664,873	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00	
OTHER REIMBURSABLE COST CENTERS							
95.00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00	
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	88,305,308	5,645,885	148,491	106,096	12,283,793	118.00
NONREIMBURSABLE COST CENTERS							
194.00 07950 FOUNDATION	4,200	0	0	0	0	194.00	
194.01 07951 MOB	0	0	7,362	0	0	194.01	
194.02 07952 NONREIMBURSABLE OTHER	0	0	0	0	0	194.02	
194.03 07953 PIH	0	0	0	0	0	194.03	
194.04 07954 HEALTH COMPANIES	592,866	68,397	0	0	154,385	194.04	
194.05 07955 PHYSICIANS OFFICE	5,076,751	134,818	59,776	0	2,069,679	194.05	
194.06 07956 THE ARBORS	0	0	0	0	0	194.06	
194.07 07957 PAIN MANAGEMENT	0	0	0	0	0	194.07	
194.08 07958 OPS	0	0	0	41,230	0	194.08	
194.09 07959 MHL ROCHESTER HEALTH CENTER	388,454	0	0	0	201,301	194.09	
194.10 07961 RHEUMATOLOGY	0	0	0	0	0	194.10	
194.11 07960 SPORTS HEALTH	295,236	0	0	0	88,200	194.11	
194.12 07962 BEHAVIORAL HEALTH CLINIC	58,586	0	8,063	0	14,788	194.12	
200.00	Cross Foot Adjustments					200.00	
201.00	Negative Cost Centers					201.00	
202.00	TOTAL (sum lines 118 through 201)	94,721,401	5,849,100	223,692	147,326	14,812,146	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0072

Period:
From 01/01/2022
To 12/31/2022

Worksheet B
Part I
Date/Time Prepared:
5/26/2023 8:03 pm

Cost Center Description		Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		4A	5.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MOB					1.01
1.02	00102	OPS					1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,818,286	10,818,286			5.00
7.00	00700	OPERATION OF PLANT	4,386,443	565,579	4,952,022		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	234,458	30,231	14,856	279,545	8.00
9.00	00900	HOUSEKEEPING	1,247,602	160,863	93,920	0	1,502,385
10.00	01000	DIETARY	279,876	36,087	140,772	2,810	0
11.00	01100	CAFETERIA	942,343	121,504	68,041	0	0
13.00	01300	NURSING ADMINISTRATION	1,515,172	195,363	52,781	0	4,076
14.00	01400	CENTRAL SERVICES & SUPPLY	707,086	91,170	98,252	0	9,782
15.00	01500	PHARMACY	1,937,414	249,806	50,067	0	8,152
16.00	01600	MEDICAL RECORDS & LIBRARY	7,354,345	948,255	177,245	0	12,228
17.00	01700	SOCIAL SERVICE	279,619	36,054	29,569	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,070,826	653,822	829,439	99,442	502,968
31.00	03100	INTENSIVE CARE UNIT	1,408,621	181,625	125,774	7,620	81,518
43.00	04300	NURSERY	608,430	78,450	6,190	1,317	3,261
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,357,611	819,738	613,846	78,471	216,024
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,048,389	135,177	101,490	0	56,248
53.00	05300	ANESTHESIOLOGY	64,869	8,364	48,971	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,029,556	390,625	252,047	23,336	65,215
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	4,611,722	594,626	164,484	0	28,531
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	160,033	20,634	0	0	0
65.00	06500	RESPIRATORY THERAPY	1,621,783	209,109	8,190	0	36,683
66.00	06600	PHYSICAL THERAPY	1,892,070	243,960	131,559	6,549	16,304
69.00	06900	ELECTROCARDIOLOGY	563,247	72,624	78,778	0	36,683
69.01	06901	CARDIAC REHAB	619,229	79,842	132,440	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,997,104	386,441	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,704,816	219,816	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	12,128,793	1,563,848	0	0	0
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	889,694	114,715	17,451	0	0
76.01	03480	ONCOLOGY	1,445,224	186,344	215,384	0	65,215
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	EXPRESS MEDICAL CENTER	2,097,640	270,466	0	0	0
88.01	08801	FAMILY HEALTH CARE	1,265,302	163,146	65,613	0	48,911
90.00	09000	CLINIC	2,252,487	290,431	247,714	0	81,518
90.01	09001	WOUND CARE	267,786	34,528	65,184	0	20,380
90.02	09002	INTERNAL MEDICINE	3,500	451	0	0	0
90.03	09003	PODIATRY CLINIC	288,457	37,193	51,281	0	0
91.00	09100	EMERGENCY	3,357,476	432,906	364,751	60,000	130,430
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	85,457,309	9,623,793	4,246,089	279,545	1,424,127
NONREIMBURSABLE COST CENTERS							
194.00	07950	FOUNDATION	4,200	542	0	0	13,043
194.01	07951	MOB	7,362	949	35,259	0	0
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0
194.03	07953	PIH	0	0	0	0	0
194.04	07954	HEALTH COMPANIES	815,648	105,168	54,400	0	16,304
194.05	07955	PHYSICIANS OFFICE	7,341,024	946,537	393,486	0	16,304
194.06	07956	THE ARBORS	0	0	0	0	0
194.07	07957	PAIN MANAGEMENT	0	0	0	0	0
194.08	07958	OPS	41,230	5,316	184,173	0	32,607
194.09	07959	MHL ROCHESTER HEALTH CENTER	589,755	76,042	0	0	0
194.10	07961	RHEUMATOLOGY	0	0	0	0	0
194.11	07960	SPORTS HEALTH	383,436	49,439	0	0	0
194.12	07962	BEHAVIORAL HEALTH CLINIC	81,437	10,500	38,615	0	0
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	94,721,401	10,818,286	4,952,022	279,545	1,502,385

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0072

Period:
From 01/01/2022
To 12/31/2022

Worksheet B
Part I
Date/Time Prepared:
5/26/2023 8:03 pm

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MOB					1.01
1.02	00102	OPS					1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY	459,545				10.00
11.00	01100	CAFETERIA	0	1,131,888			11.00
13.00	01300	NURSING ADMINISTRATION	0	24,563	1,791,955		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	20,477	0	926,767	14.00
15.00	01500	PHARMACY	0	21,868	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	63,619	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	9,602	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	425,720	110,709	532,035	0	30.00
31.00	03100	INTENSIVE CARE UNIT	33,825	26,443	111,646	0	31.00
43.00	04300	NURSERY	0	14,950	63,122	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	161,121	680,281	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	22,920	96,771	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	49,419	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	27,211	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	32,732	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	8,464	0	0	69.00
69.01	06901	CARDIAC REHAB	0	17,929	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	926,767	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	10,568	0	0	76.00
76.01	03480	ONCOLOGY	0	32,357	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	EXPRESS MEDICAL CENTER	0	32,823	0	0	88.00
88.01	08801	FAMILY HEALTH CARE	0	27,155	0	0	88.01
90.00	09000	CLINIC	0	111,210	0	0	90.00
90.01	09001	WOUND CARE	0	5,212	0	0	90.01
90.02	09002	INTERNAL MEDICINE	0	3,193	0	0	90.02
90.03	09003	PODIATRY CLINIC	0	17,763	0	0	90.03
91.00	09100	EMERGENCY	0	72,972	308,100	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	459,545	925,280	1,791,955	926,767	2,267,307
NONREIMBURSABLE COST CENTERS							
194.00	07950	FOUNDATION	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	0	22,292	0	0	194.04
194.05	07955	PHYSICIANS OFFICE	0	172,909	0	0	194.05
194.06	07956	THE ARBORS	0	0	0	0	194.06
194.07	07957	PAIN MANAGEMENT	0	0	0	0	194.07
194.08	07958	OPS	0	0	0	0	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	0	0	0	0	194.09
194.10	07961	RHEUMATOLOGY	0	0	0	0	194.10
194.11	07960	SPORTS HEALTH	0	11,407	0	0	194.11
194.12	07962	BEHAVIORAL HEALTH CLINIC	0	0	0	0	194.12
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	459,545	1,131,888	1,791,955	926,767	2,267,307

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0072

Period:
From 01/01/2022
To 12/31/2022

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MOB					1.01
1.02	00102	OPS					1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,555,692				16.00
17.00	01700	SOCIAL SERVICE	0	354,844			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	470,572	278,754	8,974,287	0	8,974,287
31.00	03100	INTENSIVE CARE UNIT	82,805	41,540	2,101,417	0	2,101,417
43.00	04300	NURSERY	59,626	0	835,346	0	835,346
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,600,007	0	11,527,099	0	11,527,099
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	1,460,995	0	1,460,995
53.00	05300	ANESTHESIOLOGY	108,579	0	230,783	0	230,783
54.00	05400	RADIOLOGY-DIAGNOSTIC	634,838	0	4,445,036	0	4,445,036
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	965,250	0	6,364,613	0	6,364,613
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	17,286	0	197,953	0	197,953
65.00	06500	RESPIRATORY THERAPY	274,039	0	2,177,015	0	2,177,015
66.00	06600	PHYSICAL THERAPY	198,415	0	2,521,589	0	2,521,589
69.00	06900	ELECTROCARDIOLOGY	159,787	0	919,583	0	919,583
69.01	06901	CARDIAC REHAB	22,593	0	872,033	0	872,033
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	4,310,312	0	4,310,312
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	1,924,632	0	1,924,632
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	15,959,948	0	15,959,948
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	502,831	0	1,535,259	0	1,535,259
76.01	03480	ONCOLOGY	489,702	0	2,434,226	0	2,434,226
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	EXPRESS MEDICAL CENTER	113,287	0	2,514,216	0	2,514,216
88.01	08801	FAMILY HEALTH CARE	59,491	0	1,629,618	0	1,629,618
90.00	09000	CLINIC	407,708	0	3,391,068	0	3,391,068
90.01	09001	WOUND CARE	140,050	0	533,140	0	533,140
90.02	09002	INTERNAL MEDICINE	16,175	0	23,319	0	23,319
90.03	09003	PODIATRY CLINIC	82,448	0	477,142	0	477,142
91.00	09100	EMERGENCY	678,380	34,550	5,439,565	0	5,439,565
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,083,869	354,844	82,800,194	0	82,800,194
NONREIMBURSABLE COST CENTERS							
194.00	07950	FOUNDATION	0	0	17,785	0	17,785
194.01	07951	MOB	0	0	43,570	0	43,570
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0
194.03	07953	PIH	0	0	0	0	0
194.04	07954	HEALTH COMPANIES	0	0	1,013,812	0	1,013,812
194.05	07955	PHYSICIANS OFFICE	443,210	0	9,313,470	0	9,313,470
194.06	07956	THE ARBORS	0	0	0	0	0
194.07	07957	PAIN MANAGEMENT	0	0	0	0	0
194.08	07958	OPS	0	0	263,326	0	263,326
194.09	07959	MHL ROCHESTER HEALTH CENTER	26,463	0	692,260	0	692,260
194.10	07961	RHEUMATOLOGY	0	0	0	0	0
194.11	07960	SPORTS HEALTH	0	0	444,282	0	444,282
194.12	07962	BEHAVIORAL HEALTH CLINIC	2,150	0	132,702	0	132,702
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	8,555,692	354,844	94,721,401	0	94,721,401

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part II Date/Time Prepared: 5/26/2023 8:03 pm
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal			
		NEW BLDG & FIXT	MOB	OPS				
		0	1.00	1.01			1.02	2A
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00		
1.01	00101	MOB				1.01		
1.02	00102	OPS				1.02		
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	36,758	6,105	0	42,863	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	467,702	19,343	0	487,045	5.00
7.00	00700	OPERATION OF PLANT	0	1,065,849	1,322	11,704	1,078,875	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	18,678	0	0	18,678	8.00
9.00	00900	HOUSEKEEPING	0	41,816	12,264	432	54,512	9.00
10.00	01000	DIETARY	0	176,993	0	0	176,993	10.00
11.00	01100	CAFETERIA	0	85,548	0	0	85,548	11.00
13.00	01300	NURSING ADMINISTRATION	0	66,361	0	0	66,361	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	123,533	0	0	123,533	14.00
15.00	01500	PHARMACY	0	62,949	0	0	62,949	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	222,851	0	0	222,851	16.00
17.00	01700	SOCIAL SERVICE	0	37,177	0	0	37,177	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	1,042,863	0	0	1,042,863	30.00
31.00	03100	INTENSIVE CARE UNIT	0	158,136	0	0	158,136	31.00
43.00	04300	NURSERY	0	7,783	0	0	7,783	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	583,303	0	33,560	616,863	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	127,604	0	0	127,604	52.00
53.00	05300	ANESTHESIOLOGY	0	61,572	0	0	61,572	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	270,234	0	8,309	278,543	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (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	144,785	6,686	3,875	155,346	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	10,297	0	0	10,297	65.00
66.00	06600	PHYSICAL THERAPY	0	165,409	0	0	165,409	66.00
69.00	06900	ELECTROCARDIOLOGY	0	14,338	14,069	0	28,407	69.00
69.01	06901	CARDIAC REHAB	0	166,517	0	0	166,517	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	21,941	0	0	21,941	76.00
76.01	03480	ONCOLOGY	0	0	0	48,216	48,216	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	EXPRESS MEDICAL CENTER	0	0	0	0	0	88.00
88.01	08801	FAMILY HEALTH CARE	0	0	13,701	0	13,701	88.01
90.00	09000	CLINIC	0	6,286	50,682	0	56,968	90.00
90.01	09001	WOUND CARE	0	0	13,611	0	13,611	90.01
90.02	09002	INTERNAL MEDICINE	0	0	0	0	0	90.02
90.03	09003	PODIATRY CLINIC	0	0	10,708	0	10,708	90.03
91.00	09100	EMERGENCY	0	458,602	0	0	458,602	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	5,645,885	148,491	106,096	5,900,472	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	7,362	0	7,362	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	0	68,397	0	0	68,397	194.04
194.05	07955	PHYSICIANS OFFICE	0	134,818	59,776	0	194,594	194.05
194.06	07956	THE ARBORS	0	0	0	0	0	194.06
194.07	07957	PAIN MANAGEMENT	0	0	0	0	0	194.07
194.08	07958	OPS	0	0	0	41,230	41,230	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	0	0	0	0	0	194.09
194.10	07961	RHEUMATOLOGY	0	0	0	0	0	194.10
194.11	07960	SPORTS HEALTH	0	0	0	0	0	194.11
194.12	07962	BEHAVIORAL HEALTH CLINIC	0	0	8,063	0	8,063	194.12
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	5,849,100	223,692	147,326	6,220,118	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part II Date/Time Prepared: 5/26/2023 8:03 pm
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Cost Center Description		EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		4.00	5.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MOB					1.01
1.02	00102	OPS					1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	42,863				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,354	491,399			5.00
7.00	00700	OPERATION OF PLANT	858	25,691	1,105,424		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,373	3,316	23,367	8.00
9.00	00900	HOUSEKEEPING	705	7,307	20,965	0	83,489
10.00	01000	DIETARY	58	1,639	31,424	235	0
11.00	01100	CAFETERIA	359	5,519	15,189	0	0
13.00	01300	NURSING ADMINISTRATION	988	8,874	11,782	0	227
14.00	01400	CENTRAL SERVICES & SUPPLY	322	4,141	21,933	0	544
15.00	01500	PHARMACY	684	11,347	11,176	0	453
16.00	01600	MEDICAL RECORDS & LIBRARY	2,074	43,074	39,566	0	680
17.00	01700	SOCIAL SERVICE	152	1,638	6,600	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,519	29,700	185,156	8,313	27,947
31.00	03100	INTENSIVE CARE UNIT	851	8,250	28,076	637	4,530
43.00	04300	NURSERY	401	3,564	1,382	110	181
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,593	37,237	137,027	6,559	12,005
52.00	05200	DELIVERY ROOM & LABOR ROOM	614	6,140	22,655	0	3,126
53.00	05300	ANESTHESIOLOGY	0	380	10,932	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,406	17,744	56,264	1,951	3,624
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	0	27,011	36,717	0	1,586
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	937	0	0	0
65.00	06500	RESPIRATORY THERAPY	777	9,499	1,828	0	2,039
66.00	06600	PHYSICAL THERAPY	1,160	11,082	29,367	547	906
69.00	06900	ELECTROCARDIOLOGY	232	3,299	17,585	0	2,039
69.01	06901	CARDIAC REHAB	308	3,627	29,564	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	17,554	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	9,985	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	71,020	0	0	0
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	302	5,211	3,895	0	0
76.01	03480	ONCOLOGY	702	8,465	48,079	0	3,624
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	EXPRESS MEDICAL CENTER	1,249	12,286	0	0	0
88.01	08801	FAMILY HEALTH CARE	859	7,411	14,647	0	2,718
90.00	09000	CLINIC	4,423	13,193	55,296	0	4,530
90.01	09001	WOUND CARE	157	1,568	14,551	0	1,133
90.02	09002	INTERNAL MEDICINE	0	20	0	0	0
90.03	09003	PODIATRY CLINIC	529	1,689	11,447	0	0
91.00	09100	EMERGENCY	1,925	19,665	81,422	5,015	7,248
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	35,561	437,140	947,841	23,367	79,140
NONREIMBURSABLE COST CENTERS							
194.00	07950	FOUNDATION	0	25	0	0	725
194.01	07951	MOB	0	43	7,871	0	0
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0
194.03	07953	PIH	0	0	0	0	0
194.04	07954	HEALTH COMPANIES	447	4,777	12,143	0	906
194.05	07955	PHYSICIANS OFFICE	5,974	42,996	87,837	0	906
194.06	07956	THE ARBORS	0	0	0	0	0
194.07	07957	PAIN MANAGEMENT	0	0	0	0	0
194.08	07958	OPS	0	241	41,112	0	1,812
194.09	07959	MHL ROCHESTER HEALTH CENTER	583	3,454	0	0	0
194.10	07961	RHEUMATOLOGY	0	0	0	0	0
194.11	07960	SPORTS HEALTH	255	2,246	0	0	0
194.12	07962	BEHAVIORAL HEALTH CLINIC	43	477	8,620	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	42,863	491,399	1,105,424	23,367	83,489

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part II Date/Time Prepared: 5/26/2023 8:03 pm
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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MOB					1.01
1.02	00102	OPS					1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY	210,349				10.00
11.00	01100	CAFETERIA	0	106,615			11.00
13.00	01300	NURSING ADMINISTRATION	0	2,314	90,546		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,929	0	152,402	14.00
15.00	01500	PHARMACY	0	2,060	0	88,669	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,992	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	904	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	194,866	10,428	26,883	0	30.00
31.00	03100	INTENSIVE CARE UNIT	15,483	2,491	5,641	0	31.00
43.00	04300	NURSERY	0	1,408	3,189	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	15,176	34,375	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,159	4,890	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,655	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	2,563	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3,083	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	797	0	0	69.00
69.01	06901	CARDIAC REHAB	0	1,689	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	152,402	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	88,669	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	995	0	0	76.00
76.01	03480	ONCOLOGY	0	3,048	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	EXPRESS MEDICAL CENTER	0	3,092	0	0	88.00
88.01	08801	FAMILY HEALTH CARE	0	2,558	0	0	88.01
90.00	09000	CLINIC	0	10,475	0	0	90.00
90.01	09001	WOUND CARE	0	491	0	0	90.01
90.02	09002	INTERNAL MEDICINE	0	301	0	0	90.02
90.03	09003	PODIATRY CLINIC	0	1,673	0	0	90.03
91.00	09100	EMERGENCY	0	6,873	15,568	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	210,349	87,154	90,546	152,402	88,669
NONREIMBURSABLE COST CENTERS							
194.00	07950	FOUNDATION	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	0	2,100	0	0	194.04
194.05	07955	PHYSICIANS OFFICE	0	16,287	0	0	194.05
194.06	07956	THE ARBORS	0	0	0	0	194.06
194.07	07957	PAIN MANAGEMENT	0	0	0	0	194.07
194.08	07958	OPS	0	0	0	0	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	0	0	0	0	194.09
194.10	07961	RHEUMATOLOGY	0	0	0	0	194.10
194.11	07960	SPORTS HEALTH	0	1,074	0	0	194.11
194.12	07962	BEHAVIORAL HEALTH CLINIC	0	0	0	0	194.12
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	210,349	106,615	90,546	152,402	88,669

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0072		Period: From 01/01/2022 To 12/31/2022		Worksheet B Part II Date/Time Prepared: 5/26/2023 8:03 pm	
Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MOB					1.01
1.02	00102	OPS					1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	314,237				16.00
17.00	01700	SOCIAL SERVICE	0	46,471			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	17,281	36,506	1,583,462	0	1,583,462
31.00	03100	INTENSIVE CARE UNIT	3,041	5,440	232,576	0	232,576
43.00	04300	NURSERY	2,190	0	20,208	0	20,208
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	95,528	0	960,363	0	960,363
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	167,188	0	167,188
53.00	05300	ANESTHESIOLOGY	3,987	0	76,871	0	76,871
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,313	0	387,500	0	387,500
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	35,446	0	256,106	0	256,106
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	635	0	1,572	0	1,572
65.00	06500	RESPIRATORY THERAPY	10,063	0	37,066	0	37,066
66.00	06600	PHYSICAL THERAPY	7,286	0	218,840	0	218,840
69.00	06900	ELECTROCARDIOLOGY	5,868	0	58,227	0	58,227
69.01	06901	CARDIAC REHAB	830	0	202,535	0	202,535
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	169,956	0	169,956
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	9,985	0	9,985
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	159,689	0	159,689
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	18,465	0	50,809	0	50,809
76.01	03480	ONCOLOGY	17,983	0	130,117	0	130,117
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	EXPRESS MEDICAL CENTER	4,160	0	20,787	0	20,787
88.01	08801	FAMILY HEALTH CARE	2,185	0	44,079	0	44,079
90.00	09000	CLINIC	14,972	0	159,857	0	159,857
90.01	09001	WOUND CARE	5,143	0	36,654	0	36,654
90.02	09002	INTERNAL MEDICINE	594	0	915	0	915
90.03	09003	PODIATRY CLINIC	3,028	0	29,074	0	29,074
91.00	09100	EMERGENCY	24,912	4,525	625,755	0	625,755
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	296,910	46,471	5,640,191	0	5,640,191
NONREIMBURSABLE COST CENTERS							
194.00	07950	FOUNDATION	0	0	750	0	750
194.01	07951	MOB	0	0	15,276	0	15,276
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	0	0	88,770	0	88,770
194.05	07955	PHYSICIANS OFFICE	16,276	0	364,870	0	364,870
194.06	07956	THE ARBORS	0	0	0	0	194.06
194.07	07957	PAIN MANAGEMENT	0	0	0	0	194.07
194.08	07958	OPS	0	0	84,395	0	84,395
194.09	07959	MHL ROCHESTER HEALTH CENTER	972	0	5,009	0	5,009
194.10	07961	RHEUMATOLOGY	0	0	0	0	194.10
194.11	07960	SPORTS HEALTH	0	0	3,575	0	3,575
194.12	07962	BEHAVIORAL HEALTH CLINIC	79	0	17,282	0	17,282
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	314,237	46,471	6,220,118	0	6,220,118

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0072

Period:
From 01/01/2022
To 12/31/2022

Worksheet B-1
Date/Time Prepared:
5/26/2023 8:03 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
	NEW BLDG & FIXT (SQUARE FEET)	MOB (SQUARE FEET)	OPS (SQUARE FEET)			
	1.00	1.01	1.02			
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	195,407				1.00
1.01 00101	MOB	0	44,997			1.01
1.02 00102	OPS	0	0	27,643		1.02
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,228	1,228	0	45,668,083	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	15,625	3,891	0	4,637,302	-10,818,286
7.00 00700	OPERATION OF PLANT	35,608	266	2,196	914,049	0
8.00 00800	LAUNDRY & LINEN SERVICE	624	0	0	0	0
9.00 00900	HOUSEKEEPING	1,397	2,467	81	751,187	0
10.00 01000	DIETARY	5,913	0	0	62,098	0
11.00 01100	CAFETERIA	2,858	0	0	381,902	0
13.00 01300	NURSING ADMINISTRATION	2,217	0	0	1,052,689	0
14.00 01400	CENTRAL SERVICES & SUPPLY	4,127	0	0	343,116	0
15.00 01500	PHARMACY	2,103	0	0	728,908	0
16.00 01600	MEDICAL RECORDS & LIBRARY	7,445	0	0	2,208,305	0
17.00 01700	SOCIAL SERVICE	1,242	0	0	161,790	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	34,840	0	0	3,748,038	0
31.00 03100	INTENSIVE CARE UNIT	5,283	0	0	906,109	0
43.00 04300	NURSERY	260	0	0	426,839	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	19,487	0	6,297	5,956,490	0
52.00 05200	DELIVERY ROOM & LABOR ROOM	4,263	0	0	654,340	0
53.00 05300	ANESTHESIOLOGY	2,057	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	9,028	0	1,559	1,496,925	0
57.00 05700	CT SCAN	0	0	0	0	0
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00 06000	LABORATORY	4,837	1,345	727	0	0
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	344	0	0	827,619	0
66.00 06600	PHYSICAL THERAPY	5,526	0	0	1,235,152	0
69.00 06900	ELECTROCARDIOLOGY	479	2,830	0	246,977	0
69.01 06901	CARDIAC REHAB	5,563	0	0	327,633	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	27	0
76.00 03450	NUCLEAR MEDICINE - DIAGNOSTIC	733	0	0	321,099	0
76.01 03480	ONCOLOGY	0	0	9,047	747,604	0
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	EXPRESS MEDICAL CENTER	0	0	0	1,330,164	0
88.01 08801	FAMILY HEALTH CARE	0	2,756	0	914,901	0
90.00 09000	CLINIC	210	10,195	0	4,710,499	0
90.01 09001	WOUND CARE	0	2,738	0	167,507	0
90.02 09002	INTERNAL MEDICINE	0	0	0	0	0
90.03 09003	PODIATRY CLINIC	0	2,154	0	563,554	0
91.00 09100	EMERGENCY	15,321	0	0	2,049,901	0
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	188,618	29,870	19,907	37,872,724	-10,818,286
NONREIMBURSABLE COST CENTERS						
194.00 07950	FOUNDATION	0	0	0	0	0
194.01 07951	MOB	0	1,481	0	0	0
194.02 07952	NONREIMBURSABLE OTHER	0	0	0	0	0
194.03 07953	PIH	0	0	0	0	0
194.04 07954	HEALTH COMPANIES	2,285	0	0	475,993	0
194.05 07955	PHYSICIANS OFFICE	4,504	12,024	0	6,381,196	0
194.06 07956	THE ARBORS	0	0	0	0	0
194.07 07957	PAIN MANAGEMENT	0	0	0	0	0
194.08 07958	OPS	0	0	7,736	0	0
194.09 07959	MHL ROCHESTER HEALTH CENTER	0	0	0	620,640	0
194.10 07961	RHEUMATOLOGY	0	0	0	0	0
194.11 07960	SPORTS HEALTH	0	0	0	271,935	0
194.12 07962	BEHAVIORAL HEALTH CLINIC	0	1,622	0	45,595	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0072

Period:
From 01/01/2022
To 12/31/2022

Worksheet B-1
Date/Time Prepared:
5/26/2023 8:03 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
	NEW BLDG & FIXT (SQUARE FEET)	MOB (SQUARE FEET)	OPS (SQUARE FEET)			
	1.00	1.01	1.02			
202.00	Cost to be allocated (per Wkst. B, Part I)	5,849,100	223,692	147,326	14,812,146	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	29.932909	4.971265	5.329595	0.324344	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)				42,863	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)				0.000939	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0072

Period:
From 01/01/2022
To 12/31/2022

Worksheet B-1
Date/Time Prepared:
5/26/2023 8:03 pm

Cost Center Description		ADMINISTRATIVE & GENERAL (ACCU. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MOB					1.01
1.02	00102	OPS					1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	83,903,115				5.00
7.00	00700	OPERATION OF PLANT	4,386,443	208,005			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	234,458	624	293,561		8.00
9.00	00900	HOUSEKEEPING	1,247,602	3,945	0	1,843	9.00
10.00	01000	DIETARY	279,876	5,913	2,951	0	4,592
11.00	01100	CAFETERIA	942,343	2,858	0	0	0
13.00	01300	NURSING ADMINISTRATION	1,515,172	2,217	0	5	0
14.00	01400	CENTRAL SERVICES & SUPPLY	707,086	4,127	0	12	0
15.00	01500	PHARMACY	1,937,414	2,103	0	10	0
16.00	01600	MEDICAL RECORDS & LIBRARY	7,354,345	7,445	0	15	0
17.00	01700	SOCIAL SERVICE	279,619	1,242	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,070,826	34,840	104,429	617	4,254
31.00	03100	INTENSIVE CARE UNIT	1,408,621	5,283	8,002	100	338
43.00	04300	NURSERY	608,430	260	1,383	4	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,357,611	25,784	82,405	265	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,048,389	4,263	0	69	0
53.00	05300	ANESTHESIOLOGY	64,869	2,057	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,029,556	10,587	24,506	80	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	4,611,722	6,909	0	35	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	160,033	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	1,621,783	344	0	45	0
66.00	06600	PHYSICAL THERAPY	1,892,070	5,526	6,877	20	0
69.00	06900	ELECTROCARDIOLOGY	563,247	3,309	0	45	0
69.01	06901	CARDIAC REHAB	619,229	5,563	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,997,104	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,704,816	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	12,128,793	0	0	0	0
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	889,694	733	0	0	0
76.01	03480	ONCOLOGY	1,445,224	9,047	0	80	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	EXPRESS MEDICAL CENTER	2,097,640	0	0	0	0
88.01	08801	FAMILY HEALTH CARE	1,265,302	2,756	0	60	0
90.00	09000	CLINIC	2,252,487	10,405	0	100	0
90.01	09001	WOUND CARE	267,786	2,738	0	25	0
90.02	09002	INTERNAL MEDICINE	3,500	0	0	0	0
90.03	09003	PODIATRY CLINIC	288,457	2,154	0	0	0
91.00	09100	EMERGENCY	3,357,476	15,321	63,008	160	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	74,639,023	178,353	293,561	1,747	4,592
NONREIMBURSABLE COST CENTERS							
194.00	07950	FOUNDATION	4,200	0	0	16	0
194.01	07951	MOB	7,362	1,481	0	0	0
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0
194.03	07953	PIH	0	0	0	0	0
194.04	07954	HEALTH COMPANIES	815,648	2,285	0	20	0
194.05	07955	PHYSICIANS OFFICE	7,341,024	16,528	0	20	0
194.06	07956	THE ARBORS	0	0	0	0	0
194.07	07957	PAIN MANAGEMENT	0	0	0	0	0
194.08	07958	OPS	41,230	7,736	0	40	0
194.09	07959	MHL ROCHESTER HEALTH CENTER	589,755	0	0	0	0
194.10	07961	RHEUMATOLOGY	0	0	0	0	0
194.11	07960	SPORTS HEALTH	383,436	0	0	0	0
194.12	07962	BEHAVIORAL HEALTH CLINIC	81,437	1,622	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	10,818,286	4,952,022	279,545	1,502,385	459,545
203.00		Unit cost multiplier (Wkst. B, Part I)	0.128938	23.807226	0.952255	815.184482	100.075131

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0072			Period: From 01/01/2022 To 12/31/2022		Worksheet B-1 Date/Time Prepared: 5/26/2023 8:03 pm	
Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)		
		5.00	7.00	8.00	9.00	10.00		
204.00	Cost to be allocated (per Wkst. B, Part II)	491,399	1,105,424	23,367	83,489	210,349	204.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	0.005857	5.314411	0.079598	45.300597	45.807709	205.00	
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00	
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0072

Period:
From 01/01/2022
To 12/31/2022

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		CAFETERIA (MAN HOURS)	NURSING ADMINISTRATIO N (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (100% SUPPLIES)	PHARMACY (100% DRUGS)	MEDICAL RECORDS & LIBRARY (REVENUE)	
		11.00	13.00	14.00	15.00	16.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	106,615	90,546	152,402	88,669	314,237	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.119458	0.270570	1,524.020000	886.690000	0.001418	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet B-1 Date/Time Prepared: 5/26/2023 8:03 pm
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Cost Center Description		SOCIAL SERVICE (HOURS)	
		17.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101 MOB		1.01
1.02	00102 OPS		1.02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE	8,884	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	6,979	30.00
31.00	03100 INTENSIVE CARE UNIT	1,040	31.00
43.00	04300 NURSERY	0	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300 ANESTHESIOLOGY	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	54.00
57.00	05700 CT SCAN	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	59.00
60.00	06000 LABORATORY	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	65.00
66.00	06600 PHYSICAL THERAPY	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	69.00
69.01	06901 CARDIAC REHAB	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	76.00
76.01	03480 ONCOLOGY	0	76.01
OUTPATIENT SERVICE COST CENTERS			
88.00	08800 EXPRESS MEDICAL CENTER	0	88.00
88.01	08801 FAMILY HEALTH CARE	0	88.01
90.00	09000 CLINIC	0	90.00
90.01	09001 WOUND CARE	0	90.01
90.02	09002 INTERNAL MEDICINE	0	90.02
90.03	09003 PODIATRY CLINIC	0	90.03
91.00	09100 EMERGENCY	865	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	0	95.00
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	8,884	118.00
NONREIMBURSABLE COST CENTERS			
194.00	07950 FOUNDATION	0	194.00
194.01	07951 MOB	0	194.01
194.02	07952 NONREIMBURSABLE OTHER	0	194.02
194.03	07953 PIH	0	194.03
194.04	07954 HEALTH COMPANIES	0	194.04
194.05	07955 PHYSICIANS OFFICE	0	194.05
194.06	07956 THE ARBORS	0	194.06
194.07	07957 PAIN MANAGEMENT	0	194.07
194.08	07958 OPS	0	194.08
194.09	07959 MHL ROCHESTER HEALTH CENTER	0	194.09
194.10	07961 RHEUMATOLOGY	0	194.10
194.11	07960 SPORTS HEALTH	0	194.11
194.12	07962 BEHAVIORAL HEALTH CLINIC	0	194.12
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)	354,844	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	39.941918	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	46,471	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0072

Period:
From 01/01/2022
To 12/31/2022

Worksheet B-1
Date/Time Prepared:
5/26/2023 8:03 pm

Cost Center Description		SOCIAL SERVICE (HOURS)	
		17.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	5.230864	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)		206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0072

Period:
From 01/01/2022
To 12/31/2022

Worksheet C
Part I
Date/Time Prepared:
5/26/2023 8:03 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	Hospital		
					RCE Disallowance	Total Costs	
1.00	2.00	3.00	4.00	5.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	8,974,287		8,974,287	0	8,974,287	30.00
31.00	03100 INTENSIVE CARE UNIT	2,101,417		2,101,417	0	2,101,417	31.00
43.00	04300 NURSERY	835,346		835,346	0	835,346	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	11,527,099		11,527,099	191,739	11,718,838	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,460,995		1,460,995	0	1,460,995	52.00
53.00	05300 ANESTHESIOLOGY	230,783		230,783	0	230,783	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,445,036		4,445,036	15,205	4,460,241	54.00
57.00	05700 CT SCAN	0		0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000 LABORATORY	6,364,613		6,364,613	0	6,364,613	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	197,953		197,953	0	197,953	63.00
65.00	06500 RESPIRATORY THERAPY	2,177,015	0	2,177,015	0	2,177,015	65.00
66.00	06600 PHYSICAL THERAPY	2,521,589	0	2,521,589	0	2,521,589	66.00
69.00	06900 ELECTROCARDIOLOGY	919,583		919,583	0	919,583	69.00
69.01	06901 CARDIAC REHAB	872,033		872,033	0	872,033	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,310,312		4,310,312	0	4,310,312	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1,924,632		1,924,632	0	1,924,632	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	15,959,948		15,959,948	0	15,959,948	73.00
76.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	1,535,259		1,535,259	0	1,535,259	76.00
76.01	03480 ONCOLOGY	2,434,226		2,434,226	0	2,434,226	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 EXPRESS MEDICAL CENTER	2,514,216		2,514,216	0	2,514,216	88.00
88.01	08801 FAMILY HEALTH CARE	1,629,618		1,629,618	0	1,629,618	88.01
90.00	09000 CLINIC	3,391,068		3,391,068	36,460	3,427,528	90.00
90.01	09001 WOUND CARE	533,140		533,140	0	533,140	90.01
90.02	09002 INTERNAL MEDICINE	23,319		23,319	0	23,319	90.02
90.03	09003 PODIATRY CLINIC	477,142		477,142	0	477,142	90.03
91.00	09100 EMERGENCY	5,439,565		5,439,565	0	5,439,565	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,741,537		1,741,537	0	1,741,537	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0		0	0	0	95.00
200.00	Subtotal (see instructions)	84,541,731	0	84,541,731	243,404	84,785,135	200.00
201.00	Less Observation Beds	1,741,537		1,741,537		1,741,537	201.00
202.00	Total (see instructions)	82,800,194	0	82,800,194	243,404	83,043,598	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0072

Period:
From 01/01/2022
To 12/31/2022

Worksheet C
Part I
Date/Time Prepared:
5/26/2023 8:03 pm

		Title XVIII			Hospital	PPS	
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	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,379,919		6,379,919		30.00
31.00	03100	INTENSIVE CARE UNIT	1,052,372		1,052,372		31.00
43.00	04300	NURSERY	1,543,690		1,543,690		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,897,496	38,475,561	44,373,057	0.259777	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,272,449	94,742	2,367,191	0.617185	52.00
53.00	05300	ANESTHESIOLOGY	308,163	2,503,732	2,811,895	0.082074	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	790,850	15,525,869	16,316,719	0.272422	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	3,169,667	21,827,743	24,997,410	0.254611	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	174,418	362,941	537,359	0.368381	63.00
65.00	06500	RESPIRATORY THERAPY	3,359,806	2,680,411	6,040,217	0.360420	65.00
66.00	06600	PHYSICAL THERAPY	411,446	4,703,609	5,115,055	0.492974	66.00
69.00	06900	ELECTROCARDIOLOGY	628,664	4,711,391	5,340,055	0.172205	69.00
69.01	06901	CARDIAC REHAB	0	568,728	568,728	1.533304	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,267,770	6,121,022	7,388,792	0.583358	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	687,847	8,381,774	9,069,621	0.212206	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,735,419	59,616,227	68,351,646	0.233498	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	1,004,442	12,017,536	13,021,978	0.117898	76.00
76.01	03480	ONCOLOGY	201,684	11,973,173	12,174,857	0.199939	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	EXPRESS MEDICAL CENTER	0	3,432,174	3,432,174		88.00
88.01	08801	FAMILY HEALTH CARE	90,696	6,228,686	6,319,382		88.01
90.00	09000	CLINIC	5,260	3,033,982	3,039,242	1.115761	90.00
90.01	09001	WOUND CARE	19,433	2,647,567	2,667,000	0.199903	90.01
90.02	09002	INTERNAL MEDICINE	0	63,462	63,462	0.367448	90.02
90.03	09003	PODIATRY CLINIC	270	204,066	204,336	2.335085	90.03
91.00	09100	EMERGENCY	1,339,847	16,689,155	18,029,002	0.301712	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	167,512	1,611,527	1,779,039	0.978920	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
200.00		Subtotal (see instructions)	39,509,120	223,475,078	262,984,198		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	39,509,120	223,475,078	262,984,198		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared: 5/26/2023 8:03 pm
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
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.264098		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.617185		52.00
53.00	05300 ANESTHESIOLOGY	0.082074		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.273354		54.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.254611		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.368381		63.00
65.00	06500 RESPIRATORY THERAPY	0.360420		65.00
66.00	06600 PHYSICAL THERAPY	0.492974		66.00
69.00	06900 ELECTROCARDIOLOGY	0.172205		69.00
69.01	06901 CARDIAC REHAB	1.533304		69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.583358		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.212206		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.233498		73.00
76.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.117898		76.00
76.01	03480 ONCOLOGY	0.199939		76.01
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 EXPRESS MEDICAL CENTER			88.00
88.01	08801 FAMILY HEALTH CARE			88.01
90.00	09000 CLINIC	1.127758		90.00
90.01	09001 WOUND CARE	0.199903		90.01
90.02	09002 INTERNAL MEDICINE	0.367448		90.02
90.03	09003 PODIATRY CLINIC	2.335085		90.03
91.00	09100 EMERGENCY	0.301712		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.978920		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0072

Period:
From 01/01/2022
To 12/31/2022

Worksheet C
Part I
Date/Time Prepared:
5/26/2023 8:03 pm

		Title XIX		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		8,974,287		0	8,974,287 30.00
31.00	03100 INTENSIVE CARE UNIT		2,101,417		0	2,101,417 31.00
43.00	04300 NURSERY		835,346		0	835,346 43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		11,527,099		191,739	11,718,838 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		1,460,995		0	1,460,995 52.00
53.00	05300 ANESTHESIOLOGY		230,783		0	230,783 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		4,445,036		15,205	4,460,241 54.00
57.00	05700 CT SCAN		0		0	0 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0		0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION		0		0	0 59.00
60.00	06000 LABORATORY		6,364,613		0	6,364,613 60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		197,953		0	197,953 63.00
65.00	06500 RESPIRATORY THERAPY	0	2,177,015		0	2,177,015 65.00
66.00	06600 PHYSICAL THERAPY	0	2,521,589		0	2,521,589 66.00
69.00	06900 ELECTROCARDIOLOGY		919,583		0	919,583 69.00
69.01	06901 CARDIAC REHAB		872,033		0	872,033 69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		4,310,312		0	4,310,312 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		1,924,632		0	1,924,632 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		15,959,948		0	15,959,948 73.00
76.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC		1,535,259		0	1,535,259 76.00
76.01	03480 ONCOLOGY		2,434,226		0	2,434,226 76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 EXPRESS MEDICAL CENTER		2,514,216		0	2,514,216 88.00
88.01	08801 FAMILY HEALTH CARE		1,629,618		0	1,629,618 88.01
90.00	09000 CLINIC		3,391,068		36,460	3,427,528 90.00
90.01	09001 WOUND CARE		533,140		0	533,140 90.01
90.02	09002 INTERNAL MEDICINE		23,319		0	23,319 90.02
90.03	09003 PODIATRY CLINIC		477,142		0	477,142 90.03
91.00	09100 EMERGENCY		5,439,565		0	5,439,565 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1,741,537		0	1,741,537 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES		0		0	0 95.00
200.00	Subtotal (see instructions)		84,541,731		243,404	84,785,135 200.00
201.00	Less Observation Beds		1,741,537			1,741,537 201.00
202.00	Total (see instructions)		82,800,194		243,404	83,043,598 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared: 5/26/2023 8:03 pm
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Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	Cost
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,379,919		6,379,919		30.00
31.00	03100	INTENSIVE CARE UNIT	1,052,372		1,052,372		31.00
43.00	04300	NURSERY	1,543,690		1,543,690		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,897,496	38,475,561	44,373,057	0.259777	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,272,449	94,742	2,367,191	0.617185	52.00
53.00	05300	ANESTHESIOLOGY	308,163	2,503,732	2,811,895	0.082074	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	790,850	15,525,869	16,316,719	0.272422	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	3,169,667	21,827,743	24,997,410	0.254611	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	174,418	362,941	537,359	0.368381	63.00
65.00	06500	RESPIRATORY THERAPY	3,359,806	2,680,411	6,040,217	0.360420	65.00
66.00	06600	PHYSICAL THERAPY	411,446	4,703,609	5,115,055	0.492974	66.00
69.00	06900	ELECTROCARDIOLOGY	628,664	4,711,391	5,340,055	0.172205	69.00
69.01	06901	CARDIAC REHAB	0	568,728	568,728	1.533304	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,267,770	6,121,022	7,388,792	0.583358	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	687,847	8,381,774	9,069,621	0.212206	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,735,419	59,616,227	68,351,646	0.233498	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	1,004,442	12,017,536	13,021,978	0.117898	76.00
76.01	03480	ONCOLOGY	201,684	11,973,173	12,174,857	0.199939	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	EXPRESS MEDICAL CENTER	0	3,432,174	3,432,174	0.732543	88.00
88.01	08801	FAMILY HEALTH CARE	90,696	6,228,686	6,319,382	0.257876	88.01
90.00	09000	CLINIC	5,260	3,033,982	3,039,242	1.115761	90.00
90.01	09001	WOUND CARE	19,433	2,647,567	2,667,000	0.199903	90.01
90.02	09002	INTERNAL MEDICINE	0	63,462	63,462	0.367448	90.02
90.03	09003	PODIATRY CLINIC	270	204,066	204,336	2.335085	90.03
91.00	09100	EMERGENCY	1,339,847	16,689,155	18,029,002	0.301712	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	167,512	1,611,527	1,779,039	0.978920	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
200.00		Subtotal (see instructions)	39,509,120	223,475,078	262,984,198		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	39,509,120	223,475,078	262,984,198		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared: 5/26/2023 8:03 pm
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (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
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901 CARDIAC REHAB	0.000000		69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.000000		76.00
76.01	03480 ONCOLOGY	0.000000		76.01
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 EXPRESS MEDICAL CENTER	0.000000		88.00
88.01	08801 FAMILY HEALTH CARE	0.000000		88.01
90.00	09000 CLINIC	0.000000		90.00
90.01	09001 WOUND CARE	0.000000		90.01
90.02	09002 INTERNAL MEDICINE	0.000000		90.02
90.03	09003 PODIATRY CLINIC	0.000000		90.03
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0072		Period: From 01/01/2022 To 12/31/2022		Worksheet D Part I Date/Time Prepared: 5/26/2023 8:03 pm		
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)		
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00		
30.00	ADULTS & PEDIATRICS	1,583,462	0	1,583,462	4,746	333.64	30.00	
31.00	INTENSIVE CARE UNIT	232,576		232,576	338	688.09	31.00	
43.00	NURSERY	20,208		20,208	1,131	17.87	43.00	
200.00	Total (Lines 30 through 199)	1,836,246		1,836,246	6,215		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00					
30.00	ADULTS & PEDIATRICS	1,209	403,371					30.00
31.00	INTENSIVE CARE UNIT	156	107,342					31.00
43.00	NURSERY	0	0					43.00
200.00	Total (Lines 30 through 199)	1,365	510,713					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part II Date/Time Prepared: 5/26/2023 8:03 pm
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Cost Center Description		Capital Related Cost (from Wkst. C, 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	
Title XVIII Hospital PPS							
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	960,363	44,373,057	0.021643	1,439,812	31,162	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	167,188	2,367,191	0.070627	525	37	52.00
53.00	05300 ANESTHESIOLOGY	76,871	2,811,895	0.027338	67,988	1,859	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	387,500	16,316,719	0.023749	155,912	3,703	54.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	256,106	24,997,410	0.010245	977,968	10,019	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1,572	537,359	0.002925	78,010	228	63.00
65.00	06500 RESPIRATORY THERAPY	37,066	6,040,217	0.006137	1,276,280	7,833	65.00
66.00	06600 PHYSICAL THERAPY	218,840	5,115,055	0.042784	179,319	7,672	66.00
69.00	06900 ELECTROCARDIOLOGY	58,227	5,340,055	0.010904	289,015	3,151	69.00
69.01	06901 CARDIAC REHAB	202,535	568,728	0.356119	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	169,956	7,388,792	0.023002	468,856	10,785	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	9,985	9,069,621	0.001101	369,451	407	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	159,689	68,351,646	0.002336	3,310,787	7,734	73.00
76.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	50,809	13,021,978	0.003902	427,757	1,669	76.00
76.01	03480 ONCOLOGY	130,117	12,174,857	0.010687	168,579	1,802	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 EXPRESS MEDICAL CENTER	20,787	3,432,174	0.006057	0	0	88.00
88.01	08801 FAMILY HEALTH CARE	44,079	6,319,382	0.006975	0	0	88.01
90.00	09000 CLINIC	159,857	3,039,242	0.052598	3,107	163	90.00
90.01	09001 WOUND CARE	36,654	2,667,000	0.013744	5,760	79	90.01
90.02	09002 INTERNAL MEDICINE	915	63,462	0.014418	0	0	90.02
90.03	09003 PODIATRY CLINIC	29,074	204,336	0.142285	0	0	90.03
91.00	09100 EMERGENCY	625,755	18,029,002	0.034708	633,563	21,990	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	307,284	1,779,039	0.172725	91,009	15,720	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	4,111,229	254,008,217		9,943,698	126,013	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part III Date/Time Prepared: 5/26/2023 8:03 pm
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Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	PPS	
INPATIENT ROUTINE SERVICE COST CENTERS			1A	1.00	2A	2.00	3.00		
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
INPATIENT ROUTINE SERVICE COST CENTERS			4.00	5.00	6.00	7.00	8.00		
30.00	03000	ADULTS & PEDIATRICS	0	0	4,746	0.00	1,209	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	338	0.00	156	31.00	
43.00	04300	NURSERY		0	1,131	0.00	0	43.00	
200.00		Total (lines 30 through 199)		0	6,215		1,365	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
INPATIENT ROUTINE SERVICE COST CENTERS			9.00						
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
43.00	04300	NURSERY	0						43.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/26/2023 8:03 pm
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Cost Center Description	Title XVIII			Hospital		Allied Health Post-Stepdown Adjustments	Allied Health PPS	
	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program					
	1.00	2A	2.00	3A	3.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	EXPRESS MEDICAL CENTER	0	0	0	0	0	88.00
88.01	08801	FAMILY HEALTH CARE	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	INTERNAL MEDICINE	0	0	0	0	0	90.02
90.03	09003	PODIATRY CLINIC	0	0	0	0	0	90.03
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
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	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/26/2023 8:03 pm
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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	44,373,057	0.000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	2,367,191	0.000000	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	2,811,895	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	16,316,719	0.000000	54.00
57.00 05700 CT SCAN	0	0	0	0	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00 06000 LABORATORY	0	0	0	24,997,410	0.000000	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	537,359	0.000000	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	6,040,217	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	5,115,055	0.000000	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	5,340,055	0.000000	69.00
69.01 06901 CARDIAC REHAB	0	0	0	568,728	0.000000	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	7,388,792	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	9,069,621	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	68,351,646	0.000000	73.00
76.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	13,021,978	0.000000	76.00
76.01 03480 ONCOLOGY	0	0	0	12,174,857	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 EXPRESS MEDICAL CENTER	0	0	0	3,432,174	0.000000	88.00
88.01 08801 FAMILY HEALTH CARE	0	0	0	6,319,382	0.000000	88.01
90.00 09000 CLINIC	0	0	0	3,039,242	0.000000	90.00
90.01 09001 WOUND CARE	0	0	0	2,667,000	0.000000	90.01
90.02 09002 INTERNAL MEDICINE	0	0	0	63,462	0.000000	90.02
90.03 09003 PODIATRY CLINIC	0	0	0	204,336	0.000000	90.03
91.00 09100 EMERGENCY	0	0	0	18,029,002	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,779,039	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0	0	254,008,217		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/26/2023 8:03 pm
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Cost Center Description		Title XVIII					
		Outpatient Ratio of Cost to Charges (col. 6 + col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	1,439,812	0	7,135,873	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	525	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	67,988	0	419,013	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	155,912	0	1,625,971	0	54.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	977,968	0	2,240,693	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	78,010	0	135,915	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.000000	1,276,280	0	582,636	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	179,319	0	28,888	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	289,015	0	1,297,759	0	69.00
69.01	06901 CARDIAC REHAB	0.000000	0	0	210,953	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	468,856	0	1,036,069	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000	369,451	0	1,948,985	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	3,310,787	0	16,471,378	0	73.00
76.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.000000	427,757	0	3,293,220	0	76.00
76.01	03480 ONCOLOGY	0.000000	168,579	0	4,403,545	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 EXPRESS MEDICAL CENTER	0.000000	0	0	0	0	88.00
88.01	08801 FAMILY HEALTH CARE	0.000000	0	0	0	0	88.01
90.00	09000 CLINIC	0.000000	3,107	0	502,958	0	90.00
90.01	09001 WOUND CARE	0.000000	5,760	0	895,165	0	90.01
90.02	09002 INTERNAL MEDICINE	0.000000	0	0	28,079	0	90.02
90.03	09003 PODIATRY CLINIC	0.000000	0	0	196,202	0	90.03
91.00	09100 EMERGENCY	0.000000	633,563	0	3,182,743	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	91,009	0	1,344,996	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		9,943,698	0	46,981,041	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Prepared: 5/26/2023 8:03 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.259777	7,135,873	0	0	1,853,736	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.617185	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.082074	419,013	0	0	34,390	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.272422	1,625,971	0	0	442,950	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.254611	2,240,693	80	0	570,505	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.368381	135,915	0	0	50,069	63.00
65.00	06500	RESPIRATORY THERAPY	0.360420	582,636	0	0	209,994	65.00
66.00	06600	PHYSICAL THERAPY	0.492974	28,888	0	0	14,241	66.00
69.00	06900	ELECTROCARDIOLOGY	0.172205	1,297,759	0	0	223,481	69.00
69.01	06901	CARDIAC REHAB	1.533304	210,953	0	0	323,455	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.583358	1,036,069	0	0	604,399	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.212206	1,948,985	0	0	413,586	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.233498	16,471,378	9,465	123,271	3,846,034	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.117898	3,293,220	0	0	388,264	76.00
76.01	03480	ONCOLOGY	0.199939	4,403,545	0	0	880,440	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	EXPRESS MEDICAL CENTER						88.00
88.01	08801	FAMILY HEALTH CARE						88.01
90.00	09000	CLINIC	1.115761	502,958	0	0	561,181	90.00
90.01	09001	WOUND CARE	0.199903	895,165	0	0	178,946	90.01
90.02	09002	INTERNAL MEDICINE	0.367448	28,079	0	0	10,318	90.02
90.03	09003	PODIATRY CLINIC	2.335085	196,202	0	0	458,148	90.03
91.00	09100	EMERGENCY	0.301712	3,182,743	0	0	960,272	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.978920	1,344,996	0	27	1,316,643	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		46,981,041	9,545	123,298	13,341,052	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		46,981,041	9,545	123,298	13,341,052	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Prepared: 5/26/2023 8:03 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	20	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
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
69.01 06901 CARDIAC REHAB	0	0		69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2,210	28,784		73.00
76.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0		76.00
76.01 03480 ONCOLOGY	0	0		76.01
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 EXPRESS MEDICAL CENTER				88.00
88.01 08801 FAMILY HEALTH CARE				88.01
90.00 09000 CLINIC	0	0		90.00
90.01 09001 WOUND CARE	0	0		90.01
90.02 09002 INTERNAL MEDICINE	0	0		90.02
90.03 09003 PODIATRY CLINIC	0	0		90.03
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	26		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00 09500 AMBULANCE SERVICES	0			95.00
200.00 Subtotal (see instructions)	2,230	28,810		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	2,230	28,810		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/26/2023 8:03 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,746	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,746	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		3,825	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)		1,209	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)		8,974,287	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)		8,974,287	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)		8,974,287	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)		1,890.92	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,286,122	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,286,122	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/26/2023 8:03 pm		
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	2,101,417	338	6,217.21	156	969,885	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)					2,798,690	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					6,054,697	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)					510,713	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					126,013	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					636,726	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					5,417,971	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
55.01	Permanent adjustment amount per discharge					0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)					0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only): for CAH, see instructions					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					921	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,890.92	88.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0072		Period: From 01/01/2022 To 12/31/2022		Worksheet D-1 Date/Time Prepared: 5/26/2023 8:03 pm	
Cost Center Description		Title XVIII		Hospital		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,741,537	89.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,583,462	8,974,287	0.176444	1,741,537	307,284	90.00
91.00	Nursing Program cost	0	8,974,287	0.000000	1,741,537	0	91.00
92.00	Allied health cost	0	8,974,287	0.000000	1,741,537	0	92.00
93.00	All other Medical Education	0	8,974,287	0.000000	1,741,537	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/26/2023 8:03 pm
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			4,746 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			4,746 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			3,825 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)			267 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)			1,131 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)			8,974,287 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)			8,974,287 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)			8,974,287 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)			1,890.92 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			504,876 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)			504,876 41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/26/2023 8:03 pm
Title XIX			Hospital		Cost
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)	835,346	1,131	738.59	0	42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	2,101,417	338	6,217.21	0	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)					315,920 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)					820,796 49.00
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0 54.00
55.00 Target amount per discharge					0.00 55.00
55.01 Permanent adjustment amount per discharge					0.00 55.01
55.02 Adjustment amount per discharge (contractor use only)					0.00 55.02
56.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02)					0 56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00 Bonus payment (see instructions)					0 58.00
59.00 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00 59.00
60.00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00 60.00
61.00 Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0 61.00
62.00 Relief payment (see instructions)					0 62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only): for CAH, see instructions					0 66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					921 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,890.92 88.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0072		Period: From 01/01/2022 To 12/31/2022		Worksheet D-1 Date/Time Prepared: 5/26/2023 8:03 pm	
Cost Center Description		Title XIX		Hospital		Cost	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1.00	89.00
						1,741,537	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,583,462	8,974,287	0.176444	1,741,537	307,284	90.00
91.00	Nursing Program cost	0	8,974,287	0.000000	1,741,537	0	91.00
92.00	Allied health cost	0	8,974,287	0.000000	1,741,537	0	92.00
93.00	All other Medical Education	0	8,974,287	0.000000	1,741,537	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Prepared: 5/26/2023 8:03 pm
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Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		1,583,160	30.00
31.00	03100	INTENSIVE CARE UNIT		310,440	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.264098	1,439,812	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.617185	525	52.00
53.00	05300	ANESTHESIOLOGY	0.082074	67,988	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.273354	155,912	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.254611	977,968	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.368381	78,010	63.00
65.00	06500	RESPIRATORY THERAPY	0.360420	1,276,280	65.00
66.00	06600	PHYSICAL THERAPY	0.492974	179,319	66.00
69.00	06900	ELECTROCARDIOLOGY	0.172205	289,015	69.00
69.01	06901	CARDIAC REHAB	1.533304	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.583358	468,856	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.212206	369,451	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.233498	3,310,787	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.117898	427,757	76.00
76.01	03480	ONCOLOGY	0.199939	168,579	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	EXPRESS MEDICAL CENTER	0.000000		88.00
88.01	08801	FAMILY HEALTH CARE	0.000000		88.01
90.00	09000	CLINIC	1.127758	3,107	90.00
90.01	09001	WOUND CARE	0.199903	5,760	90.01
90.02	09002	INTERNAL MEDICINE	0.367448	0	90.02
90.03	09003	PODIATRY CLINIC	2.335085	0	90.03
91.00	09100	EMERGENCY	0.301712	633,563	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.978920	91,009	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		9,943,698	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		9,943,698	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Prepared: 5/26/2023 8:03 pm	
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		582,888	30.00
31.00	03100	INTENSIVE CARE UNIT		90,367	31.00
43.00	04300	NURSERY		29,115	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.259777	491,711	127,735 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.617185	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0.082074	23,648	1,941 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.272422	28,428	7,744 54.00
57.00	05700	CT SCAN	0.000000	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0 59.00
60.00	06000	LABORATORY	0.254611	133,260	33,929 60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.368381	4,012	1,478 63.00
65.00	06500	RESPIRATORY THERAPY	0.360420	127,854	46,081 65.00
66.00	06600	PHYSICAL THERAPY	0.492974	5,699	2,809 66.00
69.00	06900	ELECTROCARDIOLOGY	0.172205	13,983	2,408 69.00
69.01	06901	CARDIAC REHAB	1.533304	0	0 69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.583358	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.212206	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.233498	309,689	72,312 73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.117898	33,475	3,947 76.00
76.01	03480	ONCOLOGY	0.199939	0	0 76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	EXPRESS MEDICAL CENTER	0.732543	0	0 88.00
88.01	08801	FAMILY HEALTH CARE	0.257876	0	0 88.01
90.00	09000	CLINIC	1.115761	202	225 90.00
90.01	09001	WOUND CARE	0.199903	0	0 90.01
90.02	09002	INTERNAL MEDICINE	0.367448	0	0 90.02
90.03	09003	PODIATRY CLINIC	2.335085	0	0 90.03
91.00	09100	EMERGENCY	0.301712	50,746	15,311 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.978920	0	0 92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,222,707	315,920 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net charges (line 200 minus line 201)		1,222,707	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0072 Component CCN: 15-U072	Period: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Prepared: 5/26/2023 8:03 pm
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	54.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.000000	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.000000	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901 CARDIAC REHAB	0.000000	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	0	0	73.00
76.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.000000	0	0	76.00
76.01	03480 ONCOLOGY	0.000000	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 EXPRESS MEDICAL CENTER	0.000000	0	0	88.00
88.01	08801 FAMILY HEALTH CARE	0.000000	0	0	88.01
90.00	09000 CLINIC	0.000000	0	0	90.00
90.01	09001 WOUND CARE	0.000000	0	0	90.01
90.02	09002 INTERNAL MEDICINE	0.000000	0	0	90.02
90.03	09003 PODIATRY CLINIC	0.000000	0	0	90.03
91.00	09100 EMERGENCY	0.000000	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		0	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/26/2023 8:03 pm
		Title XVIII	Hospital	PPS
				1.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments			0 1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		2,244,811	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		653,865	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)		229,954	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		31,911	2.04
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		39.48	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
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.11	30.00
31.00	Percentage of Medicaid patient days (see instructions)		32.50	31.00
32.00	Sum of lines 30 and 31		36.61	32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.00	33.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/26/2023 8:03 pm	
		Title XVIII	Hospital	PPS	
				1.00	
34.00	Disproportionate share adjustment (see instructions)			86,960	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)	7,192,008,710	6,874,403,459		35.00
35.01	Factor 3 (see instructions)	0.000082848	0.000083353		35.01
35.02	Hospital UCP, including supplemental UCP (If line 34 is zero, enter zero on this line) (see instructions)	595,844	573,002		35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	445,659	144,428		35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	590,087			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)		3,837,588		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		4,304,430		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)		4,304,430		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		246,659		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		287,861		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 instructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		4,838,950		59.00
60.00	Primary payer payments		7,829		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		4,831,121		61.00
62.00	Deductibles billed to program beneficiaries		440,132		62.00
63.00	Coinurance billed to program beneficiaries		0		63.00
64.00	Allowable bad debts (see instructions)		24,800		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		16,120		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		24,800		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		4,407,109		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0		70.50
70.75	N95 respirator payment adjustment amount (see instructions)		0		70.75
70.87	Demonstration payment adjustment amount before sequestration		0		70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0		70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		0		70.93
70.94	HRR adjustment amount (see instructions)		0		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/26/2023 8:03 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2022	662,529	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)	2023	186,529	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		44,665	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		5,211,502	71.00
71.01	Sequestration adjustment (see instructions)		65,665	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM or CHART pass-throughs		0	71.03
72.00	Interim payments		5,324,094	72.00
72.01	Interim payments-PARHM or CHART		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM or CHART (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-178,257	74.00
74.01	Balance due provider/program-PARHM or CHART (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		192,187	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: 15-0072

Period:
From 01/01/2022
To 12/31/2022

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/26/2023 8:03 pm

		Title XVIII			Hospital		PPS	
	W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)		
	0	1.00	2.00	3.00	4.00	5.00		
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,244,811	0	2,244,811		2,244,811	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	653,865	0		653,865	653,865	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	229,954	0	229,954		229,954	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	31,911	0		31,911	31,911	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	86,960	0	67,344	19,616	86,960	11.00
11.01	Uncompensated care payments	36.00	590,087	0	445,659	144,428	590,087	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	3,837,588	0	2,987,768	849,820	3,837,588	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	4,304,430	0	3,337,059	967,371	4,304,430	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	4,304,430	0	3,337,059	967,371	4,304,430	15.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0072

Period:
From 01/01/2022
To 12/31/2022

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/26/2023 8:03 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	246,659	0	194,365	52,294	246,659	16.00
17.00	Special add-on payments for new technologies	54.00	287,861	0	272,561	15,300	287,861	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	3,803,985	1,034,965	4,838,950	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	214,378	0	165,599	48,779	214,378	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	32,281	0	28,766	3,515	32,281	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	246,659	0	194,365	52,294	246,659	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				0.174167	0.180227		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			662,529		662,529	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				186,529	186,529	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5	Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/26/2023 8:03 pm
Title XVIII		Hospital	PPS

	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
	0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00				1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,244,811	2,244,811		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	653,865		653,865	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	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	229,954	229,954		2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	31,911		31,911	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	4.00
Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	9.01
Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200	10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	86,960	67,344	19,616	11.00
11.01	Uncompensated care payments	36.00	590,087	445,659	144,428	11.01
Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	3,837,588	2,987,768	849,820	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	4,304,430	3,337,059	967,371	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	4,304,430	3,337,059	967,371	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	246,659	194,365	52,294	16.00
17.00	Special add-on payments for new technologies	54.00	287,861	272,561	15,300	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	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	18.00
19.00	SUBTOTAL			3,803,985	1,034,965	4,838,950

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5	Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/26/2023 8:03 pm
Title XVIII		Hospital	PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	214,378	165,599	48,779	214,378	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	32,281	28,766	3,515	32,281	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	246,659	194,365	52,294	246,659	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00		70.96	662,529	662,529		662,529	27.00
28.00	Low volume adjustment prior to October 1	70.97	186,529		186,529	186,529	28.00
30.00	HVBP payment adjustment (see instructions)	70.93	0	0	0	0	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		44,665	0	44,665	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/26/2023 8:03 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		31,040	1.00
2.00	Medical and other services reimbursed under OPPTS (see instructions)		13,341,052	2.00
3.00	OPPS payments		11,918,953	3.00
4.00	Outlier payment (see instructions)		128,202	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 from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		31,040	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		132,843	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)		132,843	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)		132,843	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		101,803	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)		31,040	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)		12,047,155	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)		2,382,243	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)		9,695,952	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		9,695,952	30.00
31.00	Primary payer payments		1,375	31.00
32.00	Subtotal (line 30 minus line 31)		9,694,577	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)		142,621	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		92,704	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		142,621	36.00
37.00	Subtotal (see instructions)		9,787,281	37.00
38.00	MSP-LCC reconciliation amount from PS&R		55	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.75	N95 respirator payment adjustment amount (see instructions)		0	39.75
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		9,787,226	40.00
40.01	Sequestration adjustment (see instructions)		123,319	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM or CHART pass-throughs			40.03
41.00	Interim payments		9,659,614	41.00
41.01	Interim payments-PARHM or CHART			41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM or CHART (for contractor use only)			42.01
43.00	Balance due provider/program (see instructions)		4,293	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)			93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/26/2023 8:03 pm
	Title XVIII	Hospital	PPS
			1.00
200.00 MEDICARE PART B ANCILLARY COSTS Part B Combined Billed Days			0.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0072

Period:
From 01/01/2022
To 12/31/2022

Worksheet E-1
Part I
Date/Time Prepared:
5/26/2023 8:03 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		5,324,094		9,570,266	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0	12/21/2021	89,348	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		89,348	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)		5,324,094		9,659,614	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		4,293	6.01	
6.02	SETTLEMENT TO PROGRAM		178,257		0	6.02	
7.00	Total Medicare program liability (see instructions)		5,145,837		9,663,907	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet E-1 Part II Date/Time Prepared: 5/26/2023 8:03 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days (see instructions)			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days (see instructions)			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPSS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet E-2
		Component CCN: 15-U072	Date/Time Prepared: 5/26/2023 8:03 pm	
		Title XIX	Swing Beds - SNF	PPS
			Part A	Part B
			1.00	2.00
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)		0	2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)		0	3.00
3.01	Nursing and allied health payment-PARHM or CHART (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days		0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0	7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0	8.00
9.00	Primary payer payments (see instructions)		0	9.00
10.00	Subtotal (line 8 minus line 9)		0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	11.00
12.00	Subtotal (line 10 minus line 11)		0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)		0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)			16.55
16.99	Demonstration payment adjustment amount before sequestration		0	16.99
17.00	Allowable bad debts (see instructions)		0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	18.00
19.00	Total (see instructions)		0	19.00
19.01	Sequestration adjustment (see instructions)		0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	19.02
19.03	Sequestration adjustment-PARHM or CHART pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)		0	19.25
20.00	Interim payments		0	20.00
20.01	Interim payments-PARHM or CHART			20.01
21.00	Tentative settlement (for contractor use only)		0	21.00
21.01	Tentative settlement-PARHM or CHART (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)		0	22.00
22.01	Balance due provider/program-PARHM or CHART (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
Comparison of PPS versus Cost Reimbursement				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part VII Date/Time Prepared: 5/26/2023 8:03 pm	
		Title XIX	Hospital	Cost	
			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		820,796		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)		820,796	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)		820,796	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		702,370		8.00
9.00	Ancillary service charges		1,222,707	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)		1,925,077	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)		1,925,077	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		1,104,281	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)		820,796	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		820,796	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)		820,796	0	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)		820,796	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		820,796	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		820,796	0	40.00
41.00	Interim payments		962,089	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		-141,293	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT		Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet E-5 Date/Time Prepared: 5/26/2023 8:03 pm
Title XVIII			PPS	
			1.00	
TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	1.00
2.00	Capital outlier from Wkst. L, Pt. 1, line 2		0	2.00
3.00	Operating outlier reconciliation adjustment amount (see instructions)		0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instructions)		0	4.00
5.00	The rate used to calculate the time value of money (see instructions)		0.00	5.00
6.00	Time value of money for operating expenses (see instructions)		0	6.00
7.00	Time value of money for capital related expenses (see instructions)		0	7.00

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

Provider CCN: 15-0072

Period:
From 01/01/2022
To 12/31/2022

Worksheet G

Date/Time Prepared:
5/26/2023 8:03 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	15,034,339	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	56,308,078	0	0	0	4.00
5.00	Other receivable	4,679,314	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-37,675,982	0	0	0	6.00
7.00	Inventory	1,555,984	0	0	0	7.00
8.00	Prepaid expenses	1,387,151	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	41,288,884	0	0	0	11.00
FIXED ASSETS						
12.00	Land	205,783	0	0	0	12.00
13.00	Land improvements	877,017	0	0	0	13.00
14.00	Accumulated depreciation	-556,084	0	0	0	14.00
15.00	Buildings	71,731,022	0	0	0	15.00
16.00	Accumulated depreciation	-44,046,800	0	0	0	16.00
17.00	Leasehold improvements	3,937,902	0	0	0	17.00
18.00	Accumulated depreciation	-754,754	0	0	0	18.00
19.00	Fixed equipment	7,812,025	0	0	0	19.00
20.00	Accumulated depreciation	-4,318,754	0	0	0	20.00
21.00	Automobiles and trucks	83,714	0	0	0	21.00
22.00	Accumulated depreciation	-83,714	0	0	0	22.00
23.00	Major movable equipment	36,181,134	0	0	0	23.00
24.00	Accumulated depreciation	-18,309,014	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)	52,759,477	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	1,090,693	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	13,071,289	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	14,161,982	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	108,210,343	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	25,122,132	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,107,717	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,818,000	0	0	0	40.00
41.00	Deferred income	0	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	1,771,940	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	30,819,789	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	-44,430	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	21,779,413	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	21,734,983	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	52,554,772	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	55,655,571				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	55,655,571	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	108,210,343	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0072

Period:
From 01/01/2022
To 12/31/2022

Worksheet G-1

Date/Time Prepared:
5/26/2023 8:03 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		70,555,932		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-14,900,361				2.00
3.00	Total (sum of line 1 and line 2)		55,655,571		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		55,655,571		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)		55,655,571		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 15-0072

Period:
From 01/01/2022
To 12/31/2022

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/26/2023 8:03 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	9,445,776		9,445,776	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	9,445,776		9,445,776	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	1,086,144		1,086,144	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	1,086,144		1,086,144	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	10,531,920		10,531,920	17.00
18.00	Ancillary services	25,156,632	184,767,981	209,924,613	18.00
19.00	Outpatient services	3,273,526	29,542,359	32,815,885	19.00
20.00	EXPRESS MEDICAL CENTER	0	3,432,174	3,432,174	20.00
20.01	FAMILY HEALTH CARE	90,696	6,228,686	6,319,382	20.01
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	NONREIMBURSABLE	215,516	7,561,544	7,777,060	27.00
27.01	PRO FEES	2,921,912	15,932,837	18,854,749	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	42,190,202	247,465,581	289,655,783	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		121,630,767		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)		121,630,767		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0072

Period:
From 01/01/2022
To 12/31/2022

Worksheet G-3

Date/Time Prepared:
5/26/2023 8:03 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	289,655,783	1.00
2.00	Less contractual allowances and discounts on patients' accounts	186,067,832	2.00
3.00	Net patient revenues (line 1 minus line 2)	103,587,951	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	121,630,767	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-18,042,816	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 REVENUE	3,416,975	24.00
24.01	INVESTMENT INCOME	-413,130	24.01
24.02	LOSS ON SALE OF EQUIPMENT	211,642	24.02
24.50	COVID-19 PHE Funding	-73,032	24.50
25.00	Total other income (sum of lines 6-24)	3,142,455	25.00
26.00	Total (line 5 plus line 25)	-14,900,361	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)	-14,900,361	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0072	Period: From 01/01/2022 To 12/31/2022	Worksheet L Parts I-III Date/Time Prepared: 5/26/2023 8:03 pm
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		214,378	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		32,281	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)		12.58	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		246,659	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

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0072

Period: From 01/01/2022

Worksheet M-1

Component CCN: 15-8561

To 12/31/2022

Date/Time Prepared: 5/26/2023 8:03 pm

		RHC I		Cost			
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	315,945	0	315,945	-45,877	270,068	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	584,407	0	584,407	47,873	632,280	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	502,145	0	502,145	-72,914	429,231	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,402,497	0	1,402,497	-70,918	1,331,579	10.00
11.00	Physician Services Under Agreement	0	20,000	20,000	0	20,000	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	20,000	20,000	0	20,000	14.00
15.00	Medical Supplies	0	302,230	302,230	0	302,230	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	302,230	302,230	0	302,230	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,402,497	322,230	1,724,727	-70,918	1,653,809	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	8,916	8,916	-8,916	0	29.00
30.00	Administrative Costs	0	84,964	84,964	-72,564	12,400	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	93,880	93,880	-81,480	12,400	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,402,497	416,110	1,818,607	-152,398	1,666,209	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0072
Component CCN: 15-8561

Period:
From 01/01/2022
To 12/31/2022

Worksheet M-1
Date/Time Prepared:
5/26/2023 8:03 pm

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC I	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	270,068		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	632,280		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	429,231		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,331,579		10.00
11.00	Physician Services Under Agreement	0	20,000		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	20,000		14.00
15.00	Medical Supplies	0	302,230		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	302,230		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,653,809		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	12,400		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	12,400		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,666,209		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0072

Period: From 01/01/2022

Worksheet M-1

Component CCN: 15-8563

To 12/31/2022

Date/Time Prepared: 5/26/2023 8:03 pm

		RHC II		Cost			
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	1,807,911	0	1,807,911	-1,367,078	440,833	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	714,326	0	714,326	-540,148	174,178	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	1,145,916	0	1,145,916	-866,501	279,415	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	76,708	0	76,708	-58,004	18,704	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	3,744,861	0	3,744,861	-2,831,731	913,130	10.00
11.00	Physician Services Under Agreement	0	76,355	76,355	0	76,355	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	76,355	76,355	0	76,355	14.00
15.00	Medical Supplies	0	39,384	39,384	0	39,384	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	39,384	39,384	0	39,384	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,744,861	115,739	3,860,600	-2,831,731	1,028,869	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	114,753	48,130	162,883	-236,894	-74,011	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	114,753	48,130	162,883	-236,894	-74,011	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,859,614	163,869	4,023,483	-3,068,625	954,858	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provider CCN: 15-0072	Period:	Worksheet M-1
	Component CCN: 15-8563	From 01/01/2022 To 12/31/2022	Date/Time Prepared: 5/26/2023 8:03 pm
		RHC II	Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
	6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	440,833
2.00	Physician Assistant	0	0
3.00	Nurse Practitioner	0	174,178
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	279,415
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	18,704
8.00	Laboratory Technician	0	0
9.00	Other Facility Health Care Staff Costs	0	0
10.00	Subtotal (sum of lines 1 through 9)	0	913,130
11.00	Physician Services Under Agreement	0	76,355
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	76,355
15.00	Medical Supplies	0	39,384
16.00	Transportation (Health Care Staff)	0	0
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	0
19.00	Other Health Care Costs	0	0
20.00	Allowable GME Costs	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	39,384
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,028,869
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0
24.00	Dental	0	0
25.00	Optometry	0	0
25.01	Telehealth	0	0
25.02	Chronic Care Management	0	0
26.00	All other nonreimbursable costs	0	0
27.00	Nonallowable GME costs	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0
FACILITY OVERHEAD			
29.00	Facility Costs	0	0
30.00	Administrative Costs	0	-74,011
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	-74,011
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	954,858

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0072 Component CCN: 15-8561	Period: From 01/01/2022 To 12/31/2022	Worksheet M-2 Date/Time Prepared: 5/26/2023 8:03 pm
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		RHC I		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.91	3,102	1	1	1.00
2.00	Physician Assistant	0.00	0	1	0	2.00
3.00	Nurse Practitioner	3.69	9,009	1	4	3.00
4.00	Subtotal (sum of lines 1 through 3)	4.60	12,111		5	4.00
5.00	Visiting Nurse	0.00	0			5.00
6.00	Clinical Psychologist	0.00	0			6.00
7.00	Clinical Social Worker	0.00	0			7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	4.60	12,111			8.00
9.00	Physician Services Under Agreements		0			9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				1,653,809	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				1,653,809	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet, M-1, col. 7, line 31)				12,400	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				848,007	15.00
16.00	Total overhead (sum of lines 14 and 15)				860,407	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				860,407	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				860,407	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				2,514,216	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0072 Component CCN: 15-8563	Period: From 01/01/2022 To 12/31/2022	Worksheet M-2 Date/Time Prepared: 5/26/2023 8:03 pm
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		RHC II		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positi ons						
1.00	Physi ci an	1.31	2,492	1	1	1.00
2.00	Physi ci an Assi stant	0.00	0	1	0	2.00
3.00	Nurse Practitioner	1.37	2,942	1	1	3.00
4.00	Subtotal (sum of lines 1 through 3)	2.68	5,434		2	4.00
5.00	Visi ting Nurse	0.00	0			5.00
6.00	Clini cal Psychologi st	0.00	0			6.00
7.00	Clini cal Soci al Worker	0.23	243			7.00
7.01	Medi cal Nutri ti on Therapi st (FQHC only)	0.00	0			7.01
7.02	Diabet es Sel f Management Traini ng (FQHC only)	0.00	0			7.02
8.00	Total FTEs and Visi ts (sum of lines 4 through 7)	2.91	5,677			8.00
9.00	Physi ci an Servi ces Under Agre ements		0			9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of heal th care services (from Wkst. M-1, col. 7, line 22)				1,028,869	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				1,028,869	12.00
13.00	Ratio of hospi tal -based RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total hospi tal -based RHC/FQHC overhead - (from Worksheet, M-1, col. 7, line 31)				-74,011	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				674,760	15.00
16.00	Total overhead (sum of lines 14 and 15)				600,749	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				600,749	18.00
19.00	Overhead applicabl e to hospi tal -based RHC/FQHC services (line 13 x line 18)				600,749	19.00
20.00	Total allowabl e cost of hospi tal -based RHC/FQHC services (sum of lines 10 and 19)				1,629,618	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-0072 Component CCN: 15-8561	Period: From 01/01/2022 To 12/31/2022	Worksheet M-3 Date/Time Prepared: 5/26/2023 8:03 pm
		Title XVIII	RHC I	Cost
		1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		2,514,216	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		1,312	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		2,512,904	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		12,111	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		12,111	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		207.49	7.00
		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2022 through 12/31/2022)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	207.49	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	207.49	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,097	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	227,617	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	227,617	16.00
16.01	Total program charges (see instructions)(from contractor's records)		211,102	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		8,646	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		9,323	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		163,366	16.04
16.05	Total program cost (see instructions)	0	172,689	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		14,087	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		37,674	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		172,689	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		528	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		173,217	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		173,217	26.00
26.01	Sequestration adjustment (see instructions)		2,182	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		86,693	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		84,342	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-0072 Component CCN: 15-8563	Period: From 01/01/2022 To 12/31/2022	Worksheet M-3 Date/Time Prepared: 5/26/2023 8:03 pm
		Title XVIII	RHC II	Cost
		1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		1,629,618	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		78,060	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		1,551,558	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		5,677	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		5,677	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		273.31	7.00
		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2022 through 12/31/2022)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	273.31	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	273.31	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,516	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	414,338	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	1	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	273	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	273	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	414,611	16.00
16.01	Total program charges (see instructions)(from contractor's records)		298,880	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		29,736	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		41,250	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		295,272	16.04
16.05	Total program cost (see instructions)	0	336,522	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		4,271	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		52,803	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		336,522	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		29,970	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		366,492	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		366,492	26.00
26.01	Sequestration adjustment (see instructions)		4,618	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		134,574	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		227,300	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, chapter I, §115.2		0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0072

Period: From 01/01/2022

Worksheet M-4

Component CCN: 15-8561

To 12/31/2022

Date/Time Prepared: 5/26/2023 8:03 pm

		Title XVIII		RHC I	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,331,579	1,331,579	1,331,579	1,331,579	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000052	0.000279	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	69	372	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	150	272	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	219	644	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,653,809	1,653,809	1,653,809	1,653,809	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	860,407	860,407	860,407	860,407	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000132	0.000389	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	114	335	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	333	979	0	0	10.00
11.00	Total number of injections/infusions (from your records)	3	16	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	111.00	61.19	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	2	5	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	222	306	0	0	14.00
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
					1.00	2.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)				1,312	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)				528	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0072

Period: From 01/01/2022

Worksheet M-4

Component CCN: 15-8563

To 12/31/2022

Date/Time Prepared: 5/26/2023 8:03 pm

		Title XVIII		RHC II	Cost		
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTI BODY PRODUCTS		
		1.00	2.00	2.01	2.02		
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	913,130	913,130	913,130	913,130	1.00	
2.00	Ratio of injection/infusion staff time to total health care staff time	0.004791	0.019797	0.006471	0.000000	2.00	
3.00	Injection/infusion health care staff cost (line 1 x line 2)	4,375	18,077	5,909	0	3.00	
4.00	Injections/infusions and related medical supplies costs (from your records)	8,700	12,223	0	0	4.00	
5.00	Direct cost of injections/infusions (line 3 plus line 4)	13,075	30,300	5,909	0	5.00	
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,028,869	1,028,869	1,028,869	1,028,869	6.00	
7.00	Total overhead (from Wkst. M-2, line 19)	600,749	600,749	600,749	600,749	7.00	
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.012708	0.029450	0.005743	0.000000	8.00	
9.00	Overhead cost - injection/infusion (line 7 x line 8)	7,634	17,692	3,450	0	9.00	
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	20,709	47,992	9,359	0	10.00	
11.00	Total number of injections/infusions (from your records)	174	719	235	0	11.00	
12.00	Cost per injection/infusion (line 10/line 11)	119.02	66.75	39.83	0.00	12.00	
13.00	Number of injection/infusion administered to Program beneficiaries	91	273	23	0	13.00	
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01	
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	10,831	18,223	916	0	14.00	
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION		
					1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)					78,060	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)					29,970	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0072 Component CCN: 15-8561	Period: From 01/01/2022 To 12/31/2022	Worksheet M-5 Date/Time Prepared: 5/26/2023 8:03 pm
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		RHC I	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		86,693	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	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			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		86,693	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			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		84,342	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		171,035	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0072 Component CCN: 15-8563	Period: From 01/01/2022 To 12/31/2022	Worksheet M-5 Date/Time Prepared: 5/26/2023 8:03 pm
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		RHC II	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		134,574	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	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			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		134,574	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			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		227,300	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		361,874	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00