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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0072	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/30/2024 12:38 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/30/2024 Time: 12:38 pm
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 MEMORIAL HOSPITAL LOGANSPORT (15-0072) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 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	Barret Rhoads		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	Barret Rhoads			2
3	Signatory Title	CFO			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	-92,702	173,452	0	-477,160	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	EXPRESS MEDICAL CENTER I	0		2,233		0	10.00
10.01	FAMILY HEALTH CARE II	0		12,933		0	10.01
200.00	TOTAL	0	-92,702	188,618	0	-477,160	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: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2024 12:38 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1101 MICHIGAN AVENUE	PO Box:			1.00
2.00	City: LOGANSPORT	State: IN	Zip Code: 46947-	County: CASS	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							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	MEMORIAL HOSPITAL LOGANSPORT	150072	99915	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	SWING BED - SNF	15U072	99915		05/14/2008	N	P	P	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	LOGANSPORT MEMORIAL EXPRESS MEDICAL	158561	99915		05/25/2021	N	O	O	15.00
15.01	Hospital-Based Health Clinic - RHC II	LOGANSPORT FAMILY HEALTH CARE	158563	99915		05/19/2021	N	O	O	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2023	12/31/2023	20.00
21.00	Type of Control (see instructions)	9		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N		22.00
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y		22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2024 12:38 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	409	249	0	0	1,407	78	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.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	1		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	01/01/2023	12/31/2023	36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.				57.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0072	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 12:38 pm

		V	XVIII	XIX	
		1.00	2.00	3.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 12:38 pm

				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2024 12:38 pm

					1.00	
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)					
68.00	For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?					68.00

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

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

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 12:38 pm

		V	XIX	
		1.00	2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	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?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
107.01	If this facility is a REH (line 3, column 4, is "12"), is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no. (see instructions)			107.01
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

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

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	725,284	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	Y	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	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.	Y	N	123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

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

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

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					1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.				N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.				N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.				N	149.00
		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
					1.00	
	Multicampus					
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00

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

			1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act			
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)		9.99	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 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: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 5/30/2024 12:38 pm

		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)	N			3.00

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	03/21/2024	Y	03/21/2024	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

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		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	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				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MICHAEL		ALESSANDRINI		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7959		MALESSANDRINI@BLUEANDCO.COM		43.00

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		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I Date/Time Prepared: 5/30/2024 12:38 pm

	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	32	11,680	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		32	11,680	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	5	1,825	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		37	13,505	0.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	EXPRESS MEDICAL CENTER	88.00				0	26.00
26.01	FAMILY HEALTH CARE	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		37				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		5	1,825			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2024 12:38 pm

	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)	869	409	3,379			1.00
2.00	HMO and other (see instructions)	515	1,656				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	869	409	3,379			7.00
8.00	INTENSIVE CARE UNIT	97	0	302			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	1,155			13.00
14.00	Total (see instructions)	966	409	4,836	0.00	536.17	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits	0	0	0			15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	EXPRESS MEDICAL CENTER	1,180	282	15,621	0.00	14.98	26.00
26.01	FAMILY HEALTH CARE	5,622	1,030	33,273	0.00	42.82	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	593.97	27.00
28.00	Observation Bed Days		41	1,132			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	78	440			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2024 12:38 pm

	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	306	108	1,393	1.00
2.00	HMO and other (see instructions)			141	413		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	306	108	1,393	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	EXPRESS MEDICAL CENTER	0.00					26.00
26.01	FAMILY HEALTH CARE	0.00					26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part II Date/Time Prepared: 5/30/2024 12:38 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	44,974,788	-334,622	44,640,166	1,212,479.00	36.82	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		824,047	0	824,047	4,115.00	200.25	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		7,623,146	0	7,623,146	46,268.00	164.76	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		5,212,403	0	5,212,403	121,019.00	43.07	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		4,248,777	-114,651	4,134,126	95,418.00	43.33	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,681,753	0	1,681,753	10,885.00	154.50	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		236,744	0	236,744	521.00	454.40	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		10,318,408	0	10,318,408			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		1,101,790	0	1,101,790			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		76,540	0	76,540			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		824,283	0	824,283			23.00
24.00	Wage-related costs (RHC/FQHC)		1,501,547	0	1,501,547			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part II | Date/Time Prepared: 5/30/2024 12:38 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	375,732	0	375,732	10,432.00	36.02	26.00
27.00	Administrative & General	5.00	4,489,285	-16,064	4,473,221	177,402.00	25.22	27.00
28.00	Administrative & General under contract (see inst.)		2,029,167	0	2,029,167	6,655.00	304.91	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	858,126	0	858,126	25,371.00	33.82	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	756,369	-8,185	748,184	42,688.00	17.53	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	467,837	-409,281	58,556	3,865.00	15.15	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	406,176	406,176	25,447.00	15.96	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	786,372	-14,243	772,129	13,732.00	56.23	38.00
39.00	Central Services and Supply	14.00	327,677	0	327,677	14,519.00	22.57	39.00
40.00	Pharmacy	15.00	756,189	-11,382	744,807	18,619.00	40.00	40.00
41.00	Medical Records & Medical Records Library	16.00	2,160,379	-44,535	2,115,844	79,420.00	26.64	41.00
42.00	Social Service	17.00	144,525	0	144,525	4,367.00	33.09	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part III Date/Time Prepared: 5/30/2024 12:38 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		34,168,406	-334,622	33,833,784	1,051,847.00	32.17	1.00
2.00	Excluded area salaries (see instructions)		4,248,777	-114,651	4,134,126	95,418.00	43.33	2.00
3.00	Subtotal salaries (line 1 minus line 2)		29,919,629	-219,971	29,699,658	956,429.00	31.05	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,918,497	0	1,918,497	11,406.00	168.20	4.00
5.00	Subtotal wage-related costs (see inst.)		10,394,948	0	10,394,948	0.00	35.00	5.00
6.00	Total (sum of lines 3 thru 5)		42,233,074	-219,971	42,013,103	967,835.00	43.41	6.00
7.00	Total overhead cost (see instructions)		13,151,658	-97,514	13,054,144	422,517.00	30.90	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part IV Date/Time Prepared: 5/30/2024 12:38 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	478,617	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	8,716,877	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	639,024	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	43,207	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	465,374	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	293,861	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	3,125,539	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	60,070	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	13,822,569	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part V Date/Time Prepared: 5/30/2024 12:38 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	1,681,753	13,822,569	1.00
2.00	Hospital	1,681,753	13,822,569	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I			17.00
18.00	Other	0	0	18.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0072 | Component CCN: 15-8561 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/30/2024 12:38 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			3400 E MARKET ST		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	LOGANSPORT		IN	46947	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	12:00	18:00	08:30	19:00	08:30	11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0	13.00
13.01	If line 13, column 1, is "Y", are you reporting multiple consolidated RHCs (as defined in CMS Pub. 100-02, chapter 13, section 80.2)? Enter "Y" for yes or "N" for no. If yes, enter in column 2 the number of consolidated RHC groupings and complete a separate Worksheet S-8 for each consolidated RHC grouping. Consolidated RHC groupings are comprised exclusively of grandfathered consolidated RHCs in the grouping or comprised exclusively of new consolidated RHCs in the grouping.	N	0	13.01

		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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-0072 Component CCN: 15-8561	Period: From 01/01/2023 To 12/31/2023	Worksheet S-8 Date/Time Prepared: 5/30/2024 12:38 pm
		RHC I	Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		CASS				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	19:00	08:30	19:00	08:30	19:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:30	19:00	10:00	18:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0072 | Component CCN: 15-8563 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/30/2024 12:38 pm

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1201 MICHIGAN AVE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	LOGANSPORT		IN	46947	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	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	12:00	18:00	08:30	19:00	08:30	11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0	13.00
13.01	If line 13, column 1, is "Y", are you reporting multiple consolidated RHCs (as defined in CMS Pub. 100-02, chapter 13, section 80.2)? Enter "Y" for yes or "N" for no. If yes, enter in column 2 the number of consolidated RHC groupings and complete a separate Worksheet S-8 for each consolidated RHC grouping. Consolidated RHC groupings are comprised exclusively of grandfathered consolidated RHCs in the grouping or comprised exclusively of new consolidated RHCs in the grouping.	N	0	13.01

		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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-0072 Component CCN: 15-8563	Period: From 01/01/2023 To 12/31/2023	Worksheet S-8 Date/Time Prepared: 5/30/2024 12:38 pm
		RHC II	Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County						2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	19:00	08:30	19:00	08:30	19:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:30	19:00	10:00	18:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 5/30/2024 12:38 pm

		1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.289802	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	7,665,176	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	54,567,945	6.00
7.00	Medicaid cost (line 1 times line 6)	15,813,900	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	8,148,724	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	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 (see instructions)	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)	8,148,724	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	1,582,490	0	1,582,490	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	458,609	0	458,609	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (see instructions)	458,609	0	458,609	23.00

		1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
25.01	Charges for insured patients' liability (see instructions)	0	25.01
26.00	Bad debt amount (see instructions)	7,751,252	26.00
27.00	Medicare reimbursable bad debts (see instructions)	203,498	27.00
27.01	Medicare allowable bad debts (see instructions)	313,073	27.01
28.00	Non-Medicare bad debt amount (see instructions)	7,438,179	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	2,265,174	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	2,723,783	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	10,872,507	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 5/30/2024 12:38 pm

		1.00	
	PART II - HOSPITAL DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.267505	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		5.00
6.00	Medicaid charges		6.00
7.00	Medicaid cost (line 1 times line 6)		7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)		8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP		9.00
10.00	Stand-alone CHIP charges		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)		12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)		16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	1,582,490	0	1,582,490	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	423,324	0	423,324	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (see instructions)	423,324	0	423,324	23.00

		1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
25.01	Charges for insured patients' liability (see instructions)	0	25.01
26.00	Bad debt amount (see instructions)	7,751,252	26.00
27.00	Medicare reimbursable bad debts (see instructions)	203,498	27.00
27.01	Medicare allowable bad debts (see instructions)	313,073	27.01
28.00	Non-Medicare bad debt amount (see instructions)	7,438,179	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	2,099,325	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	2,522,649	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,522,649	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/30/2024 12:38 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		8,047,663	8,047,663	-1,135,265	6,912,398	1.00
1.01	00101	MOB		0	0	223,692	223,692	1.01
1.02	00102	OPS		0	0	147,326	147,326	1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	375,732	14,060,811	14,436,543	334,622	14,771,165	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,489,285	11,074,405	15,563,690	574,071	16,137,761	5.00
7.00	00700	OPERATION OF PLANT	858,126	1,737,709	2,595,835	263,333	2,859,168	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	227,010	227,010	0	227,010	8.00
9.00	00900	HOUSEKEEPING	756,369	150,027	906,396	-8,185	898,211	9.00
10.00	01000	DIETARY	467,837	386,689	854,526	-745,004	109,522	10.00
11.00	01100	CAFETERIA	0	0	0	741,899	741,899	11.00
13.00	01300	NURSING ADMINISTRATION	786,372	77,450	863,822	-14,243	849,579	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	327,677	272,493	600,170	-65,179	534,991	14.00
15.00	01500	PHARMACY	756,189	710,187	1,466,376	-11,382	1,454,994	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,160,379	3,534,536	5,694,915	-50,153	5,644,762	16.00
17.00	01700	SOCIAL SERVICE	144,525	35,313	179,838	0	179,838	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,559,329	266,995	4,826,324	-1,140,445	3,685,879	30.00
31.00	03100	INTENSIVE CARE UNIT	719,982	30,131	750,113	-5,341	744,772	31.00
43.00	04300	NURSERY	0	90	90	402,627	402,717	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,301,518	2,096,966	8,398,484	-24,674	8,373,810	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	677,322	677,322	52.00
53.00	05300	ANESTHESIOLOGY	0	2,600,387	2,600,387	0	2,600,387	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,557,304	1,011,309	2,568,613	-5,971	2,562,642	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	4,250,663	4,250,663	0	4,250,663	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	151,083	151,083	0	151,083	63.00
65.00	06500	RESPIRATORY THERAPY	814,190	105,293	919,483	-8,290	911,193	65.00
66.00	06600	PHYSICAL THERAPY	889,506	34,477	923,983	-9,528	914,455	66.00
69.00	06900	ELECTROCARDIOLOGY	343,014	133,607	476,621	0	476,621	69.00
69.01	06901	CARDIAC REHAB	349,266	16,707	365,973	-221	365,752	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,809,926	3,809,926	-946,990	2,862,936	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	946,990	946,990	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,070,817	11,070,817	0	11,070,817	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	282,579	480,187	762,766	-4,969	757,797	76.00
76.01	03480	ONCOLOGY	788,374	2,218,348	3,006,722	-5,207	3,001,515	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EXPRESS MEDICAL CENTER	1,379,215	286,877	1,666,092	207,316	1,873,408	88.00
88.01	08801	FAMILY HEALTH CARE	3,793,781	204,675	3,998,456	-184,328	3,814,128	88.01
90.00	09000	CLINIC	4,842,621	1,566,238	6,408,859	-25,064	6,383,795	90.00
90.01	09001	WOUND CARE	246,076	666,269	912,345	0	912,345	90.01
90.02	09002	INTERNAL MEDICINE	59,631	442,338	501,969	0	501,969	90.02
90.03	09003	PODIATRY CLINIC	640,352	134,461	774,813	-2,145	772,668	90.03
91.00	09100	EMERGENCY	2,036,782	1,195,429	3,232,211	-11,963	3,220,248	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	40,726,011	73,087,566	113,813,577	114,651	113,928,228	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	0	2,250	2,250	0	2,250	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	421,074	131,305	552,379	0	552,379	194.04
194.05	07955	PHYSICIANS OFFICE	3,371,385	1,823,846	5,195,231	-109,340	5,085,891	194.05
194.06	07956	THE ARBORS	0	0	0	0	0	194.06
194.07	07957	PAIN MANAGEMENT	0	0	0	0	0	194.07
194.08	07958	OPS	0	0	0	0	0	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	255,019	35,123	290,142	0	290,142	194.09
194.10	07961	RHEUMATOLOGY	0	0	0	0	0	194.10
194.11	07960	SPORTS HEALTH	201,299	24,261	225,560	-5,311	220,249	194.11
194.12	07962	BEHAVIORAL HEALTH CLINIC	0	3,266	3,266	0	3,266	194.12
200.00		TOTAL (SUM OF LINES 118 through 199)	44,974,788	75,107,617	120,082,405	0	120,082,405	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/30/2024 12:38 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-430,121	6,482,277		1.00
1.01	00101	MOB	0	223,692		1.01
1.02	00102	OPS	0	147,326		1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-92,989	14,678,176		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-6,569,930	9,567,831		5.00
7.00	00700	OPERATION OF PLANT	-9,886	2,849,282		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	227,010		8.00
9.00	00900	HOUSEKEEPING	0	898,211		9.00
10.00	01000	DIETARY	-46,226	63,296		10.00
11.00	01100	CAFETERIA	-4,399	737,500		11.00
13.00	01300	NURSING ADMINISTRATION	-2,751	846,828		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-191,556	343,435		14.00
15.00	01500	PHARMACY	0	1,454,994		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-20,126	5,624,636		16.00
17.00	01700	SOCIAL SERVICE	-2,899	176,939		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,426,524	2,259,355		30.00
31.00	03100	INTENSIVE CARE UNIT	0	744,772		31.00
43.00	04300	NURSERY	0	402,717		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-4,391,835	3,981,975		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	677,322		52.00
53.00	05300	ANESTHESIOLOGY	-2,597,109	3,278		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-66,235	2,496,407		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	4,250,663		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	151,083		63.00
65.00	06500	RESPIRATORY THERAPY	0	911,193		65.00
66.00	06600	PHYSICAL THERAPY	0	914,455		66.00
69.00	06900	ELECTROCARDIOLOGY	0	476,621		69.00
69.01	06901	CARDIAC REHAB	0	365,752		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,862,936		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	946,990		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-489,661	10,581,156		73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	757,797		76.00
76.01	03480	ONCOLOGY	-1,819,751	1,181,764		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	EXPRESS MEDICAL CENTER	-463	1,872,945		88.00
88.01	08801	FAMILY HEALTH CARE	0	3,814,128		88.01
90.00	09000	CLINIC	-5,273,133	1,110,662		90.00
90.01	09001	WOUND CARE	-671,896	240,449		90.01
90.02	09002	INTERNAL MEDICINE	-438,068	63,901		90.02
90.03	09003	PODIATRY CLINIC	-491,215	281,453		90.03
91.00	09100	EMERGENCY	-1,005,122	2,215,126		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-26,041,895	87,886,333		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07950	FOUNDATION	0	2,250		194.00
194.01	07951	MOB	0	0		194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0		194.02
194.03	07953	PIH	0	0		194.03
194.04	07954	HEALTH COMPANIES	-136,606	415,773		194.04
194.05	07955	PHYSICIANS OFFICE	-3,404,751	1,681,140		194.05
194.06	07956	THE ARBORS	0	0		194.06
194.07	07957	PAIN MANAGEMENT	0	0		194.07
194.08	07958	OPS	0	0		194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	-164,880	125,262		194.09
194.10	07961	RHEUMATOLOGY	0	0		194.10
194.11	07960	SPORTS HEALTH	-11,000	209,249		194.11
194.12	07962	BEHAVIORAL HEALTH CLINIC	-2,353	913		194.12
200.00		TOTAL (SUM OF LINES 118 through 199)	-29,761,485	90,320,920		200.00

RECLASSIFICATIONS | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/30/2024 12:38 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	406,176	335,723		1.00
	0		406,176	335,723		
	B - OB RECLASS					
1.00	NURSERY	43.00	372,883	29,744		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	627,142	50,180		2.00
	0		1,000,025	79,924		
	C - MALPRACTICE INS. RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	764,247		1.00
	0		0	764,247		
	D - IMPLANT EXPENSE RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	946,990		1.00
	0		0	946,990		
	E - UTILITIES RECLASS					
1.00	OPERATION OF PLANT	7.00	0	263,333		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
	0		0	263,333		
	F - DEPRECIATION RECLASS					
1.00	MOB	1.01	0	223,692		1.00
2.00	OPS	1.02	0	147,326		2.00
	0		0	371,018		
	G - SHORT TERM DISABILITY RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	334,622		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
	0		0	334,622		
	H - RHC EXPENSE ALLOCATION RECLASS					
1.00	EXPRESS MEDICAL CENTER	88.00	230,898	0		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	0		230,898	0		
500.00	Grand Total: Increases		1,637,099	3,095,857		500.00

RECLASSIFICATIONS | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/30/2024 12:38 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	406,176	335,723	0		1.00
	0		406,176	335,723			
	B - OB RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	1,000,025	79,924	0		1.00
2.00		0.00	0	0	0		2.00
	0		1,000,025	79,924			
	C - MALPRACTICE INS. RECLASS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	764,247	12		1.00
	0		0	764,247			
	D - IMPLANT EXPENSE RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	946,990	0		1.00
	0		0	946,990			
	E - UTILITIES RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	174,112	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	65,179	0		2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	0	5,618	0		3.00
4.00	OPERATING ROOM	50.00	0	2,005	0		4.00
5.00	EXPRESS MEDICAL CENTER	88.00	0	16,419	0		5.00
	0		0	263,333			
	F - DEPRECIATION RECLASS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	371,018	9		1.00
2.00		0.00	0	0	9		2.00
	0		0	371,018			
	G - SHORT TERM DISABILITY RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	16,064	0	0		1.00
2.00	HOUSEKEEPING	9.00	8,185	0	0		2.00
3.00	DIETARY	10.00	3,105	0	0		3.00
4.00	NURSING ADMINISTRATION	13.00	14,243	0	0		4.00
5.00	PHARMACY	15.00	11,382	0	0		5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	44,535	0	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	49,862	0	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	5,341	0	0		8.00
9.00	OPERATING ROOM	50.00	22,669	0	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	5,971	0	0		10.00
11.00	RESPIRATORY THERAPY	65.00	8,290	0	0		11.00
12.00	PHYSICAL THERAPY	66.00	9,528	0	0		12.00
13.00	CARDIAC REHAB	69.01	221	0	0		13.00
14.00	NUCLEAR MEDICINE - DIAGNOSTIC	76.00	4,969	0	0		14.00
15.00	ONCOLOGY	76.01	5,207	0	0		15.00
16.00	EXPRESS MEDICAL CENTER	88.00	7,163	0	0		16.00
17.00	FAMILY HEALTH CARE	88.01	14,099	0	0		17.00
18.00	CLINIC	90.00	25,064	0	0		18.00
19.00	PODIATRY CLINIC	90.03	2,145	0	0		19.00
20.00	EMERGENCY	91.00	11,963	0	0		20.00
21.00	SPORTS HEALTH	194.11	5,311	0	0		21.00
22.00	PHYSICIANS OFFICE	194.05	59,305	0	0		22.00
	0		334,622	0			
	H - RHC EXPENSE ALLOCATION RECLASS						
1.00	FAMILY HEALTH CARE	88.01	170,229	0	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	10,634	0	0		2.00
3.00	PHYSICIANS OFFICE	194.05	50,035	0	0		3.00
	0		230,898	0			
500.00	Grand Total: Decreases		1,971,721	2,761,235			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 5/30/2024 12:38 pm

		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	205,783	0	0	0	0	1.00
2.00	Land Improvements	877,017	153,040	0	153,040	0	2.00
3.00	Buildings and Fixtures	71,731,022	141,250	0	141,250	0	3.00
4.00	Building Improvements	3,937,902	266,410	0	266,410	0	4.00
5.00	Fixed Equipment	7,812,025	0	0	0	0	5.00
6.00	Movable Equipment	36,264,848	774,917	0	774,917	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	120,828,597	1,335,617	0	1,335,617	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	120,828,597	1,335,617	0	1,335,617	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	205,783	0	1.00
2.00	Land Improvements	1,030,057	0	2.00
3.00	Buildings and Fixtures	71,872,272	0	3.00
4.00	Building Improvements	4,204,312	0	4.00
5.00	Fixed Equipment	7,812,025	0	5.00
6.00	Movable Equipment	37,039,765	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	122,164,214	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	122,164,214	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part II | Date/Time Prepared: 5/30/2024 12:38 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	5,763,173	0	1,344,407	940,083	0	1.00
1.01	MOB	0	0	0	0	0	1.01
1.02	OPS	0	0	0	0	0	1.02
3.00	Total (sum of lines 1-2)	5,763,173	0	1,344,407	940,083	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	8,047,663	1.00
1.01	MOB	0	0	1.01
1.02	OPS	0	0	1.02
3.00	Total (sum of lines 1-2)	0	8,047,663	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part III | Date/Time Prepared: 5/30/2024 12:38 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	122,164,214	0	122,164,214	1.000000	0	1.00
1.01	MOB	0	0	0	0.000000	0	1.01
1.02	OPS	0	0	0	0.000000	0	1.02
3.00	Total (sum of lines 1-2)	122,164,214	0	122,164,214	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	5,370,246	0	1.00
1.01	MOB	0	0	0	223,692	0	1.01
1.02	OPS	0	0	0	147,326	0	1.02
3.00	Total (sum of lines 1-2)	0	0	0	5,741,264	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	936,195	175,836	0	0	6,482,277	1.00
1.01	MOB	0	0	0	0	223,692	1.01
1.02	OPS	0	0	0	0	147,326	1.02
3.00	Total (sum of lines 1-2)	936,195	175,836	0	0	6,853,295	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/30/2024 12:38 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - MOB (chapter 2)		0	MOB	1.01	0	1.01
1.02	Investment income - OPS (chapter 2)		0	OPS	1.02	0	1.02
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-191,556	CENTRAL SERVICES & SUPPLY	14.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-17,993,466			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	A	0	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	A	-4,399	CAFETERIA	11.00	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
26.01	Depreciation - MOB		0	MOB	1.01	0	26.01
26.02	Depreciation - OPS		0	OPS	1.02	0	26.02
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/30/2024 12:38 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER REVENUE - MISCELLANEOUS	B	-3,043	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	OTHER REVENUE - CPR TRAINING	B	-2,751	NURSING ADMINISTRATION	13.00	0	34.00
34.01	EXPRESS MED	B	-463	EXPRESS MEDICAL CENTER	88.00	0	34.01
35.00	CLINIC	B	-20,986	CLINIC	90.00	0	35.00
35.01	HIM MEDICAL RECORDS FEES	B	-20,126	MEDICAL RECORDS & LIBRARY	16.00	0	35.01
35.02	OTHER REVENUE - MED/SURGICAL SERVICE	B	-3,700	ADULTS & PEDIATRICS	30.00	0	35.02
35.03	DRUGS CHARGED TO PATIENTS	B	-24,910	DRUGS CHARGED TO PATIENTS	73.00	0	35.03
37.00	INTEREST INCOME	B	-408,212	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	37.00
38.00	DIETARY REVENUE	B	-46,226	DIETARY	10.00	0	38.00
39.00	PATIENT TELEVISIONS	A	-1,112	OPERATION OF PLANT	7.00	0	39.00
40.00	PATIENT TELEPHONES	A	-3,559	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.00
41.00	PATIENT TELEPHONES	A	-2,138	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	41.00
45.00	PATIENT TELEPHONES	A	-1,750	ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.01	IHA & AHA LOBBYING FEES	A	-9,635	ADMINISTRATIVE & GENERAL	5.00	0	45.01
45.02	GIFT SHOP	A	-19,771	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	45.02
45.03	GIFT SHOP	A	-8,774	OPERATION OF PLANT	7.00	0	45.03
45.04	ADVERTISING	A	-545,233	ADMINISTRATIVE & GENERAL	5.00	0	45.04
45.05	TAXES	A	-59,311	ADMINISTRATIVE & GENERAL	5.00	0	45.05
45.06	DONATION EXPENSE	A	-52,865	ADMINISTRATIVE & GENERAL	5.00	0	45.06
45.07	PHYSICIAN RECRUITMENT	A	-145,487	ADMINISTRATIVE & GENERAL	5.00	0	45.07
45.08	HOSPITAL ASSESSMENT FEE OFFSET	A	-5,745,553	ADMINISTRATIVE & GENERAL	5.00	0	45.08
45.09	HOSPITALIST OFFSET	A	-172,688	ADULTS & PEDIATRICS	30.00	0	45.09
45.10	HOSPITALIST OFFSET	A	-89,430	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.10
45.12	340B OFFSET	A	-464,751	DRUGS CHARGED TO PATIENTS	73.00	0	45.12
45.13	PROFESSIONAL OFFSET	A	-136,606	HEALTH COMPANIES	194.04	0	45.13
45.14	PROFESSIONAL OFFSET	A	-3,404,751	PHYSICIANS OFFICE	194.05	0	45.14
45.15	PROFESSIONAL OFFSET	A	-164,880	MHL ROCHESTER HEALTH CENTER	194.09	0	45.15
45.16	PROFESSIONAL OFFSET	A	-11,000	SPORTS HEALTH	194.11	0	45.16
45.17	PROFESSIONAL OFFSET	A	-2,353	BEHAVIORAL HEALTH CLINIC	194.12	0	45.17
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-29,761,485				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 5/30/2024 12:38 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	22,000	0	22,000	211,500	147	1.00
2.00	17.00	SOCIAL SERVICE	9,000	0	9,000	211,500	60	2.00
3.00	30.00	ADULTS & PEDIATRICS	1,250,136	1,250,136	0	211,500	0	3.00
4.00	50.00	OPERATING ROOM	4,470,375	4,204,641	265,734	246,400	663	4.00
5.00	53.00	ANESTHESIOLOGY	2,597,109	2,597,109	0	211,500	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	205,744	0	205,744	211,500	1,372	6.00
7.00	76.01	ONCOLOGY	1,819,751	1,819,751	0	211,500	0	7.00
8.00	90.00	CLINIC	5,603,156	4,856,620	746,536	211,500	3,452	8.00
9.00	90.01	WOUND CARE	671,896	671,896	0	211,500	0	9.00
10.00	90.02	INTERNAL MEDICINE	438,068	438,068	0	211,500	0	10.00
11.00	90.03	PODIATRY CLINIC	491,215	491,215	0	211,500	0	11.00
12.00	91.00	EMERGENCY	1,005,122	1,005,122	0	211,500	0	12.00
200.00			18,583,572	17,334,558	1,249,014		5,694	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	14,947	747	0	0	0	1.00
2.00	17.00	SOCIAL SERVICE	6,101	305	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	78,540	3,927	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	139,509	6,975	0	0	0	6.00
7.00	76.01	ONCOLOGY	0	0	0	0	0	7.00
8.00	90.00	CLINIC	351,009	17,550	0	0	0	8.00
9.00	90.01	WOUND CARE	0	0	0	0	0	9.00
10.00	90.02	INTERNAL MEDICINE	0	0	0	0	0	10.00
11.00	90.03	PODIATRY CLINIC	0	0	0	0	0	11.00
12.00	91.00	EMERGENCY	0	0	0	0	0	12.00
200.00			590,106	29,504	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	14,947	7,053	7,053		1.00
2.00	17.00	SOCIAL SERVICE	0	6,101	2,899	2,899		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,250,136		3.00
4.00	50.00	OPERATING ROOM	0	78,540	187,194	4,391,835		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	2,597,109		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	139,509	66,235	66,235		6.00
7.00	76.01	ONCOLOGY	0	0	0	1,819,751		7.00
8.00	90.00	CLINIC	0	351,009	395,527	5,252,147		8.00
9.00	90.01	WOUND CARE	0	0	0	671,896		9.00
10.00	90.02	INTERNAL MEDICINE	0	0	0	438,068		10.00
11.00	90.03	PODIATRY CLINIC	0	0	0	491,215		11.00
12.00	91.00	EMERGENCY	0	0	0	1,005,122		12.00
200.00			0	590,106	658,908	17,993,466		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/30/2024 12:38 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
				NEW BLDG & FIXT	MOB	OPS		
			0	1.00	1.01	1.02	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	6,482,277	6,482,277				1.00
1.01	00101	MOB	223,692	0	223,692			1.01
1.02	00102	OPS	147,326	0	0	147,326		1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	14,678,176	40,737	6,105	0	14,725,018	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,567,831	518,331	27,407	0	1,488,062	5.00
7.00	00700	OPERATION OF PLANT	2,849,282	1,181,231	1,322	11,704	285,464	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	227,010	20,700	0	0	0	8.00
9.00	00900	HOUSEKEEPING	898,211	46,343	12,264	432	248,891	9.00
10.00	01000	DIETARY	63,296	196,153	0	0	19,479	10.00
11.00	01100	CAFETERIA	737,500	94,809	0	0	135,119	11.00
13.00	01300	NURSING ADMINISTRATION	846,828	73,545	0	0	256,856	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	343,435	136,906	0	0	109,005	14.00
15.00	01500	PHARMACY	1,454,994	69,763	0	0	247,767	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,624,636	246,975	0	0	703,857	16.00
17.00	01700	SOCIAL SERVICE	176,939	41,201	0	0	48,078	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,259,355	1,125,036	0	0	1,163,913	30.00
31.00	03100	INTENSIVE CARE UNIT	744,772	175,254	0	0	237,732	31.00
43.00	04300	NURSERY	402,717	8,625	0	0	124,043	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,981,975	646,446	0	33,560	2,088,735	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	677,322	172,136	0	0	208,625	52.00
53.00	05300	ANESTHESIOLOGY	3,278	68,237	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,496,407	299,488	0	8,309	516,066	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	4,250,663	160,459	6,686	3,875	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	151,083	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	911,193	11,412	0	0	268,091	65.00
66.00	06600	PHYSICAL THERAPY	914,455	183,315	0	0	292,733	66.00
69.00	06900	ELECTROCARDIOLOGY	476,621	15,890	14,069	0	114,107	69.00
69.01	06901	CARDIAC REHAB	365,752	184,543	0	0	116,113	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,862,936	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	946,990	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,581,156	0	0	0	0	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	757,797	24,316	0	0	92,350	76.00
76.01	03480	ONCOLOGY	1,181,764	0	0	48,216	260,528	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EXPRESS MEDICAL CENTER	1,872,945	0	0	0	533,237	88.00
88.01	08801	FAMILY HEALTH CARE	3,814,128	0	56,191	0	1,200,721	88.01
90.00	09000	CLINIC	1,110,662	6,966	50,682	0	1,602,609	90.00
90.01	09001	WOUND CARE	240,449	0	13,611	0	81,860	90.01
90.02	09002	INTERNAL MEDICINE	63,901	0	0	0	19,837	90.02
90.03	09003	PODIATRY CLINIC	281,453	0	10,708	0	212,306	90.03
91.00	09100	EMERGENCY	2,215,126	508,247	0	0	673,576	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	87,886,333	6,257,064	199,045	106,096	13,349,760	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	2,250	0	0	0	0	194.00
194.01	07951	MOB	0	0	7,362	0	0	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	415,773	75,801	0	0	140,074	194.04
194.05	07955	PHYSICIANS OFFICE	1,681,140	149,412	17,285	0	1,085,152	194.05
194.06	07956	THE ARBORS	0	0	0	0	0	194.06
194.07	07957	PAIN MANAGEMENT	0	0	0	0	0	194.07
194.08	07958	OPS	0	0	0	41,230	0	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	125,262	0	0	0	84,835	194.09
194.10	07961	RHEUMATOLOGY	0	0	0	0	0	194.10
194.11	07960	SPORTS HEALTH	209,249	0	0	0	65,197	194.11
194.12	07962	BEHAVIORAL HEALTH CLINIC	913	0	0	0	0	194.12
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	90,320,920	6,482,277	223,692	147,326	14,725,018	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/30/2024 12:38 pm

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4A	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	OPS						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,601,631	11,601,631				5.00
7.00	00700	OPERATION OF PLANT	4,329,003	638,008	4,967,011			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	247,710	36,507	15,018	299,235		8.00
9.00	00900	HOUSEKEEPING	1,206,141	177,761	94,944	0	1,478,846	9.00
10.00	01000	DIETARY	278,928	41,108	142,308	2,686	0	10.00
11.00	01100	CAFETERIA	967,428	142,580	68,783	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,177,229	173,500	53,356	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	589,346	86,858	99,324	0	5,052	14.00
15.00	01500	PHARMACY	1,772,524	261,235	50,613	0	5,052	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,575,468	969,092	179,179	0	0	16.00
17.00	01700	SOCIAL SERVICE	266,218	39,235	29,891	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,548,304	670,329	816,208	104,796	248,788	30.00
31.00	03100	INTENSIVE CARE UNIT	1,157,758	170,630	127,146	7,501	75,773	31.00
43.00	04300	NURSERY	535,385	78,905	6,257	424	2,526	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,750,716	994,921	620,542	83,698	239,949	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,058,083	155,940	124,883	0	41,675	52.00
53.00	05300	ANESTHESIOLOGY	71,515	10,540	49,506	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,320,270	489,341	254,797	26,433	50,516	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	4,421,683	651,668	166,279	0	25,258	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	151,083	22,267	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,190,696	175,485	8,279	0	25,258	65.00
66.00	06600	PHYSICAL THERAPY	1,390,503	204,932	132,994	6,429	50,516	66.00
69.00	06900	ELECTROCARDIOLOGY	620,687	91,477	79,638	0	64,407	69.00
69.01	06901	CARDIAC REHAB	666,408	98,215	133,884	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,862,936	421,940	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	946,990	139,567	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,581,156	1,559,435	0	0	0	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	874,463	128,878	17,641	0	0	76.00
76.01	03480	ONCOLOGY	1,490,508	219,671	217,734	0	55,567	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EXPRESS MEDICAL CENTER	2,406,182	354,623	0	0	0	88.00
88.01	08801	FAMILY HEALTH CARE	5,071,040	747,370	272,029	0	101,031	88.01
90.00	09000	CLINIC	2,770,919	408,378	250,417	0	138,918	90.00
90.01	09001	WOUND CARE	335,920	49,508	65,895	0	50,516	90.01
90.02	09002	INTERNAL MEDICINE	83,738	12,341	0	0	0	90.02
90.03	09003	PODIATRY CLINIC	504,467	74,348	51,840	0	0	90.03
91.00	09100	EMERGENCY	3,396,949	500,642	368,730	67,268	133,867	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
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	86,219,985	10,997,235	4,498,115	299,235	1,314,669	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	2,250	332	0	0	12,629	194.00
194.01	07951	MOB	7,362	1,085	35,643	0	0	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	631,648	93,092	54,993	0	37,887	194.04
194.05	07955	PHYSICIANS OFFICE	2,932,989	432,264	192,078	0	50,516	194.05
194.06	07956	THE ARBORS	0	0	0	0	0	194.06
194.07	07957	PAIN MANAGEMENT	0	0	0	0	0	194.07
194.08	07958	OPS	41,230	6,076	186,182	0	63,145	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	210,097	30,964	0	0	0	194.09
194.10	07961	RHEUMATOLOGY	0	0	0	0	0	194.10
194.11	07960	SPORTS HEALTH	274,446	40,448	0	0	0	194.11
194.12	07962	BEHAVIORAL HEALTH CLINIC	913	135	0	0	0	194.12
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	90,320,920	11,601,631	4,967,011	299,235	1,478,846	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/30/2024 12:38 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	OPS						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	465,030					10.00
11.00	01100	CAFETERIA	0	1,178,791				11.00
13.00	01300	NURSING ADMINISTRATION	0	14,106	1,418,191			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	19,258	0	799,838		14.00
15.00	01500	PHARMACY	0	24,693	0	0	2,114,117	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	105,331	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	5,791	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	438,295	143,932	474,406	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	26,735	31,941	94,969	0	0	31.00
43.00	04300	NURSERY	0	12,832	38,152	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	173,036	514,483	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	21,583	64,171	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	57,911	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	27,704	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	34,360	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	11,559	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	10,300	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	799,838	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	2,114,117	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	11,698	0	0	0	76.00
76.01	03480	ONCOLOGY	0	36,030	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EXPRESS MEDICAL CENTER	0	0	0	0	0	88.00
88.01	08801	FAMILY HEALTH CARE	0	118,127	0	0	0	88.01
90.00	09000	CLINIC	0	116,378	0	0	0	90.00
90.01	09001	WOUND CARE	0	8,430	0	0	0	90.01
90.02	09002	INTERNAL MEDICINE	0	2,533	0	0	0	90.02
90.03	09003	PODIATRY CLINIC	0	10,166	0	0	0	90.03
91.00	09100	EMERGENCY	0	78,032	232,010	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
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	465,030	1,075,731	1,418,191	799,838	2,114,117	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	0	19,299	0	0	0	194.04
194.05	07955	PHYSICIANS OFFICE	0	69,948	0	0	0	194.05
194.06	07956	THE ARBORS	0	0	0	0	0	194.06
194.07	07957	PAIN MANAGEMENT	0	0	0	0	0	194.07
194.08	07958	OPS	0	0	0	0	0	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	0	0	0	0	0	194.09
194.10	07961	RHEUMATOLOGY	0	0	0	0	0	194.10
194.11	07960	SPORTS HEALTH	0	13,813	0	0	0	194.11
194.12	07962	BEHAVIORAL HEALTH CLINIC	0	0	0	0	0	194.12
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)	465,030	1,178,791	1,418,191	799,838	2,114,117	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/30/2024 12:38 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	OPS						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,829,070					16.00
17.00	01700	SOCIAL SERVICE	0	341,135				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	475,204	296,151	8,216,413	0	8,216,413	30.00
31.00	03100	INTENSIVE CARE UNIT	79,200	24,068	1,795,721	0	1,795,721	31.00
43.00	04300	NURSERY	55,921	0	730,402	0	730,402	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,057,708	0	11,435,053	0	11,435,053	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	1,466,335	0	1,466,335	52.00
53.00	05300	ANESTHESIOLOGY	100,643	0	232,204	0	232,204	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	565,169	0	4,764,437	0	4,764,437	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	966,909	0	6,231,797	0	6,231,797	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	14,642	0	187,992	0	187,992	63.00
65.00	06500	RESPIRATORY THERAPY	296,723	0	1,724,145	0	1,724,145	65.00
66.00	06600	PHYSICAL THERAPY	145,379	0	1,965,113	0	1,965,113	66.00
69.00	06900	ELECTROCARDIOLOGY	157,830	0	1,025,598	0	1,025,598	69.00
69.01	06901	CARDIAC REHAB	17,624	0	926,431	0	926,431	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	4,084,714	0	4,084,714	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	1,086,557	0	1,086,557	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	14,254,708	0	14,254,708	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	469,829	0	1,502,509	0	1,502,509	76.00
76.01	03480	ONCOLOGY	479,026	0	2,498,536	0	2,498,536	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EXPRESS MEDICAL CENTER	119,170	0	2,879,975	0	2,879,975	88.00
88.01	08801	FAMILY HEALTH CARE	214,882	0	6,524,479	0	6,524,479	88.01
90.00	09000	CLINIC	321,725	0	4,006,735	0	4,006,735	90.00
90.01	09001	WOUND CARE	145,544	0	655,813	0	655,813	90.01
90.02	09002	INTERNAL MEDICINE	28,891	0	127,503	0	127,503	90.02
90.03	09003	PODIATRY CLINIC	57,918	0	698,739	0	698,739	90.03
91.00	09100	EMERGENCY	815,401	20,916	5,613,815	0	5,613,815	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
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,585,338	341,135	84,635,724	0	84,635,724	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	0	0	15,211	0	15,211	194.00
194.01	07951	MOB	0	0	44,090	0	44,090	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	0	0	836,919	0	836,919	194.04
194.05	07955	PHYSICIANS OFFICE	235,076	0	3,912,871	0	3,912,871	194.05
194.06	07956	THE ARBORS	0	0	0	0	0	194.06
194.07	07957	PAIN MANAGEMENT	0	0	0	0	0	194.07
194.08	07958	OPS	0	0	296,633	0	296,633	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	8,656	0	249,717	0	249,717	194.09
194.10	07961	RHEUMATOLOGY	0	0	0	0	0	194.10
194.11	07960	SPORTS HEALTH	0	0	328,707	0	328,707	194.11
194.12	07962	BEHAVIORAL HEALTH CLINIC	0	0	1,048	0	1,048	194.12
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,829,070	341,135	90,320,920	0	90,320,920	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/30/2024 12:38 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS MOB	CAPITAL RELATED COSTS OPS	CAPITAL RELATED COSTS Subtotal	
			0	1.00	1.01	1.02	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	OPS						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	40,737	6,105	0	46,842	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	518,331	27,407	0	545,738	5.00
7.00	00700	OPERATION OF PLANT	0	1,181,231	1,322	11,704	1,194,257	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	20,700	0	0	20,700	8.00
9.00	00900	HOUSEKEEPING	0	46,343	12,264	432	59,039	9.00
10.00	01000	DIETARY	0	196,153	0	0	196,153	10.00
11.00	01100	CAFETERIA	0	94,809	0	0	94,809	11.00
13.00	01300	NURSING ADMINISTRATION	0	73,545	0	0	73,545	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	136,906	0	0	136,906	14.00
15.00	01500	PHARMACY	0	69,763	0	0	69,763	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	246,975	0	0	246,975	16.00
17.00	01700	SOCIAL SERVICE	0	41,201	0	0	41,201	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,125,036	0	0	1,125,036	30.00
31.00	03100	INTENSIVE CARE UNIT	0	175,254	0	0	175,254	31.00
43.00	04300	NURSERY	0	8,625	0	0	8,625	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	646,446	0	33,560	680,006	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	172,136	0	0	172,136	52.00
53.00	05300	ANESTHESIOLOGY	0	68,237	0	0	68,237	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	299,488	0	8,309	307,797	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	160,459	6,686	3,875	171,020	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	11,412	0	0	11,412	65.00
66.00	06600	PHYSICAL THERAPY	0	183,315	0	0	183,315	66.00
69.00	06900	ELECTROCARDIOLOGY	0	15,890	14,069	0	29,959	69.00
69.01	06901	CARDIAC REHAB	0	184,543	0	0	184,543	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	24,316	0	0	24,316	76.00
76.01	03480	ONCOLOGY	0	0	0	48,216	48,216	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EXPRESS MEDICAL CENTER	0	0	0	0	0	88.00
88.01	08801	FAMILY HEALTH CARE	0	0	56,191	0	56,191	88.01
90.00	09000	CLINIC	0	6,966	50,682	0	57,648	90.00
90.01	09001	WOUND CARE	0	0	13,611	0	13,611	90.01
90.02	09002	INTERNAL MEDICINE	0	0	0	0	0	90.02
90.03	09003	PODIATRY CLINIC	0	0	10,708	0	10,708	90.03
91.00	09100	EMERGENCY	0	508,247	0	0	508,247	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
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	6,257,064	199,045	106,096	6,562,205	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	7,362	0	7,362	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	0	75,801	0	0	75,801	194.04
194.05	07955	PHYSICIANS OFFICE	0	149,412	17,285	0	166,697	194.05
194.06	07956	THE ARBORS	0	0	0	0	0	194.06
194.07	07957	PAIN MANAGEMENT	0	0	0	0	0	194.07
194.08	07958	OPS	0	0	0	41,230	41,230	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	0	0	0	0	0	194.09
194.10	07961	RHEUMATOLOGY	0	0	0	0	0	194.10
194.11	07960	SPORTS HEALTH	0	0	0	0	0	194.11
194.12	07962	BEHAVIORAL HEALTH CLINIC	0	0	0	0	0	194.12
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	6,482,277	223,692	147,326	6,853,295	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/30/2024 12:38 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4.00	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	OPS						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	46,842					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,733	550,471				5.00
7.00	00700	OPERATION OF PLANT	908	30,273	1,225,438			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,732	3,705	26,137		8.00
9.00	00900	HOUSEKEEPING	792	8,435	23,424	0	91,690	9.00
10.00	01000	DIETARY	62	1,951	35,110	235	0	10.00
11.00	01100	CAFETERIA	430	6,765	16,970	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	817	8,232	13,164	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	347	4,121	24,505	0	313	14.00
15.00	01500	PHARMACY	788	12,395	12,487	0	313	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,239	45,982	44,206	0	0	16.00
17.00	01700	SOCIAL SERVICE	153	1,862	7,375	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,702	31,806	201,369	9,152	15,426	30.00
31.00	03100	INTENSIVE CARE UNIT	756	8,096	31,369	655	4,698	31.00
43.00	04300	NURSERY	395	3,744	1,544	37	157	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,651	47,208	153,097	7,311	14,877	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	664	7,399	30,811	0	2,584	52.00
53.00	05300	ANESTHESIOLOGY	0	500	12,214	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,641	23,219	62,862	2,309	3,132	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	30,921	41,023	0	1,566	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,057	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	853	8,327	2,043	0	1,566	65.00
66.00	06600	PHYSICAL THERAPY	931	9,724	32,812	562	3,132	66.00
69.00	06900	ELECTROCARDIOLOGY	363	4,340	19,648	0	3,993	69.00
69.01	06901	CARDIAC REHAB	369	4,660	33,031	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	20,021	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	6,622	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73,982	0	0	0	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	294	6,115	4,352	0	0	76.00
76.01	03480	ONCOLOGY	829	10,423	53,718	0	3,445	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EXPRESS MEDICAL CENTER	1,696	16,826	0	0	0	88.00
88.01	08801	FAMILY HEALTH CARE	3,819	35,462	67,114	0	6,264	88.01
90.00	09000	CLINIC	5,097	19,377	61,782	0	8,613	90.00
90.01	09001	WOUND CARE	260	2,349	16,257	0	3,132	90.01
90.02	09002	INTERNAL MEDICINE	63	586	0	0	0	90.02
90.03	09003	PODIATRY CLINIC	675	3,528	12,790	0	0	90.03
91.00	09100	EMERGENCY	2,142	23,755	90,971	5,876	8,300	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	42,469	521,795	1,109,753	26,137	81,511	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	0	16	0	0	783	194.00
194.01	07951	MOB	0	51	8,794	0	0	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	445	4,417	13,568	0	2,349	194.04
194.05	07955	PHYSICIANS OFFICE	3,451	20,510	47,389	0	3,132	194.05
194.06	07956	THE ARBORS	0	0	0	0	0	194.06
194.07	07957	PAIN MANAGEMENT	0	0	0	0	0	194.07
194.08	07958	OPS	0	288	45,934	0	3,915	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	270	1,469	0	0	0	194.09
194.10	07961	RHEUMATOLOGY	0	0	0	0	0	194.10
194.11	07960	SPORTS HEALTH	207	1,919	0	0	0	194.11
194.12	07962	BEHAVIORAL HEALTH CLINIC	0	6	0	0	0	194.12
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)	46,842	550,471	1,225,438	26,137	91,690	202.00

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		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	OPS						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	233,511					10.00
11.00	01100	CAFETERIA	0	118,974				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,424	97,182			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,944	0	168,136		14.00
15.00	01500	PHARMACY	0	2,492	0	0	98,238	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,631	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	584	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	220,086	14,527	32,509	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	13,425	3,224	6,508	0	0	31.00
43.00	04300	NURSERY	0	1,295	2,614	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	17,463	35,255	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,178	4,397	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,845	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	2,796	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3,468	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,167	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	1,040	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	168,136	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	98,238	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	1,181	0	0	0	76.00
76.01	03480	ONCOLOGY	0	3,636	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EXPRESS MEDICAL CENTER	0	0	0	0	0	88.00
88.01	08801	FAMILY HEALTH CARE	0	11,922	0	0	0	88.01
90.00	09000	CLINIC	0	11,746	0	0	0	90.00
90.01	09001	WOUND CARE	0	851	0	0	0	90.01
90.02	09002	INTERNAL MEDICINE	0	256	0	0	0	90.02
90.03	09003	PODIATRY CLINIC	0	1,026	0	0	0	90.03
91.00	09100	EMERGENCY	0	7,876	15,899	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
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	233,511	108,572	97,182	168,136	98,238	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	0	1,948	0	0	0	194.04
194.05	07955	PHYSICIANS OFFICE	0	7,060	0	0	0	194.05
194.06	07956	THE ARBORS	0	0	0	0	0	194.06
194.07	07957	PAIN MANAGEMENT	0	0	0	0	0	194.07
194.08	07958	OPS	0	0	0	0	0	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	0	0	0	0	0	194.09
194.10	07961	RHEUMATOLOGY	0	0	0	0	0	194.10
194.11	07960	SPORTS HEALTH	0	1,394	0	0	0	194.11
194.12	07962	BEHAVIORAL HEALTH CLINIC	0	0	0	0	0	194.12
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)	233,511	118,974	97,182	168,136	98,238	202.00

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		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	OPS						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	350,033					16.00
17.00	01700	SOCIAL SERVICE	0	51,175				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,244	44,426	1,719,283	0	1,719,283	30.00
31.00	03100	INTENSIVE CARE UNIT	3,541	3,611	251,137	0	251,137	31.00
43.00	04300	NURSERY	2,500	0	20,911	0	20,911	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	92,021	0	1,053,889	0	1,053,889	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	220,169	0	220,169	52.00
53.00	05300	ANESTHESIOLOGY	4,499	0	85,450	0	85,450	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,266	0	432,071	0	432,071	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	43,226	0	287,756	0	287,756	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	655	0	1,712	0	1,712	63.00
65.00	06500	RESPIRATORY THERAPY	13,265	0	40,262	0	40,262	65.00
66.00	06600	PHYSICAL THERAPY	6,499	0	240,443	0	240,443	66.00
69.00	06900	ELECTROCARDIOLOGY	7,056	0	66,526	0	66,526	69.00
69.01	06901	CARDIAC REHAB	788	0	224,431	0	224,431	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	188,157	0	188,157	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	6,622	0	6,622	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	172,220	0	172,220	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	21,004	0	57,262	0	57,262	76.00
76.01	03480	ONCOLOGY	21,415	0	141,682	0	141,682	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EXPRESS MEDICAL CENTER	5,328	0	23,850	0	23,850	88.00
88.01	08801	FAMILY HEALTH CARE	9,606	0	190,378	0	190,378	88.01
90.00	09000	CLINIC	14,383	0	178,646	0	178,646	90.00
90.01	09001	WOUND CARE	6,507	0	42,967	0	42,967	90.01
90.02	09002	INTERNAL MEDICINE	1,292	0	2,197	0	2,197	90.02
90.03	09003	PODIATRY CLINIC	2,589	0	31,316	0	31,316	90.03
91.00	09100	EMERGENCY	36,453	3,138	702,657	0	702,657	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
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	339,137	51,175	6,381,994	0	6,381,994	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	0	0	799	0	799	194.00
194.01	07951	MOB	0	0	16,207	0	16,207	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	0	0	98,528	0	98,528	194.04
194.05	07955	PHYSICIANS OFFICE	10,509	0	258,748	0	258,748	194.05
194.06	07956	THE ARBORS	0	0	0	0	0	194.06
194.07	07957	PAIN MANAGEMENT	0	0	0	0	0	194.07
194.08	07958	OPS	0	0	91,367	0	91,367	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	387	0	2,126	0	2,126	194.09
194.10	07961	RHEUMATOLOGY	0	0	0	0	0	194.10
194.11	07960	SPORTS HEALTH	0	0	3,520	0	3,520	194.11
194.12	07962	BEHAVIORAL HEALTH CLINIC	0	0	6	0	6	194.12
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	350,033	51,175	6,853,295	0	6,853,295	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/30/2024 12:38 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	MOB (SQUARE FEET)	OPS (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.00	1.01	1.02	4.00	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	195,407					1.00
1.01	00101	MOB	0	44,997				1.01
1.02	00102	OPS	0	0	27,643			1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,228	1,228	0	44,264,434		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,625	5,513	0	4,473,221	-11,601,631	5.00
7.00	00700	OPERATION OF PLANT	35,608	266	2,196	858,126	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	624	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,397	2,467	81	748,184	0	9.00
10.00	01000	DIETARY	5,913	0	0	58,556	0	10.00
11.00	01100	CAFETERIA	2,858	0	0	406,176	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,217	0	0	772,129	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,127	0	0	327,677	0	14.00
15.00	01500	PHARMACY	2,103	0	0	744,807	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,445	0	0	2,115,844	0	16.00
17.00	01700	SOCIAL SERVICE	1,242	0	0	144,525	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	33,914	0	0	3,498,808	0	30.00
31.00	03100	INTENSIVE CARE UNIT	5,283	0	0	714,641	0	31.00
43.00	04300	NURSERY	260	0	0	372,883	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,487	0	6,297	6,278,849	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,189	0	0	627,142	0	52.00
53.00	05300	ANESTHESIOLOGY	2,057	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,028	0	1,559	1,551,333	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	4,837	1,345	727	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	344	0	0	805,900	0	65.00
66.00	06600	PHYSICAL THERAPY	5,526	0	0	879,978	0	66.00
69.00	06900	ELECTROCARDIOLOGY	479	2,830	0	343,014	0	69.00
69.01	06901	CARDIAC REHAB	5,563	0	0	349,045	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	733	0	0	277,610	0	76.00
76.01	03480	ONCOLOGY	0	0	9,047	783,167	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EXPRESS MEDICAL CENTER	0	0	0	1,602,950	0	88.00
88.01	08801	FAMILY HEALTH CARE	0	11,303	0	3,609,453	0	88.01
90.00	09000	CLINIC	210	10,195	0	4,817,557	0	90.00
90.01	09001	WOUND CARE	0	2,738	0	246,076	0	90.01
90.02	09002	INTERNAL MEDICINE	0	0	0	59,631	0	90.02
90.03	09003	PODIATRY CLINIC	0	2,154	0	638,207	0	90.03
91.00	09100	EMERGENCY	15,321	0	0	2,024,819	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
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	188,618	40,039	19,907	40,130,308	-11,601,631	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	MOB	0	1,481	0	0	0	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	2,285	0	0	421,074	0	194.04
194.05	07955	PHYSICIANS OFFICE	4,504	3,477	0	3,262,045	0	194.05
194.06	07956	THE ARBORS	0	0	0	0	0	194.06
194.07	07957	PAIN MANAGEMENT	0	0	0	0	0	194.07
194.08	07958	OPS	0	0	7,736	0	0	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	0	0	0	255,019	0	194.09
194.10	07961	RHEUMATOLOGY	0	0	0	0	0	194.10
194.11	07960	SPORTS HEALTH	0	0	0	195,988	0	194.11
194.12	07962	BEHAVIORAL HEALTH CLINIC	0	0	0	0	0	194.12
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/30/2024 12:38 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	MOB (SQUARE FEET)	OPS (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.00	1.01	1.02	4.00	5A	
202.00		Cost to be allocated (per Wkst. B, Part I)	6,482,277	223,692	147,326	14,725,018		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	33.173208	4.971265	5.329595	0.332660		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				46,842		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.001058		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/30/2024 12:38 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	OPS						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	78,719,289					5.00
7.00	00700	OPERATION OF PLANT	4,329,003	206,383				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	247,710	624	294,118			8.00
9.00	00900	HOUSEKEEPING	1,206,141	3,945	0	1,171		9.00
10.00	01000	DIETARY	278,928	5,913	2,640	0	5,253	10.00
11.00	01100	CAFETERIA	967,428	2,858	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,177,229	2,217	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	589,346	4,127	0	4	0	14.00
15.00	01500	PHARMACY	1,772,524	2,103	0	4	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,575,468	7,445	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	266,218	1,242	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,548,304	33,914	103,003	197	4,951	30.00
31.00	03100	INTENSIVE CARE UNIT	1,157,758	5,283	7,373	60	302	31.00
43.00	04300	NURSERY	535,385	260	417	2	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,750,716	25,784	82,267	190	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,058,083	5,189	0	33	0	52.00
53.00	05300	ANESTHESIOLOGY	71,515	2,057	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,320,270	10,587	25,981	40	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	4,421,683	6,909	0	20	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	151,083	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,190,696	344	0	20	0	65.00
66.00	06600	PHYSICAL THERAPY	1,390,503	5,526	6,319	40	0	66.00
69.00	06900	ELECTROCARDIOLOGY	620,687	3,309	0	51	0	69.00
69.01	06901	CARDIAC REHAB	666,408	5,563	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,862,936	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	946,990	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,581,156	0	0	0	0	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	874,463	733	0	0	0	76.00
76.01	03480	ONCOLOGY	1,490,508	9,047	0	44	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EXPRESS MEDICAL CENTER	2,406,182	0	0	0	0	88.00
88.01	08801	FAMILY HEALTH CARE	5,071,040	11,303	0	80	0	88.01
90.00	09000	CLINIC	2,770,919	10,405	0	110	0	90.00
90.01	09001	WOUND CARE	335,920	2,738	0	40	0	90.01
90.02	09002	INTERNAL MEDICINE	83,738	0	0	0	0	90.02
90.03	09003	PODIATRY CLINIC	504,467	2,154	0	0	0	90.03
91.00	09100	EMERGENCY	3,396,949	15,321	66,118	106	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
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	74,618,354	186,900	294,118	1,041	5,253	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	2,250	0	0	10	0	194.00
194.01	07951	MOB	7,362	1,481	0	0	0	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	631,648	2,285	0	30	0	194.04
194.05	07955	PHYSICIANS OFFICE	2,932,989	7,981	0	40	0	194.05
194.06	07956	THE ARBORS	0	0	0	0	0	194.06
194.07	07957	PAIN MANAGEMENT	0	0	0	0	0	194.07
194.08	07958	OPS	41,230	7,736	0	50	0	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	210,097	0	0	0	0	194.09
194.10	07961	RHEUMATOLOGY	0	0	0	0	0	194.10
194.11	07960	SPORTS HEALTH	274,446	0	0	0	0	194.11
194.12	07962	BEHAVIORAL HEALTH CLINIC	913	0	0	0	0	194.12
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	11,601,631	4,967,011	299,235	1,478,846	465,030	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.147380	24.066958	1.017398	1,262.891546	88.526556	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/30/2024 12:38 pm

	Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	
		5.00	7.00	8.00	9.00	10.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	550,471	1,225,438	26,137	91,690	233,511	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.006993	5.937689	0.088866	78.300598	44.452884	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/30/2024 12:38 pm

		Cost Center Description	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (100% SUPPLIES)	PHARMACY (100% DRUGS)	MEDICAL RECORDS & LIBRARY (REVENUE)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	OPS						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	888,789					11.00
13.00	01300	NURSING ADMINISTRATION	10,636	359,637				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14,520	0	100			14.00
15.00	01500	PHARMACY	18,618	0	0	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	79,418	0	0	0	253,440,809	16.00
17.00	01700	SOCIAL SERVICE	4,366	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	108,522	120,304	0	0	15,383,240	30.00
31.00	03100	INTENSIVE CARE UNIT	24,083	24,083	0	0	2,563,854	31.00
43.00	04300	NURSERY	9,675	9,675	0	0	1,810,260	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	130,467	130,467	0	0	66,610,944	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,273	16,273	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	3,258,012	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	43,664	0	0	0	18,295,584	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	31,300,679	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	473,984	63.00
65.00	06500	RESPIRATORY THERAPY	20,888	0	0	0	9,605,472	65.00
66.00	06600	PHYSICAL THERAPY	25,907	0	0	0	4,706,178	66.00
69.00	06900	ELECTROCARDIOLOGY	8,715	0	0	0	5,109,240	69.00
69.01	06901	CARDIAC REHAB	7,766	0	0	0	570,526	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	100	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	100	0	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	8,820	0	0	0	15,209,259	76.00
76.01	03480	ONCOLOGY	27,166	0	0	0	15,506,977	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EXPRESS MEDICAL CENTER	0	0	0	0	3,857,768	88.00
88.01	08801	FAMILY HEALTH CARE	89,066	0	0	0	6,956,144	88.01
90.00	09000	CLINIC	87,747	0	0	0	10,414,834	90.00
90.01	09001	WOUND CARE	6,356	0	0	0	4,711,548	90.01
90.02	09002	INTERNAL MEDICINE	1,910	0	0	0	935,243	90.02
90.03	09003	PODIATRY CLINIC	7,665	0	0	0	1,874,930	90.03
91.00	09100	EMERGENCY	58,835	58,835	0	0	26,396,055	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	811,083	359,637	100	100	245,550,731	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	14,551	0	0	0	0	194.04
194.05	07955	PHYSICIANS OFFICE	52,740	0	0	0	7,609,866	194.05
194.06	07956	THE ARBORS	0	0	0	0	0	194.06
194.07	07957	PAIN MANAGEMENT	0	0	0	0	0	194.07
194.08	07958	OPS	0	0	0	0	0	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	0	0	0	0	280,212	194.09
194.10	07961	RHEUMATOLOGY	0	0	0	0	0	194.10
194.11	07960	SPORTS HEALTH	10,415	0	0	0	0	194.11
194.12	07962	BEHAVIORAL HEALTH CLINIC	0	0	0	0	0	194.12
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,178,791	1,418,191	799,838	2,114,117	7,829,070	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.326289	3.943396	7,998.380000	21,141.170000	0.030891	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/30/2024 12:38 pm

		Cost Center Description	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (100% SUPPLIES)	PHARMACY (100% DRUGS)	MEDICAL RECORDS & LIBRARY (REVENUE)	
			11.00	13.00	14.00	15.00	16.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	118,974	97,182	168,136	98,238	350,033	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.133861	0.270222	1,681.360000	982.380000	0.001381	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/30/2024 12:38 pm

		Cost Center Description	SOCIAL SERVICE (HOURS)		
			17.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	MOB			1.01
1.02	00102	OPS			1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE	11,906		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	10,336		30.00
31.00	03100	INTENSIVE CARE UNIT	840		31.00
43.00	04300	NURSERY	0		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
57.00	05700	CT SCAN	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0		59.00
60.00	06000	LABORATORY	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		63.00
65.00	06500	RESPIRATORY THERAPY	0		65.00
66.00	06600	PHYSICAL THERAPY	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
69.01	06901	CARDIAC REHAB	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0		76.00
76.01	03480	ONCOLOGY	0		76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	EXPRESS MEDICAL CENTER	0		88.00
88.01	08801	FAMILY HEALTH CARE	0		88.01
90.00	09000	CLINIC	0		90.00
90.01	09001	WOUND CARE	0		90.01
90.02	09002	INTERNAL MEDICINE	0		90.02
90.03	09003	PODIATRY CLINIC	0		90.03
91.00	09100	EMERGENCY	730		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,906		118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	FOUNDATION	0		194.00
194.01	07951	MOB	0		194.01
194.02	07952	NONREIMBURSABLE OTHER	0		194.02
194.03	07953	PIH	0		194.03
194.04	07954	HEALTH COMPANIES	0		194.04
194.05	07955	PHYSICIANS OFFICE	0		194.05
194.06	07956	THE ARBORS	0		194.06
194.07	07957	PAIN MANAGEMENT	0		194.07
194.08	07958	OPS	0		194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	0		194.09
194.10	07961	RHEUMATOLOGY	0		194.10
194.11	07960	SPORTS HEALTH	0		194.11
194.12	07962	BEHAVIORAL HEALTH CLINIC	0		194.12
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	341,135		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.652360		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	51,175		204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/30/2024 12:38 pm

		Cost Center Description	SOCIAL SERVICE (HOURS)		
			17.00		
205.00		Unit cost multiplier (Wkst. B, Part II)	4.298253		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/30/2024 12:38 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,216,413		8,216,413	0	8,216,413	30.00
31.00	03100	INTENSIVE CARE UNIT	1,795,721		1,795,721	0	1,795,721	31.00
43.00	04300	NURSERY	730,402		730,402	0	730,402	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,435,053		11,435,053	187,194	11,622,247	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,466,335		1,466,335	0	1,466,335	52.00
53.00	05300	ANESTHESIOLOGY	232,204		232,204	0	232,204	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,764,437		4,764,437	66,235	4,830,672	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	6,231,797		6,231,797	0	6,231,797	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	187,992		187,992	0	187,992	63.00
65.00	06500	RESPIRATORY THERAPY	1,724,145	0	1,724,145	0	1,724,145	65.00
66.00	06600	PHYSICAL THERAPY	1,965,113	0	1,965,113	0	1,965,113	66.00
69.00	06900	ELECTROCARDIOLOGY	1,025,598		1,025,598	0	1,025,598	69.00
69.01	06901	CARDIAC REHAB	926,431		926,431	0	926,431	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,084,714		4,084,714	0	4,084,714	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,086,557		1,086,557	0	1,086,557	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,254,708		14,254,708	0	14,254,708	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	1,502,509		1,502,509	0	1,502,509	76.00
76.01	03480	ONCOLOGY	2,498,536		2,498,536	0	2,498,536	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EXPRESS MEDICAL CENTER	2,879,975		2,879,975	0	2,879,975	88.00
88.01	08801	FAMILY HEALTH CARE	6,524,479		6,524,479	0	6,524,479	88.01
90.00	09000	CLINIC	4,006,735		4,006,735	395,527	4,402,262	90.00
90.01	09001	WOUND CARE	655,813		655,813	0	655,813	90.01
90.02	09002	INTERNAL MEDICINE	127,503		127,503	0	127,503	90.02
90.03	09003	PODIATRY CLINIC	698,739		698,739	0	698,739	90.03
91.00	09100	EMERGENCY	5,613,815		5,613,815	0	5,613,815	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,061,847		2,061,847		2,061,847	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	86,697,571	0	86,697,571	648,956	87,346,527	200.00
201.00		Less Observation Beds	2,061,847		2,061,847		2,061,847	201.00
202.00		Total (see instructions)	84,635,724	0	84,635,724	648,956	85,284,680	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/30/2024 12:38 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,208,029		7,208,029			30.00
31.00	03100	INTENSIVE CARE UNIT	908,190		908,190			31.00
43.00	04300	NURSERY	1,807,330		1,807,330			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,691,650	40,284,843	45,976,493	0.248715	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,835,921	208,901	3,044,822	0.481583	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	320,856	2,937,156	3,258,012	0.071272	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	717,147	17,548,669	18,265,816	0.260839	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	3,161,360	28,139,299	31,300,659	0.199095	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	197,353	380,447	577,800	0.325358	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	4,432,805	3,974,211	8,407,016	0.205084	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	330,885	4,364,843	4,695,728	0.418490	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	610,381	5,777,615	6,387,996	0.160551	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	568,803	568,803	1.628738	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,296,271	6,403,982	7,700,253	0.530465	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	348,361	4,689,626	5,037,987	0.215673	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,983,756	64,366,498	69,350,254	0.205547	0.000000	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	1,003,759	14,200,358	15,204,117	0.098823	0.000000	76.00
76.01	03480	ONCOLOGY	4,194	14,770,132	14,774,326	0.169113	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EXPRESS MEDICAL CENTER	0	3,857,768	3,857,768			88.00
88.01	08801	FAMILY HEALTH CARE	62,838	6,893,306	6,956,144			88.01
90.00	09000	CLINIC	6,572	2,647,182	2,653,754	1.509837	0.000000	90.00
90.01	09001	WOUND CARE	3,075	3,370,423	3,373,498	0.194401	0.000000	90.01
90.02	09002	INTERNAL MEDICINE	0	92,234	92,234	1.382386	0.000000	90.02
90.03	09003	PODIATRY CLINIC	4,028	298,641	302,669	2.308591	0.000000	90.03
91.00	09100	EMERGENCY	1,658,485	26,090,905	27,749,390	0.202304	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	141,600	2,445,852	2,587,452	0.796864	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	37,734,846	254,311,694	292,046,540			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	37,734,846	254,311,694	292,046,540			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/30/2024 12:38 pm

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		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.252787		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.481583		52.00
53.00	05300	ANESTHESIOLOGY	0.071272		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.264465		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.199095		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.325358		63.00
65.00	06500	RESPIRATORY THERAPY	0.205084		65.00
66.00	06600	PHYSICAL THERAPY	0.418490		66.00
69.00	06900	ELECTROCARDIOLOGY	0.160551		69.00
69.01	06901	CARDIAC REHAB	1.628738		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.530465		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.215673		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.205547		73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.098823		76.00
76.01	03480	ONCOLOGY	0.169113		76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	EXPRESS MEDICAL CENTER			88.00
88.01	08801	FAMILY HEALTH CARE			88.01
90.00	09000	CLINIC	1.658881		90.00
90.01	09001	WOUND CARE	0.194401		90.01
90.02	09002	INTERNAL MEDICINE	1.382386		90.02
90.03	09003	PODIATRY CLINIC	2.308591		90.03
91.00	09100	EMERGENCY	0.202304		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.796864		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/30/2024 12:38 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,216,413		8,216,413	0	8,216,413	30.00
31.00	03100	INTENSIVE CARE UNIT	1,795,721		1,795,721	0	1,795,721	31.00
43.00	04300	NURSERY	730,402		730,402	0	730,402	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,435,053		11,435,053	187,194	11,622,247	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,466,335		1,466,335	0	1,466,335	52.00
53.00	05300	ANESTHESIOLOGY	232,204		232,204	0	232,204	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,764,437		4,764,437	66,235	4,830,672	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	6,231,797		6,231,797	0	6,231,797	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	187,992		187,992	0	187,992	63.00
65.00	06500	RESPIRATORY THERAPY	1,724,145	0	1,724,145	0	1,724,145	65.00
66.00	06600	PHYSICAL THERAPY	1,965,113	0	1,965,113	0	1,965,113	66.00
69.00	06900	ELECTROCARDIOLOGY	1,025,598		1,025,598	0	1,025,598	69.00
69.01	06901	CARDIAC REHAB	926,431		926,431	0	926,431	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,084,714		4,084,714	0	4,084,714	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,086,557		1,086,557	0	1,086,557	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,254,708		14,254,708	0	14,254,708	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	1,502,509		1,502,509	0	1,502,509	76.00
76.01	03480	ONCOLOGY	2,498,536		2,498,536	0	2,498,536	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EXPRESS MEDICAL CENTER	2,879,975		2,879,975	0	2,879,975	88.00
88.01	08801	FAMILY HEALTH CARE	6,524,479		6,524,479	0	6,524,479	88.01
90.00	09000	CLINIC	4,006,735		4,006,735	395,527	4,402,262	90.00
90.01	09001	WOUND CARE	655,813		655,813	0	655,813	90.01
90.02	09002	INTERNAL MEDICINE	127,503		127,503	0	127,503	90.02
90.03	09003	PODIATRY CLINIC	698,739		698,739	0	698,739	90.03
91.00	09100	EMERGENCY	5,613,815		5,613,815	0	5,613,815	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,061,847		2,061,847		2,061,847	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	86,697,571	0	86,697,571	648,956	87,346,527	200.00
201.00		Less Observation Beds	2,061,847		2,061,847		2,061,847	201.00
202.00		Total (see instructions)	84,635,724	0	84,635,724	648,956	85,284,680	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/30/2024 12:38 pm

Title XIX | 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	7,208,029		7,208,029			30.00
31.00	03100	INTENSIVE CARE UNIT	908,190		908,190			31.00
43.00	04300	NURSERY	1,807,330		1,807,330			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,691,650	40,284,843	45,976,493	0.248715	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,835,921	208,901	3,044,822	0.481583	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	320,856	2,937,156	3,258,012	0.071272	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	717,147	17,548,669	18,265,816	0.260839	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	3,161,360	28,139,299	31,300,659	0.199095	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	197,353	380,447	577,800	0.325358	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	4,432,805	3,974,211	8,407,016	0.205084	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	330,885	4,364,843	4,695,728	0.418490	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	610,381	5,777,615	6,387,996	0.160551	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	568,803	568,803	1.628738	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,296,271	6,403,982	7,700,253	0.530465	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	348,361	4,689,626	5,037,987	0.215673	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,983,756	64,366,498	69,350,254	0.205547	0.000000	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	1,003,759	14,200,358	15,204,117	0.098823	0.000000	76.00
76.01	03480	ONCOLOGY	4,194	14,770,132	14,774,326	0.169113	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EXPRESS MEDICAL CENTER	0	3,857,768	3,857,768	0.746539	0.000000	88.00
88.01	08801	FAMILY HEALTH CARE	62,838	6,893,306	6,956,144	0.937945	0.000000	88.01
90.00	09000	CLINIC	6,572	2,647,182	2,653,754	1.509837	0.000000	90.00
90.01	09001	WOUND CARE	3,075	3,370,423	3,373,498	0.194401	0.000000	90.01
90.02	09002	INTERNAL MEDICINE	0	92,234	92,234	1.382386	0.000000	90.02
90.03	09003	PODIATRY CLINIC	4,028	298,641	302,669	2.308591	0.000000	90.03
91.00	09100	EMERGENCY	1,658,485	26,090,905	27,749,390	0.202304	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	141,600	2,445,852	2,587,452	0.796864	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	37,734,846	254,311,694	292,046,540			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	37,734,846	254,311,694	292,046,540			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/30/2024 12:38 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	CARDIAC REHAB	0.000000		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.000000		76.00
76.01	03480	ONCOLOGY	0.000000		76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	EXPRESS MEDICAL CENTER	0.000000		88.00
88.01	08801	FAMILY HEALTH CARE	0.000000		88.01
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	WOUND CARE	0.000000		90.01
90.02	09002	INTERNAL MEDICINE	0.000000		90.02
90.03	09003	PODIATRY CLINIC	0.000000		90.03
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part I Date/Time Prepared: 5/30/2024 12:38 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,719,283	0	1,719,283	4,511	381.13	30.00
31.00	INTENSIVE CARE UNIT	251,137		251,137	302	831.58	31.00
43.00	NURSERY	20,911		20,911	1,155	18.10	43.00
200.00	Total (lines 30 through 199)	1,991,331		1,991,331	5,968		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	869	331,202	30.00
31.00	INTENSIVE CARE UNIT	97	80,663	31.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	966	411,865	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/30/2024 12:38 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,053,889	45,976,493	0.022922	1,121,409	25,705	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	220,169	3,044,822	0.072309	200	14	52.00
53.00	05300	ANESTHESIOLOGY	85,450	3,258,012	0.026228	56,839	1,491	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	432,071	18,265,816	0.023655	252,148	5,965	54.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	287,756	31,300,659	0.009193	842,269	7,743	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,712	577,800	0.002963	41,176	122	63.00
65.00	06500	RESPIRATORY THERAPY	40,262	8,407,016	0.004789	1,598,363	7,655	65.00
66.00	06600	PHYSICAL THERAPY	240,443	4,695,728	0.051205	131,882	6,753	66.00
69.00	06900	ELECTROCARDIOLOGY	66,526	6,387,996	0.010414	225,711	2,351	69.00
69.01	06901	CARDIAC REHAB	224,431	568,803	0.394567	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	188,157	7,700,253	0.024435	357,201	8,728	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,622	5,037,987	0.001314	169,922	223	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	172,220	69,350,254	0.002483	1,337,846	3,322	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	57,262	15,204,117	0.003766	402,060	1,514	76.00
76.01	03480	ONCOLOGY	141,682	14,774,326	0.009590	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EXPRESS MEDICAL CENTER	23,850	3,857,768	0.006182	0	0	88.00
88.01	08801	FAMILY HEALTH CARE	190,378	6,956,144	0.027368	0	0	88.01
90.00	09000	CLINIC	178,646	2,653,754	0.067318	0	0	90.00
90.01	09001	WOUND CARE	42,967	3,373,498	0.012737	2,810	36	90.01
90.02	09002	INTERNAL MEDICINE	2,197	92,234	0.023820	0	0	90.02
90.03	09003	PODIATRY CLINIC	31,316	302,669	0.103466	0	0	90.03
91.00	09100	EMERGENCY	702,657	27,749,390	0.025322	919,752	23,290	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	431,441	2,587,452	0.166744	95,589	15,939	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	4,822,104	282,122,991		7,555,177	110,851	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part III Date/Time Prepared: 5/30/2024 12:38 pm

Title XVIII | Hospital | PPS

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	4,511	0.00	869	30.00
31.00	03100	INTENSIVE CARE UNIT		0	302	0.00	97	31.00
43.00	04300	NURSERY		0	1,155	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	5,968		966	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
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/30/2024 12:38 pm

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		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
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EXPRESS MEDICAL CENTER	0	0	0	0	0	88.00
88.01	08801	FAMILY HEALTH CARE	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	INTERNAL MEDICINE	0	0	0	0	0	90.02
90.03	09003	PODIATRY CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/30/2024 12:38 pm

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		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	45,976,493	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,044,822	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,258,012	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	18,265,816	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	31,300,659	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	577,800	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,407,016	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,695,728	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	6,387,996	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	0	0	568,803	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	7,700,253	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	5,037,987	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	69,350,254	0.000000	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	15,204,117	0.000000	76.00
76.01	03480	ONCOLOGY	0	0	0	14,774,326	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EXPRESS MEDICAL CENTER	0	0	0	3,857,768	0.000000	88.00
88.01	08801	FAMILY HEALTH CARE	0	0	0	6,956,144	0.000000	88.01
90.00	09000	CLINIC	0	0	0	2,653,754	0.000000	90.00
90.01	09001	WOUND CARE	0	0	0	3,373,498	0.000000	90.01
90.02	09002	INTERNAL MEDICINE	0	0	0	92,234	0.000000	90.02
90.03	09003	PODIATRY CLINIC	0	0	0	302,669	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	27,749,390	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,587,452	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	282,122,991		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/30/2024 12:38 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	1,121,409	0	7,107,701	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	200	0	320	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	56,839	0	479,178	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	252,148	0	2,756,202	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	842,269	0	2,389,520	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	41,176	0	125,246	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,598,363	0	751,511	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	131,882	0	18,804	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	225,711	0	1,427,523	0	69.00
69.01	06901	CARDIAC REHAB	0.000000	0	0	180,603	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	357,201	0	1,008,311	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	169,922	0	900,561	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,337,846	0	20,382,781	0	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.000000	402,060	0	3,414,240	0	76.00
76.01	03480	ONCOLOGY	0.000000	0	0	3,260,876	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EXPRESS MEDICAL CENTER	0.000000	0	0	0	0	88.00
88.01	08801	FAMILY HEALTH CARE	0.000000	0	0	0	0	88.01
90.00	09000	CLINIC	0.000000	0	0	374,138	0	90.00
90.01	09001	WOUND CARE	0.000000	2,810	0	847,862	0	90.01
90.02	09002	INTERNAL MEDICINE	0.000000	0	0	36,489	0	90.02
90.03	09003	PODIATRY CLINIC	0.000000	0	0	223,495	0	90.03
91.00	09100	EMERGENCY	0.000000	919,752	0	4,502,715	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	95,589	0	321,093	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		7,555,177	0	50,509,169	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/30/2024 12:38 pm

Title XVIII | Hospital | PPS

		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	0.248715	7,107,701	0	0	1,767,792	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.481583	320	0	0	154	52.00
53.00	05300	ANESTHESIOLOGY	0.071272	479,178	0	0	34,152	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.260839	2,756,202	0	0	718,925	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.199095	2,389,520	0	0	475,741	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.325358	125,246	0	0	40,750	63.00
65.00	06500	RESPIRATORY THERAPY	0.205084	751,511	0	0	154,123	65.00
66.00	06600	PHYSICAL THERAPY	0.418490	18,804	0	0	7,869	66.00
69.00	06900	ELECTROCARDIOLOGY	0.160551	1,427,523	0	0	229,190	69.00
69.01	06901	CARDIAC REHAB	1.628738	180,603	0	0	294,155	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.530465	1,008,311	0	0	534,874	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.215673	900,561	0	0	194,227	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.205547	20,382,781	0	159,849	4,189,619	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.098823	3,414,240	0	0	337,405	76.00
76.01	03480	ONCOLOGY	0.169113	3,260,876	0	0	551,457	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	EXPRESS MEDICAL CENTER						88.00
88.01	08801	FAMILY HEALTH CARE						88.01
90.00	09000	CLINIC	1.509837	374,138	0	0	564,887	90.00
90.01	09001	WOUND CARE	0.194401	847,862	0	0	164,825	90.01
90.02	09002	INTERNAL MEDICINE	1.382386	36,489	0	0	50,442	90.02
90.03	09003	PODIATRY CLINIC	2.308591	223,495	0	0	515,959	90.03
91.00	09100	EMERGENCY	0.202304	4,502,715	0	0	910,917	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.796864	321,093	0	0	255,867	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		50,509,169	0	159,849	11,993,330	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		50,509,169	0	159,849	11,993,330	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/30/2024 12:38 pm

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		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
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIAC REHAB	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	32,856		73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0		76.00
76.01	03480	ONCOLOGY	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	EXPRESS MEDICAL CENTER				88.00
88.01	08801	FAMILY HEALTH CARE				88.01
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CARE	0	0		90.01
90.02	09002	INTERNAL MEDICINE	0	0		90.02
90.03	09003	PODIATRY CLINIC	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	32,856		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	32,856		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/30/2024 12:38 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,511	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,511	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,379	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	869	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	8,216,413	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,216,413	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)	8,216,413	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,821.42	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,582,814	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)	1,582,814	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/30/2024 12:38 pm

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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,795,721	302	5,946.10	97	576,772	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)	1,758,267	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)	3,917,853	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)	411,865	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	110,851	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	522,716	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3,395,137	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)	1,132	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,821.42	88.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/30/2024 12:38 pm

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	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,061,847	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	1,719,283	8,216,413	0.209250	2,061,847	431,441	90.00
91.00	Nursing Program cost	0	8,216,413	0.000000	2,061,847	0	91.00
92.00	Allied health cost	0	8,216,413	0.000000	2,061,847	0	92.00
93.00	All other Medical Education	0	8,216,413	0.000000	2,061,847	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/30/2024 12:38 pm

Title XIX | 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)	4,511	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,511	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,379	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	409	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	1,155	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	8,216,413	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,216,413	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)	8,216,413	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,821.42	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	744,961	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)	744,961	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/30/2024 12:38 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	730,402	1,155	632.38	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,795,721	302	5,946.10	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	296,307	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)	1,041,268	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,132	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,821.42	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0072	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/30/2024 12:38 pm
	Title XIX	Hospital	Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,061,847	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	1,719,283	8,216,413	0.209250	2,061,847	431,441	90.00
91.00	Nursing Program cost	0	8,216,413	0.000000	2,061,847	0	91.00
92.00	Allied health cost	0	8,216,413	0.000000	2,061,847	0	92.00
93.00	All other Medical Education	0	8,216,413	0.000000	2,061,847	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/30/2024 12:38 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,250,710		30.00
31.00	03100	INTENSIVE CARE UNIT		211,736		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.252787	1,121,409	283,478	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.481583	200	96	52.00
53.00	05300	ANESTHESIOLOGY	0.071272	56,839	4,051	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.264465	252,148	66,684	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.199095	842,269	167,692	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.325358	41,176	13,397	63.00
65.00	06500	RESPIRATORY THERAPY	0.205084	1,598,363	327,799	65.00
66.00	06600	PHYSICAL THERAPY	0.418490	131,882	55,191	66.00
69.00	06900	ELECTROCARDIOLOGY	0.160551	225,711	36,238	69.00
69.01	06901	CARDIAC REHAB	1.628738	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.530465	357,201	189,483	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.215673	169,922	36,648	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.205547	1,337,846	274,990	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.098823	402,060	39,733	76.00
76.01	03480	ONCOLOGY	0.169113	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	EXPRESS MEDICAL CENTER	0.000000		0	88.00
88.01	08801	FAMILY HEALTH CARE	0.000000		0	88.01
90.00	09000	CLINIC	1.658881	0	0	90.00
90.01	09001	WOUND CARE	0.194401	2,810	546	90.01
90.02	09002	INTERNAL MEDICINE	1.382386	0	0	90.02
90.03	09003	PODIATRY CLINIC	2.308591	0	0	90.03
91.00	09100	EMERGENCY	0.202304	919,752	186,070	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.796864	95,589	76,171	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		7,555,177	1,758,267	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)		7,555,177		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/30/2024 12:38 pm

Title XIX | 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		1,107,768		30.00
31.00	03100	INTENSIVE CARE UNIT		53,322		31.00
43.00	04300	NURSERY		94,521		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.248715	396,962	98,730	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.481583	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.071272	795	57	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.260839	35,143	9,167	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.199095	228,107	45,415	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.325358	9,386	3,054	63.00
65.00	06500	RESPIRATORY THERAPY	0.205084	179,006	36,711	65.00
66.00	06600	PHYSICAL THERAPY	0.418490	3,936	1,647	66.00
69.00	06900	ELECTROCARDIOLOGY	0.160551	7,534	1,210	69.00
69.01	06901	CARDIAC REHAB	1.628738	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.530465	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.215673	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.205547	367,271	75,491	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.098823	32,761	3,238	76.00
76.01	03480	ONCOLOGY	0.169113	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	EXPRESS MEDICAL CENTER	0.746539	0	0	88.00
88.01	08801	FAMILY HEALTH CARE	0.937945	0	0	88.01
90.00	09000	CLINIC	1.509837	228	344	90.00
90.01	09001	WOUND CARE	0.194401	0	0	90.01
90.02	09002	INTERNAL MEDICINE	1.382386	0	0	90.02
90.03	09003	PODIATRY CLINIC	2.308591	296	683	90.03
91.00	09100	EMERGENCY	0.202304	87,414	17,684	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.796864	3,609	2,876	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,352,448	296,307	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,352,448		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0072 | Component CCN: 15-U072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/30/2024 12:38 pm

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
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.000000	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901	CARDIAC REHAB	0.000000	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	73.00
76.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.000000	0	0	76.00
76.01	03480	ONCOLOGY	0.000000	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	EXPRESS MEDICAL CENTER	0.000000	0	0	88.00
88.01	08801	FAMILY HEALTH CARE	0.000000	0	0	88.01
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CARE	0.000000	0	0	90.01
90.02	09002	INTERNAL MEDICINE	0.000000	0	0	90.02
90.03	09003	PODIATRY CLINIC	0.000000	0	0	90.03
91.00	09100	EMERGENCY	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0072	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/30/2024 12:38 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	1,672,117	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	711,050	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	33,170	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	9,140	2.04
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	38.90	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
5.01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)	0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)	0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	3.74	30.00
31.00	Percentage of Medicaid patient days (see instructions)	40.62	31.00
32.00	Sum of lines 30 and 31	44.36	32.00
33.00	Allowable disproportionate share percentage (see instructions)	12.00	33.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0072	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/30/2024 12:38 pm
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			1.00	
34.00	Disproportionate share adjustment (see instructions)		71,496	34.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Payment Adjustment			
35.00	Total uncompensated care amount (see instructions)	6,874,403,459	5,938,006,757	35.00
35.01	Factor 3 (see instructions)	0.000083353	0.000084770	35.01
35.02	Hospital UCP, including supplemental UCP (see instructions)	573,002	503,365	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	428,574	126,529	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	555,103		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	3,052,076		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	3,541,386		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	3,541,386	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	185,738	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	13,226	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
55.01	Cellular therapy acquisition cost (see instructions)	0	55.01
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	3,740,350	59.00
60.00	Primary payer payments	13,836	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	3,726,514	61.00
62.00	Deductibles billed to program beneficiaries	409,248	62.00
63.00	Coinsurance billed to program beneficiaries	0	63.00
64.00	Allowable bad debts (see instructions)	36,569	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	23,770	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	36,569	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	3,341,036	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)	0	70.75
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	-7,023	70.93
70.94	HRR adjustment amount (see instructions)	0	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A | Date/Time Prepared: 5/30/2024 12:38 pm

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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2023	478,795	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2024	195,071	70.97
70.98	Low Volume Payment-3	0	0	70.98
70.99	HAC adjustment amount (see instructions)		12,718	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		3,995,161	71.00
71.01	Sequestration adjustment (see instructions)		79,903	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		4,007,960	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-92,702	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		243,855	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/30/2024 12:38 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	1,672,117	0	1,672,117		1,672,117	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	711,050	0		711,050	711,050	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	33,170	0	33,170		33,170	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	9,140	0		9,140	9,140	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	71,496	0	50,164	21,332	71,496	11.00
11.01	Uncompensated care payments	36.00	555,103	0	428,574	126,529	555,103	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	3,052,076	0	2,184,025	868,051	3,052,076	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	3,541,386	0	2,513,940	1,027,446	3,541,386	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	3,541,386	0	2,513,940	1,027,446	3,541,386	15.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/30/2024 12:38 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	185,738	0	129,456	56,282	185,738	16.00
17.00	Special add-on payments for new technologies	54.00	13,226	0	13,226	0	13,226	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	2,656,622	1,083,728	3,740,350	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	180,329	0	125,549	54,780	180,329	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	5,409	0	3,907	1,502	5,409	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	185,738	0	129,456	56,282	185,738	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.180227	0.180000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			478,795		478,795	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				195,071	195,071	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/30/2024 12:38 pm

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	1,672,117	1,672,117		1,672,117	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	711,050		711,050	711,050	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	33,170	33,170		33,170	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	9,140		9,140	9,140	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	71,496	50,164	21,332	71,496	11.00
11.01	Uncompensated care payments	36.00	555,103	428,574	126,529	555,103	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	3,052,076	2,184,025	868,051	3,052,076	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	3,541,386	2,513,940	1,027,446	3,541,386	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	3,541,386	2,513,940	1,027,446	3,541,386	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	185,738	129,456	56,282	185,738	16.00
17.00	Special add-on payments for new technologies	54.00	13,226	13,226	0	13,226	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			2,656,622	1,083,728	3,740,350	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/30/2024 12:38 pm

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	180,329	125,549	54,780	180,329	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	5,409	3,907	1,502	5,409	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	185,738	129,456	56,282	185,738	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	478,795	478,795		478,795	28.00
29.00	Low volume adjustment on or after October 1	70.97	195,071		195,071	195,071	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-7,023	0	-7,023	-7,023	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	12,718	12,718	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0072	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/30/2024 12:38 pm
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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	32,856	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	11,993,330	2.00
3.00	OPPS or REH payments	12,022,624	3.00
4.00	Outlier payment (see instructions)	13,679	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	32,856	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	159,849	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)	159,849	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)	159,849	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	126,993	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)	32,856	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	12,036,303	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,256,514	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	9,812,645	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount (see instructions)		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	9,812,645	30.00
31.00	Primary payer payments	1,487	31.00
32.00	Subtotal (line 30 minus line 31)	9,811,158	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)	276,504	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	179,728	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	276,504	36.00
37.00	Subtotal (see instructions)	9,990,886	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-249	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	9,991,135	40.00
40.01	Sequestration adjustment (see instructions)	199,823	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	9,617,860	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)	173,452	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0072	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/30/2024 12:38 pm
	Title XVIII	Hospital	PPS

		1.00	
94.00	Total (sum of lines 91 and 93)	0	94.00
		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: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I Date/Time Prepared: 5/30/2024 12:38 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,916,971		9,617,860	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	12/31/2023	90,989		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)		90,989		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)		4,007,960		9,617,860	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		173,452	6.01
6.02	SETTLEMENT TO PROGRAM		92,702		0	6.02
7.00	Total Medicare program liability (see instructions)		3,915,258		9,791,312	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0072	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/30/2024 12:38 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-0072 | Component CCN: 15-U072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-2 | Date/Time Prepared: 5/30/2024 12:38 pm

Title XIX | Swing Beds - SNF | PPS

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	0		3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)	0.00		4.00
5.00	Program days	0		5.00
6.00	Interns and residents not in approved teaching program (see instructions)	0		6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	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: 15-0072	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/30/2024 12:38 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	1,041,268		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	1,041,268	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	1,041,268	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	1,255,611		8.00
9.00	Ancillary service charges	1,352,448	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	2,608,059	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	2,608,059	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,566,791	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	1,041,268	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	1,041,268	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	1,041,268	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	1,041,268	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	1,041,268	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	1,041,268	0	40.00
41.00	Interim payments	1,518,428	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-477,160	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0072	Period: From 01/01/2023 To 12/31/2023	Worksheet E-5 Date/Time Prepared: 5/30/2024 12:38 pm
	Title XVIII		PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR		
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2	0	2.00
3.00	Operating outlier reconciliation adjustment amount (see instructions)	0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instructions)	0	4.00
5.00	The rate used to calculate the time value of money (see instructions)	0.00	5.00
6.00	Time value of money for operating expenses (see instructions)	0	6.00
7.00	Time value of money for capital related expenses (see instructions)	0	7.00

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

Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G | Date/Time Prepared: 5/30/2024 12:38 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	3,546,700	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	51,872,034	0	0	0	4.00
5.00	Other receivable	2,854,882	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-31,407,118	0	0	0	6.00
7.00	Inventory	1,324,459	0	0	0	7.00
8.00	Prepaid expenses	1,287,362	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	29,478,319	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	205,783	0	0	0	12.00
13.00	Land improvements	1,030,057	0	0	0	13.00
14.00	Accumulated depreciation	-597,581	0	0	0	14.00
15.00	Buildings	71,872,272	0	0	0	15.00
16.00	Accumulated depreciation	-46,029,615	0	0	0	16.00
17.00	Leasehold improvements	4,204,312	0	0	0	17.00
18.00	Accumulated depreciation	-1,589,667	0	0	0	18.00
19.00	Fixed equipment	7,812,025	0	0	0	19.00
20.00	Accumulated depreciation	-4,695,182	0	0	0	20.00
21.00	Automobiles and trucks	69,214	0	0	0	21.00
22.00	Accumulated depreciation	-69,214	0	0	0	22.00
23.00	Major movable equipment	36,970,551	0	0	0	23.00
24.00	Accumulated depreciation	-21,159,571	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	48,023,384	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	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	3,280,549	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,280,549	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	80,782,252	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	22,966,162	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,101,338	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,343,075	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	26,410,575	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	10,824,138	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	10,824,138	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	37,234,713	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	43,547,539				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)	43,547,539	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	80,782,252	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 5/30/2024 12:38 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		53,528,481		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-9,980,942				2.00
3.00	Total (sum of line 1 and line 2)		43,547,539		0		3.00
4.00	ADDITIONS	75		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)		75		0		10.00
11.00	Subtotal (line 3 plus line 10)		43,547,614		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)		43,547,614		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		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0072 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/30/2024 12:38 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	10,849,013		10,849,013	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	10,849,013		10,849,013	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	930,465		930,465	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)	930,465		930,465	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	11,779,478		11,779,478	17.00
18.00	Ancillary services	21,882,483	204,789,591	226,672,074	18.00
19.00	Outpatient services	3,444,133	39,435,901	42,880,034	19.00
20.00	EXPRESS MEDICAL CENTER	0	3,857,768	3,857,768	20.00
20.01	FAMILY HEALTH CARE	62,838	6,893,306	6,956,144	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NONREIMBURSABLE	161,378	8,505,084	8,666,462	27.00
27.01	PRO FEES	3,021,661	17,778,891	20,800,552	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	40,351,971	281,260,541	321,612,512	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		120,082,405		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)		120,082,405		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0072	Period: From 01/01/2023 To 12/31/2023	Worksheet G-3 Date/Time Prepared: 5/30/2024 12:38 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	321,612,512	1.00
2.00	Less contractual allowances and discounts on patients' accounts	215,391,590	2.00
3.00	Net patient revenues (line 1 minus line 2)	106,220,922	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	120,082,405	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-13,861,483	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	3,394,359	24.00
24.01	INVESTMENT INCOME	697,119	24.01
24.02	LOSS ON SALE OF EQUIPMENT	-210,937	24.02
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	3,880,541	25.00
26.00	Total (line 5 plus line 25)	-9,980,942	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-9,980,942	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0072	Period: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III Date/Time Prepared: 5/30/2024 12:38 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	180,329	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	5,409	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	11.29	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	185,738	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0072 | Component CCN: 15-8561 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/30/2024 12:38 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	292,825	0	292,825	0	292,825	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	596,920	0	596,920	230,898	827,818	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	489,470	0	489,470	0	489,470	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
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
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)	1,379,215	0	1,379,215	230,898	1,610,113	10.00
11.00	Physician Services Under Agreement	0	20,000	20,000	0	20,000	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	20,000	20,000	0	20,000	14.00
15.00	Medical Supplies	0	195,440	195,440	0	195,440	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	195,440	195,440	0	195,440	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,379,215	215,440	1,594,655	230,898	1,825,553	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	8,776	8,776	-8,776	0	29.00
30.00	Administrative Costs	0	62,661	62,661	-14,806	47,855	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	71,437	71,437	-23,582	47,855	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,379,215	286,877	1,666,092	207,316	1,873,408	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0072 | Component CCN: 15-8561 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/30/2024 12:38 pm

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	292,825		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	827,818		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	489,470		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
7.10	Marriage and Family Therapist				7.10
7.11	Mental Health Counselor				7.11
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	1,610,113		10.00
11.00	Physician Services Under Agreement	0	20,000		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	20,000		14.00
15.00	Medical Supplies	0	195,440		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	195,440		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,825,553		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	0		29.00
30.00	Administrative Costs	-463	47,392		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-463	47,392		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-463	1,872,945		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

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

Period: From 01/01/2023 To 12/31/2023

Worksheet M-1
Date/Time Prepared: 5/30/2024 12:38 pm

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,516,024	0	1,516,024	0	1,516,024	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	948,486	0	948,486	-170,229	778,257	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	1,154,574	0	1,154,574	0	1,154,574	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	63,486	0	63,486	0	63,486	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	3,682,570	0	3,682,570	-170,229	3,512,341	10.00
11.00	Physician Services Under Agreement	0	78,000	78,000	0	78,000	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	78,000	78,000	0	78,000	14.00
15.00	Medical Supplies	0	40,406	40,406	0	40,406	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	40,406	40,406	0	40,406	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,682,570	118,406	3,800,976	-170,229	3,630,747	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	111,211	86,269	197,480	-14,099	183,381	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	111,211	86,269	197,480	-14,099	183,381	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,793,781	204,675	3,998,456	-184,328	3,814,128	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0072 | Component CCN: 15-8563 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/30/2024 12:38 pm

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	1,516,024		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	778,257		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	1,154,574		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	63,486		7.00
7.10	Marriage and Family Therapist				7.10
7.11	Mental Health Counselor				7.11
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	3,512,341		10.00
11.00	Physician Services Under Agreement	0	78,000		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	78,000		14.00
15.00	Medical Supplies	0	40,406		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	40,406		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	3,630,747		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	0		29.00
30.00	Administrative Costs	0	183,381		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	183,381		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	3,814,128		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0072 | Component CCN: 15-8561 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/30/2024 12:38 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.75	3,713	4,200	3,150		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	3.74	11,908	2,100	7,854		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.49	15,621		11,004	15,621	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
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	4.49	15,621			15,621	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)	1,825,553	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)	1,825,553	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)	47,392	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	1,007,030	15.00
16.00	Total overhead (sum of lines 14 and 15)	1,054,422	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	1,054,422	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	1,054,422	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	2,879,975	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0072 | Component CCN: 15-8563 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/30/2024 12:38 pm

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	4.07	13,968	4,200	17,094		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	5.21	18,173	2,100	10,941		3.00
4.00	Subtotal (sum of lines 1 through 3)	9.28	32,141		28,035	32,141	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	0.87	1,132			1,132	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
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	10.15	33,273			33,273	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)	3,630,747	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)	3,630,747	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)	183,381	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	2,710,351	15.00
16.00	Total overhead (sum of lines 14 and 15)	2,893,732	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	2,893,732	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	2,893,732	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	6,524,479	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0072 Component CCN: 15-8561	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/30/2024 12:38 pm
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,879,975	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			1,817	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			2,878,158	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			15,621	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)			15,621	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			184.25	7.00
		Calculation of Limit (1)			
		Rate Period N/A	Rate Period 1 (01/01/2023 through 12/31/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	126.00		8.00
9.00	Rate for Program covered visits (see instructions)	0.00	126.00		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,180		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	148,680		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	148,680		16.00
16.01	Total program charges (see instructions)(from contractor's records)		239,322		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		7,908		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		4,913		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.)		92,438		16.04
16.05	Total program cost (see instructions)	0	97,351		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		28,220		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		40,481		19.00
20.00	Net program cost excluding injections/infusions (see instructions)		97,351		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		649		21.00
21.50	Total program IOP OPPS payments (see instructions)				21.50
21.55	Total program IOP Costs (see instructions)				21.55
21.60	Program IOP deductible and coinsurance (see instructions)				21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		98,000		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)		98,000		26.00
26.01	Sequestration adjustment (see instructions)		1,960		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		93,807		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)		2,233		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: 15-0072 Component CCN: 15-8563	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/30/2024 12:38 pm
	Title XVIII	RHC II	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			6,524,479	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			12,874	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			6,511,605	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			33,273	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)			33,273	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			195.70	7.00
		Calculation of Limit (1)			
		Rate Period N/A	Rate Period 1 (01/01/2023 through 12/31/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	126.00		8.00
9.00	Rate for Program covered visits (see instructions)	0.00	126.00		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	5,613		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	707,238		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	9		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	1,134		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	1,134		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	708,372		16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,123,295		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		111,913		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		70,574		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.)		423,546		16.04
16.05	Total program cost (see instructions)	0	494,120		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		108,366		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		180,561		19.00
20.00	Net program cost excluding injections/infusions (see instructions)		494,120		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		8,782		21.00
21.50	Total program IOP OPPS payments (see instructions)				21.50
21.55	Total program IOP Costs (see instructions)				21.55
21.60	Program IOP deductible and coinsurance (see instructions)				21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		502,902		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)		502,902		26.00
26.01	Sequestration adjustment (see instructions)		10,058		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		479,911		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)		12,933		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: 15-0072 | Component CCN: 15-8561 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 5/30/2024 12:38 pm

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)	1,610,113	1,610,113	1,610,113	1,610,113	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000054	0.000357	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	87	575	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	150	340	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	237	915	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,825,553	1,825,553	1,825,553	1,825,553	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,054,422	1,054,422	1,054,422	1,054,422	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000130	0.000501	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	137	528	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	374	1,443	0	0	10.00
11.00	Total number of injections/infusions (from your records)	3	20	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	124.67	72.15	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	9	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	649	0	0	14.00

		COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		1,817	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)		649	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0072 | Component CCN: 15-8563 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 5/30/2024 12:38 pm

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)	3,512,341	3,512,341	3,512,341	3,512,341	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000302	0.000794	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,061	2,789	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	1,750	1,564	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	2,811	4,353	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	3,630,747	3,630,747	3,630,747	3,630,747	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,893,732	2,893,732	2,893,732	2,893,732	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000774	0.001199	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	2,240	3,470	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	5,051	7,823	0	0	10.00
11.00	Total number of injections/infusions (from your records)	35	92	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	144.31	85.03	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	9	88	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)	1,299	7,483	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)		12,874	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)		8,782	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0072 Component CCN: 15-8561	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/30/2024 12:38 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		93,807	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)		93,807	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		2,233	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		96,040	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0072 Component CCN: 15-8563	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/30/2024 12:38 pm

			RHC II	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			479,911	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)			479,911	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			12,933	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			492,844	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00