

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 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0072	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 5/27/2022 1:47 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report	Date: 5/27/2022	Time: 1:47 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 type="checkbox"/> Medicare Utilization. Enter "F" for Full or "L" for Low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MEMORIAL HOSPITAL LOGANSPO RT (15-0072) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 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	Sherri Gehlhausen	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	Sherri Gehlhausen		2
3	Signatory Title	CFO		3
4	Date	(Dated when report is electronic)		4

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-71,119	-47,097	0	15,783	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing Bed - SNF	0	0	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
10.00 EXPRESS MEDICAL CENTER I	0		0		0	10.00
10.01 FAMILY HEALTH CARE II	0		0		0	10.01
200.00 Total	0	-71,119	-47,097	0	15,783	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 valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0072		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/27/2022 1:47 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)					01/01/2021		12/31/2021		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 uncompensated care payments 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 final uncompensated care payments 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.				N	N		N		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 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/27/2022 1:47 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.	276	755	0	0	988	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.					01/01/2021	12/31/2021	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)					N	Y	40.00	
						V	XVIII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					N			56.00
57.00	If line 56 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.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0072		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/27/2022 1:47 pm	
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criteria Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N					60.00
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00		61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00		61.20
						1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00		62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00		62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)				N		63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 15-0072

Period:
From 01/01/2021
To 12/31/2021

Worksheet S-2
Part I
Date/Time Prepared:
5/27/2022 1:47 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
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))	
		1.00	2.00	3.00	4.00	5.00	
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0072	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/27/2022 1:47 pm	
			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
			V 1.00		
			XIX 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
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. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0072	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/27/2022 1:47 pm
		V	XIX	
		1.00	2.00	
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	Occupational	Speech
		1.00	2.00	3.00
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
			Respiratory	
			4.00	
			1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N		110.00
			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
			3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model 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
		1.00	2.00	3.00
		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
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	625,838	0	118.01
			1.00	2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	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
		Transplant Center Information		
125.00	Does this facility operate a 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 center, 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 center, 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 center, 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 center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0072		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/27/2022 1:47 pm	
		1.00	2.00				
130.00	If this is a Medicare certified pancreas transplant center, 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 center, 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 center, 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 an 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	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						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	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC	N		N		N	
						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	
		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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0072	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/27/2022 1:47 pm	
			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 01/01/2021 To 12/31/2021		Worksheet S-2 Part II Date/Time Prepared: 5/27/2022 1:47 pm	
		Y/N	Date				
		1.00	2.00				
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				
		1.00	2.00				
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				
		1.00	2.00				
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 is 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					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 co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	03/22/2022	Y	03/22/2022		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0072	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/27/2022 1:47 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	Are 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 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/27/2022 1:47 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 01/01/2021
To 12/31/2021

Worksheet S-3
Part I
Date/Time Prepared:
5/27/2022 1:47 pm

Component	Worksheet A Line Number	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	
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0072

Period:
From 01/01/2021
To 12/31/2021

Worksheet S-3
Part I
Date/Time Prepared:
5/27/2022 1:47 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	
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)	1,395	276	4,220			1.00
2.00 HMO and other (see instructions)	644	1,733				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,395	276	4,220			7.00
8.00 INTENSIVE CARE UNIT	192	0	602			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	983			13.00
14.00 Total (see instructions)	1,587	276	5,805	0.00	579.83	14.00
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	0	0	0	0.00	0.00	26.00
26.01 FAMILY HEALTH CARE	0	0	0	0.00	0.00	26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	579.83	27.00
28.00 Observation Bed Days		9	600			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	10	566			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0072

Period:
From 01/01/2021
To 12/31/2021

Worksheet S-3
Part I
Date/Time Prepared:
5/27/2022 1:47 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
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	442	61	1,421	1.00
2.00 HMO and other (see instructions)				148	412		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	442	61		1,421	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

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0072

Period:
From 01/01/2021
To 12/31/2021

Worksheet S-3
Part II
Date/Time Prepared:
5/27/2022 1:47 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	42,171,203	-262,623	41,908,580	1,194,231.00	35.09 1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00 2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00 3.00
4.00	Physician-Part A - Administrative		358,029	0	358,029	1,743.00	205.41 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		8,733,544	0	8,733,544	62,911.00	138.82 5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00 6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00 7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00 7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00 8.00
9.00	SNF	44.00	0	0	0	0.00	0.00 9.00
10.00	Excluded area salaries (see instructions)		7,585,712	-39,152	7,546,560	170,297.00	44.31 10.00
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		5,257,125	0	5,257,125	59,972.00	87.66 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		69,131	0	69,131	788.00	87.73 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)		10,339,554	0	10,339,554		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		1,938,091	0	1,938,091		
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		26,874	0	26,874		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		953,463	0	953,463		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
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 01/01/2021
To 12/31/2021

Worksheet S-3
Part II
Date/Time Prepared:
5/27/2022 1:47 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	335,448	0	335,448	10,400.00	32.25	26.00
27.00	Administrative & General	4,112,081	-18,623	4,093,458	168,588.00	24.28	27.00
28.00	Administrative & General under contract (see inst.)	444,530	0	444,530	1,869.00	237.84	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	796,827	0	796,827	26,447.00	30.13	30.00
31.00	Laundry & Linen Service	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	655,062	-5,796	649,266	38,315.00	16.95	32.00
33.00	Housekeeping under contract (see instructions)	0	0	0	0.00	0.00	33.00
34.00	Dietary	418,318	-345,873	72,445	5,316.00	13.63	34.00
35.00	Dietary under contract (see instructions)	0	0	0	0.00	0.00	35.00
36.00	Cafeteria	0	341,264	341,264	23,701.00	14.40	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	890,426	0	890,426	24,034.00	37.05	38.00
39.00	Central Services and Supply	295,175	0	295,175	16,782.00	17.59	39.00
40.00	Pharmacy	688,010	0	688,010	17,325.00	39.71	40.00
41.00	Medical Records & Medical Records Library	1,998,619	-3,294	1,995,325	81,123.00	24.60	41.00
42.00	Social Service	138,284	0	138,284	4,016.00	34.43	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0072

Period:
From 01/01/2021
To 12/31/2021

Worksheet S-3
Part III
Date/Time Prepared:
5/27/2022 1:47 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)	33,882,189	-262,623	33,619,566	1,133,189.00	29.67	1.00
2.00	Excluded area salaries (see instructions)	7,585,712	-39,152	7,546,560	170,297.00	44.31	2.00
3.00	Subtotal salaries (line 1 minus line 2)	26,296,477	-223,471	26,073,006	962,892.00	27.08	3.00
4.00	Subtotal other wages & related costs (see inst.)	5,326,256	0	5,326,256	60,760.00	87.66	4.00
5.00	Subtotal wage-related costs (see inst.)	10,366,428	0	10,366,428	0.00	39.76	5.00
6.00	Total (sum of lines 3 thru 5)	41,989,161	-223,471	41,765,690	1,023,652.00	40.80	6.00
7.00	Total overhead cost (see instructions)	10,772,780	-32,322	10,740,458	417,916.00	25.70	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0072	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part IV Date/Time Prepared: 5/27/2022 1:47 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	438,317	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)	9,114,531	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	149,737	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	38,576	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)	453,217	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	280,183	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	2,721,681	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	15,144	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	46,595	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	13,257,981	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 01/01/2021 To 12/31/2021	Worksheet S-3 Part V Date/Time Prepared: 5/27/2022 1:47 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	5,257,125	13,257,981	1.00
2.00	Hospital	5,257,125	13,257,981	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	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			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			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 01/01/2021 To 12/31/2021		Worksheet S-8 Date/Time Prepared: 5/27/2022 1:47 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	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?			N		0 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 number			
		1.00		2.00			
14.00	RHC/FQHC name, CCN number					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	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 01/01/2021 To 12/31/2021		Worksheet S-8 Date/Time Prepared: 5/27/2022 1:47 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 01/01/2021 To 12/31/2021		Worksheet S-8 Date/Time Prepared: 5/27/2022 1:47 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?			N		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.			0		13.00	
		Provider name		CCN number			
		1.00		2.00			
14.00	RHC/FQHC name, CCN number					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	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: 15-8563		Period: From 01/01/2021 To 12/31/2021		Worksheet S-8 Date/Time Prepared: 5/27/2022 1:47 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 01/01/2021 To 12/31/2021	Worksheet S-10 Date/Time Prepared: 5/27/2022 1:47 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)			0.303455	1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			8,316,617	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			40,868,138	6.00	
7.00	Medicaid cost (line 1 times line 6)			12,401,641	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)			4,085,024	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)			4,085,024	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)	2,029,963	0	2,029,963	20.00	
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	616,002	0	616,002	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)	616,002	0	616,002	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)			8,160,191	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)			7,992,770	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			2,484,043	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			3,100,045	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			7,185,069	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0072

Period:
From 01/01/2021
To 12/31/2021

Worksheet A
Date/Time Prepared:
5/27/2022 1:47 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		5,498,914	5,498,914	-1,051,343	4,447,571	1.00
1.01	00101			0	223,692	223,692	1.01
1.02	00102			0	147,326	147,326	1.02
4.00	00400	335,448	13,570,565	13,906,013	0	13,906,013	4.00
5.00	00500	4,112,081	5,953,333	10,065,414	515,689	10,581,103	5.00
7.00	00700	796,827	1,987,976	2,784,803	208,581	2,993,384	7.00
8.00	00800		215,672	215,672	0	215,672	8.00
9.00	00900	655,062	162,483	817,545	0	817,545	9.00
10.00	01000	418,318	312,074	730,392	-595,854	134,538	10.00
11.00	01100			0	595,854	595,854	11.00
13.00	01300	890,426	106,461	996,887	0	996,887	13.00
14.00	01400	295,175	266,625	561,800	-42,284	519,516	14.00
15.00	01500	688,010	207,144	895,154	0	895,154	15.00
16.00	01600	1,998,619	5,273,119	7,271,738	0	7,271,738	16.00
17.00	01700	138,284	31,534	169,818	0	169,818	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	4,396,485	342,534	4,739,019	-966,158	3,772,861	30.00
31.00	03100	894,005	77,446	971,451	0	971,451	31.00
43.00	04300		1,698	1,698	380,320	382,018	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	5,378,259	2,076,454	7,454,713	0	7,454,713	50.00
52.00	05200			0	585,838	585,838	52.00
53.00	05300		2,379,382	2,379,382	0	2,379,382	53.00
54.00	05400	1,318,802	920,991	2,239,793	0	2,239,793	54.00
57.00	05700			0	0	0	57.00
58.00	05800			0	0	0	58.00
59.00	05900			0	0	0	59.00
60.00	06000		4,048,057	4,048,057	0	4,048,057	60.00
63.00	06300		218,062	218,062	0	218,062	63.00
65.00	06500	985,630	200,495	1,186,125	0	1,186,125	65.00
66.00	06600	997,285	77,190	1,074,475	0	1,074,475	66.00
69.00	06900	266,905	103,069	369,974	0	369,974	69.00
69.01	06901	307,265	19,966	327,231	0	327,231	69.01
71.00	07100		4,430,778	4,430,778	-1,941,752	2,489,026	71.00
72.00	07200			0	1,941,752	1,941,752	72.00
73.00	07300	40	10,254,392	10,254,432	0	10,254,432	73.00
76.00	03450	230,418	452,715	683,133	0	683,133	76.00
76.01	03480	714,383	1,732,388	2,446,771	0	2,446,771	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	1	0	1	0	1	88.00
88.01	08801	1	0	1	0	1	88.01
90.00	09000	6,918,109	551,056	7,469,165	-1,661	7,467,504	90.00
90.01	09001	147,975	603,182	751,157	0	751,157	90.01
91.00	09100	1,701,678	1,018,895	2,720,573	0	2,720,573	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		34,585,491	63,094,650	97,680,141	0	97,680,141	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	0	1,872	1,872	0	1,872	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	475,075	137,013	612,088	0	612,088	194.04
194.05	07955	4,838,457	1,823,133	6,661,590	0	6,661,590	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07958	0	0	0	0	0	194.08
194.09	07959	598,801	47,269	646,070	0	646,070	194.09
194.10	07961	1,223,595	118,400	1,341,995	0	1,341,995	194.10
194.11	07960	251,520	33,408	284,928	0	284,928	194.11
194.12	07962	198,264	21,165	219,429	0	219,429	194.12
200.00		42,171,203	65,276,910	107,448,113	0	107,448,113	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0072

Period:
From 01/01/2021
To 12/31/2021

Worksheet A
Date/Time Prepared:
5/27/2022 1:47 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	-51,941	4,395,630	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	-74,655	13,831,358	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-3,187,138	7,393,965	5.00
7.00	00700 OPERATION OF PLANT	-12,908	2,980,476	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	215,672	8.00
9.00	00900 HOUSEKEEPING	0	817,545	9.00
10.00	01000 DIETARY	-30,448	104,090	10.00
11.00	01100 CAFETERIA	-1,433	594,421	11.00
13.00	01300 NURSING ADMINISTRATION	-3,094	993,793	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	-84,437	435,079	14.00
15.00	01500 PHARMACY	0	895,154	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-25,449	7,246,289	16.00
17.00	01700 SOCIAL SERVICE	-967	168,851	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-1,262,442	2,510,419	30.00
31.00	03100 INTENSIVE CARE UNIT	0	971,451	31.00
43.00	04300 NURSERY	0	382,018	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-3,644,518	3,810,195	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	585,838	52.00
53.00	05300 ANESTHESIOLOGY	-2,379,110	272	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	2,239,793	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	4,048,057	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	218,062	63.00
65.00	06500 RESPIRATORY THERAPY	0	1,186,125	65.00
66.00	06600 PHYSICAL THERAPY	0	1,074,475	66.00
69.00	06900 ELECTROCARDIOLOGY	0	369,974	69.00
69.01	06901 CARDIAC REHAB	0	327,231	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,489,026	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	1,941,752	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	-189,240	10,065,192	73.00
76.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	683,133	76.00
76.01	03480 ONCOLOGY	-1,512,857	933,914	76.01
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 EXPRESS MEDICAL CENTER	0	1	88.00
88.01	08801 FAMILY HEALTH CARE	0	1	88.01
90.00	09000 CLINIC	-6,750,773	716,731	90.00
90.01	09001 WOUND CARE	-681,762	69,395	90.01
91.00	09100 EMERGENCY	-842,886	1,877,687	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)	-20,736,058	76,944,083	118.00
NONREIMBURSABLE COST CENTERS				
194.00	07950 FOUNDATION	0	1,872	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	0	612,088	194.04
194.05	07955 PHYSICIANS OFFICE	0	6,661,590	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	0	646,070	194.09
194.10	07961 RHEUMATOLOGY	0	1,341,995	194.10
194.11	07960 SPORTS HEALTH	0	284,928	194.11
194.12	07962 BEHAVIORAL HEALTH CLINIC	0	219,429	194.12
200.00	TOTAL (SUM OF LINES 118 through 199)	-20,736,058	86,712,055	200.00

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - CAFETERIA RECLASS						
1.00	CAFETERIA	11.00	341,264	254,590	1.00	
	O		341,264	254,590		
B - OB RECLASS						
1.00	NURSERY	43.00	341,077	39,243	1.00	
2.00	DELIVERY ROOM & LABOR ROOM	52.00	523,054	62,784	2.00	
	O		864,131	102,027		
C - MALPRACTICE INS. RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	680,325	1.00	
	O		0	680,325		
D - IMPLANT EXPENSE RECLASS						
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	1,941,752	1.00	
	O		0	1,941,752		
E - UTILITIES RECLASS						
1.00	OPERATION OF PLANT	7.00	0	208,581	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
	O		0	208,581		
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		
H - SHORT TERM DISABILITY RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	18,623	1.00	
2.00	HOUSEKEEPING	9.00	0	5,796	2.00	
3.00	DIETARY	10.00	0	4,609	3.00	
4.00	MEDICAL RECORDS & LIBRARY	16.00	0	3,294	4.00	
5.00	ADULTS & PEDIATRICS	30.00	0	28,458	5.00	
6.00	OPERATING ROOM	50.00	0	19,615	6.00	
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	10,439	7.00	
8.00	RESPIRATORY THERAPY	65.00	0	19,121	8.00	
9.00	PHYSICAL THERAPY	66.00	0	1,797	9.00	
10.00	ELECTROCARDIOLOGY	69.00	0	3,786	10.00	
11.00	ONCOLOGY	76.01	0	14,937	11.00	
12.00	CLINIC	90.00	0	68,527	12.00	
13.00	EMERGENCY	91.00	0	24,469	13.00	
14.00	HEALTH COMPANIES	194.04	0	1,886	14.00	
15.00	PHYSICIANS OFFICE	194.05	0	23,458	15.00	
16.00	MHL ROCHESTER HEALTH CENTER	194.09	0	13,808	16.00	
	O		0	262,623		
500.00	Grand Total: Increases		1,205,395	3,820,916	500.00	

RECLASSIFICATIONS

Provider CCN: 15-0072

Period:
From 01/01/2021
To 12/31/2021

Worksheet A-6

Date/Time Prepared:
5/27/2022 1:47 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	341,264	254,590	0		1.00
	O		341,264	254,590			
B - OB RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	864,131	102,027	0		1.00
2.00		0.00	0	0	0		2.00
	O		864,131	102,027			
C - MALPRACTICE INS. RECLASS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	680,325	12		1.00
	O		0	680,325			
D - IMPLANT EXPENSE RECLASS							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,941,752	0		1.00
	O		0	1,941,752			
E - UTILITIES RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	164,636	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	42,284	0		2.00
3.00	CLINIC	90.00	0	1,661	0		3.00
	O		0	208,581			
F - DEPRECIATION RECLASS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	371,018	9		1.00
2.00		0.00	0	0	9		2.00
	O		0	371,018			
H - SHORT TERM DISABILITY RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	18,623	0	0		1.00
2.00	HOUSEKEEPING	9.00	5,796	0	0		2.00
3.00	DIETARY	10.00	4,609	0	0		3.00
4.00	MEDICAL RECORDS & LIBRARY	16.00	3,294	0	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	28,458	0	0		5.00
6.00	OPERATING ROOM	50.00	19,615	0	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	10,439	0	0		7.00
8.00	RESPIRATORY THERAPY	65.00	19,121	0	0		8.00
9.00	PHYSICAL THERAPY	66.00	1,797	0	0		9.00
10.00	ELECTROCARDIOLOGY	69.00	3,786	0	0		10.00
11.00	ONCOLOGY	76.01	14,937	0	0		11.00
12.00	CLINIC	90.00	68,527	0	0		12.00
13.00	EMERGENCY	91.00	24,469	0	0		13.00
14.00	HEALTH COMPANIES	194.04	1,886	0	0		14.00
15.00	PHYSICIANS OFFICE	194.05	23,458	0	0		15.00
16.00	MHL ROCHESTER HEALTH CENTER	194.09	13,808	0	0		16.00
	O		262,623	0			
500.00	Grand Total: Decreases		1,468,018	3,558,293			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0072

Period:
From 01/01/2021
To 12/31/2021

Worksheet A-7
Part I
Date/Time Prepared:
5/27/2022 1:47 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	0	1.00
2.00	Land Improvements	838,517	0	0	0	0	2.00
3.00	Buildings and Fixtures	65,043,978	6,648,911	0	6,648,911	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	7,611,191	617,863	0	617,863	0	5.00
6.00	Movable Equipment	48,872,907	0	0	0	2,207,156	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	122,572,376	7,266,774	0	7,266,774	2,207,156	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	122,572,376	7,266,774	0	7,266,774	2,207,156	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	838,517	0				2.00
3.00	Buildings and Fixtures	71,692,889	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	8,229,054	0				5.00
6.00	Movable Equipment	46,665,751	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	127,631,994	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	127,631,994	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0072

Period:
From 01/01/2021
To 12/31/2021

Worksheet A-7
Part II
Date/Time Prepared:
5/27/2022 1:47 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	4,057,136	0	639,326	802,452	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)	4,057,136	0	639,326	802,452	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	5,498,914				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	5,498,914				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0072

Period:
From 01/01/2021
To 12/31/2021

Worksheet A-7
Part III
Date/Time Prepared:
5/27/2022 1:47 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	127,631,994	0	127,631,994	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)	127,631,994	0	127,631,994	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	3,665,552	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	4,036,570	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	607,951	122,127	0	0	4,395,630	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)	607,951	122,127	0	0	4,766,648	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0072

Period:
From 01/01/2021
To 12/31/2021

Worksheet A-8

Date/Time Prepared:
5/27/2022 1:47 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	-84,437	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	-16,987,661			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	-1,433	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

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0072

Period:
From 01/01/2021
To 12/31/2021

Worksheet A-8

Date/Time Prepared:
5/27/2022 1:47 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00
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)			0ADULTS & 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	-33,703	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00 OTHER REVENUE - CPR TRAINING	B	-3,094	NURSING ADMINISTRATION	13.00	0	34.00
35.00 HIM MEDICAL RECORDS FEES	B	-25,449	MEDICAL RECORDS & LIBRARY	16.00	0	35.00
37.00 OTHER REVENUE - MED/SURGICAL SERVICE	B	-3,800	ADULTS & PEDIATRICS	30.00	0	37.00
38.00 INTEREST INCOME	B	-31,375	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	38.00
39.00 DIETARY REVENUE	B	-30,448	DIETARY	10.00	0	39.00
40.00 PATIENT TELEVISIONS	A	-1,575	OPERATION OF PLANT	7.00	0	40.00
41.00 PATIENT TELEPHONES	A	-3,207	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	41.00
45.00 PATIENT TELEPHONES	A	-2,138	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	45.00
45.01 PATIENT TELEPHONES	A	-1,494	ADMINISTRATIVE & GENERAL	5.00	0	45.01
45.02 IHA & AHA LOBBYING FEES	A	-8,628	ADMINISTRATIVE & GENERAL	5.00	0	45.02
45.03 GIFT SHOP	A	-15,306	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	45.03
45.04 GIFT SHOP	A	-9,413	OPERATION OF PLANT	7.00	0	45.04
45.05 ADVERTISING	A	-708,043	ADMINISTRATIVE & GENERAL	5.00	0	45.05
45.06 TAXES	A	-70,023	ADMINISTRATIVE & GENERAL	5.00	0	45.06
45.07 DONATION EXPENSE	A	-78,489	ADMINISTRATIVE & GENERAL	5.00	0	45.07
45.08 PHYSICIAN RECRUITMENT	A	-193,564	ADMINISTRATIVE & GENERAL	5.00	0	45.08
45.09 VENDING	A	-3,122	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	45.09
45.10 VENDING	A	-1,920	OPERATION OF PLANT	7.00	0	45.10
45.12 HOSPITAL ASSESSMENT FEE OFFSET	A	-2,093,194	ADMINISTRATIVE & GENERAL	5.00	0	45.12
45.13 HOSPITALIST OFFSET	A	-83,854	ADULTS & PEDIATRICS	30.00	0	45.13
45.14 HOSPITALIST OFFSET	A	-71,448	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.14
45.15 340B OFFSET	A	-189,240	DRUGS CHARGED TO PATIENTS	73.00	0	45.15
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-20,736,058				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 01/01/2021
To 12/31/2021

Worksheet A-8-2

Date/Time Prepared:
5/27/2022 1:47 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	22,888	0	22,888	211,500	267	1.00
2.00	17.00	SOCIAL SERVICE	9,000	0	9,000	211,500	79	2.00
3.00	30.00	ADULTS & PEDIATRICS	1,174,788	1,174,788	0	211,500	0	3.00
4.00	50.00	OPERATING ROOM	3,783,947	3,439,606	344,341	246,400	1,177	4.00
5.00	53.00	ANESTHESIOLOGY	2,379,110	2,379,110	0	211,500	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	44,061	0	44,061	211,500	512	6.00
7.00	76.01	ONCOLOGY	1,512,857	1,512,857	0	211,500	0	7.00
8.00	90.00	CLINIC	6,808,325	6,702,044	106,281	211,500	566	8.00
9.00	90.01	WOUND CARE	681,762	681,762	0	211,500	0	9.00
10.00	91.00	EMERGENCY	842,886	842,886	0	211,500	0	10.00
200.00			17,259,624	16,733,053	526,571		2,601	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	27,149	1,357	0	0	0	1.00
2.00	17.00	SOCIAL SERVICE	8,033	402	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	52,062	2,603	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	91.00	EMERGENCY	0	0	0	0	0	10.00
200.00			284,225	14,211	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	27,149	0	0		1.00
2.00	17.00	SOCIAL SERVICE	0	8,033	967	967		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,174,788		3.00
4.00	50.00	OPERATING ROOM	0	139,429	204,912	3,644,518		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	2,379,110		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	52,062	0	0		6.00
7.00	76.01	ONCOLOGY	0	0	0	1,512,857		7.00
8.00	90.00	CLINIC	0	57,552	48,729	6,750,773		8.00
9.00	90.01	WOUND CARE	0	0	0	681,762		9.00
10.00	91.00	EMERGENCY	0	0	0	842,886		10.00
200.00			0	284,225	254,608	16,987,661		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0072

Period: From 01/01/2021 To 12/31/2021

Worksheet B Part I Date/Time Prepared: 5/27/2022 1:47 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	4,395,630	4,395,630				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	13,831,358	27,624	6,105	0	13,865,087	4.00	
5.00 00500 ADMINISTRATIVE & GENERAL	7,393,965	351,480	20,417	0	1,365,213	5.00	
7.00 00700 OPERATION OF PLANT	2,980,476	800,993	1,322	11,704	265,751	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	215,672	14,037	0	0	0	8.00	
9.00 00900 HOUSEKEEPING	817,545	31,425	12,264	432	216,537	9.00	
10.00 01000 DIETARY	104,090	133,011	0	0	24,161	10.00	
11.00 01100 CAFETERIA	594,421	64,290	0	0	113,815	11.00	
13.00 01300 NURSING ADMINISTRATION	993,793	49,871	0	0	296,967	13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY	435,079	92,836	0	0	98,444	14.00	
15.00 01500 PHARMACY	895,154	47,306	0	0	229,459	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	7,246,289	167,473	0	0	665,463	16.00	
17.00 01700 SOCIAL SERVICE	168,851	27,938	0	0	46,119	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	2,510,419	783,717	0	0	1,168,588	30.00	
31.00 03100 INTENSIVE CARE UNIT	971,451	118,840	0	0	298,161	31.00	
43.00 04300 NURSERY	382,018	5,849	0	0	113,753	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	3,810,195	438,355	0	33,560	1,787,167	50.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	585,838	95,895	0	0	174,444	52.00	
53.00 05300 ANESTHESIOLOGY	272	46,272	0	0	0	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	2,239,793	203,083	0	8,309	436,353	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	4,048,057	108,807	6,686	3,875	0	60.00	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	218,062	0	0	0	0	63.00	
65.00 06500 RESPIRATORY THERAPY	1,186,125	7,738	0	0	322,341	65.00	
66.00 06600 PHYSICAL THERAPY	1,074,475	124,306	0	0	332,006	66.00	
69.00 06900 ELECTROCARDIOLOGY	369,974	10,775	14,069	0	87,753	69.00	
69.01 06901 CARDIAC REHAB	327,231	125,138	0	0	102,476	69.01	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,489,026	0	0	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	1,941,752	0	0	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	10,065,192	0	0	0	13	73.00	
76.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	683,133	16,489	0	0	76,847	76.00	
76.01 03480 ONCOLOGY	933,914	0	0	48,216	233,273	76.01	
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 EXPRESS MEDICAL CENTER	1	0	0	0	0	88.00	
88.01 08801 FAMILY HEALTH CARE	1	0	0	0	0	88.01	
90.00 09000 CLINIC	716,731	4,724	78,780	0	2,284,403	90.00	
90.01 09001 WOUND CARE	69,395	0	13,611	0	49,351	90.01	
91.00 09100 EMERGENCY	1,877,687	344,642	0	0	559,368	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)	76,944,083	4,242,914	153,254	106,096	11,348,226	118.00
NONREIMBURSABLE COST CENTERS							
194.00 07950 FOUNDATION	1,872	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	612,088	51,400	0	0	157,814	194.04	
194.05 07955 PHYSICIANS OFFICE	6,661,590	101,316	27,993	0	1,605,855	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	646,070	0	0	0	195,102	194.09	
194.10 07961 RHEUMATOLOGY	1,341,995	0	28,093	0	408,082	194.10	
194.11 07960 SPORTS HEALTH	284,928	0	0	0	83,885	194.11	
194.12 07962 BEHAVIORAL HEALTH CLINIC	219,429	0	6,990	0	66,123	194.12	
200.00	Cross Foot Adjustments					200.00	
201.00	Negative Cost Centers					201.00	
202.00	TOTAL (sum lines 118 through 201)	86,712,055	4,395,630	223,692	147,326	13,865,087	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0072	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Prepared: 5/27/2022 1:47 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	9,131,075	9,131,075		5.00
7.00	00700	OPERATION OF PLANT	4,060,246	477,879	4,538,125	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	229,709	27,036	13,628	270,373
9.00	00900	HOUSEKEEPING	1,078,203	126,901	86,159	0
10.00	01000	DIETARY	261,262	30,750	129,140	2,772
11.00	01100	CAFETERIA	772,526	90,924	62,419	0
13.00	01300	NURSING ADMINISTRATION	1,340,631	157,788	48,419	0
14.00	01400	CENTRAL SERVICES & SUPPLY	626,359	73,721	90,134	0
15.00	01500	PHARMACY	1,171,919	137,931	45,930	0
16.00	01600	MEDICAL RECORDS & LIBRARY	8,079,225	950,901	162,599	0
17.00	01700	SOCIAL SERVICE	242,908	28,590	27,125	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,462,724	525,249	760,909	89,075
31.00	03100	INTENSIVE CARE UNIT	1,388,452	163,417	115,381	9,072
43.00	04300	NURSERY	501,620	59,039	5,678	4,282
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,069,277	714,336	563,124	72,132
52.00	05200	DELIVERY ROOM & LABOR ROOM	856,177	100,769	93,104	0
53.00	05300	ANESTHESIOLOGY	46,544	5,478	44,925	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,887,538	339,855	231,221	22,780
57.00	05700	CT SCAN	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0
60.00	06000	LABORATORY	4,167,425	490,493	150,893	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	218,062	25,665	0	0
65.00	06500	RESPIRATORY THERAPY	1,516,204	178,453	7,513	0
66.00	06600	PHYSICAL THERAPY	1,530,787	180,169	120,688	7,756
69.00	06900	ELECTROCARDIOLOGY	482,571	56,797	72,269	0
69.01	06901	CARDIAC REHAB	554,845	65,304	121,496	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,489,026	292,951	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,941,752	228,538	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	10,065,205	1,184,672	0	0
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	776,469	91,388	16,009	0
76.01	03480	ONCOLOGY	1,215,403	143,049	197,587	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EXPRESS MEDICAL CENTER	1	0	0	0
88.01	08801	FAMILY HEALTH CARE	1	0	0	0
90.00	09000	CLINIC	3,084,638	363,053	350,686	0
90.01	09001	WOUND CARE	132,357	15,578	59,798	0
91.00	09100	EMERGENCY	2,781,697	327,397	334,612	62,504
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	112,101
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	74,162,838	7,654,071	3,911,446	270,373
NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	1,872	220	0	0
194.01	07951	MOB	7,362	866	32,345	0
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0
194.03	07953	PIH	0	0	0	0
194.04	07954	HEALTH COMPANIES	821,302	96,665	49,905	0
194.05	07955	PHYSICIANS OFFICE	8,396,754	988,273	221,349	0
194.06	07956	THE ARBORS	0	0	0	0
194.07	07957	PAIN MANAGEMENT	0	0	0	0
194.08	07958	OPS	41,230	4,853	168,955	0
194.09	07959	MHL ROCHESTER HEALTH CENTER	841,172	99,003	0	0
194.10	07961	RHEUMATOLOGY	1,778,170	209,285	123,418	0
194.11	07960	SPORTS HEALTH	368,813	43,408	0	0
194.12	07962	BEHAVIORAL HEALTH CLINIC	292,542	34,431	30,707	0
200.00		Cross Foot Adjustments	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	86,712,055	9,131,075	4,538,125	270,373

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0072	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Prepared: 5/27/2022 1:47 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	423,924				10.00
11.00	01100	CAFETERIA	0	925,869			11.00
13.00	01300	NURSING ADMINISTRATION	0	22,388	1,572,729		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	18,157	0	816,779	14.00
15.00	01500	PHARMACY	0	18,709	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	52,287	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	4,337	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	376,559	93,678	479,912	0	30.00
31.00	03100	INTENSIVE CARE UNIT	47,365	30,252	136,708	0	31.00
43.00	04300	NURSERY	0	11,819	53,411	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	122,721	554,575	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	18,125	81,906	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	45,456	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	24,347	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	32,194	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	6,699	0	0	69.00
69.01	06901	CARDIAC REHAB	0	13,691	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	816,779	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	6,583	0	0	76.00
76.01	03480	ONCOLOGY	0	24,789	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	EXPRESS MEDICAL CENTER	0	0	0	0	88.00
88.01	08801	FAMILY HEALTH CARE	0	0	0	0	88.01
90.00	09000	CLINIC	0	152,458	0	0	90.00
90.01	09001	WOUND CARE	0	3,061	0	0	90.01
91.00	09100	EMERGENCY	0	58,911	266,217	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)	423,924	760,662	1,572,729	816,779	1,381,495
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	19,779	0	0	194.04
194.05	07955	PHYSICIANS OFFICE	0	101,655	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	25,131	0	0	194.10
194.11	07960	SPORTS HEALTH	0	12,581	0	0	194.11
194.12	07962	BEHAVIORAL HEALTH CLINIC	0	6,061	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)	423,924	925,869	1,572,729	816,779	1,381,495

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0072

Period:
From 01/01/2021
To 12/31/2021

Worksheet B
Part I
Date/Time Prepared:
5/27/2022 1:47 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	9,255,521				16.00
17.00	01700	SOCIAL SERVICE	0	302,960			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	545,661	237,996	8,004,053	0	8,004,053
31.00	03100	INTENSIVE CARE UNIT	127,701	35,466	2,123,877	0	2,123,877
43.00	04300	NURSERY	59,677	0	698,329	0	698,329
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,801,950	0	11,055,757	0	11,055,757
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,285	0	1,201,710	0	1,201,710
53.00	05300	ANESTHESIOLOGY	107,560	0	204,507	0	204,507
54.00	05400	RADIOLOGY-DIAGNOSTIC	733,927	0	4,316,827	0	4,316,827
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	1,075,811	0	5,909,144	0	5,909,144
63.00	06300	BLOOD STORAGE, PROCESSING & TRANS.	34,948	0	278,675	0	278,675
65.00	06500	RESPIRATORY THERAPY	380,075	0	2,138,120	0	2,138,120
66.00	06600	PHYSICAL THERAPY	208,637	0	2,094,244	0	2,094,244
69.00	06900	ELECTROCARDIOLOGY	161,853	0	811,717	0	811,717
69.01	06901	CARDIAC REHAB	24,672	0	780,008	0	780,008
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	3,598,756	0	3,598,756
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	2,170,290	0	2,170,290
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	12,631,372	0	12,631,372
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	509,259	0	1,399,708	0	1,399,708
76.01	03480	ONCOLOGY	528,294	0	2,165,172	0	2,165,172
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	EXPRESS MEDICAL CENTER	0	0	1	0	1
88.01	08801	FAMILY HEALTH CARE	0	0	1	0	1
90.00	09000	CLINIC	548,657	0	4,538,027	0	4,538,027
90.01	09001	WOUND CARE	108,344	0	336,654	0	336,654
91.00	09100	EMERGENCY	788,439	29,498	4,761,376	0	4,761,376
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)	8,748,750	302,960	71,218,325	0	71,218,325
NONREIMBURSABLE COST CENTERS							
194.00	07950	FOUNDATION	0	0	13,302	0	13,302
194.01	07951	MOB	0	0	40,573	0	40,573
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	1,001,664	0	1,001,664
194.05	07955	PHYSICIANS OFFICE	399,320	0	10,191,427	0	10,191,427
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	243,063	0	243,063
194.09	07959	MHL ROCHESTER HEALTH CENTER	25,913	0	966,088	0	966,088
194.10	07961	RHEUMATOLOGY	65,273	0	2,232,805	0	2,232,805
194.11	07960	SPORTS HEALTH	0	0	424,802	0	424,802
194.12	07962	BEHAVIORAL HEALTH CLINIC	16,265	0	380,006	0	380,006
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)	9,255,521	302,960	86,712,055	0	86,712,055

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0072	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Prepared: 5/27/2022 1:47 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	27,624	6,105	0	33,729	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	351,480	20,417	0	371,897	5.00
7.00	00700	OPERATION OF PLANT	0	800,993	1,322	11,704	814,019	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	14,037	0	0	14,037	8.00
9.00	00900	HOUSEKEEPING	0	31,425	12,264	432	44,121	9.00
10.00	01000	DIETARY	0	133,011	0	0	133,011	10.00
11.00	01100	CAFETERIA	0	64,290	0	0	64,290	11.00
13.00	01300	NURSING ADMINISTRATION	0	49,871	0	0	49,871	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	92,836	0	0	92,836	14.00
15.00	01500	PHARMACY	0	47,306	0	0	47,306	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	167,473	0	0	167,473	16.00
17.00	01700	SOCIAL SERVICE	0	27,938	0	0	27,938	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	783,717	0	0	783,717	30.00
31.00	03100	INTENSIVE CARE UNIT	0	118,840	0	0	118,840	31.00
43.00	04300	NURSERY	0	5,849	0	0	5,849	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	438,355	0	33,560	471,915	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	95,895	0	0	95,895	52.00
53.00	05300	ANESTHESIOLOGY	0	46,272	0	0	46,272	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	203,083	0	8,309	211,392	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	108,807	6,686	3,875	119,368	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	7,738	0	0	7,738	65.00
66.00	06600	PHYSICAL THERAPY	0	124,306	0	0	124,306	66.00
69.00	06900	ELECTROCARDIOLOGY	0	10,775	14,069	0	24,844	69.00
69.01	06901	CARDIAC REHAB	0	125,138	0	0	125,138	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	16,489	0	0	16,489	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	0	0	0	88.01
90.00	09000	CLINIC	0	4,724	78,780	0	83,504	90.00
90.01	09001	WOUND CARE	0	0	13,611	0	13,611	90.01
91.00	09100	EMERGENCY	0	344,642	0	0	344,642	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	4,242,914	153,254	106,096	4,502,264	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	51,400	0	0	51,400	194.04
194.05	07955	PHYSICIANS OFFICE	0	101,316	27,993	0	129,309	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	28,093	0	28,093	194.10
194.11	07960	SPORTS HEALTH	0	0	0	0	0	194.11
194.12	07962	BEHAVIORAL HEALTH CLINIC	0	0	6,990	0	6,990	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	4,395,630	223,692	147,326	4,766,648	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0072	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Prepared: 5/27/2022 1:47 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	33,729				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,320	375,217			5.00
7.00	00700	OPERATION OF PLANT	646	19,635	834,300		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,111	2,505	17,653	8.00
9.00	00900	HOUSEKEEPING	527	5,214	15,840	0	65,702
10.00	01000	DIETARY	59	1,263	23,741	181	0
11.00	01100	CAFETERIA	277	3,736	11,475	0	0
13.00	01300	NURSING ADMINISTRATION	722	6,483	8,902	0	178
14.00	01400	CENTRAL SERVICES & SUPPLY	239	3,029	16,570	0	428
15.00	01500	PHARMACY	558	5,667	8,444	0	356
16.00	01600	MEDICAL RECORDS & LIBRARY	1,618	39,071	29,893	0	535
17.00	01700	SOCIAL SERVICE	112	1,175	4,987	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,842	21,582	139,887	5,816	21,996
31.00	03100	INTENSIVE CARE UNIT	725	6,715	21,212	592	3,565
43.00	04300	NURSERY	277	2,426	1,044	280	143
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,346	29,351	103,526	4,710	8,021
52.00	05200	DELIVERY ROOM & LABOR ROOM	424	4,140	17,117	0	2,460
53.00	05300	ANESTHESIOLOGY	0	225	8,259	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,061	13,964	42,508	1,487	2,852
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	20,154	27,741	0	1,248
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,055	0	0	0
65.00	06500	RESPIRATORY THERAPY	784	7,332	1,381	0	1,604
66.00	06600	PHYSICAL THERAPY	807	7,403	22,188	506	713
69.00	06900	ELECTROCARDIOLOGY	213	2,334	13,286	0	1,604
69.01	06901	CARDIAC REHAB	249	2,683	22,336	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,037	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	9,390	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	48,711	0	0	0
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	187	3,755	2,943	0	0
76.01	03480	ONCOLOGY	567	5,878	36,325	0	2,852
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	EXPRESS MEDICAL CENTER	0	0	0	0	0
88.01	08801	FAMILY HEALTH CARE	0	0	0	0	0
90.00	09000	CLINIC	5,569	14,917	64,471	0	1,961
90.01	09001	WOUND CARE	120	640	10,993	0	891
91.00	09100	EMERGENCY	1,360	13,452	61,516	4,081	5,704
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)	27,609	314,528	719,090	17,653	57,111
NONREIMBURSABLE COST CENTERS							
194.00	07950	FOUNDATION	0	9	0	0	570
194.01	07951	MOB	0	36	5,946	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	384	3,972	9,175	0	713
194.05	07955	PHYSICIANS OFFICE	3,905	40,607	40,693	0	4,278
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	199	31,061	0	1,426
194.09	07959	MHL ROCHESTER HEALTH CENTER	474	4,068	0	0	0
194.10	07961	RHEUMATOLOGY	992	8,599	22,690	0	1,604
194.11	07960	SPORTS HEALTH	204	1,784	0	0	0
194.12	07962	BEHAVIORAL HEALTH CLINIC	161	1,415	5,645	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)	33,729	375,217	834,300	17,653	65,702

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0072	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Prepared: 5/27/2022 1:47 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	158,255				10.00
11.00	01100	CAFETERIA	0	79,778			11.00
13.00	01300	NURSING ADMINISTRATION	0	1,929	68,085		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,565	0	114,667	14.00
15.00	01500	PHARMACY	0	1,612	0	63,943	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,505	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	374	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	140,573	8,072	20,776	0	30.00
31.00	03100	INTENSIVE CARE UNIT	17,682	2,607	5,918	0	31.00
43.00	04300	NURSERY	0	1,018	2,312	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	10,574	24,008	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,562	3,546	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,917	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	2,098	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,774	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	577	0	0	69.00
69.01	06901	CARDIAC REHAB	0	1,180	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	114,667	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	63,943	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	567	0	0	76.00
76.01	03480	ONCOLOGY	0	2,136	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	EXPRESS MEDICAL CENTER	0	0	0	0	88.00
88.01	08801	FAMILY HEALTH CARE	0	0	0	0	88.01
90.00	09000	CLINIC	0	13,137	0	0	90.00
90.01	09001	WOUND CARE	0	264	0	0	90.01
91.00	09100	EMERGENCY	0	5,076	11,525	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)	158,255	65,544	68,085	114,667	63,943
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	1,704	0	0	194.04
194.05	07955	PHYSICIANS OFFICE	0	8,759	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	2,165	0	0	194.10
194.11	07960	SPORTS HEALTH	0	1,084	0	0	194.11
194.12	07962	BEHAVIORAL HEALTH CLINIC	0	522	0	0	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)	158,255	79,778	68,085	114,667	63,943

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0072	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Prepared: 5/27/2022 1:47 pm
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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	243,095				16.00
17.00	01700	SOCIAL SERVICE	0	34,586			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	14,336	27,169	1,186,766	0	1,186,766
31.00	03100	INTENSIVE CARE UNIT	3,355	4,049	185,260	0	185,260
43.00	04300	NURSERY	1,568	0	14,917	0	14,917
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	73,539	0	729,990	0	729,990
52.00	05200	DELIVERY ROOM & LABOR ROOM	86	0	125,230	0	125,230
53.00	05300	ANESTHESIOLOGY	2,826	0	57,582	0	57,582
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,283	0	296,464	0	296,464
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	28,265	0	196,776	0	196,776
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	918	0	1,973	0	1,973
65.00	06500	RESPIRATORY THERAPY	9,986	0	30,923	0	30,923
66.00	06600	PHYSICAL THERAPY	5,482	0	164,179	0	164,179
69.00	06900	ELECTROCARDIOLOGY	4,252	0	47,110	0	47,110
69.01	06901	CARDIAC REHAB	648	0	152,234	0	152,234
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	126,704	0	126,704
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	9,390	0	9,390
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	112,654	0	112,654
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	13,380	0	37,321	0	37,321
76.01	03480	ONCOLOGY	13,880	0	109,854	0	109,854
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	EXPRESS MEDICAL CENTER	0	0	0	0	88.00
88.01	08801	FAMILY HEALTH CARE	0	0	0	0	88.01
90.00	09000	CLINIC	14,415	0	197,974	0	197,974
90.01	09001	WOUND CARE	2,847	0	29,366	0	29,366
91.00	09100	EMERGENCY	20,715	3,368	471,439	0	471,439
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)	229,781	34,586	4,284,106	0	4,284,106
NONREIMBURSABLE COST CENTERS							
194.00	07950	FOUNDATION	0	0	579	0	579
194.01	07951	MOB	0	0	13,344	0	13,344
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	67,348	0	67,348
194.05	07955	PHYSICIANS OFFICE	10,491	0	238,042	0	238,042
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	73,916	0	73,916
194.09	07959	MHL ROCHESTER HEALTH CENTER	681	0	5,223	0	5,223
194.10	07961	RHEUMATOLOGY	1,715	0	65,858	0	65,858
194.11	07960	SPORTS HEALTH	0	0	3,072	0	3,072
194.12	07962	BEHAVIORAL HEALTH CLINIC	427	0	15,160	0	15,160
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)	243,095	34,586	4,766,648	0	4,766,648

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0072

Period:
From 01/01/2021
To 12/31/2021

Worksheet B-1
Date/Time Prepared:
5/27/2022 1:47 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	41,573,132	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,625	4,107	0	4,093,458	-9,131,075
7.00	00700	OPERATION OF PLANT	35,608	266	2,196	796,827	0
8.00	00800	LAUNDRY & LINEN SERVICE	624	0	0	0	0
9.00	00900	HOUSEKEEPING	1,397	2,467	81	649,266	0
10.00	01000	DIETARY	5,913	0	0	72,445	0
11.00	01100	CAFETERIA	2,858	0	0	341,264	0
13.00	01300	NURSING ADMINISTRATION	2,217	0	0	890,426	0
14.00	01400	CENTRAL SERVICES & SUPPLY	4,127	0	0	295,175	0
15.00	01500	PHARMACY	2,103	0	0	688,010	0
16.00	01600	MEDICAL RECORDS & LIBRARY	7,445	0	0	1,995,325	0
17.00	01700	SOCIAL SERVICE	1,242	0	0	138,284	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	34,840	0	0	3,503,896	0
31.00	03100	INTENSIVE CARE UNIT	5,283	0	0	894,005	0
43.00	04300	NURSERY	260	0	0	341,077	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	19,487	0	6,297	5,358,644	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,263	0	0	523,054	0
53.00	05300	ANESTHESIOLOGY	2,057	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,028	0	1,559	1,308,363	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	966,509	0
66.00	06600	PHYSICAL THERAPY	5,526	0	0	995,488	0
69.00	06900	ELECTROCARDIOLOGY	479	2,830	0	263,119	0
69.01	06901	CARDIAC REHAB	5,563	0	0	307,265	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	40	0
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	733	0	0	230,418	0
76.01	03480	ONCOLOGY	0	0	9,047	699,446	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	EXPRESS MEDICAL CENTER	0	0	0	1	0
88.01	08801	FAMILY HEALTH CARE	0	0	0	1	0
90.00	09000	CLINIC	210	15,847	0	6,849,582	0
90.01	09001	WOUND CARE	0	2,738	0	147,975	0
91.00	09100	EMERGENCY	15,321	0	0	1,677,209	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					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)	188,618	30,828	19,907	34,026,572	-9,131,075
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	473,189	0
194.05	07955	PHYSICIANS OFFICE	4,504	5,631	0	4,814,999	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	584,993	0
194.10	07961	RHEUMATOLOGY	0	5,651	0	1,223,595	0
194.11	07960	SPORTS HEALTH	0	0	0	251,520	0
194.12	07962	BEHAVIORAL HEALTH CLINIC	0	1,406	0	198,264	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,395,630	223,692	147,326	13,865,087	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	22.494742	4.971265	5.329595	0.333511	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0072

Period:
From 01/01/2021
To 12/31/2021

Worksheet B-1
Date/Time Prepared:
5/27/2022 1:47 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			
204.00	Cost to be allocated (per Wkst. B, Part II)			33,729		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000811		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 01/01/2021
To 12/31/2021

Worksheet B-1

Date/Time Prepared:
5/27/2022 1:47 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	77,580,980				5.00
7.00	00700	OPERATION OF PLANT	4,060,246	207,789			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	229,709	624	289,013		8.00
9.00	00900	HOUSEKEEPING	1,078,203	3,945	0	1,843	9.00
10.00	01000	DIETARY	261,262	5,913	2,963	0	10.00
11.00	01100	CAFETERIA	772,526	2,858	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,340,631	2,217	0	5	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	626,359	4,127	0	12	14.00
15.00	01500	PHARMACY	1,171,919	2,103	0	10	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,079,225	7,445	0	15	16.00
17.00	01700	SOCIAL SERVICE	242,908	1,242	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,462,724	34,840	95,217	617	4,786
31.00	03100	INTENSIVE CARE UNIT	1,388,452	5,283	9,697	100	602
43.00	04300	NURSERY	501,620	260	4,577	4	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,069,277	25,784	77,105	225	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	856,177	4,263	0	69	0
53.00	05300	ANESTHESIOLOGY	46,544	2,057	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,887,538	10,587	24,350	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	4,167,425	6,909	0	35	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	218,062	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	1,516,204	344	0	45	0
66.00	06600	PHYSICAL THERAPY	1,530,787	5,526	8,291	20	0
69.00	06900	ELECTROCARDIOLOGY	482,571	3,309	0	45	0
69.01	06901	CARDIAC REHAB	554,845	5,563	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,489,026	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,941,752	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	10,065,205	0	0	0	0
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	776,469	733	0	0	0
76.01	03480	ONCOLOGY	1,215,403	9,047	0	80	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	EXPRESS MEDICAL CENTER	1	0	0	0	0
88.01	08801	FAMILY HEALTH CARE	1	0	0	0	0
90.00	09000	CLINIC	3,084,638	16,057	0	55	0
90.01	09001	WOUND CARE	132,357	2,738	0	25	0
91.00	09100	EMERGENCY	2,781,697	15,321	66,813	160	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
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)	65,031,763	179,095	289,013	1,602	5,388
NONREIMBURSABLE COST CENTERS							
194.00	07950	FOUNDATION	1,872	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	821,302	2,285	0	20	0
194.05	07955	PHYSICIANS OFFICE	8,396,754	10,135	0	120	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	841,172	0	0	0	0
194.10	07961	RHEUMATOLOGY	1,778,170	5,651	0	45	0
194.11	07960	SPORTS HEALTH	368,813	0	0	0	0
194.12	07962	BEHAVIORAL HEALTH CLINIC	292,542	1,406	0	0	0
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)	9,131,075	4,538,125	270,373	1,291,263	423,924
203.00		Unit cost multiplier (Wkst. B, Part I)	0.117697	21.840064	0.935505	700.631036	78.679287
204.00		Cost to be allocated (per Wkst. B, Part II)	375,217	834,300	17,653	65,702	158,255

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0072			Period: From 01/01/2021 To 12/31/2021		Worksheet B-1 Date/Time Prepared: 5/27/2022 1:47 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		
205.00	Unit cost multiplier (Wkst. B, Part II)	0.004836	4.015131	0.061080	35.649485	29.371752	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 01/01/2021
To 12/31/2021

Worksheet B-1
Date/Time Prepared:
5/27/2022 1:47 pm

Cost Center Description		CAFETERIA (MAN HOURS)	NURSING ADMINISTRATIVE (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	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	857,377					11.00
13.00	01300	20,732	322,282				13.00
14.00	01400	16,814	0	100			14.00
15.00	01500	17,325	0	0	100		15.00
16.00	01600	48,419	0	0	0	205,206,660	16.00
17.00	01700	4,016	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	86,748	98,343	0	0	12,098,106	30.00
31.00	03100	28,014	28,014	0	0	2,831,323	31.00
43.00	04300	10,945	10,945	0	0	1,323,123	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	113,643	113,643	0	0	62,121,548	50.00
52.00	05200	16,784	16,784	0	0	72,834	52.00
53.00	05300	0	0	0	0	2,384,753	53.00
54.00	05400	42,093	0	0	0	16,272,235	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	0	23,852,306	60.00
63.00	06300	0	0	0	0	774,839	63.00
65.00	06500	22,546	0	0	0	8,426,828	65.00
66.00	06600	29,812	0	0	0	4,625,797	66.00
69.00	06900	6,203	0	0	0	3,588,510	69.00
69.01	06901	12,678	0	0	0	547,009	69.01
71.00	07100	0	0	100	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	100	0	73.00
76.00	03450	6,096	0	0	0	11,291,024	76.00
76.01	03480	22,955	0	0	0	11,713,051	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
88.01	08801	0	0	0	0	0	88.01
90.00	09000	141,180	0	0	0	12,164,536	90.00
90.01	09001	2,835	0	0	0	2,402,141	90.01
91.00	09100	54,553	54,553	0	0	17,480,848	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		704,391	322,282	100	100	193,970,811	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	18,316	0	0	0	0	194.04
194.05	07955	94,135	0	0	0	8,853,514	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07958	0	0	0	0	0	194.08
194.09	07959	0	0	0	0	574,527	194.09
194.10	07961	23,272	0	0	0	1,447,197	194.10
194.11	07960	11,650	0	0	0	0	194.11
194.12	07962	5,613	0	0	0	360,611	194.12
200.00							200.00
201.00							201.00
202.00		925,869	1,572,729	816,779	1,381,495	9,255,521	202.00
203.00		1.079886	4.879978	8,167.790000	13,814.950000	0.045103	203.00
204.00		79,778	68,085	114,667	63,943	243,095	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0072

Period:
From 01/01/2021
To 12/31/2021

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	
205.00	Unit cost multiplier (Wkst. B, Part II)	0.093049	0.211259	1,146.670000	639.430000	0.001185	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 01/01/2021 To 12/31/2021	Worksheet B-1 Date/Time Prepared: 5/27/2022 1:47 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
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)	302,960	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	34.101756	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	34,586	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	3.893066	205.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0072	Period: From 01/01/2021 To 12/31/2021	Worksheet B-1 Date/Time Prepared: 5/27/2022 1:47 pm
Cost Center Description		SOCIAL SERVICE (HOURS)		
		17.00		
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 01/01/2021
To 12/31/2021

Worksheet C
Part I
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Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
				Total Costs	RCE Disallowance	Total Costs		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,004,053		8,004,053	0	8,004,053	30.00
31.00	03100	INTENSIVE CARE UNIT	2,123,877		2,123,877	0	2,123,877	31.00
43.00	04300	NURSERY	698,329		698,329	0	698,329	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,055,757		11,055,757	204,912	11,260,669	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,201,710		1,201,710	0	1,201,710	52.00
53.00	05300	ANESTHESIOLOGY	204,507		204,507	0	204,507	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,316,827		4,316,827	0	4,316,827	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	5,909,144		5,909,144	0	5,909,144	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	278,675		278,675	0	278,675	63.00
65.00	06500	RESPIRATORY THERAPY	2,138,120	0	2,138,120	0	2,138,120	65.00
66.00	06600	PHYSICAL THERAPY	2,094,244	0	2,094,244	0	2,094,244	66.00
69.00	06900	ELECTROCARDIOLOGY	811,717		811,717	0	811,717	69.00
69.01	06901	CARDIAC REHAB	780,008		780,008	0	780,008	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,598,756		3,598,756	0	3,598,756	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,170,290		2,170,290	0	2,170,290	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,631,372		12,631,372	0	12,631,372	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	1,399,708		1,399,708	0	1,399,708	76.00
76.01	03480	ONCOLOGY	2,165,172		2,165,172	0	2,165,172	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	EXPRESS MEDICAL CENTER	1		1	0	1	88.00
88.01	08801	FAMILY HEALTH CARE	1		1	0	1	88.01
90.00	09000	CLINIC	4,538,027		4,538,027	48,729	4,586,756	90.00
90.01	09001	WOUND CARE	336,654		336,654	0	336,654	90.01
91.00	09100	EMERGENCY	4,761,376		4,761,376	0	4,761,376	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	996,354		996,354	0	996,354	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	72,214,679	0	72,214,679	253,641	72,468,320	200.00
201.00		Less Observation Beds	996,354		996,354		996,354	201.00
202.00		Total (see instructions)	71,218,325	0	71,218,325	253,641	71,471,966	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0072

Period:
From 01/01/2021
To 12/31/2021

Worksheet C
Part I
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		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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,898,860		6,898,860		30.00
31.00	03100	INTENSIVE CARE UNIT	1,578,705		1,578,705		31.00
43.00	04300	NURSERY	1,322,606		1,322,606		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,695,891	33,941,976	39,637,867	0.278919	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,957,430	71,624	2,029,054	0.592251	52.00
53.00	05300	ANESTHESIOLOGY	293,383	2,091,370	2,384,753	0.085756	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,022,142	15,213,156	16,235,298	0.265891	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	3,844,799	20,007,499	23,852,298	0.247739	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	422,673	611,904	1,034,577	0.269361	63.00
65.00	06500	RESPIRATORY THERAPY	5,286,984	2,241,094	7,528,078	0.284019	65.00
66.00	06600	PHYSICAL THERAPY	413,175	4,197,222	4,610,397	0.454244	66.00
69.00	06900	ELECTROCARDIOLOGY	715,170	4,690,221	5,405,391	0.150168	69.00
69.01	06901	CARDIAC REHAB	0	547,009	547,009	1.425951	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,277,675	4,497,105	5,774,780	0.623185	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,335,461	9,119,517	10,454,978	0.207584	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,858,851	43,978,775	58,837,626	0.214682	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	1,142,862	10,148,162	11,291,024	0.123966	76.00
76.01	03480	ONCOLOGY	397	11,320,685	11,321,082	0.191251	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	EXPRESS MEDICAL CENTER	0	0	0		88.00
88.01	08801	FAMILY HEALTH CARE	0	0	0		88.01
90.00	09000	CLINIC	125,963	2,924,398	3,050,361	1.487702	90.00
90.01	09001	WOUND CARE	6,931	1,632,278	1,639,209	0.205376	90.01
91.00	09100	EMERGENCY	1,884,712	16,545,007	18,429,719	0.258353	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	203,353	624,575	827,928	1.203431	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
200.00		Subtotal (see instructions)	50,288,023	184,403,577	234,691,600		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	50,288,023	184,403,577	234,691,600		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0072	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Prepared: 5/27/2022 1:47 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
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	0.284089		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.592251		52.00
53.00	05300 ANESTHESIOLOGY	0.085756		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.265891		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	0.247739		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.269361		63.00
65.00	06500 RESPIRATORY THERAPY	0.284019		65.00
66.00	06600 PHYSICAL THERAPY	0.454244		66.00
69.00	06900 ELECTROCARDIOLOGY	0.150168		69.00
69.01	06901 CARDIAC REHAB	1.425951		69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.623185		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.207584		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.214682		73.00
76.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.123966		76.00
76.01	03480 ONCOLOGY	0.191251		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	1.503676		90.00
90.01	09001 WOUND CARE	0.205376		90.01
91.00	09100 EMERGENCY	0.258353		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.203431		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 01/01/2021
To 12/31/2021

Worksheet C
Part I
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		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		4.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	8,004,053		8,004,053	0	8,004,053	30.00
31.00	03100 INTENSIVE CARE UNIT	2,123,877		2,123,877	0	2,123,877	31.00
43.00	04300 NURSERY	698,329		698,329	0	698,329	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	11,055,757		11,055,757	204,912	11,260,669	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,201,710		1,201,710	0	1,201,710	52.00
53.00	05300 ANESTHESIOLOGY	204,507		204,507	0	204,507	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,316,827		4,316,827	0	4,316,827	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	5,909,144		5,909,144	0	5,909,144	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	278,675		278,675	0	278,675	63.00
65.00	06500 RESPIRATORY THERAPY	2,138,120	0	2,138,120	0	2,138,120	65.00
66.00	06600 PHYSICAL THERAPY	2,094,244	0	2,094,244	0	2,094,244	66.00
69.00	06900 ELECTROCARDIOLOGY	811,717		811,717	0	811,717	69.00
69.01	06901 CARDIAC REHAB	780,008		780,008	0	780,008	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3,598,756		3,598,756	0	3,598,756	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	2,170,290		2,170,290	0	2,170,290	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	12,631,372		12,631,372	0	12,631,372	73.00
76.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	1,399,708		1,399,708	0	1,399,708	76.00
76.01	03480 ONCOLOGY	2,165,172		2,165,172	0	2,165,172	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 EXPRESS MEDICAL CENTER	1		1	0	1	88.00
88.01	08801 FAMILY HEALTH CARE	1		1	0	1	88.01
90.00	09000 CLINIC	4,538,027		4,538,027	48,729	4,586,756	90.00
90.01	09001 WOUND CARE	336,654		336,654	0	336,654	90.01
91.00	09100 EMERGENCY	4,761,376		4,761,376	0	4,761,376	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	996,354		996,354	0	996,354	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0		0	0	0	95.00
200.00	Subtotal (see instructions)	72,214,679	0	72,214,679	253,641	72,468,320	200.00
201.00	Less Observation Beds	996,354		996,354		996,354	201.00
202.00	Total (see instructions)	71,218,325	0	71,218,325	253,641	71,471,966	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0072

Period:
From 01/01/2021
To 12/31/2021

Worksheet C
Part I
Date/Time Prepared:
5/27/2022 1:47 pm

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,898,860		6,898,860		30.00
31.00	03100	INTENSIVE CARE UNIT	1,578,705		1,578,705		31.00
43.00	04300	NURSERY	1,322,606		1,322,606		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,695,891	33,941,976	39,637,867	0.278919	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,957,430	71,624	2,029,054	0.592251	52.00
53.00	05300	ANESTHESIOLOGY	293,383	2,091,370	2,384,753	0.085756	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,022,142	15,213,156	16,235,298	0.265891	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	3,844,799	20,007,499	23,852,298	0.247739	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	422,673	611,904	1,034,577	0.269361	63.00
65.00	06500	RESPIRATORY THERAPY	5,286,984	2,241,094	7,528,078	0.284019	65.00
66.00	06600	PHYSICAL THERAPY	413,175	4,197,222	4,610,397	0.454244	66.00
69.00	06900	ELECTROCARDIOLOGY	715,170	4,690,221	5,405,391	0.150168	69.00
69.01	06901	CARDIAC REHAB	0	547,009	547,009	1.425951	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,277,675	4,497,105	5,774,780	0.623185	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,335,461	9,119,517	10,454,978	0.207584	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,858,851	43,978,775	58,837,626	0.214682	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	1,142,862	10,148,162	11,291,024	0.123966	76.00
76.01	03480	ONCOLOGY	397	11,320,685	11,321,082	0.191251	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	EXPRESS MEDICAL CENTER	0	0	0	0.000000	88.00
88.01	08801	FAMILY HEALTH CARE	0	0	0	0.000000	88.01
90.00	09000	CLINIC	125,963	2,924,398	3,050,361	1.487702	90.00
90.01	09001	WOUND CARE	6,931	1,632,278	1,639,209	0.205376	90.01
91.00	09100	EMERGENCY	1,884,712	16,545,007	18,429,719	0.258353	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	203,353	624,575	827,928	1.203431	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
200.00		Subtotal (see instructions)	50,288,023	184,403,577	234,691,600		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	50,288,023	184,403,577	234,691,600		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0072	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Prepared: 5/27/2022 1:47 pm
Cost Center Description		PPS Inpatient Ratio 11.00	Title XIX	Hospital
				Cost
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
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 01/01/2021 To 12/31/2021		Worksheet D Part I Date/Time Prepared: 5/27/2022 1:47 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	1,186,766	0	1,186,766	4,820	246.22	30.00	
31.00	INTENSIVE CARE UNIT	185,260		185,260	602	307.74	31.00	
43.00	NURSERY	14,917		14,917	983	15.17	43.00	
200.00	Total (Lines 30 through 199)	1,386,943		1,386,943	6,405		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	1,395	343,477					30.00
31.00	INTENSIVE CARE UNIT	192	59,086					31.00
43.00	NURSERY	0	0					43.00
200.00	Total (Lines 30 through 199)	1,587	402,563					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0072

Period:
From 01/01/2021
To 12/31/2021

Worksheet D
Part II
Date/Time Prepared:
5/27/2022 1:47 pm

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital		Capital Costs (column 3 x column 4)	
					Inpatient Program Charges	PPS		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	729,990	39,637,867	0.018416	1,263,997	23,278	50.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	125,230	2,029,054	0.061718	0	0	52.00	
53.00	05300 ANESTHESIOLOGY	57,582	2,384,753	0.024146	59,120	1,428	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	296,464	16,235,298	0.018260	386,995	7,067	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	196,776	23,852,298	0.008250	1,212,138	10,000	60.00	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1,973	1,034,577	0.001907	111,927	213	63.00	
65.00	06500 RESPIRATORY THERAPY	30,923	7,528,078	0.004108	1,893,102	7,777	65.00	
66.00	06600 PHYSICAL THERAPY	164,179	4,610,397	0.035611	189,686	6,755	66.00	
69.00	06900 ELECTROCARDIOLOGY	47,110	5,405,391	0.008715	326,509	2,846	69.00	
69.01	06901 CARDIAC REHAB	152,234	547,009	0.278303	0	0	69.01	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	126,704	5,774,780	0.021941	432,436	9,488	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	9,390	10,454,978	0.000898	455,823	409	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	112,654	58,837,626	0.001915	4,175,739	7,997	73.00	
76.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	37,321	11,291,024	0.003305	434,862	1,437	76.00	
76.01	03480 ONCOLOGY	109,854	11,321,082	0.009703	0	0	76.01	
OUTPATIENT SERVICE COST CENTERS								
88.00	08800 EXPRESS MEDICAL CENTER	0	0	0.000000	0	0	88.00	
88.01	08801 FAMILY HEALTH CARE	0	0	0.000000	0	0	88.01	
90.00	09000 CLINIC	197,974	3,050,361	0.064902	0	0	90.00	
90.01	09001 WOUND CARE	29,366	1,639,209	0.017915	5,689	102	90.01	
91.00	09100 EMERGENCY	471,439	18,429,719	0.025580	850,311	21,751	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	147,730	827,928	0.178433	84,198	15,024	92.00	
OTHER REIMBURSABLE COST CENTERS								
95.00	09500 AMBULANCE SERVICES						95.00	
200.00	Total (lines 50 through 199)	3,044,893	224,891,429		11,882,532	115,572	200.00	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 15-0072		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part III Date/Time Prepared: 5/27/2022 1:47 pm		
Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	PPS	
Title XVIII			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
INPATIENT ROUTINE SERVICE COST CENTERS			4.00	5.00	6.00	7.00	8.00		
30.00	03000	ADULTS & PEDIATRICS	0	0	4,820	0.00	1,395	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	602	0.00	192	31.00	
43.00	04300	NURSERY		0	983	0.00	0	43.00	
200.00		Total (lines 30 through 199)		0	6,405		1,587	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 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prepared: 5/27/2022 1:47 pm
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Cost Center Description	Title XVIII			Hospital		PPS	
	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health		
	1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	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	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	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	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	EXPRESS MEDICAL CENTER	0	0	0	0	88.00
88.01	08801	FAMILY HEALTH CARE	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	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
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0072

Period:
From 01/01/2021
To 12/31/2021

Worksheet D
Part IV
Date/Time Prepared:
5/27/2022 1:47 pm

Cost Center Description		Title XVIII			Hospital	PPS		
		All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	39,637,867	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,029,054	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,384,753	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	16,235,298	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	23,852,298	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	1,034,577	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,528,078	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,610,397	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	5,405,391	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	0	0	547,009	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	5,774,780	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	10,454,978	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	58,837,626	0.000000	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	11,291,024	0.000000	76.00
76.01	03480	ONCOLOGY	0	0	0	11,321,082	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	EXPRESS MEDICAL CENTER	0	0	0	0	0.000000	88.00
88.01	08801	FAMILY HEALTH CARE	0	0	0	0	0.000000	88.01
90.00	09000	CLINIC	0	0	0	3,050,361	0.000000	90.00
90.01	09001	WOUND CARE	0	0	0	1,639,209	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	18,429,719	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	827,928	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	224,891,429		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0072	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prepared: 5/27/2022 1:47 pm
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Cost Center Description		Title XVIII				Hospital	
		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)	PPS
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	1,263,997	0	6,275,787	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	59,120	0	341,036	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	386,995	0	2,671,911	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	1,212,138	0	1,994,318	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	111,927	0	86,935	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.000000	1,893,102	0	531,016	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	189,686	0	32,072	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	326,509	0	1,123,617	0	69.00
69.01	06901 CARDIAC REHAB	0.000000	0	0	166,207	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	432,436	0	798,167	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000	455,823	0	2,057,139	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	4,175,739	0	11,868,395	0	73.00
76.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.000000	434,862	0	2,856,264	0	76.00
76.01	03480 ONCOLOGY	0.000000	0	0	2,422,497	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	0	0	565,114	0	90.00
90.01	09001 WOUND CARE	0.000000	5,689	0	469,023	0	90.01
91.00	09100 EMERGENCY	0.000000	850,311	0	2,950,332	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	84,198	0	212,690	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		11,882,532	0	37,422,520	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0072	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Prepared: 5/27/2022 1:47 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	0.278919	6,275,787	0	0	1,750,436	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.592251	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.085756	341,036	0	0	29,246	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.265891	2,671,911	0	0	710,437	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	0.247739	1,994,318	0	0	494,070	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.269361	86,935	0	0	23,417	63.00
65.00	06500	RESPIRATORY THERAPY	0.284019	531,016	0	0	150,819	65.00
66.00	06600	PHYSICAL THERAPY	0.454244	32,072	0	0	14,569	66.00
69.00	06900	ELECTROCARDIOLOGY	0.150168	1,123,617	0	0	168,731	69.00
69.01	06901	CARDIAC REHAB	1.425951	166,207	0	0	237,003	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.623185	798,167	0	0	497,406	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.207584	2,057,139	0	0	427,029	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.214682	11,868,395	45	83,535	2,547,931	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.123966	2,856,264	0	0	354,080	76.00
76.01	03480	ONCOLOGY	0.191251	2,422,497	0	0	463,305	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	1.487702	565,114	0	48	840,721	90.00
90.01	09001	WOUND CARE	0.205376	469,023	0	0	96,326	90.01
91.00	09100	EMERGENCY	0.258353	2,950,332	0	0	762,227	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.203431	212,690	0	0	255,958	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		37,422,520	45	83,583	9,823,711	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00		Net Charges (line 200 - line 201)		37,422,520	45	83,583	9,823,711	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0072	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Prepared: 5/27/2022 1:47 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	0	0		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
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	10	17,933		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	71		90.00
90.01 09001 WOUND CARE	0	0		90.01
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00 09500 AMBULANCE SERVICES	0			95.00
200.00 Subtotal (see instructions)	10	18,004		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	10	18,004		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0072	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/27/2022 1:47 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,820	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,820	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)		4,220	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)		1,395	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)		8,004,053	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)		8,004,053	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)		8,004,053	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)		1,660.59	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,316,523	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)		2,316,523	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0072	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/27/2022 1:47 pm	
Title XVIII			Hospital		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	2,123,877	602	3,528.03	192	677,382	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						
					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					3,107,019	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					6,100,924	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)					402,563	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					115,572	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					518,135	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					5,582,789	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					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 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 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)					600	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,660.59	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					996,354	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0072		Period: From 01/01/2021 To 12/31/2021		Worksheet D-1 Date/Time Prepared: 5/27/2022 1:47 pm	
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	1,186,766	8,004,053	0.148271	996,354	147,730	90.00
91.00	Nursing Program cost	0	8,004,053	0.000000	996,354	0	91.00
92.00	Allied health cost	0	8,004,053	0.000000	996,354	0	92.00
93.00	All other Medical Education	0	8,004,053	0.000000	996,354	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0072	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/27/2022 1:47 pm
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,820	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,820	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)		4,220	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)		276	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)		983	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)		8,004,053	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)		8,004,053	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)		8,004,053	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)		1,660.59	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		458,323	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)		458,323	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0072	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/27/2022 1:47 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)	698,329	983	710.41	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	2,123,877	602	3,528.03	0	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)					361,212	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					819,535	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					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 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 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)					600	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,660.59	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					996,354	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0072		Period: From 01/01/2021 To 12/31/2021		Worksheet D-1 Date/Time Prepared: 5/27/2022 1:47 pm	
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	1,186,766	8,004,053	0.148271	996,354	147,730	90.00
91.00	Nursing Program cost	0	8,004,053	0.000000	996,354	0	91.00
92.00	Allied health cost	0	8,004,053	0.000000	996,354	0	92.00
93.00	All other Medical Education	0	8,004,053	0.000000	996,354	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0072	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/27/2022 1:47 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		1,826,055	30.00
31.00	03100	INTENSIVE CARE UNIT		390,080	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.284089	1,263,997	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.592251	0	52.00
53.00	05300	ANESTHESIOLOGY	0.085756	59,120	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.265891	386,995	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	0.247739	1,212,138	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.269361	111,927	63.00
65.00	06500	RESPIRATORY THERAPY	0.284019	1,893,102	65.00
66.00	06600	PHYSICAL THERAPY	0.454244	189,686	66.00
69.00	06900	ELECTROCARDIOLOGY	0.150168	326,509	69.00
69.01	06901	CARDIAC REHAB	1.425951	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.623185	432,436	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.207584	455,823	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.214682	4,175,739	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.123966	434,862	76.00
76.01	03480	ONCOLOGY	0.191251	0	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	1.503676	0	90.00
90.01	09001	WOUND CARE	0.205376	5,689	90.01
91.00	09100	EMERGENCY	0.258353	850,311	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.203431	84,198	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)		11,882,532	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)		11,882,532	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0072	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/27/2022 1:47 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		449,572	30.00
31.00	03100	INTENSIVE CARE UNIT		77,939	31.00
43.00	04300	NURSERY		35,130	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.278919	271,398	75,698 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.592251	140	83 52.00
53.00	05300	ANESTHESIOLOGY	0.085756	13,161	1,129 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.265891	21,069	5,602 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	0.247739	111,370	27,591 60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.269361	11,432	3,079 63.00
65.00	06500	RESPIRATORY THERAPY	0.284019	110,875	31,491 65.00
66.00	06600	PHYSICAL THERAPY	0.454244	4,524	2,055 66.00
69.00	06900	ELECTROCARDIOLOGY	0.150168	7,327	1,100 69.00
69.01	06901	CARDIAC REHAB	1.425951	0	0 69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.623185	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.207584	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.214682	323,522	69,454 73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.123966	24,663	3,057 76.00
76.01	03480	ONCOLOGY	0.191251	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	1.487702	86,031	127,988 90.00
90.01	09001	WOUND CARE	0.205376	0	0 90.01
91.00	09100	EMERGENCY	0.258353	48,614	12,560 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.203431	270	325 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)		1,034,396	361,212 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		1,034,396	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0072 Component CCN: 15-U072	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/27/2022 1:47 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			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
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 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/27/2022 1:47 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)		2,552,809	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		919,463	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)		69,036	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		41,992	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)		40.36	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
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
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
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
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (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		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)		3.07	30.00
31.00	Percentage of Medicaid patient days (see instructions)		31.69	31.00
32.00	Sum of lines 30 and 31		34.76	32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.00	33.00
34.00	Disproportionate share adjustment (see instructions)		104,168	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0072	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/27/2022 1:47 pm
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)	8,290,014,521	7,192,008,710	35.00
35.01	Factor 3 (see instructions)	0.000104522	0.000082848	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	866,489	595,844	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	648,086	150,185	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	798,271		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)	4,485,739		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	5,286,412		48.00
				Amount
				1.00
49.00	Total payment for inpatient operating costs (see instructions)		5,286,412	49.00
50.00	Payment for inpatient program capital (From Wkst. L, Pt. I and Pt. II, as applicable)		278,051	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		389,191	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
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)		5,953,654	59.00
60.00	Primary payer payments		5,551	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		5,948,103	61.00
62.00	Deductibles billed to program beneficiaries		500,819	62.00
63.00	Coinurance billed to program beneficiaries		742	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)		5,462,662	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
70.87	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)		-11,585	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 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/27/2022 1:47 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)	2021	714,176	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)	2022	270,062	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		18,207	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		6,417,108	71.00
71.01	Sequestration adjustment (see instructions)		0	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		6,488,227	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-71,119	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		241,477	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 01/01/2021
To 12/31/2021

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/27/2022 1:47 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	1.00	
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,552,809	0	2,552,809	2,552,809	1.01	
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	919,463	0	919,463	919,463	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	2.01	
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	69,036	0	69,036	69,036	2.02	
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	41,992	0	41,992	41,992	2.03	
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00	
4.00	Managed care simulated payments	3.00	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	6.00	
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01	
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	7.00	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00	
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01	
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00	
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01	
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200	0.1200	10.00	
11.00	Disproportionate share adjustment (see instructions)	34.00	104,168	0	76,584	27,584	11.00	
11.01	Uncompensated care payments	36.00	798,271	0	648,086	150,185	11.01	
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00	
13.00	Subtotal (see instructions)	47.00	4,485,739	0	3,346,515	1,139,224	13.00	
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	5,286,412	0	3,928,615	1,357,797	14.00	
15.00	Total payment for inpatient operating costs (see instructions)	49.00	5,286,412	0	3,928,615	1,357,797	15.00	

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0072

Period:
From 01/01/2021
To 12/31/2021

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/27/2022 1:47 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	278,051	0	204,554	73,497	278,051	16.00
17.00	Special add-on payments for new technologies	54.00	389,191	0	269,891	119,300	389,191	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	4,403,060	1,550,594	5,953,654	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	253,654	0	188,119	65,535	253,654	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	24,397	0	16,435	7,962	24,397	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	278,051	0	204,554	73,497	278,051	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				0.162200	0.174167		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			714,176		714,176	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				270,062	270,062	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 01/01/2021 To 12/31/2021	Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/27/2022 1:47 pm
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		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	2,552,809	2,552,809		2,552,809	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	919,463		919,463	919,463	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	69,036	69,036		69,036	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	41,992		41,992	41,992	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	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		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	104,168	76,584	27,584	104,168	11.00
11.01	Uncompensated care payments	36.00	798,271	648,086	150,185	798,271	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	4,485,739	3,346,515	1,139,224	4,485,739	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	5,286,412	3,928,615	1,357,797	5,286,412	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	5,286,412	3,928,615	1,357,797	5,286,412	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	278,051	204,554	73,497	278,051	16.00
17.00	Special add-on payments for new technologies	54.00	389,191	269,891	119,300	389,191	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			4,403,060	1,550,594	5,953,654	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 15-0072	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/27/2022 1:47 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	253,654	188,119	65,535	253,654	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	24,397	16,435	7,962	24,397	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	278,051	204,554	73,497	278,051	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	714,176	714,176		714,176	27.00
28.00	Low volume adjustment prior to October 1	70.96					28.00
29.00	Low volume adjustment on or after October 1	70.97	270,062		270,062	270,062	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-11,585	-11,585	0	-11,585	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	18,207	18,207	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 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/27/2022 1:47 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		18,014	1.00
2.00	Medical and other services reimbursed under OPPTS (see instructions)		9,823,711	2.00
3.00	OPPS payments		9,908,969	3.00
4.00	Outlier payment (see instructions)		166,509	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)		18,014	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		83,628	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)		83,628	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)		83,628	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		65,614	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		18,014	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)		10,075,478	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)		1,961,625	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)		8,131,867	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)		8,131,867	30.00
31.00	Primary payer payments		1,012	31.00
32.00	Subtotal (line 30 minus line 31)		8,130,855	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)		8,223,559	37.00
38.00	MSP-LCC reconciliation amount from PS&R		76	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	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)		8,223,483	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		8,270,580	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		-47,097	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0072

Period:
From 01/01/2021
To 12/31/2021

Worksheet E-1
Part I
Date/Time Prepared:
5/27/2022 1:47 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		6,488,227		8,134,916	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	12/08/2021	135,664	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		135,664	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		6,488,227		8,270,580	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		71,119		47,097	6.02	
7.00	Total Medicare program liability (see instructions)		6,417,108		8,223,483	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 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Prepared: 5/27/2022 1:47 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 (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 15-0072	Period: From 01/01/2021 To 12/31/2021	Worksheet E-2
		Component CCN: 15-U072	Date/Time Prepared: 5/27/2022 1:47 pm	
		Title XIX	Swing Beds - SNF	PPS
		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	0		3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)	0.00		4.00
5.00	Program days	0		5.00
6.00	Interns and residents not in approved teaching program (see instructions)	0		6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	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 pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0		19.25
20.00	Interim payments	0		20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0		21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	0		22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0		23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
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 01/01/2021 To 12/31/2021	Worksheet E-3 Part VII Date/Time Prepared: 5/27/2022 1:47 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		819,535		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		819,535	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)		819,535	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		562,640		8.00
9.00	Ancillary service charges		1,034,396	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)		1,597,036	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)		1,597,036	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		777,501	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)		819,535	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)		819,535	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)		819,535	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)		819,535	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		819,535	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)		819,535	0	40.00
41.00	Interim payments		803,752	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		15,783	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 15-0072

Period:
From 01/01/2021
To 12/31/2021

Worksheet G
Date/Time Prepared:
5/27/2022 1:47 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	24,389,655	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	75,981,732	0	0	0	4.00
5.00	Other receivable	4,228,001	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-51,960,042	0	0	0	6.00
7.00	Inventory	1,676,143	0	0	0	7.00
8.00	Prepaid expenses	1,172,203	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)	55,487,692	0	0	0	11.00
FIXED ASSETS						
12.00	Land	205,783	0	0	0	12.00
13.00	Land improvements	838,517	0	0	0	13.00
14.00	Accumulated depreciation	-519,061	0	0	0	14.00
15.00	Buildings	71,692,889	0	0	0	15.00
16.00	Accumulated depreciation	-42,528,424	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	8,229,054	0	0	0	19.00
20.00	Accumulated depreciation	-4,388,434	0	0	0	20.00
21.00	Automobiles and trucks	108,602	0	0	0	21.00
22.00	Accumulated depreciation	-108,602	0	0	0	22.00
23.00	Major movable equipment	46,557,149	0	0	0	23.00
24.00	Accumulated depreciation	-27,923,033	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)	52,164,440	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	2,100,018	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	13,674,910	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	15,774,928	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	123,427,060	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	19,326,875	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,876,315	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,867,000	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	1,939,091	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	25,009,281	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	5,284,485	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	20,992,999	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	26,277,484	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	51,286,765	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	72,140,295				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)	72,140,295	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	123,427,060	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0072

Period:
From 01/01/2021
To 12/31/2021

Worksheet G-1

Date/Time Prepared:
5/27/2022 1:47 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		72,908,927		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-768,632				2.00
3.00	Total (sum of line 1 and line 2)		72,140,295		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)		72,140,295		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)		72,140,295		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 01/01/2021
To 12/31/2021

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/27/2022 1:47 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	9,929,979		9,929,979	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)	9,929,979		9,929,979	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	1,627,404		1,627,404	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)	1,627,404		1,627,404	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	11,557,383		11,557,383	17.00
18.00	Ancillary services	34,695,336	155,492,713	190,188,049	18.00
19.00	Outpatient services	3,700,785	29,275,831	32,976,616	19.00
20.00	EXPRESS MEDICAL CENTER	0	0	0	20.00
20.01	FAMILY HEALTH CARE	0	0	0	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	200,264	11,870,444	12,070,708	27.00
27.01	PRO FEES	2,817,102	14,137,553	16,954,655	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	52,970,870	210,776,541	263,747,411	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		107,448,113		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)		107,448,113		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0072

Period:
From 01/01/2021
To 12/31/2021

Worksheet G-3

Date/Time Prepared:
5/27/2022 1:47 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	263,747,411	1.00
2.00	Less contractual allowances and discounts on patients' accounts	163,673,884	2.00
3.00	Net patient revenues (line 1 minus line 2)	100,073,527	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	107,448,113	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-7,374,586	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	2,507,957	24.00
24.01	INVESTMENT INCOME	520,898	24.01
24.02	LOSS ON SALE OF EQUIPMENT	187,460	24.02
24.03	OTHER NON-OPERATING REVENUE	0	24.03
24.50	COVID-19 PHE Funding	3,389,639	24.50
25.00	Total other income (sum of lines 6-24)	6,605,954	25.00
26.00	Total (line 5 plus line 25)	-768,632	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)	-768,632	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0072	Period: From 01/01/2021 To 12/31/2021	Worksheet L Parts I-III Date/Time Prepared: 5/27/2022 1:47 pm
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		253,654	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		24,397	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)		14.76	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)		278,051	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)		4.00	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 01/01/2021

Worksheet M-1

Component CCN: 15-8561

To 12/31/2021

Date/Time Prepared: 5/27/2022 1:47 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	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	1	0	1	0	1	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	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	0	1	0	1	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	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	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	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						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1	0	1	0	1	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						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	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1	0	1	0	1	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

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

Period:
From 01/01/2021
To 12/31/2021

Worksheet M-1
Date/Time Prepared:
5/27/2022 1:47 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	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	1		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		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		10.00
11.00	Physician Services Under Agreement	0	0		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	0		14.00
15.00	Medical Supplies	0	0		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	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1		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	0		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0072
Component CCN: 15-8563

Period:
From 01/01/2021
To 12/31/2021

Worksheet M-1
Date/Time Prepared:
5/27/2022 1:47 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	0	0	0	0	0	1.00	
2.00	Physician Assistant	0	0	0	0	0	2.00	
3.00	Nurse Practitioner	1	0	1	0	1	3.00	
4.00	Visiting Nurse	0	0	0	0	0	4.00	
5.00	Other Nurse	0	0	0	0	0	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	0	1	0	1	10.00	
11.00	Physician Services Under Agreement	0	0	0	0	0	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	0	0	0	0	14.00	
15.00	Medical Supplies	0	0	0	0	0	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						20.00	
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00	
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1	0	1	0	1	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						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	0	0	0	0	0	30.00	
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00	
32.00	Total facility costs (sum of lines 22, 28 and 31)	1	0	1	0	1	32.00	

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0072
Component CCN: 15-8563

Period:
From 01/01/2021
To 12/31/2021

Worksheet M-1
Date/Time Prepared:
5/27/2022 1:47 pm

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC II	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	1		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		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		10.00
11.00	Physician Services Under Agreement	0	0		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	0		14.00
15.00	Medical Supplies	0	0		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	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1		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	0		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1		32.00