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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-1330	Period: From 01/01/2022 To 12/31/2022	Worksheet S Parts I-III Date/Time Prepared: 3/2/2024 10:07 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 3/2/2024 Time: 10:07 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ADAMS MEMORIAL HOSPITAL (15-1330) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	Dane Wheeler		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Dane Wheeler			2
3	Signatory Title	CFO			3
4	Date	03/04/2024 04:11:48 AM (PT)			4

Encryption Information
ECR: Date: 3/2/2024 Time: 10:07 am
lje:yD4Kzz7VDwuqQX2bRZHXSKxHo0
29XrB0Z:GgzgHPWr9piDY0pJKFfT4J
Xqwm0omZ0Q0TzXQn

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	-2,493	-480,947	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	121,133	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	MONROE FAMILY MEDICINE I	0		213,717		0	10.00
10.01	WOODCREST II	0		113,913		0	10.01
10.02	STAT CARE III	0		22,521		0	10.02
10.03	BERNE FAMILY MEDICINE IV	0		139,908		0	10.03
10.04	HIGH STREET V	0		22,477		0	10.04
200.00	TOTAL	0	118,640	31,589	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1330	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 3/2/2024 10:07 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1100 MERCER AVENEUE	PO Box:			1.00
2.00	City: DECATUR	State: IN	Zip Code: 46733	County: ADAMS	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	ADAMS MEMORIAL HOSPITAL	151330	99915	1	11/01/2005	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ADAMS MEMORIAL HOSPITAL	15Z330	99915		11/01/2005	N	O	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	MONROE FAMILY MEDICINE	158526	99915		10/25/2017	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	DECATUR FAMILY MEDICINE-WOODCREST	158536	99915		12/26/2018	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	STAT CARE & PRIMARY CARE CLINIC	158537	99915		12/18/2018	N	O	N	15.02
15.03	Hospital-Based Health Clinic - RHC IV	BERNE FAMILY MEDICINE	158559	99915		07/01/2020	N	O	N	15.03
15.04	Hospital-Based Health Clinic - RHC V	HIGH STREET FAMILY MEDICINE	158555	99915		01/24/2020	N	O	N	15.04
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2022	12/31/2022	20.00
21.00	Type of Control (see instructions)	9		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N			22.00
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				22.04

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 3/2/2024 10:07 am

		1.00	2.00	3.00	
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.	2	N		23.00

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

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 3/2/2024 10:07 am

		V	XVIII	XIX	
		1.00	2.00	3.00	
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1330	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 3/2/2024 10:07 am

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

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

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

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

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 3/2/2024 10:07 am

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00
						1.00	
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)						
68.00	For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?					N	68.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

		Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
		1.00	2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.		0	88.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 3/2/2024 10:07 am

		Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge	
		1.00	2.00	3.00	
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.	0.00		0	89.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	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. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		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)	Y		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1330	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 3/2/2024 10:07 am

				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00
			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.		N		111.00
		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	575,003	0	0	118.01
			1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		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.		Y	5.00	122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.				123.00
	Certified Transplant Center Information				
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00

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		1.00	2.00	
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H060	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: ADAMS HEALTH NETWORK	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 1100 MERCER AVE	PO Box:		142.00
143.00	City: DECATUR	State: IN	Zip Code: 46733	143.00

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

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

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	Y	Y	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 3/2/2024 10:07 am

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II | Date/Time Prepared: 3/2/2024 10:07 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/25/2023	Y	04/25/2023	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: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II Date/Time Prepared: 3/2/2024 10:07 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00

		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	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	Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	Y		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.	ANDREW	MCCABE	41.00
42.00	Enter the employer/company name of the cost report preparer.	WIPFLI		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	715-858-6660	AMCCABE@WIPFLI.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1330	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Prepared: 3/2/2024 10:07 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CPA		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: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I Date/Time Prepared: 3/2/2024 10:07 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,665	54,312.00	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)		21	7,665	54,312.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	9,648.00	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)		25	9,125	63,960.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF	40.00	0	2,730		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	MONROE FAMILY MEDICINE	88.00				0	26.00
26.01	WOODCREST	88.01				0	26.01
26.02	STAT CARE	88.02				0	26.02
26.03	BERNE FAMILY MEDICINE	88.03				0	26.03
26.04	HIGH STREET	88.04				0	26.04
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 3/2/2024 10:07 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	827	0	2,263			1.00
2.00	HMO and other (see instructions)	749	205				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	541	0	1,036			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	114			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,368	0	3,413			7.00
8.00	INTENSIVE CARE UNIT	249	114	880			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		90	239			13.00
14.00	Total (see instructions)	1,617	204	4,532	0.00	404.85	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	MONROE FAMILY MEDICINE	3,705	0	9,915	0.00	15.17	26.00
26.01	WOODCREST	1,366	0	7,815	0.00	10.89	26.01
26.02	STAT CARE	789	0	11,748	0.00	11.38	26.02
26.03	BERNE FAMILY MEDICINE	1,296	0	7,960	0.00	11.42	26.03
26.04	HIGH STREET	1,849	0	7,510	0.00	7.87	26.04
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	461.58	27.00
28.00	Observation Bed Days		0	1,847			28.00
29.00	Ambulance Trips	712					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			80			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 3/2/2024 10:07 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	312	0	957	1.00
2.00	HMO and other (see instructions)			190	179		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	312	0	957	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	MONROE FAMILY MEDICINE	0.00					26.00
26.01	WOODCREST	0.00					26.01
26.02	STAT CARE	0.00					26.02
26.03	BERNE FAMILY MEDICINE	0.00					26.03
26.04	HIGH STREET	0.00					26.04
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1330 | Component CCN: 15-8526 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 3/2/2024 10:07 am

		RHC I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	205 TOWER DRIVE	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	MONROE	IN	46772	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	
	Source of Federal Funds			
4.00	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.)	Y	1	10.00
12.00	Have you received an approval for an exception to the productivity standard?	Y		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0	13.00

		Provider name	CCN	
		1.00	2.00	
14.00	RHC/FQHC name, CCN			14.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	20:00	08:00	11.00

		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	ADAMS		2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1330 Component CCN: 15-8526	Period: From 01/01/2022 To 12/31/2022	Worksheet S-8 Date/Time Prepared: 3/2/2024 10:07 am
		RHC I	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1330 | Component CCN: 15-8536 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 3/2/2024 10:07 am

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1300 MERCER AVE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	DECATUR		IN	46733	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	
	Source of Federal Funds					
4.00	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	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	17:00	08:00	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			Y		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
				Provider name	CCN	
				1.00	2.00	
14.00	RHC/FQHC name, CCN					14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County		ADAMS				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1330 Component CCN: 15-8536	Period: From 01/01/2022 To 12/31/2022	Worksheet S-8 Date/Time Prepared: 3/2/2024 10:07 am
		RHC II	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1330 | Component CCN: 15-8537 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 3/2/2024 10:07 am

RHC III | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1100 MERCER AVE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	DECATUR		IN	46733	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	
	Source of Federal Funds					
4.00	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	
	Facility hours of operations (1)						
11.00	CLINIC	09:00	17:00	07:30	20:30	07:30	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.	N	0	13.00

		Provider name	CCN	
		1.00	2.00	
14.00	RHC/FQHC name, CCN			14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County		ADAMS				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	20:30	07:30	20:30	07:30	20:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1330
Component CCN: 15-8537

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

Worksheet S-8
Date/Time Prepared:
3/2/2024 10:07 am

RHC III | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:30	20:30	09:00	17:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1330 | Component CCN: 15-8559 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 3/2/2024 10:07 am

RHC IV | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1521 WEST MAIN STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	BERNE		IN	46711	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	
	Source of Federal Funds					
4.00	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	
	Facility hours of operations (1)						
11.00	CLINIC			07:30	17:00	07:30	11.00

	1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0 13.00

		Provider name	CCN	
		1.00	2.00	
14.00	RHC/FQHC name, CCN			14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County		ADAMS				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	07:00	17:00	07:30	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1330
Component CCN: 15-8559

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

Worksheet S-8

Date/Time Prepared:
3/2/2024 10:07 am

RHC IV

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:00	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1330 | Component CCN: 15-8555 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 3/2/2024 10:07 am

RHC V | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			955 HIGH STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	DECATUR		IN	46733	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	
	Source of Federal Funds					
4.00	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	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	17:00	08:00	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?					12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
			Provider name		CCN	
			1.00		2.00	
14.00	RHC/FQHC name, CCN					14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County		ADAMS				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1330 Component CCN: 15-8555	Period: From 01/01/2022 To 12/31/2022	Worksheet S-8 Date/Time Prepared: 3/2/2024 10:07 am
		RHC V	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1330	Period: From 01/01/2022 To 12/31/2022	Worksheet S-10 Date/Time Prepared: 3/2/2024 10:07 am

		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)	0.558606	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	5,933,138	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	21,787,257	6.00
7.00	Medicaid cost (line 1 times line 6)	12,170,492	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)	6,237,354	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)	6,237,354	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)	117,543	61,491	179,034	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	65,660	61,491	127,151	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)	65,660	61,491	127,151	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)	5,706,904	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	159,281	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	245,048	27.01
28.00	Non-Medicare bad debt expense (see instructions)	5,461,856	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	3,136,793	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,263,944	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	9,501,298	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 3/2/2024 10:07 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		2,010,881	2,010,881	73,354	2,084,235	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	154,942	139,226	294,168	0	294,168	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,397,762	8,822,982	12,220,744	-86,338	12,134,406	5.00
7.00	00700	OPERATION OF PLANT	0	1,876,310	1,876,310	1,073	1,877,383	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	70,782	175,000	245,782	0	245,782	8.00
9.00	00900	HOUSEKEEPING	493,421	296,658	790,079	3,598	793,677	9.00
10.00	01000	DIETARY	623,816	639,970	1,263,786	0	1,263,786	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	879,369	224,082	1,103,451	0	1,103,451	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	868,295	453,070	1,321,365	0	1,321,365	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	310,582	286,325	596,907	0	596,907	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,833,159	3,415,170	7,248,329	-29,893	7,218,436	30.00
31.00	03100	INTENSIVE CARE UNIT	686,935	1,306,697	1,993,632	0	1,993,632	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	8,815	8,815	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,307,270	2,550,224	4,857,494	0	4,857,494	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	21,078	21,078	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,164,702	1,633,737	2,798,439	0	2,798,439	54.00
60.00	06000	LABORATORY	1,246,838	3,482,806	4,729,644	6,438	4,736,082	60.00
65.00	06500	RESPIRATORY THERAPY	512,669	516,412	1,029,081	0	1,029,081	65.00
66.00	06600	PHYSICAL THERAPY	1,780,676	547,725	2,328,401	0	2,328,401	66.00
67.00	06700	OCCUPATIONAL THERAPY	557,815	139,897	697,712	0	697,712	67.00
68.00	06800	SPEECH PATHOLOGY	248,450	49,245	297,695	0	297,695	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,080,859	1,080,859	0	1,080,859	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,256,810	1,256,810	0	1,256,810	73.00
76.00	03020	OP PSYCH	901,924	240,321	1,142,245	0	1,142,245	76.00
76.01	03030	WOUND CARE	193,378	94,724	288,102	0	288,102	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	1,358,085	535,768	1,893,853	0	1,893,853	88.00
88.01	08801	WOODCREST	1,221,305	483,367	1,704,672	0	1,704,672	88.01
88.02	08802	STAT CARE	1,139,784	474,323	1,614,107	0	1,614,107	88.02
88.03	08803	BERNE FAMILY MEDICINE	978,281	589,153	1,567,434	0	1,567,434	88.03
88.04	08804	HIGH STREET	1,052,129	438,078	1,490,207	0	1,490,207	88.04
90.00	09000	CLINIC	2,693,747	1,463,212	4,156,959	-53,669	4,103,290	90.00
90.01	09001	CLINIC - AMO	1,997,376	439,488	2,436,864	19,224	2,456,088	90.01
90.02	09002	CLINIC - AMH NEURO	699,873	94,937	794,810	23,923	818,733	90.02
90.03	09003	GENERAL SURGERY OFFICE	1,185,291	1,228,874	2,414,165	23,336	2,437,501	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	2,557,248	1,392,701	3,949,949	0	3,949,949	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,436,128	767,876	2,204,004	0	2,204,004	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,552,032	39,146,908	75,698,940	10,939	75,709,879	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	318,567	325,662	644,229	-23,923	620,306	194.01
194.02	07952	OTHER MOBS	0	0	0	12,984	12,984	194.02
194.03	07953	IDLE SPACE	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	55,292	55,292	0	55,292	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	36,870,599	39,527,862	76,398,461	0	76,398,461	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 3/2/2024 10:07 am

		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	-89,159	1,995,076		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	294,168		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,312,677	13,447,083		5.00
7.00	00700	OPERATION OF PLANT	321,359	2,198,742		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	245,782		8.00
9.00	00900	HOUSEKEEPING	0	793,677		9.00
10.00	01000	DIETARY	-338,849	924,937		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	1,103,451		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0		14.00
15.00	01500	PHARMACY	-137,722	1,183,643		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-25,911	570,996		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-765,926	6,452,510		30.00
31.00	03100	INTENSIVE CARE UNIT	-30,769	1,962,863		31.00
40.00	04000	SUBPROVIDER - IPF	0	0		40.00
43.00	04300	NURSERY	0	8,815		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,090,675	3,766,819		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	21,078		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,798,439		54.00
60.00	06000	LABORATORY	-34,732	4,701,350		60.00
65.00	06500	RESPIRATORY THERAPY	-81,609	947,472		65.00
66.00	06600	PHYSICAL THERAPY	0	2,328,401		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	697,712		67.00
68.00	06800	SPEECH PATHOLOGY	0	297,695		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,080,859		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-209,159	1,047,651		73.00
76.00	03020	OP PSYCH	-277,178	865,067		76.00
76.01	03030	WOUND CARE	0	288,102		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	MONROE FAMILY MEDICINE	0	1,893,853		88.00
88.01	08801	WOODCREST	0	1,704,672		88.01
88.02	08802	STAT CARE	0	1,614,107		88.02
88.03	08803	BERNE FAMILY MEDICINE	-53,859	1,513,575		88.03
88.04	08804	HIGH STREET	-6,912	1,483,295		88.04
90.00	09000	CLINIC	-1,904,028	2,199,262		90.00
90.01	09001	CLINIC - AMO	-1,792,838	663,250		90.01
90.02	09002	CLINIC - AMH NEURO	-643,104	175,629		90.02
90.03	09003	GENERAL SURGERY OFFICE	-1,906,672	530,829		90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0		90.04
91.00	09100	EMERGENCY	-813,490	3,136,459		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	2,204,004		95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-8,568,556	67,141,323		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	TITLE XX	0	0		194.00
194.01	07951	OTHER NRCC	0	620,306		194.01
194.02	07952	OTHER MOBS	0	12,984		194.02
194.03	07953	IDLE SPACE	0	0		194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	55,292		194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-8,568,556	67,829,905		200.00

RECLASSIFICATIONS | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 3/2/2024 10:07 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - OB, NURSERY AND L&D				
1.00	NURSERY	43.00	6,679	2,136	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	15,970	5,108	2.00
	0		22,649	7,244	
	B - INSURANCE				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	73,354	1.00
2.00	OTHER MOBS	194.02	0	12,984	2.00
	0		0	86,338	
	K - RECLASS MOC BUILDING MAINTENACE				
1.00	OPERATION OF PLANT	7.00	0	1,073	1.00
2.00	HOUSEKEEPING	9.00	0	3,598	2.00
3.00	LABORATORY	60.00	0	6,438	3.00
4.00	CLINIC	90.00	0	66,104	4.00
5.00	CLINIC - AMO	90.01	0	19,224	5.00
6.00	GENERAL SURGERY OFFICE	90.03	0	23,336	6.00
	TOTALS		0	119,773	
	L - RECLASS NEURO CLINIC BUILDING COSTS				
1.00	CLINIC - AMH NEURO	90.02	0	23,923	1.00
	TOTALS		0	23,923	
500.00	Grand Total: Increases		22,649	237,278	500.00

RECLASSIFICATIONS | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 3/2/2024 10:07 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - OB, NURSERY AND L&D						
1.00	ADULTS & PEDIATRICS	30.00	22,649	7,244	0		1.00
2.00		0.00	0	0	0		2.00
	0		22,649	7,244			
	B - INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	86,338	12		1.00
2.00		0.00	0	0	0		2.00
	0		0	86,338			
	K - RECLASS MOC BUILDING MAINTENACE						
1.00	CLINIC	90.00	0	119,773	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	TOTALS		0	119,773			
	L - RECLASS NEURO CLINIC BUILDING COSTS						
1.00	OTHER NRCC	194.01	0	23,923	0		1.00
	TOTALS		0	23,923			
500.00	Grand Total: Decreases		22,649	237,278			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part I Date/Time Prepared: 3/2/2024 10:07 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	363,119	110,000	0	110,000	0	1.00
2.00	Land Improvements	2,234,502	32,686	0	32,686	0	2.00
3.00	Buildings and Fixtures	42,572,075	202,110	0	202,110	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	9,266,812	452,925	0	452,925	0	5.00
6.00	Movable Equipment	19,999,333	930,002	0	930,002	163,646	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	74,435,841	1,727,723	0	1,727,723	163,646	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	74,435,841	1,727,723	0	1,727,723	163,646	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	473,119	0	1.00
2.00	Land Improvements	2,267,188	0	2.00
3.00	Buildings and Fixtures	42,774,185	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	9,719,737	0	5.00
6.00	Movable Equipment	20,765,689	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	75,999,918	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	75,999,918	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part II Date/Time Prepared: 3/2/2024 10:07 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,581,281	0	429,600	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,581,281	0	429,600	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2,010,881	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	2,010,881	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part III Date/Time Prepared: 3/2/2024 10:07 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	54,761,110	0	54,761,110	0.725055	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	20,765,689	0	20,765,689	0.274945	0	2.00
3.00	Total (sum of lines 1-2)	75,526,799	0	75,526,799	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	1,550,715	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,550,715	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	371,007	73,354	0	0	1,995,076	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	371,007	73,354	0	0	1,995,076	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 3/2/2024 10:07 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-64,546	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-7,445	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-9,134,200			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	2,054,117			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-338,849	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-209,159	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-25,911	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 3/2/2024 10:07 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	IHA DUES	A	-1,747	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	AHA DUES	A	-3,914	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	MISC AMBULANCE REVENUE	B	0	AMBULANCE SERVICES	95.00	0	33.02
33.03	340B CONTRACT EXPENSES	A	-137,722	PHARMACY	15.00	0	33.03
33.04	WORTHMAN FITNESS CENTER	B	-81,609	RESPIRATORY THERAPY	65.00	0	33.04
33.05	MISC INCOME	B	-31,222	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	EDUCATIONAL SERVICES	B	-7,318	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	HOSPITAL PROVIDER TAX SHORTFALL	A	0	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.09	MARKETING	A	-215,192	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	PHYSICIAN RECRUITING	A	-137,632	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	VALUE ASSIGNMENT/MISC TESTING	B	-34,732	LABORATORY	60.00	0	33.11
33.12	MISC PSYCH INCOME	B	-52,730	OP PSYCH	76.00	0	33.12
34.00	RENTAL INCOME	B	-46,177	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01	RENTAL INCOME	B	-53,859	BERNE FAMILY MEDICINE	88.03	0	34.01
34.02	RENTAL INCOME	B	-6,912	HIGH STREET	88.04	0	34.02
34.03	RENTAL INCOME	B	-37,750	CLINIC - AMH NEURO	90.02	0	34.03
34.04	LAPSE LOSS ON REFINANCING	A	5,953	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	34.04
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,568,556				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-1 | Date/Time Prepared: 3/2/2024 10:07 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	NEW CAP REL COSTS-BLDG & FIX	HOME OFFICE CAPITAL ALLOCATI	50,001	80,567	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE AND IT COSTS	5,211,287	3,447,963	2.00
3.00	7.00	OPERATION OF PLANT	MAINTENANCE AND GROUNDS	829,846	508,487	3.00
3.01	0.00			0	0	3.01
3.02	0.00			0	0	3.02
3.03	0.00			0	0	3.03
3.04	0.00			0	0	3.04
3.05	0.00			0	0	3.05
3.06	0.00			0	0	3.06
4.00	0.00			0	0	4.00
5.00	0		0	6,091,134	4,037,017	5.00

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

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

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

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

6.00	B		0.00	ADAMS HEALTH NETWORK	0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-1 | Date/Time Prepared: 3/2/2024 10:07 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-30,566	9		1.00
2.00	1,763,324	0		2.00
3.00	321,359	0		3.00
3.01	0	0		3.01
3.02	0	0		3.02
3.03	0	0		3.03
3.04	0	0		3.04
3.05	0	0		3.05
3.06	0	0		3.06
4.00	0	0		4.00
5.00	2,054,117			5.00

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

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

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

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

6.00	MANAGEMENT		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-2 | Date/Time Prepared: 3/2/2024 10:07 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	765,926	765,926	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	30,769	30,769	0	0	0	2.00
3.00	50.00	OPERATING ROOM	1,090,675	1,090,675	0	0	0	3.00
4.00	76.00	OP PSYCH	224,448	224,448	0	0	0	4.00
5.00	90.00	CLINIC	1,985,111	1,904,028	81,083	0	0	5.00
6.00	90.01	CLINIC - AMO	1,792,838	1,792,838	0	0	0	6.00
7.00	90.02	CLINIC - AMH NEURO	605,354	605,354	0	0	0	7.00
8.00	90.03	GENERAL SURGERY OFFICE	1,936,672	1,906,672	30,000	0	0	8.00
9.00	91.00	EMERGENCY	1,926,788	813,490	1,113,298	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			10,358,581	9,134,200	1,224,381		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	76.00	OP PSYCH	0	0	0	0	0	4.00
5.00	90.00	CLINIC	0	0	0	0	0	5.00
6.00	90.01	CLINIC - AMO	0	0	0	0	0	6.00
7.00	90.02	CLINIC - AMH NEURO	0	0	0	0	0	7.00
8.00	90.03	GENERAL SURGERY OFFICE	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	765,926		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	30,769		2.00
3.00	50.00	OPERATING ROOM	0	0	0	1,090,675		3.00
4.00	76.00	OP PSYCH	0	0	0	224,448		4.00
5.00	90.00	CLINIC	0	0	0	1,904,028		5.00
6.00	90.01	CLINIC - AMO	0	0	0	1,792,838		6.00
7.00	90.02	CLINIC - AMH NEURO	0	0	0	605,354		7.00
8.00	90.03	GENERAL SURGERY OFFICE	0	0	0	1,906,672		8.00
9.00	91.00	EMERGENCY	0	0	0	813,490		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	9,134,200		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I Date/Time Prepared: 3/2/2024 10:07 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,995,076	1,995,076				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0		0			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	294,168	0	0	294,168		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,447,083	181,074	0	27,223	13,655,380	5.00
7.00	00700	OPERATION OF PLANT	2,198,742	273,125	0	0	2,471,867	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	245,782	31,736	0	567	278,085	8.00
9.00	00900	HOUSEKEEPING	793,677	52,514	0	3,953	850,144	9.00
10.00	01000	DIETARY	924,937	125,237	0	4,998	1,055,172	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,103,451	5,800	0	7,046	1,116,297	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,183,643	40,969	0	6,957	1,231,569	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	570,996	46,604	0	2,488	620,088	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,452,510	293,717	0	30,530	6,776,757	30.00
31.00	03100	INTENSIVE CARE UNIT	1,962,863	52,753	0	5,504	2,021,120	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	8,815	27,478	0	54	36,347	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,766,819	201,264	0	18,486	3,986,569	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	21,078	27,478	0	128	48,684	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,798,439	162,535	0	9,332	2,970,306	54.00
60.00	06000	LABORATORY	4,701,350	72,062	0	9,990	4,783,402	60.00
65.00	06500	RESPIRATORY THERAPY	947,472	75,054	0	4,108	1,026,634	65.00
66.00	06600	PHYSICAL THERAPY	2,328,401	167,546	0	14,267	2,510,214	66.00
67.00	06700	OCCUPATIONAL THERAPY	697,712	1,836	0	4,469	704,017	67.00
68.00	06800	SPEECH PATHOLOGY	297,695	918	0	1,991	300,604	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,080,859	0	0	0	1,080,859	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,047,651	0	0	0	1,047,651	73.00
76.00	03020	OP PSYCH	865,067	0	0	7,226	872,293	76.00
76.01	03030	WOUND CARE	288,102	0	0	1,549	289,651	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	1,893,853	0	0	10,881	1,904,734	88.00
88.01	08801	WOODCREST	1,704,672	0	0	9,785	1,714,457	88.01
88.02	08802	STAT CARE	1,614,107	41,317	0	9,132	1,664,556	88.02
88.03	08803	BERNE FAMILY MEDICINE	1,513,575	0	0	7,838	1,521,413	88.03
88.04	08804	HIGH STREET	1,483,295	0	0	8,430	1,491,725	88.04
90.00	09000	CLINIC	2,199,262	0	0	21,582	2,220,844	90.00
90.01	09001	CLINIC - AMO	663,250	0	0	16,003	679,253	90.01
90.02	09002	CLINIC - AMH NEURO	175,629	0	0	5,607	181,236	90.02
90.03	09003	GENERAL SURGERY OFFICE	530,829	0	0	9,497	540,326	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	3,136,459	102,055	0	20,489	3,259,003	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,204,004	0	0	11,506	2,215,510	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	67,141,323	1,983,072	0	291,616	67,126,767	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,004	0	0	12,004	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	620,306	0	0	2,552	622,858	194.01
194.02	07952	OTHER MOBS	12,984	0	0	0	12,984	194.02
194.03	07953	IDLE SPACE	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	55,292	0	0	0	55,292	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	67,829,905	1,995,076	0	294,168	67,829,905	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I Date/Time Prepared: 3/2/2024 10:07 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,655,380					5.00
7.00	00700	OPERATION OF PLANT	623,066	3,094,933				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	70,095	49,534	397,714			8.00
9.00	00900	HOUSEKEEPING	214,290	81,965	0	1,146,399		9.00
10.00	01000	DIETARY	265,970	195,473	0	76,099	1,592,714	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	281,377	9,053	0	3,524	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	310,433	63,945	0	24,894	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	156,301	72,740	0	28,318	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,708,155	458,443	323,886	178,476	1,364,442	30.00
31.00	03100	INTENSIVE CARE UNIT	509,450	82,337	54,186	32,055	228,272	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	9,162	42,888	14,716	16,697	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,004,867	567,825	0	221,060	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,271	42,888	4,926	16,697	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	748,704	112,476	0	43,788	0	54.00
60.00	06000	LABORATORY	1,205,719	117,146	0	45,606	0	60.00
65.00	06500	RESPIRATORY THERAPY	258,776	261,509	0	101,808	0	65.00
66.00	06600	PHYSICAL THERAPY	632,732	2,865	0	1,115	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	177,457	1,432	0	558	0	67.00
68.00	06800	SPEECH PATHOLOGY	75,771	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	272,445	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	264,074	0	0	0	0	73.00
76.00	03020	OP PSYCH	219,873	0	0	0	0	76.00
76.01	03030	WOUND CARE	73,010	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	480,113	0	0	0	0	88.00
88.01	08801	WOODCREST	432,151	0	0	0	0	88.01
88.02	08802	STAT CARE	419,573	64,489	0	25,106	0	88.02
88.03	08803	BERNE FAMILY MEDICINE	383,492	0	0	0	0	88.03
88.04	08804	HIGH STREET	376,009	0	0	0	0	88.04
90.00	09000	CLINIC	559,793	263,915	0	102,745	0	90.00
90.01	09001	CLINIC - AMO	171,215	61,080	0	23,779	0	90.01
90.02	09002	CLINIC - AMH NEURO	45,683	56,009	0	21,805	0	90.02
90.03	09003	GENERAL SURGERY OFFICE	136,196	74,144	0	28,865	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	821,474	159,289	0	62,013	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	558,448	0	0	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,478,145	2,841,445	397,714	1,055,008	1,592,714	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,026	18,737	0	0	0	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	156,999	131,528	0	51,205	0	194.01
194.02	07952	OTHER MOBS	3,273	103,223	0	40,186	0	194.02
194.03	07953	IDLE SPACE	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	13,937	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	13,655,380	3,094,933	397,714	1,146,399	1,592,714	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I Date/Time Prepared: 3/2/2024 10:07 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	0					11.00
13.00	01300	NURSING ADMINISTRATION	0	1,410,251				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0			14.00
15.00	01500	PHARMACY	0	0	0	1,630,841		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	877,447	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	542,951	0	0	83,849	30.00
31.00	03100	INTENSIVE CARE UNIT	0	97,881	0	0	21,979	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	952	0	0	1,381	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	328,761	0	0	89,245	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,276	0	0	1,378	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	181,729	54.00
60.00	06000	LABORATORY	0	0	0	0	130,365	60.00
65.00	06500	RESPIRATORY THERAPY	0	73,050	0	0	30,900	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	38,799	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	15,942	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	8,748	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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	30,648	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,630,841	66,549	73.00
76.00	03020	OP PSYCH	0	0	0	0	721	76.00
76.01	03030	WOUND CARE	0	0	0	0	3,141	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	0	0	0	0	16,913	88.00
88.01	08801	WOODCREST	0	0	0	0	14,609	88.01
88.02	08802	STAT CARE	0	0	0	0	16,626	88.02
88.03	08803	BERNE FAMILY MEDICINE	0	0	0	0	13,678	88.03
88.04	08804	HIGH STREET	0	0	0	0	16,489	88.04
90.00	09000	CLINIC	0	0	0	0	17,255	90.00
90.01	09001	CLINIC - AMO	0	0	0	0	5,029	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	0	1,815	90.02
90.03	09003	GENERAL SURGERY OFFICE	0	0	0	0	3,040	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	364,380	0	0	65,859	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
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,410,251	0	1,630,841	876,687	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	0	0	0	0	760	194.01
194.02	07952	OTHER MOBS	0	0	0	0	0	194.02
194.03	07953	IDLE SPACE	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,410,251	0	1,630,841	877,447	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 3/2/2024 10:07 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	11,436,959	0	11,436,959		30.00
31.00	03100	INTENSIVE CARE UNIT	3,047,280	0	3,047,280		31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0		40.00
43.00	04300	NURSERY	122,143	0	122,143		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	6,198,327	0	6,198,327		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	129,120	0	129,120		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,057,003	0	4,057,003		54.00
60.00	06000	LABORATORY	6,282,238	0	6,282,238		60.00
65.00	06500	RESPIRATORY THERAPY	1,752,677	0	1,752,677		65.00
66.00	06600	PHYSICAL THERAPY	3,185,725	0	3,185,725		66.00
67.00	06700	OCCUPATIONAL THERAPY	899,406	0	899,406		67.00
68.00	06800	SPEECH PATHOLOGY	385,123	0	385,123		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,383,952	0	1,383,952		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,009,115	0	3,009,115		73.00
76.00	03020	OP PSYCH	1,092,887	0	1,092,887		76.00
76.01	03030	WOUND CARE	365,802	0	365,802		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	MONROE FAMILY MEDICINE	2,401,760	0	2,401,760		88.00
88.01	08801	WOODCREST	2,161,217	0	2,161,217		88.01
88.02	08802	STAT CARE	2,190,350	0	2,190,350		88.02
88.03	08803	BERNE FAMILY MEDICINE	1,918,583	0	1,918,583		88.03
88.04	08804	HIGH STREET	1,884,223	0	1,884,223		88.04
90.00	09000	CLINIC	3,164,552	0	3,164,552		90.00
90.01	09001	CLINIC - AMO	940,356	0	940,356		90.01
90.02	09002	CLINIC - AMH NEURO	306,548	0	306,548		90.02
90.03	09003	GENERAL SURGERY OFFICE	782,571	0	782,571		90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0		90.04
91.00	09100	EMERGENCY	4,732,018	0	4,732,018		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	2,773,958	0	2,773,958		95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0		97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	66,603,893	0	66,603,893		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	33,767	0	33,767		190.00
194.00	07950	TITLE XX	0	0	0		194.00
194.01	07951	OTHER NRCC	963,350	0	963,350		194.01
194.02	07952	OTHER MOBS	159,666	0	159,666		194.02
194.03	07953	IDLE SPACE	0	0	0		194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	69,229	0	69,229		194.04
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	67,829,905	0	67,829,905		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 3/2/2024 10:07 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	181,074	0	181,074	0	5.00
7.00	00700	OPERATION OF PLANT	0	273,125	0	273,125	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	31,736	0	31,736	0	8.00
9.00	00900	HOUSEKEEPING	0	52,514	0	52,514	0	9.00
10.00	01000	DIETARY	0	125,237	0	125,237	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,800	0	5,800	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	40,969	0	40,969	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	46,604	0	46,604	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	293,717	0	293,717	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	52,753	0	52,753	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	27,478	0	27,478	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	201,264	0	201,264	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	27,478	0	27,478	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	162,535	0	162,535	0	54.00
60.00	06000	LABORATORY	0	72,062	0	72,062	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	75,054	0	75,054	0	65.00
66.00	06600	PHYSICAL THERAPY	0	167,546	0	167,546	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,836	0	1,836	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	918	0	918	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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	03020	OP PSYCH	0	0	0	0	0	76.00
76.01	03030	WOUND CARE	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	0	0	0	0	0	88.00
88.01	08801	WOODCREST	0	0	0	0	0	88.01
88.02	08802	STAT CARE	0	41,317	0	41,317	0	88.02
88.03	08803	BERNE FAMILY MEDICINE	0	0	0	0	0	88.03
88.04	08804	HIGH STREET	0	0	0	0	0	88.04
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - AMO	0	0	0	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	0	0	90.02
90.03	09003	GENERAL SURGERY OFFICE	0	0	0	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	102,055	0	102,055	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,983,072	0	1,983,072	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,004	0	12,004	0	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
194.02	07952	OTHER MOBS	0	0	0	0	0	194.02
194.03	07953	IDLE SPACE	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,995,076	0	1,995,076	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 3/2/2024 10:07 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	181,074					5.00
7.00	00700	OPERATION OF PLANT	8,261	281,386				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	929	4,504	37,169			8.00
9.00	00900	HOUSEKEEPING	2,841	7,452	0	62,807		9.00
10.00	01000	DIETARY	3,526	17,772	0	4,169	150,704	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,731	823	0	193	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	4,116	5,814	0	1,364	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,072	6,613	0	1,551	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,670	41,681	30,270	9,778	129,105	30.00
31.00	03100	INTENSIVE CARE UNIT	6,755	7,486	5,064	1,756	21,599	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	121	3,899	1,375	915	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,323	51,628	0	12,111	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	163	3,899	460	915	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,927	10,226	0	2,399	0	54.00
60.00	06000	LABORATORY	15,986	10,651	0	2,499	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,431	23,776	0	5,578	0	65.00
66.00	06600	PHYSICAL THERAPY	8,389	260	0	61	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,353	130	0	31	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,005	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,612	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,501	0	0	0	0	73.00
76.00	03020	OP PSYCH	2,915	0	0	0	0	76.00
76.01	03030	WOUND CARE	968	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	6,366	0	0	0	0	88.00
88.01	08801	WOODCREST	5,730	0	0	0	0	88.01
88.02	08802	STAT CARE	5,563	5,863	0	1,375	0	88.02
88.03	08803	BERNE FAMILY MEDICINE	5,085	0	0	0	0	88.03
88.04	08804	HIGH STREET	4,985	0	0	0	0	88.04
90.00	09000	CLINIC	7,422	23,995	0	5,629	0	90.00
90.01	09001	CLINIC - AMO	2,270	5,553	0	1,303	0	90.01
90.02	09002	CLINIC - AMH NEURO	606	5,092	0	1,195	0	90.02
90.03	09003	GENERAL SURGERY OFFICE	1,806	6,741	0	1,581	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	10,892	14,482	0	3,397	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	7,404	0	0	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	178,724	258,340	37,169	57,800	150,704	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	40	1,703	0	0	0	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	2,082	11,958	0	2,805	0	194.01
194.02	07952	OTHER MOBS	43	9,385	0	2,202	0	194.02
194.03	07953	IDLE SPACE	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	185	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	181,074	281,386	37,169	62,807	150,704	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 3/2/2024 10:07 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	0					11.00
13.00	01300	NURSING ADMINISTRATION	0	10,547				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0			14.00
15.00	01500	PHARMACY	0	0	0	52,263		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	56,840	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	4,058	0	0	5,434	30.00
31.00	03100	INTENSIVE CARE UNIT	0	732	0	0	1,424	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	7	0	0	89	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,460	0	0	5,783	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	17	0	0	89	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	11,756	54.00
60.00	06000	LABORATORY	0	0	0	0	8,448	60.00
65.00	06500	RESPIRATORY THERAPY	0	547	0	0	2,002	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	2,514	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	1,033	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	567	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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	1,986	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	52,263	4,313	73.00
76.00	03020	OP PSYCH	0	0	0	0	47	76.00
76.01	03030	WOUND CARE	0	0	0	0	204	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	0	0	0	0	1,096	88.00
88.01	08801	WOODCREST	0	0	0	0	947	88.01
88.02	08802	STAT CARE	0	0	0	0	1,077	88.02
88.03	08803	BERNE FAMILY MEDICINE	0	0	0	0	886	88.03
88.04	08804	HIGH STREET	0	0	0	0	1,069	88.04
90.00	09000	CLINIC	0	0	0	0	1,118	90.00
90.01	09001	CLINIC - AMO	0	0	0	0	326	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	0	118	90.02
90.03	09003	GENERAL SURGERY OFFICE	0	0	0	0	197	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	2,726	0	0	4,268	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
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	10,547	0	52,263	56,791	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	0	0	0	0	49	194.01
194.02	07952	OTHER MOBS	0	0	0	0	0	194.02
194.03	07953	IDLE SPACE	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	10,547	0	52,263	56,840	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 3/2/2024 10:07 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	536,713	0	536,713		30.00
31.00	03100	INTENSIVE CARE UNIT	97,569	0	97,569		31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0		40.00
43.00	04300	NURSERY	33,884	0	33,884		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	286,569	0	286,569		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	33,021	0	33,021		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	196,843	0	196,843		54.00
60.00	06000	LABORATORY	109,646	0	109,646		60.00
65.00	06500	RESPIRATORY THERAPY	110,388	0	110,388		65.00
66.00	06600	PHYSICAL THERAPY	178,770	0	178,770		66.00
67.00	06700	OCCUPATIONAL THERAPY	5,383	0	5,383		67.00
68.00	06800	SPEECH PATHOLOGY	2,490	0	2,490		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,598	0	5,598		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	60,077	0	60,077		73.00
76.00	03020	OP PSYCH	2,962	0	2,962		76.00
76.01	03030	WOUND CARE	1,172	0	1,172		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	MONROE FAMILY MEDICINE	7,462	0	7,462		88.00
88.01	08801	WOODCREST	6,677	0	6,677		88.01
88.02	08802	STAT CARE	55,195	0	55,195		88.02
88.03	08803	BERNE FAMILY MEDICINE	5,971	0	5,971		88.03
88.04	08804	HIGH STREET	6,054	0	6,054		88.04
90.00	09000	CLINIC	38,164	0	38,164		90.00
90.01	09001	CLINIC - AMO	9,452	0	9,452		90.01
90.02	09002	CLINIC - AMH NEURO	7,011	0	7,011		90.02
90.03	09003	GENERAL SURGERY OFFICE	10,325	0	10,325		90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0		90.04
91.00	09100	EMERGENCY	137,820	0	137,820		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	7,404	0	7,404		95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0		97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,952,620	0	1,952,620		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,747	0	13,747		190.00
194.00	07950	TITLE XX	0	0	0		194.00
194.01	07951	OTHER NRCC	16,894	0	16,894		194.01
194.02	07952	OTHER MOBS	11,630	0	11,630		194.02
194.03	07953	IDLE SPACE	0	0	0		194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	185	0	185		194.04
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,995,076	0	1,995,076		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 3/2/2024 10:07 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	108,693					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	36,715,657			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,865	0	3,397,762	-13,655,380	54,174,525	5.00
7.00	00700	OPERATION OF PLANT	14,880	0	0	0	2,471,867	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,729	0	70,782	0	278,085	8.00
9.00	00900	HOUSEKEEPING	2,861	0	493,421	0	850,144	9.00
10.00	01000	DIETARY	6,823	0	623,816	0	1,055,172	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	316	0	879,369	0	1,116,297	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	2,232	0	868,295	0	1,231,569	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,539	0	310,582	0	620,088	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,002	0	3,810,510	0	6,776,757	30.00
31.00	03100	INTENSIVE CARE UNIT	2,874	0	686,935	0	2,021,120	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	1,497	0	6,679	0	36,347	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,965	0	2,307,270	0	3,986,569	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,497	0	15,970	0	48,684	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,855	0	1,164,702	0	2,970,306	54.00
60.00	06000	LABORATORY	3,926	0	1,246,838	0	4,783,402	60.00
65.00	06500	RESPIRATORY THERAPY	4,089	0	512,669	0	1,026,634	65.00
66.00	06600	PHYSICAL THERAPY	9,128	0	1,780,676	0	2,510,214	66.00
67.00	06700	OCCUPATIONAL THERAPY	100	0	557,815	0	704,017	67.00
68.00	06800	SPEECH PATHOLOGY	50	0	248,450	0	300,604	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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	1,080,859	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,047,651	73.00
76.00	03020	OP PSYCH	0	0	901,924	0	872,293	76.00
76.01	03030	WOUND CARE	0	0	193,378	0	289,651	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	0	0	1,358,085	0	1,904,734	88.00
88.01	08801	WOODCREST	0	0	1,221,305	0	1,714,457	88.01
88.02	08802	STAT CARE	2,251	0	1,139,784	0	1,664,556	88.02
88.03	08803	BERNE FAMILY MEDICINE	0	0	978,281	0	1,521,413	88.03
88.04	08804	HIGH STREET	0	0	1,052,129	0	1,491,725	88.04
90.00	09000	CLINIC	0	0	2,693,747	0	2,220,844	90.00
90.01	09001	CLINIC - AMO	0	0	1,997,376	0	679,253	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	699,873	0	181,236	90.02
90.03	09003	GENERAL SURGERY OFFICE	0	0	1,185,291	0	540,326	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	5,560	0	2,557,248	0	3,259,003	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	1,436,128	0	2,215,510	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	108,039	0	36,397,090	-13,655,380	53,471,387	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	654	0	0	0	12,004	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	0	0	318,567	0	622,858	194.01
194.02	07952	OTHER MOBS	0	0	0	0	12,984	194.02
194.03	07953	IDLE SPACE	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	55,292	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,995,076	0	294,168		13,655,380	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.355147	0.000000	0.008012		0.252063	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 3/2/2024 10:07 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
204.00		Cost to be allocated (per Wkst. B, Part II)			0		181,074	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.003342	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: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 3/2/2024 10:07 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (NOT USED)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	108,029					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,729	6,459				8.00
9.00	00900	HOUSEKEEPING	2,861	0	102,785			9.00
10.00	01000	DIETARY	6,823	0	6,823	6,140		10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	316	0	316	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	2,232	0	2,232	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,539	0	2,539	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,002	5,260	16,002	5,260	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,874	880	2,874	880	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	1,497	239	1,497	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,820	0	19,820	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,497	80	1,497	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,926	0	3,926	0	0	54.00
60.00	06000	LABORATORY	4,089	0	4,089	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	9,128	0	9,128	0	0	65.00
66.00	06600	PHYSICAL THERAPY	100	0	100	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	50	0	50	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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	03020	OP PSYCH	0	0	0	0	0	76.00
76.01	03030	WOUND CARE	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	0	0	0	0	0	88.00
88.01	08801	WOODCREST	0	0	0	0	0	88.01
88.02	08802	STAT CARE	2,251	0	2,251	0	0	88.02
88.03	08803	BERNE FAMILY MEDICINE	0	0	0	0	0	88.03
88.04	08804	HIGH STREET	0	0	0	0	0	88.04
90.00	09000	CLINIC	9,212	0	9,212	0	0	90.00
90.01	09001	CLINIC - AMO	2,132	0	2,132	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	1,955	0	1,955	0	0	90.02
90.03	09003	GENERAL SURGERY OFFICE	2,588	0	2,588	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	5,560	0	5,560	0	0	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
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	99,181	6,459	94,591	6,140	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	654	0	0	0	0	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	4,591	0	4,591	0	0	194.01
194.02	07952	OTHER MOBS	3,603	0	3,603	0	0	194.02
194.03	07953	IDLE SPACE	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
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)	3,094,933	397,714	1,146,399	1,592,714	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.649094	61.575166	11.153369	259.399674	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	281,386	37,169	62,807	150,704	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.604727	5.754606	0.611052	24.544625	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 3/2/2024 10:07 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (NOT USED)	
			7.00	8.00	9.00	10.00	11.00	
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: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 3/2/2024 10:07 am

		Cost Center Description	NURSING ADMINISTRATION (GROSS SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	9,897,281					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0				14.00
15.00	01500	PHARMACY	0	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	117,238,241		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,810,510	0	0	11,203,776		30.00
31.00	03100	INTENSIVE CARE UNIT	686,935	0	0	2,936,838		31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0		40.00
43.00	04300	NURSERY	6,679	0	0	184,508		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,307,270	0	0	11,924,727		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,970	0	0	184,160		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	24,277,487		54.00
60.00	06000	LABORATORY	0	0	0	17,419,118		60.00
65.00	06500	RESPIRATORY THERAPY	512,669	0	0	4,128,809		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,184,297		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,130,190		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,168,844		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
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	4,095,129		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	8,892,108		73.00
76.00	03020	OP PSYCH	0	0	0	96,383		76.00
76.01	03030	WOUND CARE	0	0	0	419,726		76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	0	0	0	2,259,889		88.00
88.01	08801	WOODCREST	0	0	0	1,951,988		88.01
88.02	08802	STAT CARE	0	0	0	2,221,560		88.02
88.03	08803	BERNE FAMILY MEDICINE	0	0	0	1,827,639		88.03
88.04	08804	HIGH STREET	0	0	0	2,203,202		88.04
90.00	09000	CLINIC	0	0	0	2,305,617		90.00
90.01	09001	CLINIC - AMO	0	0	0	672,008		90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	242,497		90.02
90.03	09003	GENERAL SURGERY OFFICE	0	0	0	406,189		90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0	0		90.04
91.00	09100	EMERGENCY	2,557,248	0	0	8,800,003		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		95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0		97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,897,281	0	100	117,136,692		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
194.00	07950	TITLE XX	0	0	0	0		194.00
194.01	07951	OTHER NRCC	0	0	0	101,549		194.01
194.02	07952	OTHER MOBS	0	0	0	0		194.02
194.03	07953	IDLE SPACE	0	0	0	0		194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,410,251	0	1,630,841	877,447		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.142489	0.000000	16,308.410000	0.007484		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	10,547	0	52,263	56,840		204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 3/2/2024 10:07 am

		Cost Center Description	NURSING ADMINISTRATION (GROSS SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001066	0.000000	522.630000	0.000485		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 3/2/2024 10:07 am

Title XVIII | 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	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,436,959		11,436,959	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,047,280		3,047,280	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
43.00	04300	NURSERY	122,143		122,143	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,198,327		6,198,327	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	129,120		129,120	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,057,003		4,057,003	0	0	54.00
60.00	06000	LABORATORY	6,282,238		6,282,238	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,752,677	0	1,752,677	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,185,725	0	3,185,725	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	899,406	0	899,406	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	385,123	0	385,123	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,383,952		1,383,952	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,009,115		3,009,115	0	0	73.00
76.00	03020	OP PSYCH	1,092,887		1,092,887	0	0	76.00
76.01	03030	WOUND CARE	365,802		365,802	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	2,401,760		2,401,760	0	0	88.00
88.01	08801	WOODCREST	2,161,217		2,161,217	0	0	88.01
88.02	08802	STAT CARE	2,190,350		2,190,350	0	0	88.02
88.03	08803	BERNE FAMILY MEDICINE	1,918,583		1,918,583	0	0	88.03
88.04	08804	HIGH STREET	1,884,223		1,884,223	0	0	88.04
90.00	09000	CLINIC	3,164,552		3,164,552	0	0	90.00
90.01	09001	CLINIC - AMO	940,356		940,356	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	306,548		306,548	0	0	90.02
90.03	09003	GENERAL SURGERY OFFICE	782,571		782,571	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0		0	0	0	90.04
91.00	09100	EMERGENCY	4,732,018		4,732,018	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,099,213		4,099,213		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,773,958		2,773,958	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0		0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	70,703,106	0	70,703,106	0	0	200.00
201.00		Less Observation Beds	4,099,213		4,099,213		0	201.00
202.00		Total (see instructions)	66,603,893	0	66,603,893	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 3/2/2024 10:07 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,446,828		7,446,828			30.00
31.00	03100	INTENSIVE CARE UNIT	2,936,838		2,936,838			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
43.00	04300	NURSERY	184,508		184,508			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	918,753	11,005,974	11,924,727	0.519788	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	174,525	9,635	184,160	0.701129	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,689,361	22,588,126	24,277,487	0.167110	0.000000	54.00
60.00	06000	LABORATORY	2,170,694	15,248,424	17,419,118	0.360652	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,360,949	2,767,860	4,128,809	0.424499	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	431,965	4,752,332	5,184,297	0.614495	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	492,792	1,637,398	2,130,190	0.422219	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	124,281	1,044,563	1,168,844	0.329491	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	477,119	3,618,010	4,095,129	0.337951	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,280,018	5,612,090	8,892,108	0.338403	0.000000	73.00
76.00	03020	OP PSYCH	0	96,383	96,383	11.339002	0.000000	76.00
76.01	03030	WOUND CARE	651	419,075	419,726	0.871526	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	0	2,259,889	2,259,889			88.00
88.01	08801	WOODCREST	0	1,951,988	1,951,988			88.01
88.02	08802	STAT CARE	0	2,221,560	2,221,560			88.02
88.03	08803	BERNE FAMILY MEDICINE	0	1,827,639	1,827,639			88.03
88.04	08804	HIGH STREET	0	2,203,202	2,203,202			88.04
90.00	09000	CLINIC	92	2,305,525	2,305,617	1.372540	0.000000	90.00
90.01	09001	CLINIC - AMO	0	672,008	672,008	1.399323	0.000000	90.01
90.02	09002	CLINIC - AMH NEURO	0	242,497	242,497	1.264131	0.000000	90.02
90.03	09003	GENERAL SURGERY OFFICE	0	406,189	406,189	1.926618	0.000000	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0	0.000000	0.000000	90.04
91.00	09100	EMERGENCY	18,072	8,781,931	8,800,003	0.537729	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	257,038	3,499,910	3,756,948	1.091102	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,095,667	2,095,667	1.323664	0.000000	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	0.000000	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	21,964,484	97,267,875	119,232,359			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	21,964,484	97,267,875	119,232,359			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 3/2/2024 10:07 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
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
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
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	03020	OP PSYCH	0.000000		76.00
76.01	03030	WOUND CARE	0.000000		76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	MONROE FAMILY MEDICINE			88.00
88.01	08801	WOODCREST			88.01
88.02	08802	STAT CARE			88.02
88.03	08803	BERNE FAMILY MEDICINE			88.03
88.04	08804	HIGH STREET			88.04
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	CLINIC - AMO	0.000000		90.01
90.02	09002	CLINIC - AMH NEURO	0.000000		90.02
90.03	09003	GENERAL SURGERY OFFICE	0.000000		90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0.000000		90.04
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
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000		97.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE			116.00
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: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 3/2/2024 10:07 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,436,959		11,436,959	0	11,436,959	30.00
31.00	03100	INTENSIVE CARE UNIT	3,047,280		3,047,280	0	3,047,280	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
43.00	04300	NURSERY	122,143		122,143	0	122,143	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,198,327		6,198,327	0	6,198,327	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	129,120		129,120	0	129,120	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,057,003		4,057,003	0	4,057,003	54.00
60.00	06000	LABORATORY	6,282,238		6,282,238	0	6,282,238	60.00
65.00	06500	RESPIRATORY THERAPY	1,752,677	0	1,752,677	0	1,752,677	65.00
66.00	06600	PHYSICAL THERAPY	3,185,725	0	3,185,725	0	3,185,725	66.00
67.00	06700	OCCUPATIONAL THERAPY	899,406	0	899,406	0	899,406	67.00
68.00	06800	SPEECH PATHOLOGY	385,123	0	385,123	0	385,123	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,383,952		1,383,952	0	1,383,952	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,009,115		3,009,115	0	3,009,115	73.00
76.00	03020	OP PSYCH	1,092,887		1,092,887	0	1,092,887	76.00
76.01	03030	WOUND CARE	365,802		365,802	0	365,802	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	2,401,760		2,401,760	0	2,401,760	88.00
88.01	08801	WOODCREST	2,161,217		2,161,217	0	2,161,217	88.01
88.02	08802	STAT CARE	2,190,350		2,190,350	0	2,190,350	88.02
88.03	08803	BERNE FAMILY MEDICINE	1,918,583		1,918,583	0	1,918,583	88.03
88.04	08804	HIGH STREET	1,884,223		1,884,223	0	1,884,223	88.04
90.00	09000	CLINIC	3,164,552		3,164,552	0	3,164,552	90.00
90.01	09001	CLINIC - AMO	940,356		940,356	0	940,356	90.01
90.02	09002	CLINIC - AMH NEURO	306,548		306,548	0	306,548	90.02
90.03	09003	GENERAL SURGERY OFFICE	782,571		782,571	0	782,571	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0		0	0	0	90.04
91.00	09100	EMERGENCY	4,732,018		4,732,018	0	4,732,018	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,099,213		4,099,213		4,099,213	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,773,958		2,773,958	0	2,773,958	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0		0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	70,703,106	0	70,703,106	0	70,703,106	200.00
201.00		Less Observation Beds	4,099,213		4,099,213		4,099,213	201.00
202.00		Total (see instructions)	66,603,893	0	66,603,893	0	66,603,893	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 3/2/2024 10:07 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,446,828		7,446,828			30.00
31.00	03100	INTENSIVE CARE UNIT	2,936,838		2,936,838			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
43.00	04300	NURSERY	184,508		184,508			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	918,753	11,005,974	11,924,727	0.519788	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	174,525	9,635	184,160	0.701129	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,689,361	22,588,126	24,277,487	0.167110	0.000000	54.00
60.00	06000	LABORATORY	2,170,694	15,248,424	17,419,118	0.360652	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,360,949	2,767,860	4,128,809	0.424499	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	431,965	4,752,332	5,184,297	0.614495	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	492,792	1,637,398	2,130,190	0.422219	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	124,281	1,044,563	1,168,844	0.329491	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	477,119	3,618,010	4,095,129	0.337951	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,280,018	5,612,090	8,892,108	0.338403	0.000000	73.00
76.00	03020	OP PSYCH	0	96,383	96,383	11.339002	0.000000	76.00
76.01	03030	WOUND CARE	651	419,075	419,726	0.871526	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	0	2,259,889	2,259,889	1.062778	0.000000	88.00
88.01	08801	WOODCREST	0	1,951,988	1,951,988	1.107188	0.000000	88.01
88.02	08802	STAT CARE	0	2,221,560	2,221,560	0.985951	0.000000	88.02
88.03	08803	BERNE FAMILY MEDICINE	0	1,827,639	1,827,639	1.049760	0.000000	88.03
88.04	08804	HIGH STREET	0	2,203,202	2,203,202	0.855220	0.000000	88.04
90.00	09000	CLINIC	92	2,305,525	2,305,617	1.372540	0.000000	90.00
90.01	09001	CLINIC - AMO	0	672,008	672,008	1.399323	0.000000	90.01
90.02	09002	CLINIC - AMH NEURO	0	242,497	242,497	1.264131	0.000000	90.02
90.03	09003	GENERAL SURGERY OFFICE	0	406,189	406,189	1.926618	0.000000	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0	0.000000	0.000000	90.04
91.00	09100	EMERGENCY	18,072	8,781,931	8,800,003	0.537729	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	257,038	3,499,910	3,756,948	1.091102	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,095,667	2,095,667	1.323664	0.000000	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	0.000000	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	21,964,484	97,267,875	119,232,359			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	21,964,484	97,267,875	119,232,359			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 3/2/2024 10:07 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.519788		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.701129		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.167110		54.00
60.00	06000	LABORATORY	0.360652		60.00
65.00	06500	RESPIRATORY THERAPY	0.424499		65.00
66.00	06600	PHYSICAL THERAPY	0.614495		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.422219		67.00
68.00	06800	SPEECH PATHOLOGY	0.329491		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.337951		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.338403		73.00
76.00	03020	OP PSYCH	11.339002		76.00
76.01	03030	WOUND CARE	0.871526		76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	MONROE FAMILY MEDICINE	1.062778		88.00
88.01	08801	WOODCREST	1.107188		88.01
88.02	08802	STAT CARE	0.985951		88.02
88.03	08803	BERNE FAMILY MEDICINE	1.049760		88.03
88.04	08804	HIGH STREET	0.855220		88.04
90.00	09000	CLINIC	1.372540		90.00
90.01	09001	CLINIC - AMO	1.399323		90.01
90.02	09002	CLINIC - AMH NEURO	1.264131		90.02
90.03	09003	GENERAL SURGERY OFFICE	1.926618		90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0.000000		90.04
91.00	09100	EMERGENCY	0.537729		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.091102		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	1.323664		95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000		97.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part II Date/Time Prepared: 3/2/2024 10:07 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,198,327	286,569	5,911,758	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	129,120	33,021	96,099	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,057,003	196,843	3,860,160	0	0	54.00
60.00	06000	LABORATORY	6,282,238	109,646	6,172,592	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,752,677	110,388	1,642,289	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,185,725	178,770	3,006,955	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	899,406	5,383	894,023	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	385,123	2,490	382,633	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,383,952	5,598	1,378,354	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,009,115	60,077	2,949,038	0	0	73.00
76.00	03020	OP PSYCH	1,092,887	2,962	1,089,925	0	0	76.00
76.01	03030	WOUND CARE	365,802	1,172	364,630	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	2,401,760	7,462	2,394,298	0	0	88.00
88.01	08801	WOODCREST	2,161,217	6,677	2,154,540	0	0	88.01
88.02	08802	STAT CARE	2,190,350	55,195	2,135,155	0	0	88.02
88.03	08803	BERNE FAMILY MEDICINE	1,918,583	5,971	1,912,612	0	0	88.03
88.04	08804	HIGH STREET	1,884,223	6,054	1,878,169	0	0	88.04
90.00	09000	CLINIC	3,164,552	38,164	3,126,388	0	0	90.00
90.01	09001	CLINIC - AMO	940,356	9,452	930,904	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	306,548	7,011	299,537	0	0	90.02
90.03	09003	GENERAL SURGERY OFFICE	782,571	10,325	772,246	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	4,732,018	137,820	4,594,198	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,099,213	192,368	3,906,845	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,773,958	7,404	2,766,554	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	56,096,724	1,476,822	54,619,902	0	0	200.00
201.00		Less Observation Beds	4,099,213	192,368	3,906,845	0	0	201.00
202.00		Total (line 200 minus line 201)	51,997,511	1,284,454	50,713,057	0	0	202.00

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

Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part II | Date/Time Prepared: 3/2/2024 10:07 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	6,198,327	11,924,727	0.519788		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	129,120	184,160	0.701129		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,057,003	24,277,487	0.167110		54.00
60.00	06000	LABORATORY	6,282,238	17,419,118	0.360652		60.00
65.00	06500	RESPIRATORY THERAPY	1,752,677	4,128,809	0.424499		65.00
66.00	06600	PHYSICAL THERAPY	3,185,725	5,184,297	0.614495		66.00
67.00	06700	OCCUPATIONAL THERAPY	899,406	2,130,190	0.422219		67.00
68.00	06800	SPEECH PATHOLOGY	385,123	1,168,844	0.329491		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,383,952	4,095,129	0.337951		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,009,115	8,892,108	0.338403		73.00
76.00	03020	OP PSYCH	1,092,887	96,383	11.339002		76.00
76.01	03030	WOUND CARE	365,802	419,726	0.871526		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	MONROE FAMILY MEDICINE	2,401,760	2,259,889	1.062778		88.00
88.01	08801	WOODCREST	2,161,217	1,951,988	1.107188		88.01
88.02	08802	STAT CARE	2,190,350	2,221,560	0.985951		88.02
88.03	08803	BERNE FAMILY MEDICINE	1,918,583	1,827,639	1.049760		88.03
88.04	08804	HIGH STREET	1,884,223	2,203,202	0.855220		88.04
90.00	09000	CLINIC	3,164,552	2,305,617	1.372540		90.00
90.01	09001	CLINIC - AMO	940,356	672,008	1.399323		90.01
90.02	09002	CLINIC - AMH NEURO	306,548	242,497	1.264131		90.02
90.03	09003	GENERAL SURGERY OFFICE	782,571	406,189	1.926618		90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0.000000		90.04
91.00	09100	EMERGENCY	4,732,018	8,800,003	0.537729		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,099,213	3,756,948	1.091102		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	2,773,958	2,095,667	1.323664		95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000		97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	0.000000		116.00
200.00		Subtotal (sum of lines 50 thru 199)	56,096,724	108,664,185			200.00
201.00		Less Observation Beds	4,099,213	0			201.00
202.00		Total (line 200 minus line 201)	51,997,511	108,664,185			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part II Date/Time Prepared: 3/2/2024 10:07 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	286,569	11,924,727	0.024031	247,390	5,945	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	33,021	184,160	0.179306	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	196,843	24,277,487	0.008108	427,569	3,467	54.00
60.00	06000	LABORATORY	109,646	17,419,118	0.006295	391,292	2,463	60.00
65.00	06500	RESPIRATORY THERAPY	110,388	4,128,809	0.026736	353,491	9,451	65.00
66.00	06600	PHYSICAL THERAPY	178,770	5,184,297	0.034483	86,024	2,966	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,383	2,130,190	0.002527	92,906	235	67.00
68.00	06800	SPEECH PATHOLOGY	2,490	1,168,844	0.002130	28,157	60	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,598	4,095,129	0.001367	82,143	112	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	60,077	8,892,108	0.006756	765,262	5,170	73.00
76.00	03020	OP PSYCH	2,962	96,383	0.030732	0	0	76.00
76.01	03030	WOUND CARE	1,172	419,726	0.002792	651	2	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	7,462	2,259,889	0.003302	0	0	88.00
88.01	08801	WOODCREST	6,677	1,951,988	0.003421	0	0	88.01
88.02	08802	STAT CARE	55,195	2,221,560	0.024845	0	0	88.02
88.03	08803	BERNE FAMILY MEDICINE	5,971	1,827,639	0.003267	0	0	88.03
88.04	08804	HIGH STREET	6,054	2,203,202	0.002748	0	0	88.04
90.00	09000	CLINIC	38,164	2,305,617	0.016553	92	2	90.00
90.01	09001	CLINIC - AMO	9,452	672,008	0.014065	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	7,011	242,497	0.028912	0	0	90.02
90.03	09003	GENERAL SURGERY OFFICE	10,325	406,189	0.025419	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0.000000	0	0	90.04
91.00	09100	EMERGENCY	137,820	8,800,003	0.015661	18,072	283	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	192,368	3,756,948	0.051203	13,460	689	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	0	97.00
200.00		Total (lines 50 through 199)	1,469,418	106,568,518		2,506,509	30,845	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 3/2/2024 10:07 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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	03020	OP PSYCH	0	0	0	0	0	76.00
76.01	03030	WOUND CARE	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	0	0	0	0	0	88.00
88.01	08801	WOODCREST	0	0	0	0	0	88.01
88.02	08802	STAT CARE	0	0	0	0	0	88.02
88.03	08803	BERNE FAMILY MEDICINE	0	0	0	0	0	88.03
88.04	08804	HIGH STREET	0	0	0	0	0	88.04
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - AMO	0	0	0	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	0	0	90.02
90.03	09003	GENERAL SURGERY OFFICE	0	0	0	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 3/2/2024 10:07 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	11,924,727	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	184,160	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	24,277,487	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	17,419,118	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,128,809	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,184,297	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,130,190	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,168,844	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	4,095,129	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,892,108	0.000000	73.00
76.00	03020	OP PSYCH	0	0	0	96,383	0.000000	76.00
76.01	03030	WOUND CARE	0	0	0	419,726	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	0	0	0	2,259,889	0.000000	88.00
88.01	08801	WOODCREST	0	0	0	1,951,988	0.000000	88.01
88.02	08802	STAT CARE	0	0	0	2,221,560	0.000000	88.02
88.03	08803	BERNE FAMILY MEDICINE	0	0	0	1,827,639	0.000000	88.03
88.04	08804	HIGH STREET	0	0	0	2,203,202	0.000000	88.04
90.00	09000	CLINIC	0	0	0	2,305,617	0.000000	90.00
90.01	09001	CLINIC - AMO	0	0	0	672,008	0.000000	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	242,497	0.000000	90.02
90.03	09003	GENERAL SURGERY OFFICE	0	0	0	406,189	0.000000	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0	0	0.000000	90.04
91.00	09100	EMERGENCY	0	0	0	8,800,003	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,756,948	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0.000000	97.00
200.00		Total (lines 50 through 199)	0	0	0	106,568,518		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 3/2/2024 10:07 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	247,390	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	427,569	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	391,292	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	353,491	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	86,024	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	92,906	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	28,157	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	82,143	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	765,262	0	0	0	73.00
76.00	03020	OP PSYCH	0.000000	0	0	0	0	76.00
76.01	03030	WOUND CARE	0.000000	651	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	0.000000	0	0	0	0	88.00
88.01	08801	WOODCREST	0.000000	0	0	0	0	88.01
88.02	08802	STAT CARE	0.000000	0	0	0	0	88.02
88.03	08803	BERNE FAMILY MEDICINE	0.000000	0	0	0	0	88.03
88.04	08804	HIGH STREET	0.000000	0	0	0	0	88.04
90.00	09000	CLINIC	0.000000	92	0	0	0	90.00
90.01	09001	CLINIC - AMO	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0.000000	0	0	0	0	90.02
90.03	09003	GENERAL SURGERY OFFICE	0.000000	0	0	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0.000000	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.000000	18,072	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	13,460	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00
200.00		Total (lines 50 through 199)		2,506,509	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 3/2/2024 10:07 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.519788	0	2,714,769	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.701129	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.167110	0	5,922,094	0	0	54.00
60.00	06000	LABORATORY	0.360652	0	3,673,703	1,228	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.424499	0	634,046	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.614495	0	1,531,189	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.422219	0	431,116	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.329491	0	89,621	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.337951	0	990,904	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.338403	0	1,445,269	28,999	0	73.00
76.00	03020	OP PSYCH	11.339002	0	10,767	0	0	76.00
76.01	03030	WOUND CARE	0.871526	0	52,338	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE						88.00
88.01	08801	WOODCREST						88.01
88.02	08802	STAT CARE						88.02
88.03	08803	BERNE FAMILY MEDICINE						88.03
88.04	08804	HIGH STREET						88.04
90.00	09000	CLINIC	1.372540	0	297,237	10,557	0	90.00
90.01	09001	CLINIC - AMO	1.399323	0	296,894	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	1.264131	0	70,348	0	0	90.02
90.03	09003	GENERAL SURGERY OFFICE	1.926618	0	106,489	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0.000000	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.537729	0	1,543,121	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.091102	0	1,418,852	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1.323664		0			95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00
200.00		Subtotal (see instructions)		0	21,228,757	40,784	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	21,228,757	40,784	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 3/2/2024 10:07 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1,411,104	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	989,641	0		54.00
60.00	06000	LABORATORY	1,324,928	443		60.00
65.00	06500	RESPIRATORY THERAPY	269,152	0		65.00
66.00	06600	PHYSICAL THERAPY	940,908	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	182,025	0		67.00
68.00	06800	SPEECH PATHOLOGY	29,529	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	334,877	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	489,083	9,813		73.00
76.00	03020	OP PSYCH	122,087	0		76.00
76.01	03030	WOUND CARE	45,614	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	MONROE FAMILY MEDICINE				88.00
88.01	08801	WOODCREST				88.01
88.02	08802	STAT CARE				88.02
88.03	08803	BERNE FAMILY MEDICINE				88.03
88.04	08804	HIGH STREET				88.04
90.00	09000	CLINIC	407,970	14,490		90.00
90.01	09001	CLINIC - AMO	415,451	0		90.01
90.02	09002	CLINIC - AMH NEURO	88,929	0		90.02
90.03	09003	GENERAL SURGERY OFFICE	205,164	0		90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0		90.04
91.00	09100	EMERGENCY	829,781	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,548,112	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
200.00		Subtotal (see instructions)	9,634,355	24,746		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	9,634,355	24,746		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1330 | Component CCN: 15-Z330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 3/2/2024 10:07 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.519788	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.701129	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.167110	0	0	0	0	54.00
60.00	06000	LABORATORY	0.360652	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.424499	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.614495	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.422219	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.329491	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.337951	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.338403	0	0	0	0	73.00
76.00	03020	OP PSYCH	11.339002	0	0	0	0	76.00
76.01	03030	WOUND CARE	0.871526	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE						88.00
88.01	08801	WOODCREST						88.01
88.02	08802	STAT CARE						88.02
88.03	08803	BERNE FAMILY MEDICINE						88.03
88.04	08804	HIGH STREET						88.04
90.00	09000	CLINIC	1.372540	0	0	0	0	90.00
90.01	09001	CLINIC - AMO	1.399323	0	0	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	1.264131	0	0	0	0	90.02
90.03	09003	GENERAL SURGERY OFFICE	1.926618	0	0	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0.000000	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.537729	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.091102	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1.323664		0			95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1330 | Component CCN: 15-Z330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 3/2/2024 10:07 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: 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
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	OP PSYCH	0	0		76.00
76.01	03030	WOUND CARE	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	MONROE FAMILY MEDICINE				88.00
88.01	08801	WOODCREST				88.01
88.02	08802	STAT CARE				88.02
88.03	08803	BERNE FAMILY MEDICINE				88.03
88.04	08804	HIGH STREET				88.04
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CLINIC - AMO	0	0		90.01
90.02	09002	CLINIC - AMH NEURO	0	0		90.02
90.03	09003	GENERAL SURGERY OFFICE	0	0		90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0		90.04
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
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part I Date/Time Prepared: 3/2/2024 10:07 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	536,713	123,531	413,182	4,110	100.53	30.00
31.00	INTENSIVE CARE UNIT	97,569		97,569	880	110.87	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
43.00	NURSERY	33,884		33,884	239	141.77	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	668,166		544,635	5,229		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	0				30.00
31.00	INTENSIVE CARE UNIT	114	12,639				31.00
40.00	SUBPROVIDER - IPF	0	0				40.00
43.00	NURSERY	90	12,759				43.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
200.00	Total (lines 30 through 199)	204	25,398				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part II Date/Time Prepared: 3/2/2024 10:07 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	286,569	11,924,727	0.024031	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	33,021	184,160	0.179306	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	196,843	24,277,487	0.008108	0	0	54.00
60.00	06000	LABORATORY	109,646	17,419,118	0.006295	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	110,388	4,128,809	0.026736	0	0	65.00
66.00	06600	PHYSICAL THERAPY	178,770	5,184,297	0.034483	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,383	2,130,190	0.002527	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,490	1,168,844	0.002130	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,598	4,095,129	0.001367	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	60,077	8,892,108	0.006756	0	0	73.00
76.00	03020	OP PSYCH	2,962	96,383	0.030732	0	0	76.00
76.01	03030	WOUND CARE	1,172	419,726	0.002792	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	7,462	2,259,889	0.003302	0	0	88.00
88.01	08801	WOODCREST	6,677	1,951,988	0.003421	0	0	88.01
88.02	08802	STAT CARE	55,195	2,221,560	0.024845	0	0	88.02
88.03	08803	BERNE FAMILY MEDICINE	5,971	1,827,639	0.003267	0	0	88.03
88.04	08804	HIGH STREET	6,054	2,203,202	0.002748	0	0	88.04
90.00	09000	CLINIC	38,164	2,305,617	0.016553	0	0	90.00
90.01	09001	CLINIC - AMO	9,452	672,008	0.014065	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	7,011	242,497	0.028912	0	0	90.02
90.03	09003	GENERAL SURGERY OFFICE	10,325	406,189	0.025419	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0.000000	0	0	90.04
91.00	09100	EMERGENCY	137,820	8,800,003	0.015661	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	192,368	3,756,948	0.051203	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	0	97.00
200.00		Total (lines 50 through 199)	1,469,418	106,568,518		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part III Date/Time Prepared: 3/2/2024 10:07 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	4,110	0.00	0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	880	0.00	114	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00
43.00	04300	NURSERY		0	239	0.00	90	43.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00
200.00		Total (lines 30 through 199)		0	5,229		204	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 3/2/2024 10:07 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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	03020	OP PSYCH	0	0	0	0	0	76.00
76.01	03030	WOUND CARE	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	0	0	0	0	0	88.00
88.01	08801	WOODCREST	0	0	0	0	0	88.01
88.02	08802	STAT CARE	0	0	0	0	0	88.02
88.03	08803	BERNE FAMILY MEDICINE	0	0	0	0	0	88.03
88.04	08804	HIGH STREET	0	0	0	0	0	88.04
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - AMO	0	0	0	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	0	0	90.02
90.03	09003	GENERAL SURGERY OFFICE	0	0	0	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 3/2/2024 10:07 am

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	11,924,727	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	184,160	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	24,277,487	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	17,419,118	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,128,809	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,184,297	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,130,190	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,168,844	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	4,095,129	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,892,108	0.000000	73.00
76.00	03020	OP PSYCH	0	0	0	96,383	0.000000	76.00
76.01	03030	WOUND CARE	0	0	0	419,726	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	0	0	0	2,259,889	0.000000	88.00
88.01	08801	WOODCREST	0	0	0	1,951,988	0.000000	88.01
88.02	08802	STAT CARE	0	0	0	2,221,560	0.000000	88.02
88.03	08803	BERNE FAMILY MEDICINE	0	0	0	1,827,639	0.000000	88.03
88.04	08804	HIGH STREET	0	0	0	2,203,202	0.000000	88.04
90.00	09000	CLINIC	0	0	0	2,305,617	0.000000	90.00
90.01	09001	CLINIC - AMO	0	0	0	672,008	0.000000	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	242,497	0.000000	90.02
90.03	09003	GENERAL SURGERY OFFICE	0	0	0	406,189	0.000000	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0	0	0.000000	90.04
91.00	09100	EMERGENCY	0	0	0	8,800,003	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,756,948	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0.000000	97.00
200.00		Total (lines 50 through 199)	0	0	0	106,568,518		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 3/2/2024 10:07 am

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
76.00	03020	OP PSYCH	0.000000	0	0	0	0	76.00
76.01	03030	WOUND CARE	0.000000	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	MONROE FAMILY MEDICINE	0.000000	0	0	0	0	88.00
88.01	08801	WOODCREST	0.000000	0	0	0	0	88.01
88.02	08802	STAT CARE	0.000000	0	0	0	0	88.02
88.03	08803	BERNE FAMILY MEDICINE	0.000000	0	0	0	0	88.03
88.04	08804	HIGH STREET	0.000000	0	0	0	0	88.04
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC - AMO	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0.000000	0	0	0	0	90.02
90.03	09003	GENERAL SURGERY OFFICE	0.000000	0	0	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0.000000	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 3/2/2024 10:07 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,260	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,110	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)	2,263	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,036	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	114	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)	827	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)	541	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	140.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	140.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	11,436,959	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)	15,960	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)	2,315,248	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	9,121,711	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)	9,121,711	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)	2,219.39	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,835,436	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,835,436	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 3/2/2024 10:07 am

Title XVIII | 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)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,047,280	880	3,462.82	249	862,242	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)	904,407	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	3,602,085	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	1,200,690	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	1,200,690	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)	1,847	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,219.39	88.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 3/2/2024 10:07 am

Title XVIII | Hospital | Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	4,099,213	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	536,713	11,436,959	0.046928	4,099,213	192,368	90.00
91.00	Nursing Program cost	0	11,436,959	0.000000	4,099,213	0	91.00
92.00	Allied health cost	0	11,436,959	0.000000	4,099,213	0	92.00
93.00	All other Medical Education	0	11,436,959	0.000000	4,099,213	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 3/2/2024 10:07 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,260	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,110	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)	2,263	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,225	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	58	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	239	15.00
16.00	Nursery days (title V or XIX only)	90	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	140.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	140.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	11,436,959	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)	8,120	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)	2,632,364	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,804,595	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)	8,804,595	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)	2,142.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	0	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	0	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 3/2/2024 10:07 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	122,143	239	511.06	90	45,995	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,047,280	880	3,462.82	114	394,761	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	440,756	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)	25,398	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)	25,398	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	415,358	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,847	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,142.24	88.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 3/2/2024 10:07 am

Title XIX | Hospital | PPS

	Cost Center Description						
						1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,956,717	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	536,713	11,436,959	0.046928	3,956,717	185,681	90.00
91.00	Nursing Program cost	0	11,436,959	0.000000	3,956,717	0	91.00
92.00	Allied health cost	0	11,436,959	0.000000	3,956,717	0	92.00
93.00	All other Medical Education	0	11,436,959	0.000000	3,956,717	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 3/2/2024 10:07 am

Title XVIII | Hospital | Cost

		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		1,486,636		30.00
31.00	03100	INTENSIVE CARE UNIT		742,578		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.519788	247,390	128,590	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.701129	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.167110	427,569	71,451	54.00
60.00	06000	LABORATORY	0.360652	391,292	141,120	60.00
65.00	06500	RESPIRATORY THERAPY	0.424499	353,491	150,057	65.00
66.00	06600	PHYSICAL THERAPY	0.614495	86,024	52,861	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.422219	92,906	39,227	67.00
68.00	06800	SPEECH PATHOLOGY	0.329491	28,157	9,277	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.337951	82,143	27,760	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.338403	765,262	258,967	73.00
76.00	03020	OP PSYCH	11.339002	0	0	76.00
76.01	03030	WOUND CARE	0.871526	651	567	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	MONROE FAMILY MEDICINE	0.000000		0	88.00
88.01	08801	WOODCREST	0.000000		0	88.01
88.02	08802	STAT CARE	0.000000		0	88.02
88.03	08803	BERNE FAMILY MEDICINE	0.000000		0	88.03
88.04	08804	HIGH STREET	0.000000		0	88.04
90.00	09000	CLINIC	1.372540	92	126	90.00
90.01	09001	CLINIC - AMO	1.399323	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	1.264131	0	0	90.02
90.03	09003	GENERAL SURGERY OFFICE	1.926618	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0.000000	0	0	90.04
91.00	09100	EMERGENCY	0.537729	18,072	9,718	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.091102	13,460	14,686	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,506,509	904,407	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)		2,506,509		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3

Component CCN: 15-Z330 | Date/Time Prepared: 3/2/2024 10:07 am

Title XVIII | Swing Beds - SNF | Cost

		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
40.00	04000	SUBPROVIDER - IPF				40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.519788	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.701129	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.167110	15,929	2,662	54.00
60.00	06000	LABORATORY	0.360652	37,950	13,687	60.00
65.00	06500	RESPIRATORY THERAPY	0.424499	25,717	10,917	65.00
66.00	06600	PHYSICAL THERAPY	0.614495	102,644	63,074	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.422219	117,037	49,415	67.00
68.00	06800	SPEECH PATHOLOGY	0.329491	37,373	12,314	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.337951	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.338403	192,059	64,993	73.00
76.00	03020	OP PSYCH	11.339002	0	0	76.00
76.01	03030	WOUND CARE	0.871526	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	MONROE FAMILY MEDICINE	0.000000		0	88.00
88.01	08801	WOODCREST	0.000000		0	88.01
88.02	08802	STAT CARE	0.000000		0	88.02
88.03	08803	BERNE FAMILY MEDICINE	0.000000		0	88.03
88.04	08804	HIGH STREET	0.000000		0	88.04
90.00	09000	CLINIC	1.372540	0	0	90.00
90.01	09001	CLINIC - AMO	1.399323	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	1.264131	0	0	90.02
90.03	09003	GENERAL SURGERY OFFICE	1.926618	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0.000000	0	0	90.04
91.00	09100	EMERGENCY	0.537729	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.091102	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		528,709	217,062	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)		528,709		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 3/2/2024 10:07 am

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.519788	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.701129	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.167110	0	0	54.00
60.00	06000	LABORATORY	0.360652	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.424499	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.614495	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.422219	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.329491	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.337951	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.338403	0	0	73.00
76.00	03020	OP PSYCH	11.339002	0	0	76.00
76.01	03030	WOUND CARE	0.871526	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	MONROE FAMILY MEDICINE	1.062778	0	0	88.00
88.01	08801	WOODCREST	1.107188	0	0	88.01
88.02	08802	STAT CARE	0.985951	0	0	88.02
88.03	08803	BERNE FAMILY MEDICINE	1.049760	0	0	88.03
88.04	08804	HIGH STREET	0.855220	0	0	88.04
90.00	09000	CLINIC	1.372540	0	0	90.00
90.01	09001	CLINIC - AMO	1.399323	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	1.264131	0	0	90.02
90.03	09003	GENERAL SURGERY OFFICE	1.926618	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0.000000	0	0	90.04
91.00	09100	EMERGENCY	0.537729	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.091102	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		0		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3

Component CCN: 15-Z330 | Date/Time Prepared: 3/2/2024 10:07 am

Title XIX | Swing Beds - SNF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.519788	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.701129	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.167110	0	0	54.00
60.00	06000	LABORATORY	0.360652	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.424499	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.614495	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.422219	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.329491	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.337951	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.338403	0	0	73.00
76.00	03020	OP PSYCH	11.339002	0	0	76.00
76.01	03030	WOUND CARE	0.871526	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	MONROE FAMILY MEDICINE	1.062778	0	0	88.00
88.01	08801	WOODCREST	1.107188	0	0	88.01
88.02	08802	STAT CARE	0.985951	0	0	88.02
88.03	08803	BERNE FAMILY MEDICINE	1.049760	0	0	88.03
88.04	08804	HIGH STREET	0.855220	0	0	88.04
90.00	09000	CLINIC	1.372540	0	0	90.00
90.01	09001	CLINIC - AMO	1.399323	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	1.264131	0	0	90.02
90.03	09003	GENERAL SURGERY OFFICE	1.926618	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0.000000	0	0	90.04
91.00	09100	EMERGENCY	0.537729	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.091102	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E Part B Date/Time Prepared: 3/2/2024 10:07 am

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	9,659,101	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments	0	3.00
4.00	Outlier payment (see instructions)	0	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)	9,659,101	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	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)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	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)	9,755,692	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)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	115,869	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,215,619	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	6,424,204	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	6,424,204	30.00
31.00	Primary payer payments	8,316	31.00
32.00	Subtotal (line 30 minus line 31)	6,415,888	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)	237,157	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	154,152	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	237,157	36.00
37.00	Subtotal (see instructions)	6,570,040	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	6,570,040	40.00
40.01	Sequestration adjustment (see instructions)	82,782	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	6,968,205	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-480,947	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1330	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 3/2/2024 10:07 am
	Title XVIII	Hospital	Cost

		1.00	
	MEDICARE PART B ANCILLARY COSTS		
200.00	Part B Combined Billed Days	0	200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I Date/Time Prepared: 3/2/2024 10:07 am

Title XVIII | Hospital | Cost

		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		2,896,982		6,824,305	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	10/14/2022	328,600	10/14/2022	143,900	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)		328,600		143,900	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)		3,225,582		6,968,205	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		2,493		480,947	6.02
7.00	Total Medicare program liability (see instructions)		3,223,089		6,487,258	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1330 | Component CCN: 15-Z330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I | Date/Time Prepared: 3/2/2024 10:07 am

Title XVIII | Swing Beds - SNF | Cost

		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		1,180,136		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	10/14/2022	86,500		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		86,500		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,266,636		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		121,133		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,387,769		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1330	Period: From 01/01/2022 To 12/31/2022	Worksheet E-1 Part II Date/Time Prepared: 3/2/2024 10:07 am
	Title XVIII	Hospital	Cost

			1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days (see instructions)		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days (see instructions)		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1330 | Component CCN: 15-Z330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-2 | Date/Time Prepared: 3/2/2024 10:07 am

Title XVIII | Swing Beds - SNF | Cost

		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)	1,212,697	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	219,233	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	541	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)	1,431,930	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,431,930	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,431,930	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	26,452	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	1,405,478	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,405,478	0	19.00
19.01	Sequestration adjustment (see instructions)	17,709	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	1,266,636	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	121,133	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1330 | Component CCN: 15-Z330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-2 | Date/Time Prepared: 3/2/2024 10:07 am

Title XIX | Swing Beds - SNF | PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1330	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part V Date/Time Prepared: 3/2/2024 10:07 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,602,085	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
3.01	Cellular therapy acquisition cost (see instructions)	0	3.01
4.00	Subtotal (sum of lines 1 through 3.01)	3,602,085	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,638,106	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	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	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	3,638,106	19.00
20.00	Deductibles (exclude professional component)	379,016	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,259,090	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	3,259,090	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	7,891	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	5,129	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	7,891	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,264,219	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	3,264,219	30.00
30.01	Sequestration adjustment (see instructions)	41,130	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	3,225,582	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-2,493	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G | Date/Time Prepared: 3/2/2024 10:07 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	2,249,694	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	34,251,886	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-20,936,442	0	0	0	6.00
7.00	Inventory	1,133,983	0	0	0	7.00
8.00	Prepaid expenses	1,069,412	0	0	0	8.00
9.00	Other current assets	22,875	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)	17,791,408	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	473,119	0	0	0	12.00
13.00	Land improvements	2,267,188	0	0	0	13.00
14.00	Accumulated depreciation	-1,723,870	0	0	0	14.00
15.00	Buildings	42,774,185	0	0	0	15.00
16.00	Accumulated depreciation	-25,965,558	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	9,719,737	0	0	0	19.00
20.00	Accumulated depreciation	-5,623,432	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	20,765,689	0	0	0	23.00
24.00	Accumulated depreciation	-17,214,622	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	365,701	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	25,838,137	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	6,658,334	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	9,333,021	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	15,991,355	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	59,620,900	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	114,655	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,752,986	0	0	0	38.00
39.00	Payroll taxes payable	228,958	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	3,963,658	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	9,060,257	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	22,960,000	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	22,960,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	32,020,257	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	27,600,643				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)	27,600,643	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	59,620,900	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-1 | Date/Time Prepared: 3/2/2024 10:07 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		28,190,357		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-589,714				2.00
3.00	Total (sum of line 1 and line 2)		27,600,643		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)		27,600,643		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)		27,600,643		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: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-2 Parts I & II | Date/Time Prepared: 3/2/2024 10:07 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	6,681,044		6,681,044	1.00
2.00	SUBPROVIDER - IPF	0		0	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	950,292		950,292	6.00
7.00	SKILLED NURSING FACILITY	0		0	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)	7,631,336		7,631,336	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	2,936,838		2,936,838	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)	2,936,838		2,936,838	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	10,568,174		10,568,174	17.00
18.00	Ancillary services	11,121,108	68,799,870	79,920,978	18.00
19.00	Outpatient services	275,202	15,908,060	16,183,262	19.00
20.00	MONROE FAMILY MEDICINE	0	2,259,889	2,259,889	20.00
20.01	WOODCREST	0	1,951,988	1,951,988	20.01
20.02	STAT CARE	0	2,221,560	2,221,560	20.02
20.03	BERNE FAMILY MEDICINE	0	1,827,639	1,827,639	20.03
20.04	HIGH STREET	0	2,203,202	2,203,202	20.04
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES	0	2,095,667	2,095,667	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	PROFESSIONAL FEES	0	23,400,180	23,400,180	27.00
27.01	OTHER CLINICS	0	101,549	101,549	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	21,964,484	120,769,604	142,734,088	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		76,398,461		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)		76,398,461		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1330 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-3 | Date/Time Prepared: 3/2/2024 10:07 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	142,734,088	1.00
2.00	Less contractual allowances and discounts on patients' accounts	66,247,044	2.00
3.00	Net patient revenues (line 1 minus line 2)	76,487,044	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	76,398,461	4.00
5.00	Net income from service to patients (line 3 minus line 4)	88,583	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	437,584	6.00
7.00	Income from investments	200,789	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	338,849	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	476,027	17.00
18.00	Revenue from sale of medical records and abstracts	25,911	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	187,365	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC	1,130,179	24.00
24.01	CEDIT INCOME	1,649,287	24.01
24.02	FITNESS REVENUE	81,608	24.02
24.03	TRANSPORTATION REVENUE	9,481	24.03
24.50	COVID-19 PHE Funding	491,527	24.50
25.00	Total other income (sum of lines 6-24)	5,028,607	25.00
26.00	Total (line 5 plus line 25)	5,117,190	26.00
27.00	BAD DEBTS	5,706,904	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	5,706,904	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-589,714	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1330 | Component CCN: 15-8526 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 3/2/2024 10:07 am

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	395,704	95,417	491,121	0	491,121	1.00
2.00	Physician Assistant	7,509	1,811	9,320	0	9,320	2.00
3.00	Nurse Practitioner	605,706	146,056	751,762	0	751,762	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	301,082	72,601	373,683	0	373,683	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)	1,310,001	315,885	1,625,886	0	1,625,886	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	115,475	115,475	0	115,475	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	115,475	115,475	0	115,475	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,310,001	431,360	1,741,361	0	1,741,361	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	21,231	5,120	26,351	0	26,351	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)	21,231	5,120	26,351	0	26,351	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	61,608	61,608	0	61,608	29.00
30.00	Administrative Costs	26,852	37,681	64,533	0	64,533	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	26,852	99,289	126,141	0	126,141	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,358,084	535,769	1,893,853	0	1,893,853	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1330 | Component CCN: 15-8526 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 3/2/2024 10:07 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	491,121		1.00
2.00	Physician Assistant	0	9,320		2.00
3.00	Nurse Practitioner	0	751,762		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	373,683		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	1,625,886		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	115,475		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				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	115,475		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,741,361		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	26,351		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				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	26,351		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	61,608		29.00
30.00	Administrative Costs	0	64,533		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	126,141		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,893,853		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1330
Component CCN: 15-8536

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

Worksheet M-1
Date/Time Prepared: 3/2/2024 10:07 am

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	613,028	73,961	686,989	0	686,989	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	266,458	41,934	308,392	0	308,392	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	320,916	63,694	384,610	0	384,610	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)	1,200,402	179,589	1,379,991	0	1,379,991	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	200,810	200,810	0	200,810	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	200,810	200,810	0	200,810	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,200,402	380,399	1,580,801	0	1,580,801	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	618	123	741	0	741	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)	618	123	741	0	741	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	73,140	73,140	0	73,140	29.00
30.00	Administrative Costs	20,285	29,705	49,990	0	49,990	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	20,285	102,845	123,130	0	123,130	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,221,305	483,367	1,704,672	0	1,704,672	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1330 | Component CCN: 15-8536 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 3/2/2024 10:07 am

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	686,989		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	308,392		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	384,610		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	1,379,991		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	200,810		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				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	200,810		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,580,801		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	741		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				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	741		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	73,140		29.00
30.00	Administrative Costs	0	49,990		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	123,130		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,704,672		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1330 | Component CCN: 15-8537 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 3/2/2024 10:07 am

RHC III | 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	458,967	81,657	540,624	0	540,624	1.00
2.00	Physician Assistant	56,901	10,124	67,025	0	67,025	2.00
3.00	Nurse Practitioner	109,216	19,431	128,647	0	128,647	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	271,641	48,329	319,970	0	319,970	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	67,483	12,006	79,489	0	79,489	9.00
10.00	Subtotal (sum of lines 1 through 9)	964,208	171,547	1,135,755	0	1,135,755	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	70,891	70,891	0	70,891	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	70,891	70,891	0	70,891	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	964,208	242,438	1,206,646	0	1,206,646	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	25,358	25,358	0	25,358	29.00
30.00	Administrative Costs	175,576	206,527	382,103	0	382,103	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	175,576	231,885	407,461	0	407,461	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,139,784	474,323	1,614,107	0	1,614,107	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1330 | Component CCN: 15-8537 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 3/2/2024 10:07 am

RHC III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	540,624		1.00
2.00	Physician Assistant	0	67,025		2.00
3.00	Nurse Practitioner	0	128,647		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	319,970		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	79,489		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,135,755		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	70,891		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				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	70,891		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,206,646		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				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	25,358		29.00
30.00	Administrative Costs	0	382,103		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	407,461		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,614,107		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1330 | Component CCN: 15-8559 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 3/2/2024 10:07 am

RHC IV | 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	365,942	84,241	450,183	0	450,183	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	261,656	60,234	321,890	0	321,890	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	294,201	67,726	361,927	0	361,927	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)	921,799	212,201	1,134,000	0	1,134,000	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	188,267	188,267	0	188,267	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	188,267	188,267	0	188,267	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	921,799	400,468	1,322,267	0	1,322,267	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	113,377	113,377	0	113,377	29.00
30.00	Administrative Costs	56,482	75,308	131,790	0	131,790	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	56,482	188,685	245,167	0	245,167	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	978,281	589,153	1,567,434	0	1,567,434	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1330 | Component CCN: 15-8559 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 3/2/2024 10:07 am

RHC IV | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-53,859	396,324		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	321,890		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	361,927		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)	-53,859	1,080,141		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	188,267		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				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	188,267		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-53,859	1,268,408		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				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	113,377		29.00
30.00	Administrative Costs	0	131,790		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	245,167		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-53,859	1,513,575		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1330 | Component CCN: 15-8555 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 3/2/2024 10:07 am

RHC V | 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	337,627	63,584	401,211	0	401,211	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	319,063	51,708	370,771	0	370,771	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	339,827	55,073	394,900	0	394,900	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)	996,517	170,365	1,166,882	0	1,166,882	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	192,443	192,443	0	192,443	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	192,443	192,443	0	192,443	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	996,517	362,808	1,359,325	0	1,359,325	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	59	10	69	0	69	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)	59	10	69	0	69	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	29,346	29,346	0	29,346	29.00
30.00	Administrative Costs	55,553	45,914	101,467	0	101,467	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	55,553	75,260	130,813	0	130,813	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,052,129	438,078	1,490,207	0	1,490,207	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1330 | Component CCN: 15-8555 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 3/2/2024 10:07 am

RHC V | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	401,211		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	370,771		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	394,900		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	1,166,882		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	192,443		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				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	192,443		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,359,325		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	69		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				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	69		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	-6,912	22,434		29.00
30.00	Administrative Costs	0	101,467		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-6,912	123,901		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-6,912	1,483,295		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1330 | Component CCN: 15-8526 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-2 | Date/Time Prepared: 3/2/2024 10:07 am

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.10	2,073	1	1		1.00
2.00	Physician Assistant	0.03	16	1	0		2.00
3.00	Nurse Practitioner	3.48	7,826	1	3		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.61	9,915		4	9,915	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	4.61	9,915			9,915	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,741,361	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					26,351	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,767,712	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.985093	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					126,141	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					507,907	15.00
16.00	Total overhead (sum of lines 14 and 15)					634,048	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					634,048	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					624,596	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,365,957	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1330 Component CCN: 15-8536

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

Worksheet M-2

Date/Time Prepared: 3/2/2024 10:07 am

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	RHC II Minimum Visits (col. 1 x col. 3)	Cost Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.52	3,895	1	2		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	1.14	3,920	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.66	7,815		3	7,815	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.66	7,815			7,815	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,580,801	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					741	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,581,542	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.999531	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					123,130	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					456,545	15.00
16.00	Total overhead (sum of lines 14 and 15)					579,675	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					579,675	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					579,403	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,160,204	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1330 | Component CCN: 15-8537 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-2 | Date/Time Prepared: 3/2/2024 10:07 am

RHC III | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.82	4,786	4,200	3,444		1.00
2.00	Physician Assistant	0.41	2,630	2,100	861		2.00
3.00	Nurse Practitioner	0.79	4,332	2,100	1,659		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.02	11,748		5,964	11,748	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.02	11,748			11,748	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,206,646	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,206,646	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					407,461	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					576,243	15.00
16.00	Total overhead (sum of lines 14 and 15)					983,704	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					983,704	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					983,704	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,190,350	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1330 | Component CCN: 15-8559 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-2 | Date/Time Prepared: 3/2/2024 10:07 am

RHC IV | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.91	2,984	4,200	3,822		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.40	4,976	2,100	2,940		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.31	7,960		6,762	7,960	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.31	7,960			7,960	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,268,408	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,268,408	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					245,167	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					405,008	15.00
16.00	Total overhead (sum of lines 14 and 15)					650,175	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					650,175	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					650,175	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,918,583	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1330 | Component CCN: 15-8555 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-2 | Date/Time Prepared: 3/2/2024 10:07 am

RHC V | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.71	3,833	4,200	2,982		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.70	3,677	2,100	1,470		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.41	7,510		4,452	7,510	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.41	7,510			7,510	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,359,325	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					69	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,359,394	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.999949	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					123,901	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					400,928	15.00
16.00	Total overhead (sum of lines 14 and 15)					524,829	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					524,829	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					524,802	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,884,127	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1330 Component CCN: 15-8526	Period: From 01/01/2022 To 12/31/2022	Worksheet M-3 Date/Time Prepared: 3/2/2024 10:07 am
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,365,957	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			62,824	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			2,303,133	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			9,915	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			9,915	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			232.29	7.00
			Calculation of Limit (1)		
			Rate Period N/A	Rate Period 1 (01/01/2022 through 12/31/2022)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	296.67	8.00
9.00	Rate for Program covered visits (see instructions)		0.00	232.29	9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)		0	3,705	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	860,634	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	860,634	16.00
16.01	Total program charges (see instructions)(from contractor's records)			652,364	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			15,223	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			20,083	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			640,488	16.04
16.05	Total program cost (see instructions)		0	660,571	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			39,941	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			119,440	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			660,571	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			11,630	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			672,201	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			672,201	26.00
26.01	Sequestration adjustment (see instructions)			8,470	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			450,014	27.00
28.00	Tentative settlement (for contractor use only)			0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)			213,717	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1330 Component CCN: 15-8536	Period: From 01/01/2022 To 12/31/2022	Worksheet M-3 Date/Time Prepared: 3/2/2024 10:07 am
	Title XVIII	RHC II	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,160,204	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			97,501	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			2,062,703	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			7,815	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			7,815	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			263.94	7.00
			Calculation of Limit (1)		
			Rate Period N/A	Rate Period 1 (01/01/2022 through 12/31/2022)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	358.57	8.00
9.00	Rate for Program covered visits (see instructions)		0.00	263.94	9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)		0	1,366	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	360,542	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	360,542	16.00
16.01	Total program charges (see instructions)(from contractor's records)			294,100	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			2,227	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			2,730	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			255,446	16.04
16.05	Total program cost (see instructions)		0	258,176	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			38,504	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			51,119	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			258,176	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			13,821	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			271,997	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			271,997	26.00
26.01	Sequestration adjustment (see instructions)			3,427	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			154,657	27.00
28.00	Tentative settlement (for contractor use only)			0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)			113,913	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1330 Component CCN: 15-8537	Period: From 01/01/2022 To 12/31/2022	Worksheet M-3 Date/Time Prepared: 3/2/2024 10:07 am
	Title XVIII	RHC III	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,190,350	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			0	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			2,190,350	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			11,748	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			11,748	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			186.44	7.00

		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2022 through 12/31/2022)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	176.92	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	176.92	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	789	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	139,590	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	139,590	16.00
16.01	Total program charges (see instructions)(from contractor's records)		124,091	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		11,225	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		12,627	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		86,518	16.04
16.05	Total program cost (see instructions)	0	99,145	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		18,816	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		18,810	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		99,145	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		99,145	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		99,145	26.00
26.01	Sequestration adjustment (see instructions)		1,249	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		75,375	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		22,521	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1330 Component CCN: 15-8559	Period: From 01/01/2022 To 12/31/2022	Worksheet M-3 Date/Time Prepared: 3/2/2024 10:07 am
	Title XVIII	RHC IV	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,918,583	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			73,465	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,845,118	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			7,960	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			7,960	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			231.80	7.00
			Calculation of Limit (1)		
			Rate Period N/A	Rate Period 1 (01/01/2022 through 12/31/2022)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	323.86	8.00
9.00	Rate for Program covered visits (see instructions)		0.00	231.80	9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)		0	1,296	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	300,413	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	300,413	16.00
16.01	Total program charges (see instructions)(from contractor's records)			246,915	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			14,908	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			18,138	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			196,121	16.04
16.05	Total program cost (see instructions)		0	214,259	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			37,124	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			38,977	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			214,259	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			10,617	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			224,876	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			224,876	26.00
26.01	Sequestration adjustment (see instructions)			2,833	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			82,135	27.00
28.00	Tentative settlement (for contractor use only)			0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)			139,908	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1330 Component CCN: 15-8555	Period: From 01/01/2022 To 12/31/2022	Worksheet M-3 Date/Time Prepared: 3/2/2024 10:07 am
	Title XVIII	RHC V	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,884,127	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			72,720	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,811,407	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			7,510	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			7,510	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			241.20	7.00

		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2022 through 12/31/2022)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	191.96	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	191.96	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,849	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	354,934	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	354,934	16.00
16.01	Total program charges (see instructions)(from contractor's records)		305,405	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		7,476	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		8,688	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		234,369	16.04
16.05	Total program cost (see instructions)	0	243,057	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		53,285	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		48,929	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		243,057	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		20,528	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		263,585	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		263,585	26.00
26.01	Sequestration adjustment (see instructions)		3,321	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		237,787	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		22,477	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1330 | Component CCN: 15-8526 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-4 | Date/Time Prepared: 3/2/2024 10:07 am

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,625,886	1,625,886	1,625,886	1,625,886	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001491	0.004254	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	2,424	6,917	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	28,895	8,003	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	31,319	14,920	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,741,361	1,741,361	1,741,361	1,741,361	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	624,596	624,596	624,596	624,596	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.017985	0.008568	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	11,233	5,352	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	42,552	20,272	0	0	10.00
11.00	Total number of injections/infusions (from your records)	205	585	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	207.57	34.65	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	38	108	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	7,888	3,742	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		62,824	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		11,630	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1330 | Component CCN: 15-8536 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-4 | Date/Time Prepared: 3/2/2024 10:07 am

Title XVIII | RHC II | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,379,991	1,379,991	1,379,991	1,379,991	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.003360	0.006615	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	4,637	9,129	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	49,882	7,702	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	54,519	16,831	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,580,801	1,580,801	1,580,801	1,580,801	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	579,403	579,403	579,403	579,403	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.034488	0.010647	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	19,982	6,169	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	74,501	23,000	0	0	10.00
11.00	Total number of injections/infusions (from your records)	286	563	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	260.49	40.85	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	38	96	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	9,899	3,922	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		97,501	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		13,821	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1330 | Component CCN: 15-8537 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-4 | Date/Time Prepared: 3/2/2024 10:07 am

Title XVIII | RHC III | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,135,755	1,135,755	1,135,755	1,135,755	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000000	0.000000	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	0	0	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	0	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	0	0	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,206,646	1,206,646	1,206,646	1,206,646	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	983,704	983,704	983,704	983,704	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.000000	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	0	0	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	0	0	0	0	10.00
11.00	Total number of injections/infusions (from your records)	0	0	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	0.00	0.00	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	0	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	0	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		0	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		0	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1330 | Component CCN: 15-8559 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-4 | Date/Time Prepared: 3/2/2024 10:07 am

Title XVIII | RHC IV | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,080,141	1,080,141	1,080,141	1,080,141	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.002361	0.007568	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	2,550	8,175	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	30,170	7,674	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	32,720	15,849	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,268,408	1,268,408	1,268,408	1,268,408	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	650,175	650,175	650,175	650,175	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.025796	0.012495	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	16,772	8,124	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	49,492	23,973	0	0	10.00
11.00	Total number of injections/infusions (from your records)	175	561	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	282.81	42.73	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	25	83	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	7,070	3,547	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		73,465	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		10,617	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1330 | Component CCN: 15-8555 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-4 | Date/Time Prepared: 3/2/2024 10:07 am

Title XVIII | RHC V | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,166,882	1,166,882	1,166,882	1,166,882	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.002421	0.018139	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	2,825	21,166	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	17,202	11,272	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	20,027	32,438	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,359,325	1,359,325	1,359,325	1,359,325	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	524,802	524,802	524,802	524,802	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.014733	0.023863	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	7,732	12,523	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	27,759	44,961	0	0	10.00
11.00	Total number of injections/infusions (from your records)	110	824	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	252.35	54.56	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	26	256	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	6,561	13,967	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		72,720	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		20,528	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1330 Component CCN: 15-8526	Period: From 01/01/2022 To 12/31/2022	Worksheet M-5 Date/Time Prepared: 3/2/2024 10:07 am
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		450,014	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		450,014	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		213,717	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		663,731	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1330 Component CCN: 15-8536	Period: From 01/01/2022 To 12/31/2022	Worksheet M-5 Date/Time Prepared: 3/2/2024 10:07 am
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		154,657	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		154,657	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		113,913	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		268,570	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1330 Component CCN: 15-8537	Period: From 01/01/2022 To 12/31/2022	Worksheet M-5 Date/Time Prepared: 3/2/2024 10:07 am
		RHC III	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		75,375	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		75,375	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		22,521	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		97,896	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1330 Component CCN: 15-8559	Period: From 01/01/2022 To 12/31/2022	Worksheet M-5 Date/Time Prepared: 3/2/2024 10:07 am
		RHC IV	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		82,135	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		82,135	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		139,908	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		222,043	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1330 Component CCN: 15-8555	Period: From 01/01/2022 To 12/31/2022	Worksheet M-5 Date/Time Prepared: 3/2/2024 10:07 am
		RHC V	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		237,787	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		237,787	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		22,477	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		260,264	7.00

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