This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 14-1313 Worksheet S Peri od: From 10/01/2022 Parts I-III AND SETTLEMENT SUMMARY 09/30/2023 Date/Time Prepared: 2/26/2024 10:49 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 2/26/2024 Time: 10:49 am] Manually prepared cost report use only Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. NPR Date:
[12] 13. NPR Date:
[13] 14. NPR Date:
[14] 15. NPR Date:
[15] 15. NPR Date:
[16] 16. NPR Date:
[17] 17. NPR Date:
[18] 17. NPR Date:
[18] 18. NPR Date:
[18] 18. NPR Date:
[18] 19. NPR Da Contractor use only (3) Settled with Audit number of times reopened = 0-9.

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

(4) Reopened (5) Amended

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 MASON DISTRICT HOSPITAL (14-1313) for the cost reporting period beginning 10/01/2022 and ending 09/30/2023 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 FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1	Doug Kosier		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	Doug Kosier			2
3	Signatory Title	CHIEF EXECUTIVE OFFICER			3
4	Date	(Dated when report is electronica			4

		Title	XVIII			
	Title V	Part A	Part B	HIT	Title XIX	
	1.00	2. 00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY						
1. 00 HOSPI TAL	0	187, 758	271, 775	0	0	1. 00
2. 00 SUBPROVI DER - I PF	0	0	0		0	2. 00
3. 00 SUBPROVI DER - I RF	0	0	0		0	3. 00
5. 00 SWING BED - SNF	0	177, 949	0		0	5. 00
6.00 SWING BED - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9. 00
10.00 RURAL HEALTH CLINIC I	0		-10, 534		0	10.00
10.01 RURAL HEALTH CLINIC II	0		-3, 187		0	10. 01
10.02 RURAL HEALTH CLINIC III	0		5, 568		0	10. 02
200. 00 TOTAL	0	365, 707	263, 622	0	0	200.00
The above amounts represent "due to" or "due from"	the applicable	program for th	o alamant of t	he above compl	ov indicated	

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.

Health Financial Systems MASON DISTRICT HOSPITAL In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-1313 Peri od: Worksheet S-2 From 10/01/2022 Part I 09/30/2023 Date/Time Prepared: 2/26/2024 10:49 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 615 NORTH PROMENADE STREET 1.00 PO Box: 1.00 Zip Code: 62644-0530 County: MASON 2.00 City: HAVANA State: IL 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type 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 Hospi tal MASON DISTRICT HOSPITAL 141313 99914 07/01/2001 Ν 0 0 3.00 Subprovider - IPF 4.00 4.00 Subprovider - IRF 5.00 5 00 Subprovi der - (Other) 6.00 6.00 7.00 Swing Beds - SNF MASON DISTRICT HOSPITAL 147313 99914 07/01/2001 N 0 N 7.00 Swing Beds - NF 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 Hospi tal -Based OLTC 11 00 11 00 Hospi tal -Based HHA 12.00 MASON DISTRICT HHA 147202 99914 01/09/1982 Ν Ρ Ν 12.00 13.00 Separately Certified ASC 13.00 Hospi tal -Based Hospi ce 14.00 14.00 15.00 Hospital-Based Health Clinic - RHC HAVANA MEDICAL 99914 O 143457 02/01/2001 0 0 15.00 ASSOCI ATES RHC Hospital-Based Health Clinic - RHC MASON CITY MEDICAL 143462 99914 03/03/2003 15.01 15.01 0 0 0 ASSOCI ATES Hospital-Based Health Clinic - RHC MANITO MEDICAL 148592 99914 04/19/2018 0 0 0 15.02 15.02 ASSOCI ATES IIIIHospital-Based Health Clinic - FQHC 16.00 16.00 17.00 Hospital -Based (CMHC) I 17.00 Renal Dialysis 18.00 18.00 19.00 Other 19.00 From: To 2.00 1.00 10/01/2022 09/30/2023 20.00 Cost Reporting Period (mm/dd/yyyy) 20.00 21.00 Type of Control (see instructions) 21.00 11 1. 00 2. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for N 22.00 Ν 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. 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 22.01 Ν Ν 22.01 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) Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 22. 02 22.02 Ν Ν 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. Did this hospital receive a geographic reclassification from urban to N N Ν 22.03 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. 22.04 Did this hospital receive a geographic reclassification from urban to 22 04 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, yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 Ν 23.00 3 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.

Health Financial Systems MASON DISTRICT HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-1313 Peri od: Worksheet S-2 From 10/01/2022 Part I 09/30/2023 Date/Time Prepared: 2/26/2024 10: 49 am XVIII XIX 1. 00 2.00 3.00 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I Ν 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on Criterion Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for 60.00 any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. Y/N IMF 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 0.00 0.00 61.00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61 03 Enter the base line FTE count for primary care 61 03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 61.04 Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Code Unweighted IME Unweighted Program Name FTE Count Direct GME FTE Count 2.00 1.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0 00 0.00 61.10 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. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 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 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 62.01 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions)

Teaching Hospitals that Claim Residents in Nonprovider Settings

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)

63.00

Health Financial Systems	MASON	DISTRICT HOSPITAL		In Lie	eu of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPI				eriod: com 10/01/2022	Worksheet S-2 Part I	pared:
		'	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Base Yea	r FTF Residents in No	onnrovider Settings	1.00 This base year	2.00	3.00	
period that begins on or after J 64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	uly 1, 2009 and before yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter ir	re June 30, 2010. ty trained residents -primary care all nonprovider d non-primary care n column 3 the ratio	0.00			64. 00
or (cordinit i divided by (cordinit	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1. 00	2.00	3. 00	4.00	5. 00	
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			65. 00
			Unwei ghted FTEs Nonprovi der	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			Si te	Поэрт сат	2//	
Section 5504 of the ACA Current	Voor ETE Docidonts in	Nonprovidor Sotti na	1.00	2.00	3. 00	
beginning on or after July 1, 20	10		SEffective it		ng perrous	
66.00 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider settings. ry care resident 3 the ratio of	0.00	0. 00	0. 000000	66. 00
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
67.00 Enter in column 1, the program	1. 00	2.00	3. 00	4.00	5. 00 0. 000000	67 00
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		, 3. 000000	. 67. 00

97.00

0.00

0 00

applicable column.

97.00 If line 96 is "Y", enter the reduction percentage in the applicable column.

8. 01	column 1 for title V, and in column 2 for title XIX.	-	for no in			
	Does title V or XIX follow Medicare (title XVIII) for the re	eporting of ch	arges on Wkst	N	Υ	98. 01
	C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti					70.0.
- 1	title XIX.				.,	
3. 02	Does title V or XIX follow Medicare (title XVIII) for the ca bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes o	alculation of (observation in column 1	N	Y	98. 02
	for title V, and in column 2 for title XIX.	or in tol lio	THE COLUMN T			
	Does title V or XIX follow Medicare (title XVIII) for a cri			N	N	98. 03
	reimbursed 101% of inpatient services cost? Enter "Y" for ye	es or "N" for I	no in column 1			
	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH	reimbursed 10	1% of	N	N	98. 04
	outpatient services cost? Enter "Y" for yes or "N" for no i			IV	IN IN	70.04
	n column 2 for title XIX.					
	Does title V or XIX follow Medicare (title XVIII) and add ba			N	Y	98. 05
	Vkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in o column 2 for title XIX.	column 1 for t	itle V, and in			
- 1	Does title V or XIX follow Medicare (title XVIII) when cost	reimbursed fo	r Wkst. D,	N	Υ	98. 06
	Pts. I through IV? Enter "Y" for yes or "N" for no in column	n 1 for title '	V, and in			
	column 2 for title XIX.					-
	Rural Providers Does this hospital qualify as a CAH?			Υ		105. 00
	f this facility qualifies as a CAH, has it elected the all-	-inclusive met	hod of payment	Ϋ́		106. 00
	for outpatient services? (see instructions)		, ,			
	Column 1: If line 105 is Y, is this facility eligible for co			N		107. 00
	training programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do					
	approved medical education program in the CAH's excluded II	-				
	Enter "Y" for yes or "N" for no in column 2. (see instructi					
	s this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	dul e? See 42	Υ		108.00
	ork Section 9412.115(c). Enter 1 101 yes of N 101 110.	Physi cal	Occupati onal	Speech	Respi ratory	
		1.00	2. 00	3. 00	4.00	
	f this hospital qualifies as a CAH or a cost provider, are	N	N	N	N	109. 00
ľ	therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					
-						1
	or yes or in for no for each therapy.					
					1.00	
10. 00	Did this hospital participate in the Rural Community Hospita				1. 00 N	110. 00
10. 00	Did this hospital participate in the Rural Community Hospita Demonstration)for the current cost reporting period? Enter '	"Y" for yes or	"N" for no. If	yes,		110. 00
10. 00	Did this hospital participate in the Rural Community Hospita	"Y" for yes or	"N" for no. If	yes,		110. 00
10. 00	Did this hospital participate in the Rural Community Hospita Demonstration)for the current cost reporting period? Enter 'complete Worksheet E, Part A, lines 200 through 218, and Wo	"Y" for yes or	"N" for no. If	yes, h 215, as	N	110. 00
10. 00	Did this hospital participate in the Rural Community Hospit: Demonstration)for the current cost reporting period? Enter 'complete Worksheet E, Part A, lines 200 through 218, and Worapplicable.	"Y" for yes or rksheet E-2, I	"N" for no. If ines 200 throug	yes, h 215, as 1.00		
10. 00	Did this hospital participate in the Rural Community Hospita Demonstration)for the current cost reporting period? Enter 'complete Worksheet E, Part A, lines 200 through 218, and Wordspelicable. f this facility qualifies as a CAH, did it participate in the complete community of the community of	"Y" for yes or rksheet E-2, I the Frontier C	"N" for no. If ines 200 throug	yes, h 215, as	N	_
10. 00	Did this hospital participate in the Rural Community Hospit: Demonstration)for the current cost reporting period? Enter 'complete Worksheet E, Part A, lines 200 through 218, and Worapplicable.	"Y" for yes or rksheet E-2, I the Frontier Co ost reporting	"N" for no. If ines 200 throug	yes, h 215, as 1.00	N	_
11.00	Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter 'Complete Worksheet E, Part A, lines 200 through 218, and Wolapplicable. If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this country 'Y' for yes or "N" for no in column 1. If the response to contegration prong of the FCHIP demo in which this CAH is pain	"Y" for yes or rksheet E-2, I the Frontier Cost reporting of I will be still be stil	"N" for no. If ines 200 througommunity period? Enter the column 2.	yes, h 215, as 1.00	N	_
11.00	Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter 'Complete Worksheet E, Part A, lines 200 through 218, and Wolapplicable. If this facility qualifies as a CAH, did it participate in the call the line of the complete that the complete the complete that the complete the complete that the call that apply: "A" for Ambulance services; "B" for acceptance of the complete that apply: "A" for Ambulance services; "B" for acceptance of the complete that apply: "A" for Ambulance services; "B" for acceptance of the complete that apply: "A" for Ambulance services; "B" for acceptance of the complete that apply: "A" for Ambulance services; "B" for acceptance of the complete that apply: "A" for Ambulance services; "B" for acceptance of the complete that apply the complete that ap	"Y" for yes or rksheet E-2, I the Frontier Cost reporting of I will be still be stil	"N" for no. If ines 200 througommunity period? Enter the column 2.	yes, h 215, as 1.00	N	
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1.00	Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter 'Complete Worksheet E, Part A, lines 200 through 218, and Wolapplicable. If this facility qualifies as a CAH, did it participate in the call the line of the complete that the complete the complete that the complete the complete that the call that apply: "A" for Ambulance services; "B" for acceptance of the complete that apply: "A" for Ambulance services; "B" for acceptance of the complete that apply: "A" for Ambulance services; "B" for acceptance of the complete that apply: "A" for Ambulance services; "B" for acceptance of the complete that apply: "A" for Ambulance services; "B" for acceptance of the complete that apply: "A" for Ambulance services; "B" for acceptance of the complete that apply the complete that ap	"Y" for yes or rksheet E-2, I the Frontier Cost reporting of I will be still be stil	"N" for no. If ines 200 througommunity period? Enter the column 2.	yes, h 215, as 1.00	N	
1.00	Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter applicable. If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this converse or "N" for no in column 1. If the response to an application prong of the FCHIP demo in which this CAH is participate all that apply: "A" for Ambulance services; "B" for according to the content of the cont	"Y" for yes or rksheet E-2, I the Frontier Cost reporting olumn 1 is Y, orticipating in dditional beds	"N" for no. If ines 200 throug community period? Enter enter the column 2.; and/or "C"	yes, h 215, as 1.00 N	N 2. 00	1111. 00
1.00	Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter 'Complete Worksheet E, Part A, lines 200 through 218, and Wordspelicable. If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this concept of the FCHIP demonstration for this concept on the FCHIP demonstration prong of the FCHIP demonstration for the participate in the Health services. Oid this hospital participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost response to the correct cost response to the participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost response to the participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost response to the participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost response to the participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost response to the participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost response to the participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost response to the participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost response to the participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost response to the participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost response to the participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost response to the participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost response to the participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the curren	"Y" for yes or rksheet E-2, I the Frontier Cost reporting polumn 1 is Y, orticipating in dditional beds.	ommunity period? Enter enter the column 2. and/or "C"	yes, h 215, as 1.00 N	N 2. 00	1111. 00
11.00	Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter 'Complete Worksheet E, Part A, lines 200 through 218, and Wordspelicable. If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this contegration prong of the FCHIP demo in which this CAH is participate in the response to contegration prong of the FCHIP demo in which this CAH is participate all that apply: "A" for Ambulance services; "B" for action tele-health services. Old this hospital participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If contents the pennsylvania is the pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If contents the pennsylvania is the penn	"Y" for yes or rksheet E-2, I the Frontier Cost reporting of lumn 1 is Y, or ticipating in dditional beds Ith Model eporting of lumn 1 is	ommunity period? Enter enter the column 2. and/or "C"	yes, h 215, as 1.00 N	N 2. 00	1111. 00
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10. 00 11. 00 12. 00 15. 00	Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter 'Complete Worksheet E, Part A, lines 200 through 218, and Worksheet E, Part A, lines 200 through 218, and Worksheet E, Part A, lines 200 through 218, and Worksheet E, Part A, lines 200 through 218, and Worksheet E, Part A, lines 200 through 218, and Worksheet E, Part A, lines 200 through 218, and Worksheet E, Part A, lines 200 through 218, and Worksheet E, Part A, lines 200 through 218, and Worksheet E, Part A, lines 200 through 218, and Worksheet E, Part A, lines 200 through 218, and Worksheet E, Part A, lines 200 through 218, and Worksheet E, Part A, lines 200 through 218, and Worksheet E, Part A, lines 200 through 218, and Worksheet E, Part A, lines 200 through 218, and Worksheet E, Part A, lines 200 through 218, and Worksheet E, Part A, lines 200 through 218 participation of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If column 2, the date the hospital began participated and Lines 200 through 218 participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information s this an all-inclusive rate provider? Enter "Y" for yes on column 1. If column 1 is yes, enter the method used (A, In column 2. If column 2 is "E", enter in column 3 either "Gor short term hospital or "98" percent for long term care posychiatric, rehabilitation and long term hospitals provided the definition in CMS Pub. 15-1, chapter 22, \$2208.1. s this facility legally-required to carry malpractice insurance 200 through 218 participation and 100 through 22 through 22 participation in the Statistic enter 22 participation and 100 through 22 participation and 100 through 23 participation and 100 through 24 participation and 100 through 25 participat	the Frontier Cost reporting of cost reporting of cost reporting of cost reporting in the cost reporting of cost reporting in the cost reporting	"N" for no. If ines 200 throug community period? Enter enter the column 2. and/or "C" 1.00 N	yes, h 215, as 1.00 N	2. 00 3. 00	111. 00
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Health Financial Systems			HOSPI TAL				u of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA		Provi der CC	CN: 14-1313	Peri From To	od: 10/01/2022 09/30/2023	Worksheet S- Part I Date/Time Pr 2/26/2024 10	epared:
							1. 00	
147.00Was there a change in the statisti	cal hasis? Enter "Y"	for ves	s or "N" for	no			1.00 N	147. 00
148.00 Was there a change in the order of							N	148. 0
149.00Was there a change to the simplifi					or no.		N	149. 0
	<u> </u>		Part A	Part E		Title V	Title XIX	
			1. 00	2.00		3.00	4. 00	
Does this facility contain a provor charges? Enter "Y" for yes or							. 13)	
55. 00 Hospi tal			N	N		N	N	155. 0
56.00 Subprovi der - IPF			N	N		N	N	156. 0
57. 00 Subprovi der - I RF 58. 00 SUBPROVI DER			N	N		N	N	157. 0
158. 00 SUBPROVI DER 159. 00 SNF			N	l N		N	N	158. 0 159. 0
160.00 HOME HEALTH AGENCY			N	l N		N	N N	160. 0
161.00CMHC			IN	I N		N	N N	161. 0
OT. OO CHAIRC						- IV	1. 00	101.0
Multicampus								
65.00 s this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that ha	as one o	or more campu	uses in dif	ferent	CBSAs?	N	165. 0
	Name		County		Zip Coc		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)							0.0	00 166. 0
							1. 00	
Health Information Technology (HI	(r) incentive in the Ar	meri can	Recovery and	d Reinvestr	nent Ac	t		
167.00 Is this provider a meaningful user	05 is "Y") and is a me	eani ngfu	ul user (line		"), ent	ter the	N	167. 0 168. 0
reasonable cost incurred for the l 68.01 If this provider is a CAH and is a exception under §413.70(a)(6)(ii)	not a meaningful user,	does	this provider			ardshi p		168. 0
69.00 If this provider is a meaningful transition factor. (see instruction	ıser (line 167 is "Y")					enter the	0. (00169. C
						Begi nni ng	Endi ng	
170 cole / / / / / / / / / / / / / / / / / / /						1. 00	2. 00	4=-
70.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy)	peginning date and end	ding dat	te for the re	eporting				170. 0
						1. 00	2. 00	
171.00 f line 167 is "Y", does this pro- section 1876 Medicare cost plans i "Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (reported on Wkst. S-3, umn 1. If column 1 is	Pt. I,	, line 2, col	. 6? Enter				0 171. 0

Health Financial Systems MASON DISTRICT HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 14-1313 Peri od: Worksheet S-2 From 10/01/2022 Part II Date/Time Prepared: 09/30/2023 2/26/2024 10:49 am Y/N Date 1. 00 2.00 PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1 00 Has the provider changed ownership immediately prior to the beginning of the cost 1.00 N reporting period? If yes, enter the date of the change in column 2. (see instructions) Date V/I 1 00 2.00 3.00 Has the provider terminated participation in the Medicare Program? If 2.00 Ν 2.00 yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management Ν 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Type 1.00 2.00 3.00 Financial Data and Reports
Column 1: Were the financial statements prepared by a Certified Public 4 00 Α 4 00 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. 5 00 Are the cost report total expenses and total revenues different from Υ 5 00 those on the filed financial statements? If yes, submit reconciliation. Y/N Legal Oper. 1.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider Ν 6.00 the legal operator of the program? 7 00 Are costs claimed for Allied Health Programs? If "Y" see instructions. N 7.00 Were nursing programs and/or allied health programs approved and/or renewed during the Ν 8.00 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 N 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 Ν 10.00 cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved N 11.00 Teaching Program on Worksheet A? If yes, see instructions. Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting 13.00 Ν 13.00 period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see Ν 14.00 instructions. Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions N 15.00 Part B Y/N Y/N Date 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? N N 16.00 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) 17.00 Was the cost report prepared using the PS&R Report for Υ 01/03/2024 01/03/2024 17 00 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) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed Ν Ν 18.00 but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Ν Ν 19.00 Report data for corrections of other PS&R Report information? If yes, see instructions.

Heal th	Financial Systems MASON DISTRIC	CT HOSPITAL		In Lie	u of Form CMS	-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CC	CN: 14-1313	Peri od: From 10/01/2022 To 09/30/2023	Worksheet S- Part II Date/Time Pr 2/26/2024 10	epared:
		Descri	pti on	Y/N	Y/N	17 (4111
		(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 2.00	Y/N	Date	
21. 00	Was the cost report prepared only using the provider's	1. 00 N	2.00	3. 00 N	4. 00	21, 00
21.00	records? If yes, see instructions.	14				21.00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	OSPI TALS)			
22 00	Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see	N	22. 00			
22. 00 23. 00	have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	ing the cost	N	23. 00		
24. 00	Were new leases and/or amendments to existing leases entere If yes, see instructions	ed into during	this cost re	porting period?	N	24. 00
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	If yes, see	N	25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during thinstructions.	ne cost reporti	ng period? I	f yes, see	N	26. 00
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reportin	g period? If	yes, submit	N	27. 00
28. 00	Interest Expense Were new loans, mortgage agreements or letters of credit er	ntered into dur	ing the cost	reporting	Υ	28. 00
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or		bt Service R	eserve Fund)	Υ	29. 00
30. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu	ructions urity with new	debt? If yes	, see	N	30. 00
31. 00	<pre>instructions. Has debt been recalled before scheduled maturity without is instructions.</pre>	ssuance of new	debt? If yes	, see	N	31. 00
32. 00	Purchased Services Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru		d through co	ntractual	N	32. 00
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 applies, see instructions.		g to competi	tive bidding? If	N	33. 00
	Provi der-Based Physi ci ans					
34. 00	Were services furnished at the provider facility under an a If yes, see instructions.	arrangement wit	h provider-b	ased physicians?	Υ	34. 00
35. 00	If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in		ts with the	provi der-based	Υ	35. 00
				Y/N	Date	
				1. 00	2. 00	
2/ 22	Home Office Costs					1 24 25
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr	repared by the	home office?	N N		36. 00 37. 00
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end			N		38. 00
39. 00	If line 36 is yes, did the provider render services to other			, N		39. 00
40. 00	see instructions. If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	N		40. 00
		2.	00			
	Cost Report Preparer Contact Information	1.		2.		
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	DAVI D		MCCLUNG		41. 00
42. 00	respectively. Enter the employer/company name of the cost report	RSM US LLP				42. 00
43. 00	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	6414942144		DAVI D. MCCLUNG@I	RSMUS. COM	43. 00

			CT HOSPITAL		In Lie	In Lieu of Form CMS-2552-10		
HOSPITAL AN	ND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi der	CCN: 14-1313	Peri od: From 10/01/2022 To 09/30/2023		pared:	
					_			
				3. 00				
Cost	Report Preparer Contact Information							
41.00 Ente	er the first name, last name and the	ti tle/posi ti on	MANAGER				41.00	
hel d	d by the cost report preparer in colur	mns 1, 2, and 3,						
resp	pecti vel y.							
42.00 Ente	er the employer/company name of the co	ost report					42.00	
prep	parer.							
43.00 Ente	er the telephone number and email add	ress of the cost					43.00	
repo	ort preparer in columns 1 and 2, respe	ecti vel y.						

 Heal th Financial
 Systems
 MASON

 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

| Peri od: | Worksheet S-3 | From 10/01/2022 | Part | To 09/30/2023 | Date/Time Prepared:

					To 09/30/2023	Date/Time Prep	pared:
						2/26/2024 10: 4 I/P Days / 0/P	49 alli
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	Title V	
	Colliporierre	Li ne No.	No. of beas	Avai I abl e	CAIT/ KEIT HOULS	ii tie v	
		1.00	2. 00	3.00	4. 00	5. 00	
	PART I - STATISTICAL DATA	1.00	2.00	3.00	4.00	3.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	25	9, 12	5 14, 155. 90	0	1. 00
1.00	8 exclude Swing Bed, Observation Bed and	50.00	20	,, 12	11, 100. 70	Ŭ	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
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					ol	5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF					o	6. 00
7. 00	Total Adults and Peds. (exclude observation		25	9, 12	5 14, 155. 90	0	7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31. 00	0		0.00	ol	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)		25	9, 12	5 14, 155. 90	0	14. 00
15. 00	CAH visits			1,	1,	0	15. 00
15. 10	REH hours and visits					_	15. 10
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVIDER - I RF						17. 00
18. 00	SUBPROVI DER						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	101. 00				0	22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25. 00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC	88. 00				0	26. 00
26. 01	RURAL HEALTH CLINIC II	88. 01				0	26. 01
26. 02	RURAL HEALTH CLINIC III	88. 02				0	26. 02
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27.00	Total (sum of lines 14-26)		25				27. 00
28.00	Observation Bed Days					0	28. 00
29.00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31. 00
32.00	Labor & delivery days (see instructions)		0		0		32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
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		O	0	34. 00

Provider CCN: 14-1313

In Lieu of Form CMS-2552-10

| Period: | Worksheet S-3 |
| From 10/01/2022 | Part |
| To 09/30/2023 | Date/Time Prepared: | 2/26/2024 | 10: 49 am

						2/26/2024 10:	49 am
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	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)	250	0	599			1. 00
2.00	HMO and other (see instructions)	99	77				2. 00
3.00	HMO IPF Subprovider	O	0				3. 00
4.00	HMO IRF Subprovider	O	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	265	0	272			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	158			6. 00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	515	0	1, 029			7. 00
8.00	INTENSIVE CARE UNIT	0	0	0			8. 00
9. 00	CORONARY CARE UNIT	Ŭ.	· ·				9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGI CAL INTENSI VE CARE UNI T						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	515	0	1, 029	0.00	186. 72	14. 00
15. 00	CAH visits	0	0		0.00	100172	15. 00
15. 10	REH hours and visits		· ·	Ĭ			15. 10
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						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	4, 546	0	8, 224	0.00	13. 90	
23.00	AMBULATORY SURGICAL CENTER (D. P.)	·		·			23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)			0			24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC	3, 979	4, 746	17, 475	0.00	33. 76	26. 00
26. 01	RURAL HEALTH CLINIC II	156	322	957	0.00	2. 04	26. 01
26. 02	RURAL HEALTH CLINIC III	282	1, 882	4, 046	0.00	3. 26	26. 02
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	O	0	0	0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				0.00	239. 68	27. 00
28.00	Observation Bed Days		0	251			28. 00
29.00	Ambul ance Tri ps	402					29. 00
30.00	Employee discount days (see instruction)			0			30. 00
31.00	Employee discount days - IRF			0			31. 00
32.00	Labor & delivery days (see instructions)	0	0	0			32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
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

| Peri od: | Worksheet S-3 | From 10/01/2022 | Part | To 09/30/2023 | Date/Time Prepared: Provider CCN: 14-1313

				To	09/30/2023	Date/Time Prep 2/26/2024 10:4	
		Full Time Equivalents		Di sch	arges	272072024 10.	T) dill
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers	10.00	40.00	44.00	Pati ents	
	DART I CTATICTICAL RATA	11. 00	12. 00	13. 00	14. 00	15. 00	
4 00	PART I - STATISTICAL DATA			71	0.01	455	4 00
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and		0	/ 1	23	155	1. 00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			26	o		2. 00
3.00	HMO IPF Subprovider				o		3. 00
4.00	HMO IRF Subprovider				o		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						7. 00
0.00	beds) (see instructions)						0.00
8. 00 9. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT						8. 00 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	71	23	155	
15.00	CAH visits						15. 00
15. 10	REH hours and visits						15. 10
16.00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21. 00 22. 00	OTHER LONG TERM CARE HOME HEALTH AGENCY	0. 00					21. 00 22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	0.00					23. 00
24. 00	HOSPICE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC	0.00					26. 00
26. 01	RURAL HEALTH CLINIC II	0. 00					26. 01
26. 02	RURAL HEALTH CLINIC III	0. 00					26. 02
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	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00 32. 00	Employee discount days - IRF Labor & delivery days (see instructions)						31. 00 32. 00
32. 00	Total ancillary labor & delivery room						32. 00
JZ. UI	outpatient days (see instructions)						JZ. U1
33. 00	LTCH non-covered days			0	ļ		33. 00
33. 01	LTCH site neutral days and discharges			O			33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34. 00

Heal th	Financial Systems	MASON DISTRIC	T HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	IEALTH AGENCY STATISTICAL DATA	III/GOIV DI GITAT	Provi der C		Peri od:	Worksheet S-4	
			Component		From 10/01/2022 To 09/30/2023	Date/Time Pre	
					Home Health	2/26/2024 10: PPS	49 am_
					Agency I		
					1.	. 00	
0. 00	County						0.00
		Title V 1.00	Title XVIII 2.00	Title XIX 3.00	0ther 4.00	Total 5.00	
	HOME HEALTH AGENCY STATISTICAL DATA	1.00	2.00	3.00	4.00	3.00	
1.00	Home Heal th Ai de Hours	0	850		1, 319		1
2. 00	Unduplicated Census Count (see instructions)	0.00	183. 00			467.00 me Equivalent)	2. 00
		Enter the number		Staff	Contract	Total	
		your normal	work week				
		0	1	1.00	2. 00	3. 00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES	0		1.00	2.00	3.00	
3.00	Administrator and Assistant Administrator(s)		40. 00	•		1	
4. 00 5. 00	Director(s) and Assistant Director(s) Other Administrative Personnel			0. 00 1. 19		1	4. 00 5. 00
6. 00	Direct Nursing Service			7. 70		1	6. 00
7. 00 8. 00	Nursing Supervisor Physical Therapy Service			0.00			
9. 00	Physical Therapy Supervisor			0.00		1	
10.00	Occupational Therapy Service			0.00		1	
11. 00 12. 00	Occupational Therapy Supervisor Speech Pathology Service			0.00			1
13. 00	Speech Pathology Supervisor			0. 00		1	
14. 00 15. 00	Medical Social Service Medical Social Service Supervisor			0.04		1	
16. 00	Home Heal th Aide			1.04			
17. 00	Home Heal th Aide Supervisor			0.00			
18. 00	Other (specify)			0.00	0.00	CBSA Data	18. 00
						1.00	
19. 00	HOME HEALTH AGENCY CBSA CODES Enter in column 1 the number of CBSAs where	vou provided se	rvi cos duri na	the cost repor	sting poriod	3	19. 00
20. 00	List those CBSA code(s) in column 1 serviced					37900	20.00
20.01	first code).	-				44100	20.01
20. 01 20. 02						99914	20. 01 20. 02
		Full Ep Without		LUDA Enicadas	DED Only	Total (ool o	
		Outliers	With Outliers	LUPA EDISOGES	PEP Only Epi sodes	Total (cols. 1-4)	
	DDG AGTING TV DATA	1.00	2. 00	3. 00	4. 00	5. 00	
21. 00	PPS ACTIVITY DATA Skilled Nursing Visits	1, 982	570	2	7 0	2, 579	21.00
22. 00	Skilled Nursing Visit Charges	651, 971	187, 530	8, 883	3 0	848, 384	22. 00
23. 00 24. 00	Physical Therapy Visits Physical Therapy Visit Charges	715 258, 762	459 166, 158		1 C 2 C	'	
25. 00	Occupational Therapy Visits	174	339		1 0		
26. 00	Occupational Therapy Visit Charges	62, 988	122, 356				1
27. 00 28. 00	Speech Pathology Visits Speech Pathology Visit Charges	17 6, 154	30 10, 860	•			27. 00 28. 00
29. 00	Medical Social Service Visits	1	1		0	2	29. 00
30. 00 31. 00	Medical Social Service Visit Charges Home Health Aide Visits	362 150	362 79				1
32. 00	Home Health Aide Visit Charges	26, 026	14, 378			1	1
33. 00	Total visits (sum of lines 21, 23, 25, 27,	3, 039	1, 478	29	9 0	4, 546	33. 00
34. 00	29, and 31) Other Charges	o	O			0	34.00
35. 00	Total Charges (sum of lines 22, 24, 26, 28,	1, 006, 263	501, 644	1		1	
36. 00	30, 32, and 34) Total Number of Episodes (standard/non	383		20		403	36. 00
JU. UU	outlier)	383					
37. 00	Total Number of Outlier Episodes	7 500	84	•			37.00
აช. 00	Total Non-Routine Medical Supply Charges	7, 520	684	I () c	ار 8, 204	38. 00

Health Financial Systems	MASON DISTRI	CT HOSPITAL		In Li∈	eu of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			CN: 14-1313	Peri od:	Worksheet S-8	
		Component	CCN: 14-3457	From 10/01/2022 To 09/30/2023		epared:
					2/26/2024 10:	
				RHC I	Cost	
				1	00	-
Clinic Address and Identification						
1.00 Street		1		615 N PROMENAD		1.00
			ty	State	ZIP Code	
2.00 City, State, ZIP Code, County		HAVANA	00	2.00	3. 00 62644-0530	2.00
2.00 orty, state, 211 code, county		ji ir v ruvr		1.	02044 0330	2.00
					1.00	
3.00 HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rura	al or "U" for u			0	3. 00
				nt Award 1.00	Date 2.00	
Source of Federal Funds			l	1.00	2.00	
4.00 Community Health Center (Section 330(d), PHS						4. 00
5.00 Migrant Health Center (Section 329(d), PHS A						5. 00
6.00 Health Services for the Homeless (Section 34) 7.00 Appalachian Regional Commission	0(d), PHS Act)					6. 00 7. 00
7.00 Appal achi an Regional Commission 8.00 Look-Alikes			•			8.00
9. 00 OTHER (SPECIFY)						9. 00
			•			
10.00 Dans this facility are at a start than a large		NIC FOUCA F-		1.00	2.00	10.00
10.00 Does this facility operate as other than a house or "N" for no in column 1. If yes, indicated (Enter in subscripts of line 11 the type of hours.)	ate number of o	other operation	s in column	N		10.00
Tioui s.)	Sun	day	l v	londay	Tuesday	
	from	to	from	to	from	
	1.00	2.00	3.00	4. 00	5. 00	
Facility hours of operations (1)		ı	00.00	10.00	00.00	11 00
11. 00 CLINIC			08: 00	18: 00	08: 00	11. 00
				1. 00	2. 00	
12.00 Have you received an approval for an exception 13.00 Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columnumber of providers included in this report. numbers below.	d in CMS Pub. 1 umn 1. If yes,	100-04, chapter enter in colum	9, section nn 2 the	Y N	O	12. 00 13. 00
				der name	CCN	
44.00 DUO /FOUO				1. 00	2. 00	11.00
14.00 RHC/FQHC name, CCN	Y/N	V	XVIII	XIX	Total Visits	14. 00
	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
			inty			
2.00 City State 7LD Code County			00			2.00
2.00 City, State, ZIP Code, County	Tuesday	MASON Wedn	esday	Thur	sday	2. 00
	to	from	to	from	to	
	6.00	7. 00	8. 00	9. 00	10.00	
Facility hours of operations (1)	10.00	loo .oo	40.00	00.00	10.00	44.00
11. 00 CLI NI C	18: 00	08: 00	18: 00	08: 00	18: 00	11.00

Health Financial Systems	MASON DISTRICT HOSPITAL				In Lieu of Form CMS-2552-1	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CCN: 14-1313	Peri od:	Worksheet S-8	
		Component	CCN: 14-3457	From 10/01/2022 To 09/30/2023	Date/Time Pre 2/26/2024 10:	
				RHC I	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12.00	13.00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	18: 00	08: 00	12: 00		11. 00

Heal th	Financial Systems	MASON DISTRI	CT HOSPITAL		In Lie	u of Form CMS-	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA			CN: 14-1313	Peri od:	Worksheet S-8	
			Component	CCN: 14-3462	From 10/01/2022 To 09/30/2023	Date/Time Pre 2/26/2024 10:	
					RHC II	Cost	
	·						
	01: 1 1: 6: 1:				1.	00	
1. 00	Clinic Address and Identification Street				122 EAST ELM S	TDEET	1.00
1.00	1311 66		Ci	ty	State	ZIP Code	1.00
				00	2.00	3. 00	
2.00	City, State, ZIP Code, County		MASON CITY		I L	62664	2. 00
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	or "D" for run	al or "II" for i	ırhan		1.00	3.00
3.00	HOSPITAL-BASED FUNCS UNLT. DESIGNATION - EITE	ei k ioi iuia	1 01 0 101 0		nt Award	Date	3.00
					1. 00	2. 00	
	Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS						4. 00
5.00	Migrant Health Center (Section 329(d), PHS A						5. 00
6. 00 7. 00	Health Services for the Homeless (Section 34 Appalachian Regional Commission	u(a), PHS Act)					6. 00 7. 00
7. 00 8. 00	Look-Alikes						8.00
9. 00	OTHER (SPECIFY)						9. 00
	(5. 55.1.1)		-	1			
		_			1. 00	2. 00	
10. 00	Does this facility operate as other than a h yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o hours.)	ate number of o	other operation	ns in column	N	О	10.00
	110di 3.)	Sur	nday	l N	Monday	Tuesday	
		from	to	from	to	from	
		1.00	2.00	3. 00	4. 00	5. 00	
	Facility hours of operations (1) CLINIC		1	08: 00	16: 00	08: 00	11 00
11.00	CLINIC			08:00	16:00	08: 00	11. 00
					1. 00	2. 00	
12. 00 13. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	d in CMS Pub.' umn 1. If yes,	100-04, chapter enter in colum	9, section nn 2 the	YN	C	12. 00 13. 00
				Prov	ider name	CCN	
					1. 00	2. 00	
14. 00	RHC/FQHC name, CCN	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	1 1/	20/11/1	VIV	T \ \(\cdot \)	14. 00
		Y/N 1.00	V 2. 00	3. 00	XI X 4. 00	Total Visits 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)				4. 00	3.00	15. 00
				unty			
0.60	011 011 710 0 1 0			00			
2. 00	City, State, ZIP Code, County	Tuocday	MASON	oeday	Th	cday	2.00
		Tuesday to	from	esday to	Thur from	to	
		6.00	7. 00	8.00	9. 00	10. 00	
	Facility hours of operations (1)						
11. 00	CLINIC	16: 00	08: 00	16: 00			11. 00

Health Financial Systems	MASON DISTRIC	CT HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-1313	Peri od:	Worksheet S-8	1
				From 10/01/2022		
		Component	CCN: 14-3462	To 09/30/2023		
					2/26/2024 10:	<u>49 am</u>
				RHC II	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12.00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC						11. 00

Heal th	Financial Systems	MASON DISTRI	CT HOSPITAL		In Lie	eu of Form CMS-	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA			CN: 14-1313	Peri od:	Worksheet S-8	
			Component	CCN: 14-8592	From 10/01/2022 To 09/30/2023	Date/Time Pre 2/26/2024 10:	
					RHC III	Cost	17 GIII
					1.	00	
1. 00	Clinic Address and Identification Street				1301 S. EAST A	VENITE	1.00
1.00	3 ti 6 e t		Ci	ty	State	ZIP Code	1.00
				00	2.00	3. 00	
2. 00	City, State, ZIP Code, County		MANI TO		IL	61546	2. 00
						1.00	
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rura	al or "U" for u	ırban		1.00	3.00
0.00	THOSE THE BROCK FRIENDS ONET. BOST GRACTON ETT	er it rer rure	31 01 0 101 0		nt Award	Date	0.00
					1. 00	2. 00	
	Source of Federal Funds			T		Г	
4. 00 5. 00	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS A						4. 00 5. 00
6. 00	Health Services for the Homeless (Section 34						6.00
7. 00	Appal achi an Regional Commission	-(-),					7. 00
8.00	Look-Alikes						8. 00
9. 00	OTHER (SPECIFY)						9. 00
					1. 00	2. 00	
10. 00							10.00
	yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o hours.)						
	illoui s.)	Sur	nday	1	londav	Tuesday	
		from	to	from	to	from	
		1.00	2. 00	3.00	4. 00	5. 00	
	Facility hours of operations (1)			loo 00	1/ 00	00.00	11 00
11.00	CLINIC			08: 00	16: 00	08: 00	11. 00
					1. 00	2.00	
12. 00 13. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col	d in CMS Pub. 1	100-04, chapter	9, section	Y N	C	12. 00 13. 00
	number of providers included in this report. numbers below.			ders and			
				Prov	ider name	CCN	
14 00	RHC/FQHC name, CCN				1. 00	2. 00	14. 00
11.00	Tario, Fario Hamo, Con	Y/N	V	XVIII	XIX	Total Visits	1 7. 00
		1. 00	2. 00	3.00	4. 00	5. 00	
15. 00	Have you provided all or substantially all						15. 00
	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)						
	(See That detrolla)		Cou	L unty			
			4.	00			
2.00	City, State, ZIP Code, County		MASON				2. 00
		Tuesday		esday T +o		sday L +o	
		6. 00	7.00	8. 00	from 9.00	to 10.00	
	Facility hours of operations (1)	0.00	7.00	3.00	7.00	10.00	
	CLINIC	16: 00	08: 00	16: 00	08: 00	16: 00	11. 00

Health Financial Systems	MASON DISTRICT HOSPITAL			In Lieu of Form CMS-2552-1		
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-1313	Peri od:	Worksheet S-8	1
				From 10/01/2022		
		Component	CCN: 14-8592	To 09/30/2023		
					2/26/2024 10:	49 am
				RHC III	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12.00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	16: 00				11. 00

	Financial Systems MASON DISTRICT HOSPITAL TAL UNCOMPENSATED AND INDIGENT CARE DATA Provide	r CCN: 14-1313	Peri od:	Worksheet S-10	2552-10 0		
			From 10/01/2022 To 09/30/2023		nared·		
			1.0 07, 00, 2020	2/26/2024 10:			
				1. 00			
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA			11 00			
	Uncompensated and Indigent Care Cost-to-Charge Ratio						
1.00	Cost to charge ratio (see instructions)			0. 531452	1. 00		
	Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			576, 527	2.00		
3.00	Did you receive DSH or supplemental payments from Medicaid?	<i>E</i> N!:	: -10	Y	3.00		
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental pays		card?	N 100 713	4. 00 5. 00		
5. 00 6. 00	If line 4 is no, then enter DSH and/or supplemental payments from Med Medicaid charges	caru		100, 713 8, 585, 380			
7. 00	Medicaid cost (line 1 times line 6)		4, 562, 717	7.00			
8. 00	Difference between net revenue and costs for Medicaid program (see in:	structions)		3, 885, 477			
0.00	Children's Health Insurance Program (CHIP) (see instructions for each			0,000,177	0.00		
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		0	12. 00				
	Other state or local government indigent care program (see instruction						
13.00	Net revenue from state or local indigent care program (Not included or		,	0			
14. 00							
15. 00	10) State or local indigent care program cost (line 1 times line 14)			o	15. 00		
16. 00							
10.00	Grants, donations and total unreimbursed cost for Medicaid, CHIP and			0 ns (see	16. 00		
	instructions for each line)		3 p3	(
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 hospita			1, 326, 228			
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and local indig	ent care program	ns (sum of lines	3, 885, 477	19. 00		
	8, 12 and 16)	Uni nounced	Lacusod	Tatal (asl 1			
		Uni nsured pati ents		Total (col. 1 + col. 2)			
		1, 00	2. 00	3.00			
	Uncompensated care cost (see instructions for each line)	1100		0.00			
20.00	Charity care charges and uninsured discounts (see instructions)	45, 3	302 16, 899	62, 201	20. 00		
21.00	Cost of patients approved for charity care and uninsured discounts (se	ee 24, 0	076 16, 899	40, 975	21. 00		
	instructions)						
22. 00	Payments received from patients for amounts previously written off as		0 0	0	22. 00		
	charity care	24.4	1/ 000	40.075	22.00		
00 00	00 Cost of charity care (see instructions) 24,076 16,899 40,9						
23. 00							
23. 00				1 00			
	Does the amount on line 20 col. 2, include charges for patient days by	evond a Length o	of stav limit	1. 00 N	24.00		
23. 00	Does the amount on line 20 col. 2, include charges for patient days be imposed on patients covered by Medicaid or other indigent care program		of stay limit	1. 00 N	24. 00		
	imposed on patients covered by Medicaid or other indigent care program	n?	•				
24. 00	imposed on patients covered by Medicaid or other indigent care program	n?	•	N			
24. 00 25. 00 25. 01	imposed on patients covered by Medicaid or other indigent care progral If line 24 is yes, enter the charges for patient days beyond the indigent stay limit Charges for insured patients' liability (see instructions)	n?	•	N 0	25. 00 25. 01		
24. 00 25. 00 25. 01 26. 00	imposed on patients covered by Medicaid or other indigent care progral If line 24 is yes, enter the charges for patient days beyond the indigent stay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions)	n?	•	N 0 0 897, 267	25. 00 25. 01 26. 00		
24. 00 25. 00 25. 01 26. 00 27. 00	imposed on patients covered by Medicaid or other indigent care progral If line 24 is yes, enter the charges for patient days beyond the indigent stay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions)	n?	•	N 0 897, 267 96, 755	25. 00 25. 01 26. 00 27. 00		
24. 00 25. 00 25. 01 26. 00 27. 00 27. 01	imposed on patients covered by Medicaid or other indigent care program If line 24 is yes, enter the charges for patient days beyond the indigent stay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions) Medicare allowable bad debts (see instructions)	n?	•	N 0 897, 267 96, 755 148, 855	25. 00 25. 01 26. 00 27. 00 27. 01		
24. 00 25. 00 25. 01 26. 00 27. 00 27. 01 28. 00	imposed on patients covered by Medicaid or other indigent care progral If line 24 is yes, enter the charges for patient days beyond the indigent stay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions)	n? gent care progra	am's length of	N 0 897, 267 96, 755	25. 00 25. 01 26. 00 27. 00 27. 01 28. 00		

29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)
30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)
31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

449, 845 29, 00 490, 820 30, 00 4, 376, 297 31, 00

	Financial Systems MASON DISTRICT HOSP AL UNCOMPENSATED AND INDIGENT CARE DATA Pro	vider CCN: 14-1313	Peri od:	eu of Form CMS- Worksheet S-1				
03111	THE UNCOME ENGALED AND THUTGENT GAILE DATA	ovider con. 14-1313	From 10/01/2022 To 09/30/2023	2 Parts I & II	epare			
				1.00				
	PART II - HOSPITAL DATA			1.00	_			
	Uncompensated and Indigent Care Cost-to-Charge Ratio				1			
00	Cost to charge ratio (see instructions)				1 1			
	Medicaid (see instructions for each line)				1 .			
00	Net revenue from Medicaid				7 2			
00	Did you receive DSH or supplemental payments from Medicaid?				1 3			
00	If line 3 is yes, does line 2 include all DSH and/or supplemental	payments from Medi	cai d?		4			
00								
00 Medicaid charges								
00								
Difference between net revenue and costs for Medicaid program (see instructions)								
	Children's Health Insurance Program (CHIP) (see instructions for	each line)			Ī			
00	Net revenue from stand-alone CHIP				7			
00	Stand-alone CHIP charges				10			
00	Stand-alone CHIP cost (line 1 times line 10)				11			
2.00 Difference between net revenue and costs for stand-alone CHIP (see instructions)								
	Other state or local government indigent care program (see instru				4			
00	Net revenue from state or local indigent care program (Not include				13			
00	Charges for patients covered under state or local indigent care p	rogram (Not include	d in lines 6 or		14			
	10)				١.,			
. 00	State or local indigent care program cost (line 1 times line 14)		!+		15			
00	Difference between net revenue and costs for state or local indig				16			
	Grants, donations and total unreimbursed cost for Medicaid, CHIP α instructions for each line)	and State/Tocal Ind	igent care progra	ims (see				
00	Private grants, donations, or endowment income restricted to fund	ing charity care			17			
00	Government grants, appropriations or transfers for support of hos	9			18			
00	Total unreimbursed cost for Medicaid , CHIP and state and local i		ms (sum of lines		19			
00	8, 12 and 16)	nargent care progra	ins (sum or rrries		'			
		Uni nsure	d Insured	Total (col. 1				
		pati ents	pati ents	+ col . 2)				
		1.00	2. 00	3. 00				
	Uncompensated care cost (see instructions for each line)				4			
00	Charity care charges and uninsured discounts (see instructions)				20			
00	Cost of patients approved for charity care and uninsured discount	s (see			2			
00	instructions)	£ 00			1 2			
00	Payments received from patients for amounts previously written of	r as			22			
00	charity care (cost of charity care (cost instructions)				1 2			
00	Cost of charity care (see instructions)				23			
				1. 00				
00	Does the amount on line 20 col. 2, include charges for patient da	vs beyond a Length	of stav limit	1.00	2			
-	imposed on patients covered by Medicaid or other indigent care pro		-: -: a a a a a a a a a a a a a a a a a		-			
	If line 24 is yes enter the charges for natient days beyond the			1	1			

If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of

29.00 | Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)

Charges for insured patients' liability (see instructions)

31.00 \mid Total unreimbursed and uncompensated care cost (line 19 plus line 30)

25.00

25.01

26.00

27. 00

27. 01

28.00

29.00

30.00

31.00

25.00

25. 01

stay limit

Bad debt amount (see instructions)

27.00 Medicare reimbursable bad debts (see instructions)

30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)

27.01 Medicare allowable bad debts (see instructions)

28.00 Non-Medicare bad debt amount (see instructions)

	Financial Systems	MASON DISTRICT		N 44 4040 F		u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CC		Period: From 10/01/2022	Worksheet A	
					o 09/30/2023		
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	2/26/2024 10: Reclassi fi ed	49 am
	cost center bescription	Jai ai i es	other	+ col . 2)	ons (See A-6)	Trial Balance	
					(555 11 5)	(col. 3 +-	
						col . 4)	
	I	1.00	2. 00	3. 00	4. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		٥	(451, 338	451, 338	1.00
1. 00	00100 CAP REL COSTS-BEDG & TTXT		0				1.00
1. 02	00102 NEW CAP REL COSTS-NEW MED SURG		0			295, 488	1. 02
1.03	00103 NEW CAP REL COSTS - WEST CAMPUS BUI		0	(46, 740	46, 740	1. 03
2.00	00200 CAP REL COSTS-MVBLE EQUIP		1, 620, 635	1, 620, 635		911, 774	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0 0 0 0 0 0	4, 151, 380	4, 151, 380		4, 151, 380	4.00
5. 01 5. 02	00590 ADMINISTRATIVE AND GENERAL 00591 A&G HOSPITAL ONLY	856, 357 485, 253	1, 387, 944 313, 528	2, 244, 301 798, 781		2, 244, 301 798, 781	5. 01 5. 02
6.00	00600 MAI NTENANCE & REPAI RS	318, 808	289, 744	608, 552	1	608, 552	6.00
6. 01	00601 MAINTENANCE & REPAIRS - WEST CAMPUS	0	0	(ol ol	0	6. 01
7.00	00700 OPERATION OF PLANT	0	353, 434	353, 434	0	353, 434	7. 00
7. 01	00701 OPERATION OF PLANT-CLINIC	0	32, 773	32, 773		32, 773	7. 01
7. 02	00702 OPERATION OF PLANT - WEST CAMPUS BU	0 29, 597	33, 014	33, 014		33, 014	7. 02
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	29, 597 370, 795	23, 996 97, 720	53, 593 468, 515		53, 593 468, 515	8. 00 9. 00
9. 01	00901 HOUSEKEEPING - WEST CAMPUS BUILDING	370, 773	97, 720	400, 515		400, 313	9. 01
10.00	01000 DI ETARY	283, 413	295, 910	579, 323	0	579, 323	10.00
11. 00	01100 CAFETERI A	0	0	(o	0	11. 00
13.00	01300 NURSING ADMINISTRATION	177, 798	17, 618	195, 416		195, 416	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	113, 979	15, 497	129, 476		129, 476	
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0 172, 644	68, 333	240, 977	ή	0 240, 977	15. 00 16. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	172, 644	356, 095	356, 095			19.00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	000, 070	000, 070	,ı	000,070	17.00
30.00	03000 ADULTS & PEDIATRICS	1, 272, 133	632, 007	1, 904, 140	0	1, 904, 140	30. 00
31. 00	03100 I NTENSI VE CARE UNI T	0	0	(0	0	31. 00
F0 00	ANCILLARY SERVICE COST CENTERS	400.040	440.007	205 076		205 070	
50. 00 53. 00	05000 OPERATI NG ROOM 05300 ANESTHESI OLOGY	192, 942	142, 937 5, 599	335, 879 5, 599		335, 879 5, 599	50. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	704, 485	5, 599	1, 226, 166		1, 100, 555	54.00
54. 01	05401 RADI OLOGY-ULTRASOUND	77, 238	66, 867	144, 105		149, 815	54. 01
56.00	05600 RADI OI SOTOPE	0	131, 473	131, 473		131, 859	56. 00
58. 00	05800 MRI	0	160, 185	160, 185		162, 402	58. 00
60.00	06000 LABORATORY	810, 503	1, 125, 381	1, 935, 884			60.00
62. 00 64. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06400 INTRAVENOUS THERAPY	0	129, 410	129, 410 26, 710		129, 410 26, 710	62. 00 64. 00
66. 00	06600 PHYSI CAL THERAPY	743, 836	26, 710 211, 262	955, 098		955, 098	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	306, 623	51, 314	357, 937		357, 937	67.00
68. 00	06800 SPEECH PATHOLOGY	99, 725	11, 228	110, 953	0	110, 953	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	(ή	0	69. 00
69. 01	03160 CARDI OPULMONARY	492, 442	120, 367	612, 809			69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0 478, 125	470, 839 641, 652			470, 839 1, 119, 777	71. 00 73. 00
76. 00	03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES	202, 583	180, 566	383, 149		383, 149	76.00
76. 01	03952 TELEMEDICINE PSYCH SERVICES	0	0	(ol ol	0	76. 01
76. 02	03950 DI ABETI C EDUCATI ON	14, 697	4, 963	19, 660	o	19, 660	76. 02
76. 03	03951 WOUND CARE	0	138, 890	138, 890	0	138, 890	76. 03
76. 04	03953 ALLERGY 123	0	0	(0	0	76. 04
77. 00 78. 00	07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY	0	0	(0	77. 00 78. 00
76.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	U		رار ال	0	76.00
88. 00	08800 RURAL HEALTH CLINIC	3, 307, 363	1, 715, 778	5, 023, 141	-47, 875	4, 975, 266	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	129, 123	72, 268	201, 391		201, 391	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	636, 418	191, 346			827, 764	88. 02
91.00	09100 EMERGENCY	634, 244	1, 762, 484	2, 396, 728	862, 003	3, 258, 731	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95. 00		1, 292, 249	145, 721	1, 437, 970	-862, 003	575, 967	95. 00
	10100 HOME HEALTH AGENCY	695, 694	195, 878			891, 572	
	10200 OPIOID TREATMENT PROGRAM	0	0	(1		102.00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE	44 000 043	128, 297				113.00
118. 00	, ,	14, 899, 067	18, 042, 724	32, 941, 791	-47, 875	32, 893, 916	1118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	٥			0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	11, 562	12, 144	23, 706	47, 875		
194.00	07950 H0SPI CE	0	-, . , .], . 0			194. 00
194. 01	07951 FAMILY MEDICAL CENTER	0	o		o o	0	194. 01
	07952 MEALS ON WHEELS	0	0	(0		194. 02
	3 07954 FITNESS CENTER - WEST CAMPUS	0	0	(194. 03
194.04	1 07953 OTHER NONREIMBURSABLE COST AREAS	0	O	1	ןע (ו	0	194. 04

Health Financial Systems MASON DISTRICT HOSPITAL In Lieu							2552-10
RECLASSI FI CAT	ION AND ADJUSTMENTS OF TRIAL BALANCE (F EXPENSES	Provi der CO		eri od:	Worksheet A	
					rom 10/01/2022		
					o 09/30/2023	Date/Time Pre 2/26/2024 10:	
-		1 1					49 alli
(Cost Center Description	Sal ari es	Other	lotal (col. 1	Recl assi fi cati	Reclassified	
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
						col. 4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
200.00	OTAL (SUM OF LINES 118 through 199)	14, 910, 629	18, 054, 868	32, 965, 497	0	32, 965, 497	200. 00

Provider CCN: 14-1313

Peri od: From 10/01/2022 To 09/30/2023 Date/Ti me Prepared: 2/26/2024 10: 49 am

				2/26/2024 10: 4	19 am
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8) 6.00	For Allocation 7.00		
	GENERAL SERVICE COST CENTERS	0.00	7.00		
1.00	00100 CAP REL COSTS-BLDG & FIXT	-48, 378	402, 960		1.00
1. 01	00101 NEW CAP REL COSTS-CLINIC BUILDING	0			1. 01
1. 02	00102 NEW CAP REL COSTS-NEW MED SURG	-67, 501	•		1. 02
1.03	00103 NEW CAP REL COSTS - WEST CAMPUS BUI	0	1		1. 03
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	-1, 239, 416	1 ,		2. 00 4. 00
5. 01	00590 ADMINISTRATIVE AND GENERAL	-45, 204			5. 01
5. 02	00591 A&G HOSPITAL ONLY	0			5. 02
6.00	00600 MAINTENANCE & REPAIRS	0	608, 552		6.00
6. 01	00601 MAINTENANCE & REPAIRS - WEST CAMPUS	0		l .	6. 01
7. 00	00700 OPERATION OF PLANT	-397	1	1	7. 00
7. 01	00701 OPERATION OF PLANT-CLINIC	0		l l	7. 01
7. 02 8. 00	00702 OPERATION OF PLANT - WEST CAMPUS BU 00800 LAUNDRY & LINEN SERVICE	0		l l	7. 02 8. 00
9. 00	00900 HOUSEKEEPI NG		,	l l	9. 00
9. 01	00901 HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	l l	9. 01
10.00	01000 DI ETARY	-149, 685	429, 638		10.00
11. 00	01100 CAFETERI A	0			11. 00
13.00	01300 NURSING ADMINISTRATION	0		·	13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0		·	14. 00 15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	-2, 797	1		16. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	-51, 416	1	·	19. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00	03000 ADULTS & PEDIATRICS	-351, 940		·	30. 00
31. 00	03100 NTENSI VE CARE UNI T	0	0		31. 00
EO 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	11 420	224 440		EO 00
50. 00 53. 00	05300 ANESTHESI OLOGY	-11, 430 0		·	50. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-1, 155		·	54. 00
54. 01	05401 RADI OLOGY-ULTRASOUND	0		·	54. 01
56. 00	05600 RADI OI SOTOPE	0	•	·	56. 00
58.00	05800 MRI	0	162, 402		58.00
60.00	06000 LABORATORY	0	1 ' '		60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0		·	62. 00
64. 00	06400 NTRAVENOUS THERAPY	0		l l	64.00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0		l l	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY			l l	68. 00
69. 00	06900 ELECTROCARDI OLOGY			l l	69. 00
69. 01	03160 CARDI OPULMONARY	-25, 861	606, 336		69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	470, 839		71. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	-182, 655			73. 00
76. 00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0		1	76. 00
76. 01 76. 02	03952 TELEMEDICINE PSYCH SERVICES 03950 DIABETIC EDUCATION	0			76. 01 76. 02
	03950 DIABETIC EDUCATION 03951 WOUND CARE	-55, 280		·	76. 02 76. 03
	03953 ALLERGY 123	0 0	1	1	76. 04
	07700 ALLOGENEIC HSCT ACQUISITION		l .	1	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		78. 00
	OUTPATIENT SERVICE COST CENTERS	1	1		
88. 00	08800 RURAL HEALTH CLINIC	0		·	88. 00
88. 01 88. 02	08801 RURAL HEALTH CLINIC II 08802 RURAL HEALTH CLINIC III	-300			88. 01 88. 02
91.00	09100 EMERGENCY	-194, 780			91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	174,700	3, 003, 731		92. 00
	OTHER REIMBURSABLE COST CENTERS				
	09500 AMBULANCE SERVICES	0	575, 967		95. 00
	10100 HOME HEALTH AGENCY	0			101.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0		102. 00
113 00	SPECIAL PURPOSE COST CENTERS 11300 NTEREST EXPENSE	0	0		113. 00
113.00		-2, 428, 195		·	113.00
	NONREI MBURSABLE COST CENTERS	2, 120, 170	33, 100, 721		
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	,	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	71, 581		192. 00
	07950 H0SPI CE	0	0		194. 00
	07951 FAMILY MEDICAL CENTER	0	0		194. 01
	207952 MEALS ON WHEELS	0	0		194. 02
	07954 FITNESS CENTER - WEST CAMPUS 07953 OTHER NONREIMBURSABLE COST AREAS	0			194. 03 194. 04
200.00		-2, 428, 195	1		200. 00
200.00	1.01/1E (00m of Elikeo 110 till ough 177)	2, 420, 170	00,007,002	ı I	_55.00

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 MASON DISTRICT HOSPITAL Provider CCN: 14-1313 Period:

KEGENGG	TTOATONS			Trovider e	JON. 14 1313	From 10/01/2022 To 09/30/2023	Date/Time Pro 2/26/2024 10:	epared:
		Increases						
	Cost Center	Li ne #	Sal ary	0ther				
	2 00	3 00	4.00	5.00				

					2/26/2024 10:49 am
		Increases			
	Cost Center	Li ne #	Sal ary	0ther	
	2. 00	3. 00	4. 00	5. 00	
	A - INTEREST RECLASS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	47, 268	1.00
2.00	NEW CAP REL COSTS-NEW MED	1.02	0	81, 029	2.00
	SURG				
	0		0	128, 297	
	B - EMS SALARY TO ER				
1.00	EMERGENCY	91.00		0	1.00
	0		862, 003	0	
	C - DEPRECIATION				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	404, 070	
2.00	NEW CAP REL COSTS-CLINIC	1. 01	0	43, 592	2.00
	BUI LDI NG				
3.00	NEW CAP REL COSTS-NEW MED	1. 02	0	214, 459	3.00
	SURG				
4.00	NEW CAP REL COSTS - WEST	1.03	0	46, 740	4.00
	CAMPUS BUI		+		
	0		0	708, 861	
	D - RHC PHYSICIAN	, , , , , , , , , , , , , , , , , , , ,			
1.00	PHYSICIANS' PRIVATE OFFICES_	192.00		0	1.00
	0		47, 875	0	
	E - OP REGISTRATION	,			
1.00	LABORATORY	60.00	86, 027	11, 883	
2.00	CARDI OPULMONARY	69. 01	17, 035	2, 353	
3.00	RADI OLOGY-ULTRASOUND	54. 01	5, 017	693	3.00
4.00	RADI OI SOTOPE	56.00	339	47	4.00
5.00	RADI OLOGY-DI AGNOSTI C	54.00	7, 798	1, 077	5. 00
6.00	MRI	58. 00	1, 948	269	6. 00
	0		118, 164	16, 322	
500.00	Grand Total: Increases		1, 028, 042	853, 480	500.00

Heal th Financial Systems MASON DISTRICT HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 14-1313 Period: Worksheet A-6
From 10/01/2022 From 10/01/2022 Provider CCN: 14-1313 Period: Provider CCN:

						To 09/30/2023	Date/Time Pro 2/26/2024 10	epared: · 49 am
		Decreases		'			12,20,2021 10	1,7 (3
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.			
	6. 00	7. 00	8. 00	9. 00	10. 00			
	A - INTEREST RECLASS							
	INTEREST EXPENSE	113.00	0	128, 297	11			1.00
2.00		0.00	0_	0	11			2. 00
	0		0	128, 297				
	B - EMS SALARY TO ER							
1.00	AMBULANCE SERVICES	95.00	<u>862, 0</u> 03	0	0			1. 00
	0		862, 003	0				
	C - DEPRECIATION							
	CAP REL COSTS-MVBLE EQUIP	2.00	0	708, 861	9			1. 00
2.00		0.00	0	0	9			2. 00
3.00		0.00	0	0	9			3. 00
4.00		0.00	0_	0	<u> </u>			4. 00
	0		0	708, 861				
	D - RHC PHYSICIAN							
1. 00	RURAL HEALTH CLINIC	8800		0	0			1. 00
	0		47, 875	0				
	E - OP REGISTRATION							
	RADI OLOGY-DI AGNOSTI C	54.00	118, 164	16, 322	. 0			1. 00
2.00		0.00	0	0	0			2. 00
3.00		0.00	0	0	0			3. 00
4.00		0.00	0	0	0			4. 00
5.00		0.00	0	0	0			5. 00
6.00	L	0.00	0_	0	0			6. 00
	0		118, 164	16, 322				
500.00	Grand Total: Decreases		1, 028, 042	853, 480				500.00

				Т	o 09/30/2023	Date/Time Pre 2/26/2024 10:	
			Acqui si ti ons			2/20/2024 10.	47 (1111
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	Γ BALANCES					
1.00	Land	163, 928	0	0	0	0	1. 00
2.00	Land Improvements	674, 756	19, 995	0	19, 995	0	2. 00
3.00	Buildings and Fixtures	19, 098, 000	574, 121	0	574, 121	0	3. 00
4.00	Building Improvements	96, 997	0	0	0	0	4. 00
5.00	Fixed Equipment	3, 907, 604	0	0	0	0	5. 00
6.00	Movable Equipment	12, 038, 325	1, 005, 506	0	1, 005, 506	0	6. 00
7.00	HIT designated Assets	1, 231, 920	146, 188	0	146, 188	0	7. 00
8.00	Subtotal (sum of lines 1-7)	37, 211, 530	1, 745, 810	0	1, 745, 810	0	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	37, 211, 530	1, 745, 810	0	1, 745, 810	0	10. 00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		_				
1.00	Land	163, 928	0				1. 00
2.00	Land Improvements	694, 751	0				2. 00
3.00	Buildings and Fixtures	19, 672, 121	0				3. 00
4.00	Building Improvements	96, 997	0				4. 00
5.00	Fi xed Equi pment	3, 907, 604	0				5. 00
6.00	Movable Equipment	13, 043, 831	0				6. 00
7.00	HIT designated Assets	1, 378, 108	0				7. 00
8.00	Subtotal (sum of lines 1-7)	38, 957, 340	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	38, 957, 340	0				10.00

Health Financial Systems	MASON DISTRICT HOSPITAL	In Lieu of For	rm CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS	Provi der CCN: 14-1313		
		From 10/01/2022 Part I	

					rom 10/01/2022 o 09/30/2023	Part II Date/Time Prep 2/26/2024 10:4	pared: 49 am
			SU	MMARY OF CAPIT	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
		9. 00	10. 00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	0	C	0	0	1.00
1. 01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	C	0	0	1. 01
1. 02	NEW CAP REL COSTS-NEW MED SURG	0	0	C	0	0	1. 02
1.03	NEW CAP REL COSTS - WEST CAMPUS BUI	0	0	C	0	0	1. 03
2.00	CAP REL COSTS-MVBLE EQUIP	1, 620, 635	0	C	0	0	2. 00
3.00	Total (sum of lines 1-2)	1, 620, 635	0	C	0	0	3. 00
		SUMMARY OF	CAPITAL				
	Cost Center Description	Other -	Гotal (1) (sum				
		Capi tal -Relate					
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 ar	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	0				1.00
1. 01	NEW CAP REL COSTS-CLINIC BUILDING	0	0				1. 01
1. 02	NEW CAP REL COSTS-NEW MED SURG	0	0				1. 02
1. 03	NEW CAP REL COSTS - WEST CAMPUS BUI	0	0				1. 03
2.00	CAP REL COSTS-MVBLE EQUIP	0	1, 620, 635				2. 00
3.00	Total (sum of lines 1-2)	0	1, 620, 635				3. 00

	Financial Systems	MASON DISTRIC	CT HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 10/01/2022 To 09/30/2023		pared:
		COMF	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
		1. 00	2. 00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS		•	•		
1.00	CAP REL COSTS-BLDG & FIXT	24, 535, 401	0	24, 535, 40	1 0. 629802	0	1. 00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0		0. 000000	0	1. 01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0		0. 000000		1. 02
1.03	NEW CAP REL COSTS - WEST CAMPUS BUI	0	0		0. 000000		1. 03
2.00	CAP REL COSTS-MVBLE EQUIP	14, 421, 939		14, 421, 93			2.00
3.00	Total (sum of lines 1-2)	38, 957, 340		00/70//01			3. 00
		ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY OF CAPITAL		
	Cost Center Description	Taxes	Other Capital-Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE		7.00	0.00	7. 00	10.00	
1.00	CAP REL COSTS-BLDG & FLXT	0	0		0 391, 860	0	1. 00
1. 01	NEW CAP REL COSTS-CLINIC BUILDING	0	_		0 43, 592		1. 01
1. 02	NEW CAP REL COSTS-NEW MED SURG	0	Ö	,	0 213, 257		1. 02
1.03	NEW CAP REL COSTS - WEST CAMPUS BUI	0	Ö	j	0 46, 740		1. 03
2.00	CAP REL COSTS-MVBLE EQUIP	0	Ó	,	911, 774	o	2. 00
3.00	Total (sum of lines 1-2)	0	Ó	,	1, 607, 223		3. 00
			SI	JMMARY OF CAPI			
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	'		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
					d Costs (see	through 14)	
					instructions)		
		11. 00	12.00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00	CAP REL COSTS-BLDG & FIXT	0	-	1	0 11, 100		1. 00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0		0	43, 592	1. 01
1. 02	NEW CAP REL COSTS-NEW MED SURG	14, 730			0	227, 987	1. 02
1.03	NEW CAP REL COSTS - WEST CAMPUS BUI	0	0		0	46, 740	1. 03
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	1	0	911, 774	2. 00
3.00	Total (sum of lines 1-2)	14, 730	0	1	0 11, 100	1, 633, 053	3. 00

| Period: | Worksheet A-8 | From 10/01/2022 | To 09/30/2023 | Date/Time Prepared: Provider CCN: 14-1313

				To	09/30/2023	Date/Time Prep 2/26/2024 10:4	
				Expense Classification on	Worksheet A	2/20/2024 10.2	49 alli
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4. 00 1. 00	5. 00 0	1. 00
1.00	COSTS-BLDG & FIXT (chapter 2)		U	CAP REL CUSTS-BLDG & FIXT	1.00		1.00
1. 01	Investment income - NEW CAP REL COSTS-CLINIC BUILDING		0	NEW CAP REL COSTS-CLINIC	1. 01	0	1. 01
	(chapter 2)			BUI LDI NG			
1. 02	Investment income - NEW CAP REL COSTS-NEW MED SURG		0	NEW CAP REL COSTS-NEW MED	1. 02	0	1. 02
	(chapter 2)			SURG			
1.03	Investment income - NEW CAP REL COSTS - WEST CAMPUS BUI		0	NEW CAP REL COSTS - WEST CAMPUS BUI	1. 03	0	1. 03
	(chapter 2)			CAMPUS BUT			
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3.00	Investment income - other		0		0. 00	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time		0		0. 00	0	4. 00
	discounts (chapter 8)		· ·			Ĭ	
5.00	Refunds and rebates of expenses (chapter 8)		0		0. 00	0	5. 00
6.00	Rental of provider space by		0		0. 00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		0		0. 00	0	7. 00
7.00	stations excluded) (chapter		· ·		0.00	J	7.00
8. 00	21) Television and radio service		0		0. 00	0	8. 00
	(chapter 21)		O				
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	-640, 446		0. 00	0	9. 00 10. 00
	adj ustment						
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0. 00	0	11. 00
12. 00	Related organization	A-8-1	0			0	12.00
13. 00	transactions (chapter 10) Laundry and linen service		0		0. 00	0	13. 00
14.00	Cafeteria-employees and guests		0		0. 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		0		0. 00	О	16. 00
	supplies to other than patients						
17. 00	Sale of drugs to other than		0		0. 00	0	17. 00
18. 00	patients Sale of medical records and		0		0. 00	0	18. 00
19. 00	abstracts Nursing and allied health		0		0. 00	0	19. 00
19.00	education (tuition, fees,		O		0.00		19.00
20. 00	books, etc.) Vending machines		0		0. 00	0	20. 00
21. 00	Income from imposition of		0		0.00	0	21. 00
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0. 00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	*** Cost Center Deleted ***	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
26. 01	COSTS-BLDG & FIXT Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-CLINIC	1. 01	0	26. 01
	COSTS-CLINIC BUILDING			BUI LDI NG			
26. 02	Depreciation - NEW CAP REL COSTS-NEW MED SURG		0	NEW CAP REL COSTS-NEW MED SURG	1. 02	0	26. 02
26. 03	Depreciation - NEW CAP REL COSTS - WEST CAMPUS BUI			NEW CAP REL COSTS - WEST CAMPUS BUI	1. 03	О	26. 03
	100010 - WEST CAMIFUS BUT	1		Johns 03 DOI	l	<u> </u>	

From 10/01/2022 | To 09/30/2023 | Date/Time Prepared:

				''	0 09/30/2023	2/26/2024 10:	
				Expense Classification on	Worksheet A	2,20,2021 101	, , <u>u</u>
				To/From Which the Amount is			
					,		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	oost deliter beserretron	1.00	2. 00	3.00	4. 00	5. 00	
27. 00	Depreciation - CAP REL	1.00		CAP REL COSTS-MVBLE EQUIP	2.00	0.00	27. 00
27.00	COSTS-MVBLE EQUIP		0	NEE COSTS WIVELE EQUIT	2.00		27.00
28. 00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19. 00		28. 00
29. 00	Physicians' assistant		0	NON ITTS CLAN ANESTHETISTS	0.00	0	
30. 00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67.00	0	30.00
30.00	therapy costs in excess of	A-0-3	U	OCCUPATIONAL THERAPT	67.00		30.00
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
30. 99	instructions)		U	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
31.00	pathology costs in excess of	A-0-3	U	SPEECH PATHOLOGY	00.00		31.00
	. 03						
32. 00	limitation (chapter 14) CAH HIT Adjustment for	В	0	CAP REL COSTS-MVBLE EQUIP	2. 00	_	32. 00
32.00		D	U	CAP REL COSTS-WVBLE EQUIP	2.00	9	32.00
22.00	Depreciation and Interest	В	2 707	MEDICAL DECODDS & LIBRARY	1/ 00	_	22.00
33. 00	MEDICAL RECORD FEES -OTHER OP			MEDICAL RECORDS & LIBRARY	16. 00	0	33. 00
33. 01	CAFETERI A SALES -OTHER OP	В	-149, 685		10.00	0	33. 01
33. 02	DI ETARY CONSULT -OTHER OP	В		DI ETARY	10.00	0	33. 02
33. 03	SALE OF NON-PAT SUPP-OTHER OP	В		ADMINISTRATIVE AND GENERAL	5. 01	0	33. 03
33. 04	ON-CALL CRNA SERVICES	A	·	NONPHYSI CI AN ANESTHETI STS	19. 00	0	33. 04
33. 05	PROF BUILDING RENT -OTHER OP	В		CAP REL COSTS-BLDG & FIXT	1.00	9	33. 05
33. 06	MI SCELLANEOUS -OTHER OP	В		ADMINISTRATIVE AND GENERAL	5. 01	0	33. 06
33. 07	RENTAL I NCOME	В		CAP REL COSTS-BLDG & FIXT	1.00	9	33. 07
33. 08	COMMUNITY ED FEES -OTHER OP	В		ADMINISTRATIVE AND GENERAL	5. 01	0	33. 08
33. 09	LAB OUTREACH REV -OTHER OP	В		LABORATORY	60.00	0	33. 09
33. 10	INTEREST INCOME -NON OPER	В	·	CAP REL COSTS-BLDG & FIXT	1. 00	11	33. 10
33. 11	INTEREST INCOME -NON OPER	В	-66, 299	NEW CAP REL COSTS-NEW MED	1. 02	11	33. 11
				SURG			
33. 12	FI TNESS EXPENSE	A		CARDI OPULMONARY	69. 01	0	33. 12
33. 13	FITNESS CENTER REV	В		CARDI OPULMONARY	69. 01	0	33. 13
33. 14	HOME HEALTH REV	В		HOME HEALTH AGENCY	101.00	0	33. 14
33. 15	TELEPHONE OFFSET - OPERATIONS	A		OPERATION OF PLANT	7. 00	0	33. 15
33. 16	TELEPHONE OFFSET - SALARIES	Α		ADMINISTRATIVE AND GENERAL	5. 01	0	33. 16
33. 17	TELEPHONE OFFSET - BENEFITS	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 17
33. 18	MEDICAR - EXPENSES	A	·	ADMINISTRATIVE AND GENERAL	5. 01	0	33. 18
33. 19	MEDICAR - BENEFITS	A	·	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 19
33. 20	LOBBYI NG DUES	A		ADMINISTRATIVE AND GENERAL	5. 01	0	33. 20
33. 21	ADVERTI SI NG	A		ADMINISTRATIVE AND GENERAL	5. 01	0	33. 21
33. 22	ADVERTI SI NG	A		A&G HOSPITAL ONLY	5. 02	0	33. 22
33. 25	ADVERTI SI NG	A		RURAL HEALTH CLINIC III	88. 02	0	33. 25
33. 27	SPEECH THERAPY IN SCHOOLS	В		SPEECH PATHOLOGY	68. 00	0	33. 27
33. 34	SPEECH THERAPY IN SCHOOLS	В		SPEECH PATHOLOGY	68. 00	0	33. 34
33. 35	TELEVI SI ONS	A		NEW CAP REL COSTS-NEW MED	1. 02	9	33. 35
				SURG			
33. 36	SELF INSURANCE	A		EMPLOYEE BENEFITS DEPARTMENT	4.00		
33. 37	UNFUNDED POST-EMPLOYMENT	A	-107, 566	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 37
	BENEFI T						
33. 38	NON-ALLOW DONATION EXP	A		ADMINISTRATIVE AND GENERAL	5. 01	0	
33. 39	BOND AMORTIZTION COST FY14	A		CAP REL COSTS-BLDG & FIXT	1. 00		
33. 40	IMRF CONTRIBUTION	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	
33. 41	340 B	A		DRUGS CHARGED TO PATIENTS	73. 00	0	33. 41
50. 00	TOTAL (sum of lines 1 thru 49)		-2, 428, 195				50. 00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

⁽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 CCN: 14-1313

					'	0 77 307 2023	2/26/2024 10:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				'	'		Hours	
	1. 00	2. 00	3.00	4. 00	5. 00	6. 00	7. 00	
1.00	91. 00	EMERGENCY	1, 607, 424	194, 780	1, 412, 644	0	0	1. 00
2.00	60.00	LABORATORY	48, 000	0	48, 000	0	0	2. 00
3.00	69. 01	CARDI OPULMONARY	25, 861	25, 861	0	0	0	3. 00
4.00	54. 00	RADI OLOGY-DI AGNOSTI C	1, 155	1, 155	0	0	0	4. 00
5.00	30.00	ADULTS & PEDIATRICS	351, 940	351, 940	0	0	0	5. 00
6.00	76. 03	WOUND CARE	138, 200	55, 280	82, 920	0	0	6. 00
7.00	50.00	OPERATING ROOM	11, 430	11, 430		0	0	7. 00
8.00	0.00		. 0	. 0	0	0	0	8. 00
9. 00	0. 00		0	0	0	0	0	9. 00
10. 00	0. 00		0	0	0	0	0	10.00
200.00			2, 184, 010	640, 446	1, 543, 564	_	0	200. 00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er			Memberships &	Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2.00	8.00	9. 00	12. 00	13. 00	14.00	
1.00	91. 00	EMERGENCY	0	0	0	0	0	1. 00
2.00	60.00	LABORATORY	0	0	0	0	0	2. 00
3.00	69. 01	CARDI OPULMONARY	0	0	0	0	0	3.00
4.00	54. 00	RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	Ó	0	5. 00
6.00	76. 03	WOUND CARE	0	0	0	O	0	6. 00
7. 00		OPERATING ROOM	0	0	0	0	0	7. 00
8. 00	0. 00		0	0	0	0	0	8. 00
9. 00	0. 00		0	0	0	0	0	9. 00
10.00	0.00		0	0	0	0	0	1
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance	.,		
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00	91. 00	EMERGENCY	0	0	0	194, 780		1. 00
2.00	60.00	LABORATORY	0	0	0	0		2. 00
3.00	69. 01	CARDI OPULMONARY	0	0	0	25, 861		3. 00
4.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	0	1, 155		4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	351, 940		5. 00
6.00	76. 03	WOUND CARE	0	0	0	55, 280		6. 00
7.00	50.00	OPERATING ROOM	0	0	0	11, 430		7. 00
8. 00	0.00		0	Ö	0	0		8. 00
9. 00	0. 00		l o	Ö	0	0		9. 00
10. 00	0. 00		0	l o	0	0		10.00
200.00			l o	Ö	0	640, 446		200. 00
				·			1	

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 10/01/2022 | Part |
| To 09/30/2023 | Date/Time Prepared: | 2/26/2024 | 10: 49 am Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-1313

				CADITAL DEL		2/26/2024 10:		
				CAPITAL RELATED COSTS				
		Cost Center Description	Net Expenses	BLDG & FIXT	NEW CLINIC	NEW NEW MED	NEW CAP REL	
			for Cost Allocation		BUI LDI NG	SURG	COSTS - WEST CAMPUS BUI	
			(from Wkst A					
			col. 7) 0	1. 00	1. 01	1. 02	1. 03	
		AL SERVICE COST CENTERS	-					
1.00	1	CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-CLINIC BUILDING	402, 960 43, 592	402, 960 0	42 502			1.00
1. 01 1. 02	1	NEW CAP REL COSTS-CLINIC BUILDING	227, 987	0	43, 592 0	227, 987		1. 01 1. 02
1. 03	00103	NEW CAP REL COSTS - WEST CAMPUS BUI	46, 740	0	0	0	46, 740	
2.00		CAP REL COSTS-MVBLE EQUIP	911, 774	0			0	2.00
4. 00 5. 01		EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE AND GENERAL	2, 911, 964 2, 199, 097	0 89, 319	2, 313	0	0	4. 00 5. 01
5. 02	1	A&G HOSPI TAL ONLY	798, 781	9, 141	2, 848	1, 871	0	5. 02
6.00	1	MAINTENANCE & REPAIRS	608, 552	0	0	0	0	6.00
6. 01 7. 00		MAINTENANCE & REPAIRS - WEST CAMPUS OPERATION OF PLANT	353, 037	0 39, 907	365	4, 990	0	6. 01 7. 00
7. 01		OPERATION OF PLANT-CLINIC	32, 773	0	0	0	0	7. 01
7.02		OPERATION OF PLANT - WEST CAMPUS BU	33, 014	0	0	0	0	7. 02
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING	53, 593 468, 515	12, 014 2, 665	0	1, 855 1, 096	0	8. 00 9. 00
9. 01	1	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	Ö	0	0	9. 01
10.00		DIETARY	429, 638	19, 530	0	0	0	10.00
11. 00 13. 00		CAFETERIA NURSI NG ADMINI STRATI ON	195, 416	8, 302 6, 099	0	1, 264 2, 714	0	11. 00 13. 00
14. 00		CENTRAL SERVICES & SUPPLY	129, 476	11, 097	Ö	2, 714	0	14. 00
15. 00		PHARMACY	0	0	0	0	0	15. 00
16. 00 19. 00		MEDICAL RECORDS & LIBRARY NONPHYSICIAN ANESTHETISTS	238, 180 304, 679	5, 483 0		0	0	16. 00 19. 00
19.00		I ENT ROUTINE SERVICE COST CENTERS	304, 077	J	<u> </u>	<u> </u>	0	19.00
30.00		ADULTS & PEDIATRICS	1, 552, 200	5, 938		177, 730	0	
31. 00		INTENSIVE CARE UNIT LARY SERVICE COST CENTERS	0	0	0	0	0	31. 00
50.00		OPERATING ROOM	324, 449	48, 070	0	0	0	50. 00
53. 00	1	ANESTHESI OLOGY	5, 599	0	- 1	0	0	53. 00
54. 00 54. 01		RADI OLOGY-DI AGNOSTI C RADI OLOGY-ULTRASOUND	1, 099, 400 149, 815	37, 474 1, 871	0	0	0	54. 00 54. 01
56. 00	1	RADI OI SOTOPE	131, 859	4, 066	0	o	0	56. 00
58. 00	05800		162, 402	0	0	O	0	58. 00
60. 00 62. 00	1	LABORATORY WHOLE BLOOD & PACKED RED BLOOD CELL	2, 033, 794 129, 410	22, 025 0		0	0	60. 00 62. 00
64. 00		INTRAVENOUS THERAPY	26, 710	0	Ö	o	0	64. 00
66. 00	1	PHYSI CAL THERAPY	955, 098	7, 932	-	o	0	66. 00
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	357, 937 110, 953	1, 663 1, 201	0	0	0	67. 00 68. 00
69. 00		ELECTROCARDI OLOGY	0	0	0	o	0	69. 00
69. 01		CARDI OPULMONARY	606, 336	37, 689		O	0	69. 01
71. 00 73. 00		MEDICAL SUPPLIES CHARGED TO PATIENT DRUGS CHARGED TO PATIENTS	470, 839 937, 122	0	· ·	0 31, 527	0	
76. 00	1	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	383, 149	0	- 1	31, 527	0	76.00
76. 01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0	76. 01
76. 02 76. 03		DIABETIC EDUCATION WOUND CARE	19, 660 83, 610	0	0	0	0	76. 02 76. 03
76. 04		ALLERGY 123	03,010	0	0	o	0	76. 03
77. 00	1	ALLOGENEIC HSCT ACQUISITION	o	0	0	0	0	77. 00
78. 00		CAR T-CELL IMMUNOTHERAPY TIENT SERVICE COST CENTERS	0	0	0	0	0	78. 00
88. 00		RURAL HEALTH CLINIC	4, 975, 266	0	31, 991	o	0	88. 00
88. 01	08801	RURAL HEALTH CLINIC II	201, 391	0	0	O	0	88. 01
88. 02 91. 00		RURAL HEALTH CLINIC III	827, 464	0	0	0	0	88. 02
91.00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	3, 063, 951	31, 474	U	U	0	91. 00 92. 00
	OTHER	REIMBURSABLE COST CENTERS				'		
95.00		AMBULANCE SERVI CES	575, 967	0		0		95.00
		HOME HEALTH AGENCY OPIOID TREATMENT PROGRAM	891, 572 0	0		0		101. 00 102. 00
	SPECI	AL PURPOSE COST CENTERS		0	<u> </u>	<u> </u>		50
	1	INTEREST EXPENSE	20 4/5 724	100.010	40 500	222 217		113.00
118.00	_	SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	30, 465, 721	402, 960	43, 592	223, 047	0	118. 00
190. 00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	4, 940	0	190. 00
		PHYSICIANS' PRIVATE OFFICES	71, 581	0	0	o		192.00
		HOSPICE FAMILY MEDICAL CENTER	0	0	0	0		194. 00 194. 01
. , 1. 01	10,701	1Er mest site senten	<u> </u>	O ₁	١	Ч		1.7

Health Financial Systems	MASON DISTRICT HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 14-1313	Period: Worksheet B From 10/01/2022 Part I To 09/30/2023 Date/Time Prepared:

					2/26/2024 10:	49 am
		CAPITAL RELATED COSTS				
Cost Center Description	Net Expenses	BLDG & FIXT	NEW CLINIC	NEW NEW MED	NEW CAP REL	
	for Cost		BUI LDI NG	SURG	COSTS - WEST	
	Allocation				CAMPUS BUI	
	(from Wkst A					
	col . 7)					
	0	1. 00	1. 01	1. 02	1. 03	
194.02 07952 MEALS ON WHEELS	0	0	0	0	0	194. 02
194.03 07954 FITNESS CENTER - WEST CAMPUS	0	0	0	0	46, 740	194. 03
194.04 07953 OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194. 04
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)	30, 537, 302	402, 960	43, 592	227, 987	46, 740	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-1313

					'	o 09/30/2023	2/26/2024 10:	
			CAPI TAL					
		Cost Center Description	RELATED COSTS MVBLE EQUIP	EMPLOYEE	Subtotal	ADMI NI STRATI VE	Subtotal	
		cost center bescription	WIVELE EQUIP	BENEFITS	Subtotal	AND GENERAL	Subtotal	
				DEPARTMENT				
	OFNED	AL CERVI OF COCT OFFITERS	2. 00	4. 00	4A	5. 01	5A. 01	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT						1. 00
1. 00	1	NEW CAP REL COSTS-CLINIC BUILDING						1. 00
1. 02	1	NEW CAP REL COSTS-NEW MED SURG						1. 02
1.03		NEW CAP REL COSTS - WEST CAMPUS BUI						1. 03
2.00		CAP REL COSTS-MVBLE EQUIP	911, 774					2. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT	0	2, 911, 964		0 (00 (05		4. 00
5. 01 5. 02		ADMINISTRATIVE AND GENERAL A&G HOSPITAL ONLY	227, 115	172, 851	2, 690, 695		998, 778	5. 01 5. 02
6. 00		MAINTENANCE & REPAIRS	0	98, 133 64, 473			738, 057	6. 00
6. 01	1	MAINTENANCE & REPAIRS - WEST CAMPUS	o	0 .,	0,0,020		0	6. 01
7.00		OPERATION OF PLANT	12, 218	0	410, 517	39, 667	450, 184	7. 00
7. 01		OPERATION OF PLANT-CLINIC	0	0	32, 773		35, 940	7. 01
7. 02		OPERATION OF PLANT - WEST CAMPUS BU	0	0	33, 014		36, 204	7. 02
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING	0	5, 985 74. 986	73, 447		80, 544 600, 142	8. 00 9. 00
9. 00	1	HOUSEKEEPING - WEST CAMPUS BUILDING	0	74, 900	547, 262 0		000, 142	9.00
10. 00	1	DI ETARY		57, 315			555, 422	10.00
11.00	1	CAFETERI A	0	0	9, 566		10, 490	
13. 00		NURSING ADMINISTRATION	0	35, 956			263, 393	
14. 00	1	CENTRAL SERVICES & SUPPLY	0	23, 050	163, 623	15, 810	179, 433	14. 00
15. 00		PHARMACY MEDICAL RECORDS & LIBRARY	F2 400	24 014	0	22 120	0	15. 00
16. 00 19. 00	1	NONPHYSICIAN ANESTHETISTS	53, 400 0	34, 914 0	332, 420 304, 679		364, 540 334, 119	16. 00 19. 00
17.00		TENT ROUTINE SERVICE COST CENTERS	<u> </u>		001,077	27, 110	551, 117	17.00
30. 00		ADULTS & PEDIATRICS	20, 694	257, 265			2, 208, 415	
31. 00		INTENSIVE CARE UNIT	0	0	0	0	0	31. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	108, 556	39, 019	520, 094	50, 255	570, 349	50. 00
53. 00		ANESTHESI OLOGY	0	0	5, 599		6, 140	
54.00	1	RADI OLOGY-DI AGNOSTI C	266, 679	120, 149		147, 229	1, 670, 931	54. 00
54. 01	1	RADI OLOGY-ULTRASOUND	0	16, 635			184, 585	
56. 00 58. 00	05800	RADI OI SOTOPE	0	0 394	135, 925 162, 796		149, 059 178, 526	56. 00 58. 00
60.00		LABORATORY	42, 834	181, 306			2, 500, 262	60.00
62. 00	1	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0			141, 914	
64. 00		I NTRAVENOUS THERAPY	0	0	,		29, 291	64. 00
66.00		PHYSI CAL THERAPY	63, 108	150, 427	1, 176, 565		1, 290, 252	66. 00
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	62, 009 20, 167	421, 609 132, 321		462, 347 145, 107	67. 00 68. 00
69. 00		ELECTROCARDI OLOGY	0	20, 107	132, 321	12, 700	143, 107	69.00
69. 01	03160	CARDI OPULMONARY	0	0	644, 025	62, 230	706, 255	
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	470, 839		516, 334	•
73.00		DRUGS CHARGED TO PATIENTS	0	96, 692			1, 168, 281	
76. 00 76. 01		PSYCHIATRIC/PSYCHOLOGICAL SERVICES TELEMEDICINE PSYCH SERVICES	0	40, 969 0			467, 133	76. 00 76. 01
76. 02		DIABETIC EDUCATION		2, 972	22, 632		24, 819	•
76. 03		WOUND CARE	0	. 0	83, 610		91, 689	
76. 04		ALLERGY 123	0	0	0	0	0	76. 04
77. 00	1	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78. 00		CAR T-CELL IMMUNOTHERAPY TIENT SERVICE COST CENTERS	<u> </u>	0	0	1 0	0	78. 00
88. 00		RURAL HEALTH CLINIC	29, 182	659, 173	5, 695, 612	550, 333	6, 245, 945	88. 00
88. 01		RURAL HEALTH CLINIC II	1, 592	26, 113	229, 096	22, 137	251, 233	
88. 02		RURAL HEALTH CLINIC III	0	128, 703			1, 048, 558	
91. 00 92. 00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	14, 318	302, 588	3, 412, 331 0	l I	3, 742, 051 0	
92.00		REIMBURSABLE COST CENTERS					0	92.00
95.00		AMBULANCE SERVICES	64, 331	87, 009	727, 307	70, 277	797, 584	95. 00
		HOME HEALTH AGENCY	7, 747	140, 691			1, 144, 644	
102.00		OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
113 00		AL PURPOSE COST CENTERS INTEREST EXPENSE						113. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	911, 774	2, 899, 944	30, 402, 021	2, 677, 624	30, 388, 950	
	NONRE	IMBURSABLE COST CENTERS						
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	4, 940			190. 00
		PHYSICIANS' PRIVATE OFFICES	0	12, 020	83, 601	8, 078	91, 679	
	1	HOSPICE FAMILY MEDICAL CENTER		0	0	0		194. 00 194. 01
		MEALS ON WHEELS		0	0			194. 01
		FITNESS CENTER - WEST CAMPUS	0	0	46, 740	4, 516	51, 256	

Health Financial Systems	MASON DISTRIC	T HOSPITAL		In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Period: From 10/01/2022 To 09/30/2023		nared:
					2/26/2024 10:	49 am
	CAPITAL RELATED COSTS					
Cost Center Description	MVBLE EQUIP	EMPLOYEE	Subtotal	ADMI NI STRATI VE	Subtotal	
		BENEFITS DEPARTMENT		AND GENERAL		
	2.00	4.00	4A	5. 01	5A. 01	
194.04 07953 OTHER NONREIMBURSABLE COST AREAS	0	0		0	0	194. 04
200.00 Cross Foot Adjustments				O	0	200. 00
201.00 Negative Cost Centers	0	0		0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	911, 774	2, 911, 964	30, 537, 30	2, 690, 695	30, 537, 302	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-1313

				1	0 09/30/2023	Date/lime Pre 2/26/2024 10:	
	Cost Center Description	A&G HOSPI TAL	MAINTENANCE &		OPERATION OF	OPERATION OF	.,
		ONLY	REPAI RS	REPAIRS - WEST CAMPUS	PLANT	PLANT-CLINIC	
		5. 02	6. 00	6. 01	7. 00	7. 01	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01 1. 02	OO101 NEW CAP REL COSTS-CLINIC BUILDING OO102 NEW CAP REL COSTS-NEW MED SURG						1. 01 1. 02
1. 02	00103 NEW CAP REL COSTS - WEST CAMPUS BUI						1. 02
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00590 ADMINISTRATIVE AND GENERAL						5. 01
5. 02	00591 A&G HOSPI TAL ONLY	998, 778	771 040				5. 02
6. 00 6. 01	OO6OO MAINTENANCE & REPAIRS OO6O1 MAINTENANCE & REPAIRS - WEST CAMPUS	33, 886	771, 943	_			6. 00 6. 01
7. 00	00700 OPERATION OF PLANT	20, 669	62, 852	0	533, 705		7. 00
7. 01	00701 OPERATION OF PLANT-CLINIC	1, 650	0	Ö	0	37, 590	7. 01
7.02	00702 OPERATION OF PLANT - WEST CAMPUS BU	1, 662	0	0	0	0	7. 02
8.00	00800 LAUNDRY & LINEN SERVICE	3, 698	18, 626	•	18, 763	0	8. 00
9.00	00900 HOUSEKEEPING	27, 554	4, 598		4, 632	0	
9. 01 10. 00	O0901 HOUSEKEEPING - WEST CAMPUS BUILDING O1000 DIETARY	25, 501	28, 301	0	28, 510	0	9. 01 10. 00
11. 00	01100 CAFETERI A	482	12, 867	0	12, 962	0	11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	12, 093	10, 635	Ö	10, 714	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	8, 238	16, 081	0	16, 200	0	14. 00
15. 00	01500 PHARMACY	0	0	0	0	0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	16, 737	10, 033			486	16.00
19. 00	01900 NONPHYSICIAN ANESTHETISTS NPATIENT ROUTINE SERVICE COST CENTERS	15, 340	0	0	0	0	19. 00
30. 00	03000 ADULTS & PEDIATRICS	101, 395	126, 250	0	127, 180	0	30. 00
31. 00	03100 NTENSI VE CARE UNI T	0	0			0	31. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	26, 186	69, 659	0	70, 173	0	
53. 00	05300 ANESTHESI OLOGY	282	0	0	0	0	53.00
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 05401 RADI OLOGY-ULTRASOUND	76, 717	54, 303 2, 712		54, 704	0	54. 00 54. 01
56. 00	05600 RADI OI SOTOPE	8, 475 6, 844	2, 712 5, 892	0	2, 732 5, 936	0	56.00
58. 00	05800 MRI	8, 197	3, 072	0	3, 730 0	0	58. 00
60.00	06000 LABORATORY	114, 795	31, 917	0	32, 152	0	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	6, 516	0.,,,,,	Ö	02, 102	0	62. 00
64.00	06400 I NTRAVENOUS THERAPY	1, 345	0	0	0	0	64. 00
66. 00	06600 PHYSI CAL THERAPY	59, 239	11, 495	0	11, 579	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	21, 228	2, 411	0	2, 428	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	6, 662	1, 741	0	1, 754	0	68. 00
69. 00 69. 01	06900 ELECTROCARDI OLOGY	0	0 E4 414	1	0 55 010	0	69. 00 69. 01
71. 00	03160 CARDI OPULMONARY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	32, 426 23, 706	54, 616	0	55, 019	0	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	53, 639	20, 869	0	21, 023	0	73.00
76. 00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	21, 447	8, 738	•	0	2, 034	76. 00
76. 01	03952 TELEMEDICINE PSYCH SERVICES	0	0		0	0	76. 01
	03950 DI ABETI C EDUCATI ON	1, 140	0	0	0	0	76. 02
	03951 WOUND CARE	4, 210	0	0	0	0	
76. 04	03953 ALLERGY 123	0	0	0	0	0	76. 04
	07700 ALLOGENEI C HSCT ACQUISITION	0	0	0	0	0	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	U	U	0	U	0	78. 00
88. 00	08800 RURAL HEALTH CLINIC	0	150, 678	0	0	35, 070	88. 00
	08801 RURAL HEALTH CLINIC II	0	0	0	0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	48, 142	0	0	0	0	88. 02
	09100 EMERGENCY	171, 809	45, 610	0	45, 946	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
05.00	OTHER REIMBURSABLE COST CENTERS	24 (10	0	1 0	0	0	05.00
	09500 AMBULANCE SERVICES 10100 HOME HEALTH AGENCY	36, 619	17, 789	0	0	0	95. 00 101. 00
	10200 OPI OI D TREATMENT PROGRAM	0	17, 789	1	0		102.00
.02.00	SPECIAL PURPOSE COST CENTERS						102.00
113.00	11300 INTEREST EXPENSE						113. 00
118.00	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	998, 529	768, 673	0	530, 411	37, 590	118. 00
	NONREI MBURSABLE COST CENTERS			T			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	249	3, 270	0	3, 294		190.00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 HOSPICE	0	0	0	0		192. 00 194. 00
	07950 HOSPICE 07951 FAMILY MEDICAL CENTER	0	0	0	0		194. 00
	07951 FAWLEY MEDICAL CENTER	n	0		n		194. 01
	07954 FITNESS CENTER - WEST CAMPUS	O	o	0	Ö		194. 03
	07953 OTHER NONREIMBURSABLE COST AREAS	0	0	0	O		194. 04
200.00	Cross Foot Adjustments				<u> </u>		200. 00

Health Financial Systems	MASON DISTRIC	CT HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der (Period: From 10/01/2022	Worksheet B	
Cost Center Description	A&G HOSPI TAL	MAINTENANCE 8	MAINTENANCE &	OPERATION OF	OPERATION OF	
	ONLY	REPAI RS	REPAIRS - WEST	PLANT	PLANT-CLINIC	
			CAMPUS			
	5. 02	6. 00	6. 01	7. 00	7. 01	
201.00 Negative Cost Centers	0		0 (0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	998, 778	771, 94	3 (533, 705	37, 590	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-1313

			T	09/30/2023	Date/Time Pre 2/26/2024 10:	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	HOUSEKEEPING -	DI ETARY	17 4111
	PLANT - WEST	LINEN SERVICE		WEST CAMPUS		
	CAMPUS BU 7.02	8. 00	9. 00	9. 01	10. 00	
GENERAL SERVICE COST CENTERS						
1. 00 00100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01 00101 NEW CAP REL COSTS-CLINIC BUILDING						1. 01
1.02 00102 NEW CAP REL COSTS-NEW MED SURG 1.03 00103 NEW CAP REL COSTS - WEST CAMPUS BUI						1. 02 1. 03
1.03 00103 NEW CAP REL COSTS - WEST CAMPUS BUI 2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 O0400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01 00590 ADMINISTRATIVE AND GENERAL						5. 01
5. 02 00591 A&G HOSPI TAL ONLY						5. 02
6.00 00600 MAINTENANCE & REPAIRS						6. 00
6.01 00601 MAINTENANCE & REPAIRS - WEST CAMPUS						6. 01
7.00 O0700 OPERATION OF PLANT						7. 00
7.01 O0701 OPERATION OF PLANT-CLINIC						7. 01
7.02 O0702 OPERATION OF PLANT - WEST CAMPUS BU	37, 866					7. 02
8.00 00800 LAUNDRY & LINEN SERVICE	0	121, 631	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			8. 00
9. 00 00900 HOUSEKEEPI NG	0	0	636, 926			9. 00
9.01 00901 HOUSEKEEPING - WEST CAMPUS BUILDING 10.00 01000 DIETARY	0	0	0 26, 282	O O	664, 016	9. 01 10. 00
11. 00 01100 CAFETERI A	0	0	11, 949	0	539, 884	11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	0	9, 876	0	0	13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	0	14, 934	o	0	14. 00
15. 00 01500 PHARMACY	0	0	0	o	0	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	9, 317	o	0	16. 00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	48, 101	117, 241	0	96, 784	30. 00
31. 00 03100 I NTENSI VE CARE UNI T	0	0	0	0	0	31. 00
ANCILLARY SERVICE COST CENTERS		44.000	(4, (00	ما	/ 100	F0 00
50. 00 05000 OPERATI NG ROOM	0	14, 320		0	6, 420	50.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	14 772	0	0	0	53. 00 54. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05401 RADI OLOGY-ULTRASOUND	0	16, 772	50, 428 2, 518	0	0	54. 00
56. 00 05600 RADI OI SOTOPE	0	0	5, 472	0	0	56. 00
58. 00 05800 MRI	0	0	0, 4,2	0	0	58. 00
60. 00 06000 LABORATORY	0	78	29, 639	o	0	60. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	O	0	62.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	o	0	64. 00
66. 00 06600 PHYSI CAL THERAPY	0	6, 885	10, 674	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	2, 239	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	1, 617	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
69. 01 03160 CARDI OPULMONARY	0	1, 423	50, 719	0	0	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	19, 380	0	0	71. 00 73. 00
76. 00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	8, 115	0	19, 491	76.00
76. 01 03952 TELEMEDICINE PSYCH SERVICES	0	0	0,113	0	0	76. 00
76. 02 03950 DI ABETI C EDUCATI ON	0	0	Ö	ol	0	
76. 03 03951 WOUND CARE	0	0	0	ō	0	76. 03
76. 04 03953 ALLERGY 123	0	0	0	o	0	76. 04
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	o	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	758	·	0	0	88. 00
88. 01 08801 RURAL HEALTH CLINIC II	0	165	0	0	0	88. 01
88. 02 08802 RURAL HEALTH CLINIC III	0	0	42.255	0	0	88. 02
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART	0	32, 651	42, 355	U	1, 437	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS						92.00
95. 00 09500 AMBULANCE SERVI CES	0	315	0	ol	0	95. 00
101. 00 10100 HOME HEALTH AGENCY	0	145		ő		101. 00
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	o		102. 00
SPECIAL PURPOSE COST CENTERS				-1		
113. 00 11300 NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	121, 613	633, 890	0	664, 016	118. 00
NONREI MBURSABLE COST CENTERS	1					
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	3, 036	0		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	18	0	0	0	192.00
194. 00 07950 HOSPI CE	0	0	0	0		194. 00
194.01 07951 FAMILY MEDICAL CENTER 194.02 07952 MEALS ON WHEELS	0	0	0	0		194. 01 194. 02
194.02 07952 MEALS ON WHEELS 194.03 07954 FITNESS CENTER - WEST CAMPUS	37, 866	0		0		194. 02
194. 04 07953 OTHER NONREI MBURSABLE COST AREAS	37,000 n	0	n	0		194. 03
200.00 Cross Foot Adjustments		O		Ĭ		200. 00
	1					

Health Financial Systems	MASON DISTRIC	CT HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der C	CN: 14-1313	Peri od:	Worksheet B	
				From 10/01/2022	Part I	
			-	To 09/30/2023	Date/Time Pre	pared:
					2/26/2024 10: 4	49 am
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	HOUSEKEEPING -	DI ETARY	
	DI ANT _ WEST	LINEN SEDVICE		WEST CAMPILS		

						2/26/2024 10:	49 am
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	HOUSEKEEPING -	DI ETARY	
		PLANT - WEST	LINEN SERVICE		WEST CAMPUS		
		CAMPUS BU			BUI LDI NG		
		7. 02	8. 00	9. 00	9. 01	10.00	
201.00	Negative Cost Centers	0	0	C	0	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	37, 866	121, 631	636, 926	0	664, 016	202. 00

Provider CCN: 14-1313

					2/26/2024 10:	49 am
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
	11. 00	13.00	SUPPLY 14.00	15. 00	LI BRARY 16. 00	
GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	13.00	10.00	
1. 00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
1.01 00101 NEW CAP REL COSTS-CLINIC BUILDING						1. 01
1.02 00102 NEW CAP REL COSTS-NEW MED SURG						1. 02
1.03 00103 NEW CAP REL COSTS - WEST CAMPUS BUI						1. 03
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01 00590 ADMINISTRATIVE AND GENERAL						5. 01
5. 02 00591 A&G HOSPI TAL ONLY						5. 02
6. 00 00600 MAI NTENANCE & REPAI RS						6.00
6. 01 00601 MAI NTENANCE & REPAIRS - WEST CAMPUS						6. 01
7.00 00700 OPERATION OF PLANT						7. 00
7. 01 00700 OPERATION OF PLANT 7. 01 00701 OPERATION OF PLANT-CLINIC						7. 00
						7. 01
						1
8. 00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9.00
9. 01 00901 HOUSEKEEPING - WEST CAMPUS BUILDING						9. 01
10. 00 01000 DI ETARY	500 (0)					10.00
11. 00 01100 CAFETERI A	588, 634					11. 00
13. 00 01300 NURSING ADMINISTRATION	5, 875					13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	10, 458	이	245, 344			14. 00
15. 00 01500 PHARMACY	C	이	0	0		15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	11, 829	이	0	0	420, 946	16. 00
19. 00 01900 NONPHYSICIAN ANESTHETISTS	C	0	0	0	0	19. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	78, 534	180, 868	0	0	22, 010	30. 00
31.00 03100 INTENSIVE CARE UNIT	C	o	0	0	0	31. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	12, 534	33, 306	0	0	13, 231	50.00
53. 00 05300 ANESTHESI OLOGY		ol ol	0	0	8, 064	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	38, 503	l ol	4, 500	0	72, 035	54.00
54. 01 05401 RADI OLOGY-ULTRASOUND	4, 661	0	268	0	8, 767	54. 01
56. 00 05600 RADI 0I SOTOPE	39	أم	4, 079	0	3, 374	56. 00
58. 00 05800 MRI	235		378	0	14, 370	58. 00
60. 00 06000 LABORATORY	63, 689	1	124, 982	0	76, 288	1
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	00,007	1	23, 474	Ö	1, 173	62.00
64. 00 06400 I NTRAVENOUS THERAPY		1	2, 258	0	4, 498	•
66. 00 06600 PHYSI CAL THERAPY	34, 195	_	2, 230	0	30, 619	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	15, 511	1	0	0	12, 386	67. 00
	3, 995		0	0	3, 041	1
	3, 990		0	0	•	1
69. 00 06900 ELECTROCARDI OLOGY	20.025		0	U	11 020	69.00
69. 01 03160 CARDI OPULMONARY	29, 925	1	05 405	U	11, 829	69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1	85, 405	0	5, 438	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	18, 410	1	0	0	9, 033	73. 00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	13, 318	1	0	0	8, 932	76. 00
76. 01 03952 TELEMEDICINE PSYCH SERVICES	C	1	0	0	0	76. 01
76. 02 03950 DIABETIC EDUCATION	588	0	0	0	4	76. 02
76. 03 03951 WOUND CARE	C	이	0	0	5, 261	
76. 04 03953 ALLERGY 123	C	이	0	0	0	76. 04
77.00 07700 ALLOGENEIC HSCT ACQUISITION	C	0	0	0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	C	0	0	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	131, 844	- 0	0	0	37, 048	88. 00
88.01 08801 RURAL HEALTH CLINIC II	C	0	0	0	1, 732	88. 01
88.02 08802 RURAL HEALTH CLINIC III	C	0	0	0	7, 472	88. 02
91. 00 09100 EMERGENCY	114, 491	75, 518	0	0	23, 215	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	C	0	0	0	20, 550	95. 00
101.00 10100 HOME HEALTH AGENCY	C	ol ol	0	0	20, 576	101.00
102.00 10200 OPI OI D TREATMENT PROGRAM		ol ol	0	o		102.00
SPECIAL PURPOSE COST CENTERS	_	-1	- 1	- 1		
113. 00 11300 NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	588, 634	312, 586	245, 344	0	420, 946	
NONREI MBURSABLE COST CENTERS	300,00	0.127000	210,011		1207 7 10	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	ار ا	0	0	0	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES			0	0		192. 00
192. 00 19200 PHTSI CLANS PRI VALE OFFICES 194. 00 07950 H0SPI CE			0	٥		194. 00
194. 00 07950 H05P1CE 194. 01 07951 FAMILY MEDICAL CENTER			0	o o		194. 00
194.02 07951 FAMILY MEDICAL CENTER			0	o o		194. 01
			0	ol o		194. 02
194. 03 07954 FITNESS CENTER - WEST CAMPUS			0	0		
194. 04 07953 OTHER NONREIMBURSABLE COST AREAS		ή	O	O	0	194. 04
200.00 Cross Foot Adjustments	<u> </u>					200. 00

Health Financial Systems	MASON DISTRICT HOSPITAL				u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Peri od: From 10/01/2022 To 09/30/2023	Worksheet B Part I Date/Time Pre 2/26/2024 10:4	
Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	

0 588, 634

312, 586

0 245, 344 0 201. 00 420, 946 202. 00

201. 00 202. 00 Negative Cost Centers TOTAL (sum lines 118 through 201)

Heal th	Financial Systems	MASON DISTRIC	T HOSPI TAL		In Lie	u of Form CMS-2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provi der CC		eriod: rom 10/01/2022 o 09/30/2023	Worksheet B Part I Date/Time Prepared: 2/26/2024 10:49 am
	Cost Center Description	NONPHYSI CI AN ANESTHETI STS	Subtotal	Intern & Residents Cost & Post Stepdown	Total	272072021 10. 17 dim
				Adjustments		
	GENERAL SERVICE COST CENTERS	19. 00	24. 00	25. 00	26. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT					1.00
1. 01	00101 NEW CAP REL COSTS-CLINIC BUILDING					1. 01
1.02	00102 NEW CAP REL COSTS-NEW MED SURG					1. 02
1. 03 2. 00	00103 NEW CAP REL COSTS - WEST CAMPUS BUI 00200 CAP REL COSTS-MVBLE EQUIP					1. 03
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 01	00590 ADMINISTRATIVE AND GENERAL					5. 01
5. 02 6. 00	00591 A&G HOSPI TAL ONLY					5. 02
6. 01	00600 MAINTENANCE & REPAIRS 00601 MAINTENANCE & REPAIRS - WEST CAMPUS					6. 00
7. 00	00700 OPERATION OF PLANT					7. 00
7.01	00701 OPERATION OF PLANT-CLINIC					7. 01
7. 02 8. 00	00702 OPERATION OF PLANT - WEST CAMPUS BU 00800 LAUNDRY & LINEN SERVICE					7. 02 8. 00
9. 00	00900 HOUSEKEEPI NG					9.00
9. 01	00901 HOUSEKEEPING - WEST CAMPUS BUILDING					9. 01
10.00	01000 DI ETARY					10.00
11. 00 13. 00	01100 CAFETERIA 01300 NURSI NG ADMI NI STRATI ON					11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY					14. 00
15. 00	01500 PHARMACY					15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	240, 450				16.00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS I NPATI ENT ROUTI NE SERVI CE COST CENTERS	349, 459				19. 00
30.00	03000 ADULTS & PEDIATRICS	0	3, 106, 778	0	3, 106, 778	30.00
31. 00	03100 NTENSI VE CARE UNI T	0	0	0	0	31. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	880, 867	l ol	880, 867	50.00
53. 00	05300 ANESTHESI OLOGY	349, 459	363, 945		363, 945	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	2, 038, 893	0	2, 038, 893	54. 00
54. 01	05401 RADI OLOGY-ULTRASOUND	0	214, 718		214, 718	54. 01
56. 00 58. 00	05600	0	180, 695 201, 706		180, 695 201, 706	56. 00 58. 00
60.00	06000 LABORATORY	o o	2, 973, 802		2, 973, 802	60. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	173, 077	0	173, 077	62. 00
64. 00 66. 00	06400 I NTRAVENOUS THERAPY 06600 PHYSI CAL THERAPY	0	37, 392 1, 454, 938	0	37, 392 1, 454, 938	64. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY		518, 550		518, 550	67. 00
68. 00	06800 SPEECH PATHOLOGY	O	163, 917	0	163, 917	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	0	0	69. 00
69. 01 71. 00	03160 CARDI OPULMONARY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	942, 212 630, 883		942, 212 630, 883	69. 01 71. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS		1, 310, 635		1, 310, 635	73. 00
76. 00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	572, 102	0	572, 102	76. 00
76. 01 76. 02	03952 TELEMEDICINE PSYCH SERVICES 03950 DIABETIC EDUCATION	0	0 26, 551	0	0 26, 551	76. 01 76. 02
76. 02	03951 WOUND CARE		101, 160		101, 160	76. 02
76. 04	03953 ALLERGY 123	O	0	0	0	76. 04
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0	U	0	0	78. 00
88. 00	08800 RURAL HEALTH CLINIC	0	6, 741, 270	0	6, 741, 270	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	253, 130		253, 130	88. 01
88. 02 91. 00	08802 RURAL HEALTH CLINIC III 09100 EMERGENCY	0	1, 104, 172 4, 295, 083		1, 104, 172 4, 295, 083	88. 02 91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		4, 273, 003	0	4, 275, 005	92.00
	OTHER REIMBURSABLE COST CENTERS					
	09500 AMBULANCE SERVICES	0	855, 068		855, 068	95. 00
	0 10100 HOME HEALTH AGENCY 0 10200 OPIOID TREATMENT PROGRAM	0	1, 199, 673 0	0	1, 199, 673	101. 00 102. 00
102.00	SPECIAL PURPOSE COST CENTERS	<u> </u>		<u> </u>	<u> </u>	102.00
	11300 I NTEREST EXPENSE			_		113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	349, 459	30, 341, 217	0	30, 341, 217	118. 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	15, 266	O	15, 266	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES		91, 697	O	91, 697	192. 00
	07950 HOSPI CE	0	0	0	O	194. 00
	07951 FAMILY MEDICAL CENTER 2 07952 MEALS ON WHEELS		0	0	0	194. 01 194. 02
	307954 FITNESS CENTER - WEST CAMPUS		89, 122	ő	89, 122	194. 03
		<u>'</u>		'		<u> </u>

Heal th Financ	cial Systems	MASON DISTRIC	T HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATI	ION - GENERAL SERVICE COSTS		Provi der C		Peri od:	Worksheet B	
					From 10/01/2022 To 09/30/2023		nared.
					077 007 2020	2/26/2024 10:	
(Cost Center Description	NONPHYSI CI AN	Subtotal	Intern &	Total		
		ANESTHETI STS		Residents Cos	t		
				& Post			
				Stepdown			
				Adjustments			
		19.00	24.00	25. 00	26.00		
194. 04 07953	OTHER NONREIMBURSABLE COST AREAS	0	0		0 0		194. 04
200.00	Cross Foot Adjustments	0	0		0 0		200. 00
201.00	Negative Cost Centers	0	0		0		201. 00
202. 00	TOTAL (sum lines 118 through 201)	349, 459	30, 537, 302		0 30, 537, 302		202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1313

				CAPITAL REL	ATED COSTS	2/26/2024 10:	49 am_
	Cost Center Description	Di rectly	BLDG & FIXT	NEW CLINIC	NEW NEW MED	NEW CAP REL	
	Sost Senter Description	Assigned New	DEDO G TTXT	BUI LDI NG	SURG	COSTS - WEST	
		Capital Related Costs				CAMPUS BUI	
	T	0	1.00	1.01	1. 02	1. 03	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	1					1. 00
1. 01	00101 NEW CAP REL COSTS-CLINIC BUILDING						1. 01
1.02	00102 NEW CAP REL COSTS-NEW MED SURG						1. 02
1. 03 2. 00	00103 NEW CAP REL COSTS - WEST CAMPUS BUI 00200 CAP REL COSTS-MVBLE EQUIP						1. 03 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4. 00
5. 01	00590 ADMINISTRATIVE AND GENERAL	0	89, 319	2, 313	0	0	5. 01
5. 02	00591 A&G HOSPI TAL ONLY	0	9, 141		1, 871	0	5. 02
6. 00 6. 01	00600 MAINTENANCE & REPAIRS 00601 MAINTENANCE & REPAIRS - WEST CAMPUS	0	0	0	0	0	6. 00 6. 01
7. 00	00700 OPERATION OF PLANT	0	39, 907	365	4, 990	0	7. 00
7. 01	00701 OPERATION OF PLANT-CLINIC	0	0	0	0	0	7. 01
7. 02	00702 OPERATION OF PLANT - WEST CAMPUS BU	0	0	·	1 055	0	7. 02
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	12, 014 2, 665	1	1, 855 1, 096	0	8. 00 9. 00
9. 01	00901 HOUSEKEEPING - WEST CAMPUS BUILDING	0	0		0	0	9. 01
10.00	01000 DI ETARY	0	19, 530		0	0	10.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	0	8, 302 6, 099		1, 264 2, 714	0	11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	11, 097	0	2, 714	0	14.00
15. 00	01500 PHARMACY	0	0	0	0	0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	5, 483		0	0	16.00
19. 00	01900 NONPHYSICIAN ANESTHETISTS INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	19. 00
30. 00	03000 ADULTS & PEDIATRICS	0	5, 938	0	177, 730	0	30.00
31. 00	03100 INTENSIVE CARE UNIT	0			0	0	31. 00
FO 00	ANCI LLARY SERVI CE COST CENTERS	1 0	40.070		ما	^	1 50 00
50. 00 53. 00	05000 OPERATI NG ROOM 05300 ANESTHESI OLOGY	0	48, 070 0		0	0	50. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	37, 474		Ö	0	54.00
54. 01	05401 RADI OLOGY-ULTRASOUND	0	1, 871		0	0	54. 01
56. 00 58. 00	05600 RADI 0I SOTOPE 05800 MRI	0	4, 066	0	0	0	56. 00 58. 00
60.00	06000 LABORATORY	0	22, 025		0	0	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	62. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	7, 932 1, 663	1	0	0	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	0	1, 201		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	-	0	0	69. 00
69. 01	03160 CARDI OPULMONARY	0	37, 689		0	0	69. 01
71. 00 73. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	0	0 0	31, 527	0	71. 00 73. 00
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	Ö	1, 855	0	0	
	03952 TELEMEDICINE PSYCH SERVICES	0	0	0	0	0	
76. 02 76. 03	03950 DI ABETI C EDUCATI ON 03951 WOUND CARE	0	0	0	0	0	76. 02 76. 03
	03953 ALLERGY 123	0	0	0	0	0	76. 04
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
78. 00		0	0	0	0	0	78. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	1 0	0	31, 991	O	0	88. 00
	08801 RURAL HEALTH CLINIC II	0	Ö	0	0	0	88. 01
88. 02		0	0	0	0	0	88. 02
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	31, 474	0	0	0	91. 00 92. 00
92.00	OTHER REIMBURSABLE COST CENTERS						92.00
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
	10100 HOME HEALTH AGENCY	0	0		0		101.00
102.00	10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0	0	0]	0	102. 00
113.00	11300 INTEREST EXPENSE						113. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	402, 960	43, 592	223, 047	0	118. 00
100.00	NONREI MBURSABLE COST CENTERS		^		4 040	^	190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	0 0	0 0	4, 940 0		190.00
	07950 HOSPI CE	0	Ö	O	ő	0	194. 00
	07951 FAMILY MEDICAL CENTER	0	0	0	o		194. 01
194. 02	2 07952 MEALS ON WHEELS	1 0	0	0	0	0	194. 02

Health Financial Systems	MASON DISTRICT HOSPITAL	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 14-1313	Peri od: Worksheet B From 10/01/2022 Part II To 09/30/2023 Date/Time Prepared:

						2/26/2024 10:	49 am_
				CAPITAL REI	LATED COSTS		
	Cost Center Description	Di rectly	BLDG & FIXT	NEW CLINIC	NEW NEW MED	NEW CAP REL	
		Assigned New		BUI LDI NG	SURG	COSTS - WEST	
		Capi tal				CAMPUS BUI	
		Related Costs					
		0	1.00	1. 01	1. 02	1. 03	
194. 03 07954	FITNESS CENTER - WEST CAMPUS	0	0	0	0	46, 740	194. 03
194. 04 07953	OTHER NONREIMBURSABLE COST AREAS	O	0	0	0	0	194. 04
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)	o	402, 960	43, 592	227, 987	46, 740	202. 00

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 10/01/2022 | Part II |
| To 09/30/2023 | Date/Time Prepared: | 2/26/2024 | 10: 49 am | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1313

					0 09/30/2023	2/26/2024 10:	
		CAPI TAL					
	Cost Center Description	RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE	ADMI NI STRATI VE	A&G HOSPITAL	
	cost defiter bescription	WVDLL LQOTT	Subtotal	BENEFITS	AND GENERAL	ONLY	
				DEPARTMENT			
	GENERAL SERVICE COST CENTERS	2. 00	2A	4. 00	5. 01	5. 02	
1. 00	00100 CAP REL COSTS-BLDG & FIXT			I			1.00
1. 01	00101 NEW CAP REL COSTS-CLINIC BUILDING						1. 01
1.02	00102 NEW CAP REL COSTS-NEW MED SURG						1. 02
1. 03	00103 NEW CAP REL COSTS - WEST CAMPUS BUI						1. 03
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT		0	0			2. 00 4. 00
5. 01	00590 ADMINISTRATIVE AND GENERAL	227, 115	318, 747	1			5. 01
5. 02	00591 A&G HOSPI TAL ONLY	0	13, 860			24, 286	1
6.00	00600 MAINTENANCE & REPAIRS	0	0	0	7, 704	824	6. 00
6. 01	00601 MAINTENANCE & REPAIRS - WEST CAMPUS	0	0	-	1	0	6. 01
7. 00 7. 01	00700 OPERATION OF PLANT 00701 OPERATION OF PLANT-CLINIC	12, 218	57, 480 0			502 40	7. 00 7. 01
7. 01	00701 OPERATION OF PLANT - WEST CAMPUS BU		0			40	7. 01
8.00	00800 LAUNDRY & LINEN SERVICE	0	13, 869			90	8.00
9.00	00900 HOUSEKEEPI NG	0	3, 761	0	6, 265	670	9. 00
9. 01	00901 HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	1	· ·	0	9. 01
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	0	19, 530 9, 566		-,	620 12	10. 00 11. 00
13. 00	01300 NURSING ADMINISTRATION		8, 813			294	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	11, 097		· ·	200	1
15. 00	01500 PHARMACY	0	0	1	1	0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	53, 400	59, 326			407	16.00
19. 00	01900 NONPHYSICIAN ANESTHETISTS INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	3, 488	373	19. 00
30. 00	03000 ADULTS & PEDIATRICS	20, 694	204, 362	0	23, 052	2, 465	30.00
31. 00	03100 INTENSIVE CARE UNIT	0	0			0	31. 00
	ANCILLARY SERVICE COST CENTERS	100 55/	154 404	1			
50. 00 53. 00	05000 OPERATI NG ROOM 05300 ANESTHESI OLOGY	108, 556	156, 626 0	1		637 7	50. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	266, 679	304, 153			1, 865	1
54. 01	05401 RADI OLOGY-ULTRASOUND	0	1, 871	0		206	1
56. 00	05600 RADI OI SOTOPE	0	4, 066		· ·	166	1
58. 00	05800 MRI	42.024	(4.050	0	.,	199	1
60. 00 62. 00	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	42, 834	64, 859 0			2, 790 158	1
64. 00	06400 NTRAVENOUS THERAPY	l o	0		,	33	1
66.00	06600 PHYSI CAL THERAPY	63, 108	71, 040	0	13, 468	1, 440	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	1, 663			516	1
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	1, 201 0		· ·	162 0	68. 00 69. 00
69. 00	03160 CARDI OPULMONARY		37, 689		· ·	788	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	Ö		576	1
73.00	07300 DRUGS CHARGED TO PATIENTS	0	31, 527		, , ,		73. 00
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	1, 855		., .		
76. 01 76. 02	03952 TELEMEDICINE PSYCH SERVICES 03950 DIABETIC EDUCATION	0	0	0		0 28	
76. 02	03951 WOUND CARE		0	0	957	102	
76. 04	03953 ALLERGY 123	0	0	0		0	1
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	· ·	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	29, 182	61, 173	0	65, 183	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	1, 592	1, 592		· ·	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	0	0	l '	1, 170	88. 02
91.00	09100 EMERGENCY	14, 318	45, 792		39, 061	4, 185	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS		0				92. 00
95 00	09500 AMBULANCE SERVICES	64, 331	64, 331	0	8, 325	890	95. 00
	10100 HOME HEALTH AGENCY	7, 747	11, 524				101.00
102.00	10200 OPIOLD TREATMENT PROGRAM	0	0		0	0	102. 00
440.5	SPECIAL PURPOSE COST CENTERS						440.00
	11300 INTEREST EXPENSE	011 774	1 501 272		217 100	24 200	113.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	911, 774	1, 581, 373	0	317, 198	24, 280	118. 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	ol	4, 940	0	57	6	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	957	0	192. 00
	07950 HOSPI CE	0	0	0	-		194. 00
	07951 FAMILY MEDICAL CENTER 07952 MEALS ON WHEELS	0	0	0	· ·		194. 01 194. 02
	0/952 MEALS ON WHEELS 807954 FITNESS CENTER - WEST CAMPUS		46, 740				194. 02
	1 1 22 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	<u>, </u>		,			

Health Financial Systems	MASON DISTRICT HOSPITAL			In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CC		Peri od:	Worksheet B		
				From 10/01/2022 Fo 09/30/2023		pared: 49 am	
	CAPI TAL						
Cost Center Description	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMI NI STRATI VE AND GENERAL	A&G HOSPITAL ONLY		
	2.00	2A	4.00	5. 01	5. 02		
194.04 07953 OTHER NONREIMBURSABLE COST AREAS 200.00 Cross Foot Adjustments	0	0	(0	l .	194. 04 200. 00	
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers	0	0	(o		200.00	
202.00 TOTAL (sum lines 118 through 201)	911, 774	1, 633, 053	(318, 747	24, 286	202. 00	

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 10/01/2022 | Part II | To 09/30/2023 | Date/Time Prepared: | Date/Time Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1313

				Į.	0 09/30/2023	Date/lime Pre 2/26/2024 10:	
	Cost Center Description	MAINTENANCE &		OPERATION OF	OPERATION OF	OPERATION OF	, , <u>G</u> ,,,
		REPAI RS	REPAIRS - WEST CAMPUS	PLANT	PLANT-CLINIC	PLANT - WEST CAMPUS BU	
		6.00	6. 01	7. 00	7. 01	7. 02	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
1. 01 1. 02	OO101 NEW CAP REL COSTS-CLINIC BUILDING OO102 NEW CAP REL COSTS-NEW MED SURG						1. 01 1. 02
1. 02	00103 NEW CAP REL COSTS - WEST CAMPUS BUI						1. 02
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00590 ADMINISTRATIVE AND GENERAL						5. 01
5. 02 6. 00	OO591 A&G HOSPI TAL ONLY OO600 MAI NTENANCE & REPAI RS	8, 528					5. 02 6. 00
6. 01	00601 MAINTENANCE & REPAIRS - WEST CAMPUS	0, 320	0				6. 01
7. 00	00700 OPERATION OF PLANT	694	0	63, 375			7. 00
7.01	00701 OPERATION OF PLANT-CLINIC	o	0	0	415		7. 01
7. 02	00702 OPERATION OF PLANT - WEST CAMPUS BU	0	0	1	0	418	7. 02
8. 00 9. 00	O0800 LAUNDRY & LINEN SERVICE O0900 HOUSEKEEPING	206 51	0	2, 228		0	8. 00 9. 00
9. 00	00901 HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	550 0	0	0	9.00
10. 00	01000 DI ETARY	313	0	3, 385	ő	0	10.00
11. 00	01100 CAFETERI A	142	0	1, 539	0	0	11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	117	0	1, 272	0	0	13.00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	178	0	1, 924 0	0	0	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	111	0	·	5	0	16. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0			0	19. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	1, 395	0		0	0	30.00
31. 00	03100 INTENSIVE CARE UNIT ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	31. 00
50. 00	05000 OPERATING ROOM	770	0	8, 333	O	0	50.00
53.00	05300 ANESTHESI OLOGY	o	0		0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	600	0	-,	0	0	54.00
54. 01	05401 RADI OLOGY-ULTRASOUND	30	0		0	0	54. 01
56. 00 58. 00	05600	65	0	705	0	0	56. 00 58. 00
60. 00	06000 LABORATORY	353	0	3, 818	0	0	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0,010	Ö	0	62.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
66. 00	06600 PHYSI CAL THERAPY	127	0	1, 375		0	66. 00
67. 00 68. 00	O6700 OCCUPATIONAL THERAPY O6800 SPEECH PATHOLOGY	27 19	0	288 208		0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	i .	0	0	69. 00
69. 01	03160 CARDI OPULMONARY	603	0	6, 533	O	0	69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	231	0	2, 496	0	0	73.00
76. 00 76. 01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 03952 TELEMEDICINE PSYCH SERVICES	97	0	0	22	0	76. 00 76. 01
	03950 DI ABETI C EDUCATION		0		o	0	1
	03951 WOUND CARE	o	0	0	0	0	76. 03
	03953 ALLERGY 123	0	0	0	0	0	76. 04
	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	l ol	0		0	0	78. 00
88. 00	08800 RURAL HEALTH CLINIC	1, 662	0	0	388	0	88. 00
	08801 RURAL HEALTH CLINIC II	o	0	0	0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	0	0	0	0	88. 02
	09100 EMERGENCY	504	0	5, 456	0	0	91.00
92. 00	O9200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92. 00
95. 00	09500 AMBULANCE SERVICES	O	0	0	0	0	95. 00
101.00	10100 HOME HEALTH AGENCY	197	0	0	0	0	101. 00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
112 00	SPECIAL PURPOSE COST CENTERS	1					112 00
118.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	8, 492	0	62, 984	415	n	113. 00 118. 00
110.00	NONREI MBURSABLE COST CENTERS	0, 472		02, 704	710	0	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	36	0	391	0	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
	07950 HOSPI CE	0	0	0	0		194. 00
	07951 FAMILY MEDICAL CENTER 07952 MEALS ON WHEELS		0	0			194. 01 194. 02
	07954 FITNESS CENTER - WEST CAMPUS		0	0	ol		194. 02
194.04	07953 OTHER NONREIMBURSABLE COST AREAS		0	0	o		194. 04
200.00	Cross Foot Adjustments						200. 00

Health Financial Systems	MASON DISTRI	CT HOSPITAL		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der Co		Period: From 10/01/2022 To 09/30/2023	Date/Time Pre	pared:
					2/26/2024 10:	49 am
Cost Center Description	MAINTENANCE &	MAINTENANCE &	OPERATION OF	OPERATION OF	OPERATION OF	
	REPAI RS	REPAIRS - WEST	PLANT	PLANT-CLINIC	PLANT - WEST	
		CAMPUS			CAMPUS BU	
	6. 00	6. 01	7.00	7. 01	7. 02	
201.00 Negative Cost Centers	0	0		0 0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	8, 528	0	63, 37	415	418	202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 10/01/2022 | Part II | To 09/30/2023 | Date/Time Prepared: | Date/Time Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1313

				1	0 09/30/2023	Date/lime Pre 2/26/2024 10:	
	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	HOUSEKEEPING - WEST CAMPUS BUILDING	DI ETARY	CAFETERI A	T) diii
		8.00	9. 00	9. 01	10.00	11. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
1. 01 1. 02	OO101 NEW CAP REL COSTS-CLINIC BUILDING OO102 NEW CAP REL COSTS-NEW MED SURG						1. 01 1. 02
1. 02	00103 NEW CAP REL COSTS - WEST CAMPUS BUI						1. 02
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00590 ADMINISTRATIVE AND GENERAL						5. 01
5.02	00591 A&G HOSPI TAL ONLY						5. 02
6.00	00600 MAINTENANCE & REPAIRS						6. 00
6. 01	00601 MAINTENANCE & REPAIRS - WEST CAMPUS						6. 01
7.00	00700 OPERATION OF PLANT						7.00
7. 01 7. 02	OO701 OPERATION OF PLANT-CLINIC OO702 OPERATION OF PLANT - WEST CAMPUS BU						7. 01
8. 00	00800 LAUNDRY & LINEN SERVICE	17, 234					8.00
9. 00	00900 HOUSEKEEPING	17,234	11, 297				9.00
9. 01	00901 HOUSEKEEPING - WEST CAMPUS BUILDING	o	0	0			9. 01
10.00	01000 DI ETARY	O	466	0	30, 112		10.00
11. 00	01100 CAFETERI A	0	212	0	24, 483	36, 064	11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	175		0	360	1
14.00	01400 CENTRAL SERVI CES & SUPPLY	0	265		0	641	1
15. 00 16. 00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY		0 165		0	0 725	
19. 00	01900 NONPHYSICIAN ANESTHETISTS		0		0	723	
17.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	9			<u> </u>		17.00
30.00	03000 ADULTS & PEDI ATRI CS	6, 816	2, 079	0	4, 389	4, 812	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	2, 029	1, 147	0	291	768	1
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 05401 RADI OLOGY-ULTRASOUND	2, 376	894 45		0	2, 359 286	1
56. 00	05600 RADI OI SOTOPE		97	0	0	200	1
58. 00	05800 MRI		0	0	0	14	1
60.00	06000 LABORATORY	11	526	0	0	3, 902	1
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	O	0	0	0	0	62. 00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
66. 00	06600 PHYSI CAL THERAPY	975	189		0	2, 095	1
67. 00	06700 OCCUPATI ONAL THERAPY	0	40		0	950	1
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	29 0	0	0	245 0	1
69. 01	03160 CARDI OPULMONARY	202	900	0	0	1, 833	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	1
73.00	07300 DRUGS CHARGED TO PATIENTS	O	344	0	0	1, 128	1
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	O	144	0	884	816	76. 00
76. 01	03952 TELEMEDICINE PSYCH SERVICES	0	0	1	0	0	
	03950 DI ABETI C EDUCATI ON	0	0	0	0	36	
	03951 WOUND CARE	0	0	0	0	0	
	03953 ALLERGY 123 07700 ALLOGENEI C HSCT ACQUISITION	0	0	0	0	0	7 0. 0 .
	07800 CAR T-CELL IMMUNOTHERAPY		0	0	0	0	1
70.00	OUTPATIENT SERVICE COST CENTERS	31			<u> </u>		70.00
88. 00	08800 RURAL HEALTH CLINIC	107	2, 482	0	0	8, 077	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	23	0	0	0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	0	0	0	0	
	09100 EMERGENCY	4, 626	751	0	65	7, 015	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
95 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVICES	45	0	0	O	0	95. 00
	10100 HOME HEALTH AGENCY	21	293		0		101.00
	10200 OPI OI D TREATMENT PROGRAM	0	0		0		102.00
	SPECIAL PURPOSE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
113.00	11300 INTEREST EXPENSE						113. 00
118.00	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	17, 231	11, 243	0	30, 112	36, 064	118. 00
	NONREI MBURSABLE COST CENTERS			г			4
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	54	0	0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES 07950 HOSPI CE	3	0	0	0		192. 00 194. 00
	07950 HOSPICE 07951 FAMILY MEDICAL CENTER		0	0	0		194. 00
	07952 MEALS ON WHEELS		0		0		194. 01
	07954 FITNESS CENTER - WEST CAMPUS		0	0	o		194. 03
194.04	07953 OTHER NONREIMBURSABLE COST AREAS	o	0	0	0		194. 04
200.00	Cross Foot Adjustments	<u> </u>		<u> </u>	<u> </u>		200. 00

Health Financial Systems	MASON DISTRIC	CT HOSPITAL		In Lie	eu of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C		Peri od:	Worksheet B	
				From 10/01/2022 To 09/30/2023		narodi
				10 09/30/2023	2/26/2024 10:	
Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	HOUSEKEEPI NG	- DI ETARY	CAFETERI A	
	LINEN SERVICE		WEST CAMPUS			
			BUI LDI NG			
	8. 00	9. 00	9. 01	10.00	11. 00	
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	17, 234	11, 297		0 30, 112	36, 064	202. 00

| Peri od: | Worksheet B | From 10/01/2022 | Part II | To 09/30/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1313

			-	Го 09/30/2023	Date/Time Pre 2/26/2024 10:	
Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	PHARMACY	MEDI CAL RECORDS &	NONPHYSI CI AN ANESTHETI STS	47 (111)
	13.00	SUPPLY 14.00	15. 00	16. 00	19. 00	
GENERAL SERVICE COST CENTERS	10.00	11.00	10.00	10.00	17.00	
1.00 O0100 CAP REL COSTS-BLDG & FIXT 1.01 O0101 NEW CAP REL COSTS-CLINIC BUILDING						1. 00 1. 01
1. 02 OO102 NEW CAP REL COSTS-NEW MED SURG						1. 02
1.03 00103 NEW CAP REL COSTS - WEST CAMPUS BUI						1. 03
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01 00590 ADMI NI STRATI VE AND GENERAL 5. 02 00591 A&G HOSPI TAL ONLY						5. 01 5. 02
6. 00 00600 MAI NTENANCE & REPAI RS						6. 00
6.01 00601 MAINTENANCE & REPAIRS - WEST CAMPUS						6. 01
7.00 OO700 OPERATION OF PLANT						7. 00
7.01 00701 OPERATION OF PLANT-CLINIC 7.02 00702 OPERATION OF PLANT - WEST CAMPUS BU						7. 01 7. 02
7.02 00702 OPERATION OF PLANT - WEST CAMPUS BU 8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG						9. 00
9.01 00901 HOUSEKEEPING - WEST CAMPUS BUILDING						9. 01
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	13, 780					11. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	13, 760	16, 178				14. 00
15. 00 01500 PHARMACY	o	0	(15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	(65, 494		16. 00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	0	(0	3, 861	19. 00
I NPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS	7, 974	0		3, 424		20 00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	7,974	0		3, 424		30.00
ANCILLARY SERVICE COST CENTERS		<u> </u>		91 91		01.00
50. 00 05000 OPERATING ROOM	1, 468	0	(2, 058		50. 00
53. 00 05300 ANESTHESI OLOGY	0	0		1, 255		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05401 RADI OLOGY-ULTRASOUND	0	297 18		0 11, 206 0 1, 364		54. 00 54. 01
56. 00 05600 RADI 01 SOTOPE		269		525		56.00
58. 00 05800 MRI	Ö	25		2, 235		58. 00
60. 00 06000 LABORATORY	0	8, 240		11, 875		60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	1, 548	(.00		62.00
64. 00 06400 I NTRAVENOUS THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	149 0	(700		64. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0	(67.00
68. 00 06800 SPEECH PATHOLOGY	o	0	(473		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0		69. 00
69. 01 03160 CARDI OPULMONARY	0	0 F (33)	(1, 840		69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	0	5, 632 0	(0 846 0 1, 405		71.00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1, 009	Ö	(76. 00
76.01 03952 TELEMEDICINE PSYCH SERVICES	0	0	(o o		76. 01
76. 02 03950 DI ABETI C EDUCATI ON	0	0	(1		76. 02
76. 03 03951 WOUND CARE 76. 04 03953 ALLERGY 123	0	0	(818		76. 03 76. 04
77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON		0	(77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	ō	0	(0		78. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC 88.01 08801 RURAL HEALTH CLINIC II	0	0	(5, 764 270		88. 00 88. 01
88. 02 08802 RURAL HEALTH CLINIC III		0	(1, 162		88. 02
91. 00 09100 EMERGENCY	3, 329	0	,	3, 612		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	·			·		92. 00
OTHER REIMBURSABLE COST CENTERS		_1				
95.00 09500 AMBULANCE SERVICES 101.00 10100 HOME HEALTH AGENCY	0	0		3, 197 3, 201		95. 00 101. 00
102. 00 10200 OPI OI D TREATMENT PROGRAM		0		3, 201		102.00
SPECIAL PURPOSE COST CENTERS		<u> </u>		51 51		1.02.00
113. 00 11300 I NTEREST EXPENSE						113. 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 13, 780	16, 178	(65, 494	0	118. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	ما		ol o		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFICES	0	0				190.00
194. 00 07950 HOSPI CE		o	(194. 00
194. 01 07951 FAMI LY MEDI CAL CENTER	0	0	(이		194. 01
194. 02 07952 MEALS ON WHEELS	0	0	(194. 02
194.03 07954 FITNESS CENTER - WEST CAMPUS 194.04 07953 OTHER NONREIMBURSABLE COST AREAS	0	0	(194. 03 194. 04
200.00 Cross Foot Adjustments		٩	(1	3. 861	200.00
	<u> </u>			1 1	-,	

Health Financial Systems MASON DISTRICT HOSPITAL					In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CO	CN: 14-1313	Peri od:	Worksheet B		
					From 10/01/2022 To 09/30/2023		pared.
						2/26/2024 10:	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	NONPHYSI CI AN	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	ANESTHETI STS	
			SUPPLY		LI BRARY		
		13. 00	14.00	15. 00	16. 00	19. 00	
201.00	Negative Cost Centers	0	0		0 0	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	13, 780	16, 178		0 65, 494	3, 861	202. 00

| Peri od: | Worksheet B | From 10/01/2022 | Part II | To 09/30/2023 | Date/Time Prepared: | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1313

					To	o 09/30/2023 Date/Time Pr 2/26/2024 10	
		Cost Center Description	Subtotal	Intern &	Total	, = = = = = = = = = = = = = = = = = = =	
				Residents Cost & Post			
				Stepdown			
				Adjustments			
	CENED	AL CEDVICE COCT CENTERS	24. 00	25. 00	26. 00		
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT					1.00
1. 01		NEW CAP REL COSTS-CLINIC BUILDING					1. 01
1.02		NEW CAP REL COSTS-NEW MED SURG					1. 02
1.03		NEW CAP REL COSTS - WEST CAMPUS BUI					1. 03
2. 00 4. 00		CAP REL COSTS-MVBLE EQUIP					2. 00 4. 00
5. 01		EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE AND GENERAL					5. 01
5. 02		A&G HOSPITAL ONLY					5. 02
6.00		MAINTENANCE & REPAIRS					6. 00
6. 01		MAINTENANCE & REPAIRS - WEST CAMPUS					6. 01
7. 00 7. 01		OPERATION OF PLANT OPERATION OF PLANT-CLINIC					7. 00 7. 01
7. 02		OPERATION OF PLANT - WEST CAMPUS BU					7. 02
8.00		LAUNDRY & LINEN SERVICE					8. 00
9.00	1	HOUSEKEEPI NG					9. 00
9. 01 10. 00	1	HOUSEKEEPING - WEST CAMPUS BUILDING DIETARY					9. 01 10. 00
11. 00	1	CAFETERI A					11. 00
13. 00		NURSING ADMINISTRATION					13. 00
14. 00		CENTRAL SERVICES & SUPPLY					14. 00
15. 00		PHARMACY					15. 00
16. 00 19. 00	1	MEDICAL RECORDS & LIBRARY NONPHYSICIAN ANESTHETISTS					16. 00 19. 00
17.00		TENT ROUTINE SERVICE COST CENTERS					17.00
30. 00	1	ADULTS & PEDIATRICS	275, 872	0	· ·		30. 00
31. 00		INTENSIVE CARE UNIT	0	0	0		31. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	180, 081	0	180, 081		50.00
53. 00		ANESTHESI OLOGY	1, 326	Ö	•		53. 00
54.00		RADI OLOGY-DI AGNOSTI C	347, 688	0			54.00
54. 01		RADI OLOGY-ULTRASOUND	6, 071	0			54. 01
56. 00 58. 00	05800	RADI OI SOTOPE	7, 451 4, 337	0	,		56. 00 58. 00
60.00		LABORATORY	122, 473	0			60.00
62. 00		WHOLE BLOOD & PACKED RED BLOOD CELL	3, 370	0	3, 370		62. 00
64. 00		I NTRAVENOUS THERAPY	1, 188	0	,		64. 00
66. 00 67. 00	1	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	95, 472 10, 237	0			66. 00 67. 00
68. 00		SPEECH PATHOLOGY	3, 852	0			68. 00
69. 00	1	ELECTROCARDI OLOGY	0	0			69. 00
69. 01		CARDI OPULMONARY	57, 760	0			69. 01
71.00		MEDICAL SUPPLIES CHARGED TO PATIENT	12, 444	0			71.00
73. 00 76. 00		DRUGS CHARGED TO PATIENTS PSYCHIATRIC/PSYCHOLOGICAL SERVICES	50, 630 11, 614	0	50, 630 11, 614		73. 00 76. 00
76. 01		TELEMEDICINE PSYCH SERVICES	0	Ö			76. 01
76. 02	1	DIABETIC EDUCATION	324	0	324		76. 02
76. 03		WOUND CARE	1, 877	0	1, 877		76. 03
76. 04 77. 00		ALLERGY 123 ALLOGENEIC HSCT ACQUISITION	0	0	0		76. 04 77. 00
78. 00	1	CAR T-CELL IMMUNOTHERAPY	0	Ö			78. 00
		TIENT SERVICE COST CENTERS		_			
88. 00 88. 01		RURAL HEALTH CLINIC RURAL HEALTH CLINIC II	144, 836	0	144, 836		88. 00 88. 01
88. 02		RURAL HEALTH CLINIC III	4, 507 13, 277	0	4, 507 13, 277		88. 02
91.00	09100	EMERGENCY	114, 396	Ö			91. 00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART		0			92. 00
05 00		REIMBURSABLE COST CENTERS	7/ 700	0	7/ 700		05.00
		AMBULANCE SERVICES HOME HEALTH AGENCY	76, 788 27, 184	0	· ·		95. 00 101. 00
		OPI OI D TREATMENT PROGRAM	27, 104	0			102.00
		AL PURPOSE COST CENTERS					
		INTEREST EXPENSE	1 575 055	0	1 575 055		113. 00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	1, 575, 055	0	1, 575, 055		118. 00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	5, 484	0	5, 484		190. 00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	960	0			192. 00
		HOSPI CE	0	0	0		194. 00
		FAMILY MEDICAL CENTER MEALS ON WHEELS	0	0	0		194. 01 194. 02
		FITNESS CENTER - WEST CAMPUS	47, 693	0	47, 693		194. 02
			'	'	'		

Health Financial Systems	MASON DISTRICT HOSPITAL			In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CC	CN: 14-1313	Peri od: From 10/01/202	Worksheet B 2 Part II		
				To 09/30/202			
Cost Center Description	Subtotal	Intern &	Total				
		Residents Cost					
		& Post					
		Stepdown					
		Adjustments					
	24.00	25. 00	26.00				
194.04 07953 OTHER NONREIMBURSABLE COST AREAS	0	0		0	194. 04		
200.00 Cross Foot Adjustments	3, 861	0	3, 8	61	200. 00		
201.00 Negative Cost Centers	0	0		0	201. 00		
202.00 TOTAL (sum lines 118 through 201)	1, 633, 053	0	1, 633, 0	53	202. 00		

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS | Period: | Worksheet B-1 | From 10/01/2022 | To 09/30/2023 | Date/Time Prepared: 2/26/2024 10: 49 am Provider CCN: 14-1313

			CAR	TTAL RELATED CO	nete	2/26/2024 10:	
			CAP	TIAL RELATED CO	3515		
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	NEW CLINIC BUILDING (SQUARE FEET)	NEW NEW MED SURG (SQUARE FEET)	NEW CAP REL COSTS - WEST CAMPUS BUI	MVBLE EQUIP (DOLLAR VALUE)	
		1.00	1 01	1.02	(SQUARE FEET)	2.00	
	GENERAL SERVICE COST CENTERS	1.00	1. 01	1. 02	1. 03	2. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT	52, 325					1. 00
1.01	00101 NEW CAP REL COSTS-CLINIC BUILDING	0	18, 398				1. 01
1. 02 1. 03	00102 NEW CAP REL COSTS-NEW MED SURG 00103 NEW CAP REL COSTS - WEST CAMPUS BUI	0	0	13, 523 0	21, 089		1. 02 1. 03
2.00	00200 CAP REL COSTS-MVBLE EQUIP				21,007	984, 291	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	_	0	0	4. 00
5. 01 5. 02	00590 ADMINISTRATIVE AND GENERAL 00591 A&G HOSPITAL ONLY	11, 598			0	245, 178 0	5. 01 5. 02
6. 00	00600 MAINTENANCE & REPAIRS	1, 187 0	1, 202 0		0	0	6.00
6. 01	00601 MAINTENANCE & REPAIRS - WEST CAMPUS	0	0	0	0	0	6. 01
7.00	00700 OPERATION OF PLANT	5, 182	154	1	0	13, 190	7.00
7. 01 7. 02	00701 OPERATION OF PLANT-CLINIC 00702 OPERATION OF PLANT - WEST CAMPUS BU		0	0	0	0 0	7. 01 7. 02
8.00	00800 LAUNDRY & LINEN SERVICE	1, 560	0		0	0	8. 00
9.00	00900 HOUSEKEEPING	346		65	0	0	9. 00
9. 01 10. 00	O0901 HOUSEKEEPING - WEST CAMPUS BUILDING O1000 DIETARY	2, 536	0	0	0	0	9. 01 10. 00
11. 00	01100 CAFETERI A	1, 078		75	0	0	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	792	0	161	0	0	13.00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	1, 441		0	0	0	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	712	187	_	0	1	16. 00
19. 00	01900 NONPHYSI CLAN ANESTHETI STS	0	0	0	0	0	19. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	771	0	10, 542	0	22, 340	30.00
31. 00	03100 INTENSIVE CARE UNIT	0	l e	·	0		31. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	6, 242	Ιο	0	0	117, 190	50. 00
53. 00	05300 OFERATING ROOM 05300 ANESTHESI OLOGY	0, 242			0	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	4, 866	0	_	0	287, 888	1
54. 01 56. 00	05401 RADI OLOGY-ULTRASOUND 05600 RADI OI SOTOPE	243 528	0	0	0	0	54. 01 56. 00
58. 00	05800 MRI	0	Ö	Ö	0	ő	58. 00
60.00	06000 LABORATORY	2, 860	0	0	0	46, 241	60.00
62. 00 64. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06400 INTRAVENOUS THERAPY	0	0	0	0	0	62. 00 64. 00
66. 00	06600 PHYSI CAL THERAPY	1, 030	Ö	Ö	0	68, 127	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	216		0	0	0	67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	156		0	0	0	68. 00 69. 00
69. 01	03160 CARDI OPULMONARY	4, 894	Ö	Ö	0	Ö	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
76. 00	07300 DRUGS CHARGED TO PATIENTS 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0 783	.,	0	1	1
76. 01	03952 TELEMEDICINE PSYCH SERVICES	0	0	1	0	0	76. 01
76. 02	03950 DI ABETI C EDUCATI ON 03951 WOUND CARE	0	0	0	0	0	76. 02 76. 03
76. 03	1	0		0	0	0	76. 03
77. 00		0	0	0	0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	78. 00
88. 00		0	13, 502	0	0	31, 503	88. 00
88. 01		0	0	0	0	1, 719	
88. 02 91. 00		4, 087	0	0	0	0 15, 457	88. 02 91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,007				10, 10,	92.00
05 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	1 0				40.440	05.00
	010100 HOME HEALTH AGENCY				0		101.00
	10200 OPI OI D TREATMENT PROGRAM	0	0	1	0		102. 00
113 00	SPECIAL PURPOSE COST CENTERS 0 11300 INTEREST EXPENSE						113. 00
113.00		52, 325	18, 398	13, 230	0	984, 291	1
	NONREI MBURSABLE COST CENTERS						
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 19200 PHYSICIANS' PRIVATE OFFICES	0	0	293	0		190. 00 192. 00
	07950 HOSPI CE	0	0	ő	0	0	194. 00
	1 07951 FAMILY MEDICAL CENTER	0	0	0	0		194. 01
194. 02	2 07952 MEALS ON WHEELS	1 0	1 0	0	0	1 0	194. 02

Health Financial Systems MASON DISTRICT HOSPITAL In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1313
Period: From 10/01/2022 To 09/30/2023 Date/Time Prepared:

						2/26/2024 10:	49 am
			CAP	TAL RELATED CO	OSTS		
	Cook Cooks Books at the	DIDC & FLVT	NEW CLINIC	NEW NEW MED	NEW CAR DEL	MVDLE FOLLD	
	Cost Center Description	BLDG & FIXT	NEW CLINIC	NEW NEW MED	NEW CAP REL	MVBLE EQUIP	
		(SQUARE FEET)	BUI LDI NG	SURG	COSTS - WEST	(DOLLAR VALUE)	
			(SQUARE FEET)	(SQUARE FEET)	CAMPUS BUI		
					(SQUARE FEET)		
		1. 00	1. 01	1. 02	1. 03	2. 00	
194. 03 07954	FITNESS CENTER - WEST CAMPUS	0	0	0	21, 089	0	194. 03
194. 04 07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194. 04
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B,	402, 960	43, 592	227, 987	46, 740	911, 774	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	7. 701099	2. 369388	16. 859203	2. 216321	0. 926326	203. 00
204. 00	Cost to be allocated (per Wkst. B,						204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part						205. 00
	[11]						
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

	ALLOCATION - STATISTICAL BASIS	WASON DISTRICT	Provi der CC	CN: 14-1313 P	eri od:	Worksheet B-1	
				F	rom 10/01/2022 o 09/30/2023	Date/Ti me Pre 2/26/2024 10:	pared:
	Cost Center Description	EMPLOYEE RE BENEFITS DEPARTMENT (GROSS SALA RIE)	conciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	Reconciliation	A&G HOSPITAL ONLY (ACCUM. COST)	
		4.00	5A. 01	5. 01	5A. 02	5. 02	
1. 00 1. 01 1. 02 1. 03 2. 00 4. 00 5. 01 5. 02 6. 00 6. 01 7. 00 7. 01 7. 02 8. 00 9. 00 9. 01 10. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00101 NEW CAP REL COSTS-CLINIC BUILDING 00102 NEW CAP REL COSTS-NEW MED SURG 00103 NEW CAP REL COSTS - WEST CAMPUS BUI 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00590 ADMINISTRATIVE AND GENERAL 00591 A&G HOSPITAL ONLY 00600 MAINTENANCE & REPAIRS 00601 MAINTENANCE & REPAIRS - WEST CAMPUS 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT - WEST CAMPUS BU 00800 LAUNDRY & LINEN SERVICE 009001 HOUSEKEEPING 00901 HOUSEKEEPING - WEST CAMPUS BUILDING 01000 DIETARY	14, 399, 178 854, 721 485, 253 318, 808 0 0 0 0 29, 597 370, 795 0 283, 413	-2, 690, 695 0 0 0 0 0 0 0 0	27, 846, 607 910, 774 673, 025 0 410, 517 32, 773 33, 014 73, 447 547, 262 506, 483	-998, 778 0 0 0 0 0 0 0 0	21, 753, 767 738, 057 0 450, 184 35, 940 36, 204 80, 544 600, 142 0 555, 422	6. 00 6. 01 7. 00 7. 01 7. 02 8. 00 9. 00 9. 01
11.00	01100 CAFETERI A	0	0	9, 566		10, 490	
13. 00 14. 00	O1300 NURSI NG ADMI NI STRATI ON O1400 CENTRAL SERVI CES & SUPPLY	177, 798 113, 979	0	240, 185 163, 623		263, 393 179, 433	
	01500 PHARMACY	0	0	0		0	
16. 00 19. 00	01600 MEDICAL RECORDS & LIBRARY 01900 NONPHYSICIAN ANESTHETISTS	172, 644 0	0 0	332, 420 304, 679		364, 540 334, 119	
30 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	1, 272, 133	0	2, 013, 827	0	2, 208, 415	30.00
	O3100 INTENSI VE CARE UNIT ANCILLARY SERVICE COST CENTERS	1, 272, 133	0				1
50.00	1 1	192, 942	0	520, 094		570, 349	1
73. 00 76. 00 76. 01 76. 02 76. 03	05401 RADI OLOGY-ULTRASOUND 05600 RADI OI SOTOPE 05800 MRI 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06400 I NTRAVENOUS THERAPY	0 594, 120 82, 255 0 1, 948 896, 530 0 743, 836 306, 623 99, 725 0 0 478, 125 202, 583 0 14, 697 0	000000000000000000000000000000000000000	5, 599 1, 523, 702 168, 321 135, 925 162, 796 2, 279, 959 129, 410 26, 710 1, 176, 565 421, 609 132, 321 0 644, 025 470, 839 1, 065, 341 425, 973 0 22, 632 83, 610 0 0 5, 695, 612	0 0 0 0 0 0 0 0 0 0 0	6, 140 1, 670, 931 184, 585 149, 059 178, 526 2, 500, 262 141, 914 29, 291 1, 290, 252 462, 347 145, 107 0 706, 255 516, 334 1, 168, 281 467, 133 0 24, 819 91, 689 0 0	54. 00 54. 01 56. 00 58. 00 60. 00 62. 00 64. 00 66. 00 67. 00 69. 01 71. 00 73. 00 76. 01 76. 02 76. 03 76. 04 77. 00
88. 01 88. 02 91. 00	08801 RURAL HEALTH CLINIC II 08802 RURAL HEALTH CLINIC III 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 259, 488 129, 123 636, 418 1, 496, 247	0 0 0	5, 695, 612 229, 096 956, 167 3, 412, 331	-251, 233 0	0 0 1, 048, 558 3, 742, 051	88. 01 88. 02
101.00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVICES 101010 HOME HEALTH AGENCY 10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	430, 246 695, 694 0	0 0 0	727, 307 1, 043, 787 0	-1, 144, 644		95. 00 101. 00 102. 00
113. 00 118. 00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	14, 339, 741	-2, 690, 695	27, 711, 326	-8, 640, 600	21, 748, 350	113. 00 118. 00
192.00 194.00 194.01 194.02	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFI CES 07950 HOSPI CE 07951 FAMI LY MEDI CAL CENTER 07952 MEALS ON WHEELS 07954 FI TNESS CENTER - WEST CAMPUS	59, 437 0 0 0 0	0 0 0 0 0	4, 940 83, 601 0 0 0 46, 740	-91, 679 0 0 0	0 0 0 0	190. 00 192. 00 194. 00 194. 01 194. 02 194. 03

Health Financial Systems	MASON DISTRIC	CT HOSPITAL	In Lie	u of Form CMS-2	552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 14-1313	Peri od: From 10/01/2022	Worksheet B-1	
			To 09/30/2023	Date/Time Prep 2/26/2024 10:4	
Cost Center Description	EMPLOYEE	Reconciliation ADMINISTRATI		A&G HOSPITAL	

				'	0 09/30/2023	2/26/2024 10:	
	Cost Center Description	EMPLOYEE I BENEFITS DEPARTMENT (GROSS SALA RIE)	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	Reconciliation		
		4.00	5A. 01	5. 01	5A. 02	5. 02	
194. 04 079	53 OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194. 04
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	2, 911, 964		2, 690, 695		998, 778	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 202231		0. 096626		0. 045913	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	0		318, 747		24, 286	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000		0. 011447		0. 001116	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

Health Financial Systems	MASON DISTRIC		ON 44 4040 B		u of Form CMS-	
COST ALLOCATION - STATISTICAL BASIS		Provi der CO		eriod: rom 10/01/2022	Worksheet B-1	
			Ť			
Cost Center Description	MAINTENANCE &	MAINTENANCE &	OPERATION OF	OPERATION OF	2/26/2024 10: OPERATION OF	49 am
cost center bescription		REPAIRS - WEST	PLANT	PLANT-CLINIC	PLANT - WEST	
	(SQUARE FEET)	CAMPUS	(SQUARE FEET)	(SQUARE FEET)	CAMPUS BU	
		(SQUARE FEET)	7.00	7.04	(SQUARE FEET)	
GENERAL SERVICE COST CENTERS	6.00	6. 01	7. 00	7. 01	7. 02	
1. 00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
1.01 00101 NEW CAP REL COSTS-CLINIC BUILDIN	IG					1. 01
1.02 00102 NEW CAP REL COSTS-NEW MED SURG						1. 02
1. 03 00103 NEW CAP REL COSTS - WEST CAMPUS	BUI					1. 03
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 01 00590 ADMINISTRATIVE AND GENERAL						5. 01
5. 02 00591 A&G HOSPI TAL ONLY						5. 02
6.00 00600 MAINTENANCE & REPAIRS	69, 172					6. 00
6.01 00601 MAI NTENANCE & REPAIRS - WEST CAM		21, 089				6. 01
7. 00 00700 OPERATION OF PLANT	5, 632	0	47, 474			7.00
7.01 00701 OPERATION OF PLANT-CLINIC 7.02 00702 OPERATION OF PLANT - WEST CAMPUS	٥	0	0		21, 089	7. 01 7. 02
8. 00 00800 LAUNDRY & LINEN SERVICE	1, 669	0	1, 669	-	0	1
9. 00 00900 HOUSEKEEPI NG	412	0	412		0	1
9. 01 00901 HOUSEKEEPING - WEST CAMPUS BUILD	1	0	0	-	0	
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	2, 536	0	2, 536		0	10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	1, 153 953	0	1, 153 953		0 1	11. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	1, 441	0	1, 441	0	0	14. 00
15. 00 01500 PHARMACY	0	0	0	0	0	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	899	0	712		0	16. 00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19. 00
30.00 O3000 ADULTS & PEDIATRICS	11, 313	0	11, 313	0	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	0	11, 313			
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	6, 242	0	6, 242		0	
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0 4, 866	0	0 4, 866	_	0	
54. 01 05401 RADI OLOGY-ULTRASOUND	243	0	243		0	1
56. 00 05600 RADI OI SOTOPE	528	0	528		0	56.00
58. 00 05800 MRI	0	0	0	0	0	58. 00
60. 00 06000 LABORATORY	2, 860	0	2, 860	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD C 64.00 06400 I NTRAVENOUS THERAPY	ELL 0	0	1 0	0	0	62. 00 64. 00
66. 00 06600 PHYSI CAL THERAPY	1, 030	Ö	1, 030	_	Ö	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	216	0	216		0	67. 00
68. 00 06800 SPEECH PATHOLOGY	156	0	156		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY 69. 01 03160 CARDI OPULMONARY	0 4, 894	0	0 4, 894	_	0	69. 00 69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATI		0				
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 870	0	1, 870	0	0	1
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI C	ES 783	0	0	783	0	76. 00
76. 01 03952 TELEMEDICINE PSYCH SERVICES 76. 02 03950 DIABETIC EDUCATION	0	0	0	0	0	76. 01
76. 02 03950 DI ABETI C EDUCATI ON 76. 03 03951 WOUND CARE	0	0		0	0	76. 02 76. 03
76. 04 03953 ALLERGY 123	0	Ö	Ö	0	ő	76. 04
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
88.00 08800 RURAL HEALTH CLINIC	13, 502	0		13, 502	0	88. 00
88. 01 08801 RURAL HEALTH CLINIC II	13, 302	0		13, 302	0	
88.02 08802 RURAL HEALTH CLINIC III	0	0	Ö	0	0	1
91. 00 09100 EMERGENCY	4, 087	0	4, 087	0	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT P	PART					92.00
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
101. 00 10100 HOME HEALTH AGENCY	1, 594	Ö	Ö		-	101.00
102.00 10200 OPIOLD TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE			T			112 00
118.00 SUBTOTALS (SUM OF LINES 1 through	ıh 117) 68,879	0	47, 181	14, 472	n	113. 00 118. 00
NONREI MBURSABLE COST CENTERS	1117) 00,077	U	47, 101	17, 772		1110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANT	EEN 293	0	293			190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194. 00 07950 HOSPI CE 194. 01 07951 FAMI LY MEDI CAL CENTER	0	0		0		194. 00 194. 01
194.0107951 FAWLEY MEDICAL CENTER 194.02 07952 MEALS ON WHEELS		0		0	0	194. 02
194.03 07954 FITNESS CENTER - WEST CAMPUS	0	21, 089		0	21, 089	194. 03
194.04 07953 OTHER NONREIMBURSABLE COST AREAS	6 0	0	0	0	0	194. 04

Heal th F	inancial Systems	MASON DISTRI	CT HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALL	LOCATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
					From 10/01/2022 To 09/30/2023		pared: 49 am
	Cost Center Description	MAINTENANCE &	MAINTENANCE &	OPERATION OF	OPERATION OF	OPERATION OF	
		REPAI RS	REPAIRS - WEST	PLANT	PLANT-CLINIC	PLANT - WEST	
		(SQUARE FEET)	CAMPUS	(SQUARE FEET)	(SQUARE FEET)	CAMPUS BU	
			(SQUARE FEET)			(SQUARE FEET)	
		6.00	6. 01	7. 00	7. 01	7. 02	
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	771, 943	0	533, 70	5 37, 590	37, 866	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	11. 159761	0. 000000	11. 24204	2. 597430	1. 795533	203. 00
204. 00	Cost to be allocated (per Wkst. B,	8, 528	0	63, 37	5 415	418	204. 00

0. 123287

0.000000

1. 334941

0.028676

0. 019821 205. 00

206. 00

207. 00

205.00

206.00

207.00

Unit cost multiplier (Wkst. B, Part

NAHE unit cost multiplier (Wkst. D,

NAHE adjustment amount to be allocated (per Wkst. B-2)

Part II)

Parts III and IV)

	LLOCATION - STATISTICAL BASIS	WASON DISTRIC	Provi der C	CN: 14-1313 F	Peri od:	Worksheet B-1	
				F	rom 10/01/2022	Date/Ti me Pre 2/26/2024 10:	pared:
	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	HOUSEKEEPING - WEST CAMPUS BUILDING (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (FTE' S)	
		8. 00	9. 00	9. 01	10.00	11. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT		l	1			1.00
1. 01	00101 NEW CAP REL COSTS-CLINIC BUILDING						1. 01
1.02	00102 NEW CAP REL COSTS-NEW MED SURG						1. 02
1.03	00103 NEW CAP REL COSTS - WEST CAMPUS BUI						1. 03
2. 00 4. 00	OO200 CAP REL COSTS-MVBLE EQUIP OO400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 01	00590 ADMI NI STRATI VE AND GENERAL						5. 01
5.02	00591 A&G HOSPI TAL ONLY						5. 02
6.00	00600 MAI NTENANCE & REPAIRS						6.00
6. 01 7. 00	00601 MAINTENANCE & REPAIRS - WEST CAMPUS 00700 OPERATION OF PLANT						6. 01 7. 00
7. 01	00701 OPERATION OF PLANT-CLINIC						7. 01
7.02	00702 OPERATION OF PLANT - WEST CAMPUS BU	(7.447					7. 02
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	67, 117 0	61, 459				8. 00 9. 00
9. 01	00901 HOUSEKEEPING - WEST CAMPUS BUILDING	0	01, 437	ı			9. 01
10.00	01000 DI ETARY	0	2, 536	C	,		10.00
11.00	01100 CAFETERI A	0	1, 153			15, 028	
13. 00 14. 00	O1300 NURSI NG ADMI NI STRATI ON O1400 CENTRAL SERVI CES & SUPPLY	0	953 1, 441	1	0	150 267	1
15. 00	01500 PHARMACY	0	0		-	0	1
	01600 MEDICAL RECORDS & LIBRARY	0	899	1		302	
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	(0	0	19. 00
30. 00	O3000 ADULTS & PEDIATRICS	26, 543	11, 313		5, 050	2, 005	30.00
	03100 INTENSIVE CARE UNIT	0		1		0	
FO 00	ANCI LLARY SERVI CE COST CENTERS	7 000			225	220	F0 00
50. 00 53. 00	1 1	7, 902	6, 242	1		320 0	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	9, 255	-			983	
54. 01	05401 RADI OLOGY-ULTRASOUND	0	243	1		119	
56. 00 58. 00	05600	0	528 0	i		1 6	56. 00 58. 00
60.00	06000 LABORATORY	43		1	-	1, 626	1
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	1	-	0	62. 00
64. 00 66. 00	06400 I NTRAVENOUS THERAPY	3, 799	1 020		0	0	
67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	3, 799	1, 030 216	i		873 396	1
68. 00	06800 SPEECH PATHOLOGY	0	156	l .	0	102	
69.00	06900 ELECTROCARDI OLOGY	0	0	1	0	0	
69. 01 71. 00	03160 CARDI OPULMONARY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	785 0		ı	-	764 0	69. 01 71. 00
	07300 DRUGS CHARGED TO PATIENTS	0	1, 870		o o		73. 00
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0		1	1, 017		76. 00
76. 01 76. 02	03952 TELEMEDICINE PSYCH SERVICES 03950 DIABETIC EDUCATION	0	0		0	0 15	
		0				0	1
76. 04	03953 ALLERGY 123	0	Ö	d	0	0	76. 04
	07700 ALLOGENEIC HSCT ACQUISITION	0	0	(0	0	
78.00	O7800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0	0	(0	0	78. 00
88. 00	08800 RURAL HEALTH CLINIC	418	13, 502		0	3, 366	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	91		C	-	0	88. 01
88. 02 91. 00	08802 RURAL HEALTH CLINIC III 09100 EMERGENCY	19 017	0		0 75	2 023	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	18, 017	4, 087		/5	2, 923	91.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	174		(95.00
	10100 HOME HEALTH AGENCY 10200 OPIOID TREATMENT PROGRAM	80					101. 00 102. 00
102.00	SPECIAL PURPOSE COST CENTERS				<u>, </u>		102.00
	11300 I NTEREST EXPENSE	(7.407				45.000	113.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	67, 107	61, 166	(34, 647	15, 028	118. 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	293		o	0	190. 00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	10		C	o	0	192. 00
	07950 HOSPI CE	0	0				194. 00
	07951 FAMILY MEDICAL CENTER 07952 MEALS ON WHEELS	0					194. 01 194. 02
194. 03	07954 FITNESS CENTER - WEST CAMPUS	0	0	21, 089	o	0	194. 03
194. 04	07953 OTHER NONREIMBURSABLE COST AREAS	0	0	() o	0	194. 04

Heal th Fir	nancial Systems	MASON DISTRIC	CT_HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLO	CATION - STATISTICAL BASIS				Peri od: From 10/01/2022	Worksheet B-1	
					To 09/30/2023		pared: 49 am
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	HOUSEKEEPI NG	- DI ETARY	CAFETERI A	
		LINEN SERVICE	(SQUARE FEET)	WEST CAMPUS	(MEALS SERVED)	(FTE' S)	
		(POUNDS OF		BUI LDI NG			
		LAUNDRY)		(SQUARE FEET)			
		8. 00	9. 00	9. 01	10.00	11. 00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	121, 631	636, 926		0 664, 016	588, 634	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	1. 812223	10. 363429	0.00000	0 19. 165180	39. 169151	203. 00
204.00	Cost to be allocated (per Wkst. B,	17, 234	11, 297		0 30, 112	36, 064	204. 00

0. 256775

0.000000

0.869108

2. 399787 205. 00

206. 00

207. 00

0. 183814

Part II)

Parts III and IV)

11)

Unit cost multiplier (Wkst. B, Part

NAHE unit cost multiplier (Wkst. D,

NAHE adjustment amount to be allocated (per Wkst. B-2)

205.00

206.00

207.00

	ALLOCATION - STATISTICAL BASIS	MASON DISTRIC	Provider CO		eri od:	Worksheet B-1	
		,		F T	rom 10/01/2022 o 09/30/2023	Date/Time Pre 2/26/2024 10:	pared: 49 am
	Cost Center Description	NURSI NG ADMI NI STRATI ON (HOURS OF	CENTRAL SERVICES & SUPPLY (COSTED REQ	PHARMACY (COSTED REQ UISI)	MEDI CAL RECORDS & LI BRARY (GROSS REVE	NONPHYSI CI AN ANESTHETI STS (ASSI GNED TI ME)	
		SERVICE)	UISI)		NUE)		
	GENERAL SERVICE COST CENTERS	13. 00	14. 00	15. 00	16. 00	19. 00	
1.00 1.01 1.02 1.03 2.00 4.00 5.01 5.02 6.00 6.01 7.00 7.01 7.02 8.00 9.00 9.01	00100 CAP REL COSTS-BLDG & FIXT 00101 NEW CAP REL COSTS-CLINIC BUILDING 00102 NEW CAP REL COSTS-NEW MED SURG 00103 NEW CAP REL COSTS-NEW MED SURG 00200 CAP REL COSTS-MYBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00590 ADMINISTRATIVE AND GENERAL 00591 A&G HOSPITAL ONLY 00600 MAINTENANCE & REPAIRS 00601 MAINTENANCE & REPAIRS - WEST CAMPUS 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT 00701 OPERATION OF PLANT-CLINIC 00702 OPERATION OF PLANT - WEST CAMPUS BU 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 00901 HOUSEKEEPING - WEST CAMPUS BUILDING						1. 00 1. 01 1. 02 1. 03 2. 00 4. 00 5. 01 5. 02 6. 00 6. 01 7. 00 7. 01 7. 02 8. 00 9. 00
10. 00 11. 00 13. 00 14. 00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	48, 156 0	1, 352, 577				10. 00 11. 00 13. 00 14. 00
	01500 PHARMACY	0	0	100 0 0	57, 091, 159	100	15. 00 16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	0				
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT ANCILLARY SERVICE COST CENTERS	27, 864	0			0	
50.00	05000 OPERATING ROOM	5, 131	0	0		0	
53. 00 54. 01 56. 00 58. 00 60. 00 62. 00 64. 00 66. 00 67. 00 68. 00 69. 01 71. 00 73. 00 76. 01 76. 02 76. 03	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05401 RADI OLOGY-ULTRASOUND 05600 RADI OI SOTOPE 05800 MRI 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06400 INTRAVENOUS THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 03160 CARDI OPULMONARY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07300 DRUGS CHARGED TO PATI ENTS 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 03952 TELEMEDI CI NE PSYCH SERVI CES 03953 ALLERGY 123 07700 ALLOGENEI C HSCT ACQUI SI TI ON 07800 CAR T-CELL I IMMUNOTHERAPY OUTPATI ENT SERVI CE COST CENTERS 08800 RURAL HEALTH CLINI C	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	24, 810 1, 475 22, 485 2, 085 689, 025 129, 410 12, 448 0 0 0 470, 839 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	1, 093, 731 9, 770, 125 1, 189, 104 457, 597 1, 948, 954 10, 344, 919 159, 135 610, 005 4, 152, 803 1, 679, 959 412, 480 0 1, 604, 405 737, 590 1, 225, 079 1, 211, 455 0 587 713, 570 0 0	100 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	53. 00 54. 00 54. 01 56. 00 58. 00 60. 00 64. 00 66. 00 67. 00 68. 00 69. 01 71. 00 73. 00 76. 01 76. 02 76. 03 76. 04 77. 00 78. 00
88. 02 91. 00		11, 634	0	0	1, 013, 434 3, 148, 677	0 0	88. 02
101.00	09500 AMBULANCE SERVICES 0 10100 HOME HEALTH AGENCY 0 10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0 0	0 0 0		2, 790, 777	0	95. 00 101. 00 102. 00
113. 00 118. 00	11300 INTEREST EXPENSE	48, 156	1, 352, 577	100	57, 091, 159	100	113. 00 118. 00
192. 00 194. 00 194. 02 194. 02	D 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN D 19200 PHYSICIANS' PRIVATE OFFICES D 07950 HOSPICE 107951 FAMILY MEDICAL CENTER 207952 MEALS ON WHEELS 3 07954 FITNESS CENTER - WEST CAMPUS	0 0 0 0 0	0 0 0 0 0	0 0 0 0 0	0 0 0	0 0 0	190. 00 192. 00 194. 00 194. 01 194. 02 194. 03

Health Financial Systems	MASON DISTRICT HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 14-1313	Peri od: Worksheet B-1 From 10/01/2022
		To 09/30/2023 Date/Time Prepared:

				''	0 09/30/2023	2/26/2024 10:	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	NONPHYSI CI AN	
	·	ADMI NI STRATI ON	SERVICES &	(COSTED REQ	RECORDS &	ANESTHETI STS	
			SUPPLY	UISI)	LI BRARY	(ASSI GNED	
		(HOURS OF	(COSTED REQ		(GROSS REVE	TIME)	
		SERVI CE)	UISI)		NUE)		
		13. 00	14.00	15. 00	16. 00	19. 00	
194. 04	07953 OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194. 04
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	312, 586	245, 344	0	420, 946	349, 459	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	6. 491112	0. 181390	0. 000000	0. 007373	3, 494. 590000	203. 00
204.00		13, 780	16, 178	0	65, 494	3, 861	204. 00
	Part II)						
205.00		0. 286153	0. 011961	0. 000000	0. 001147	38. 610000	205. 00
206.00							206. 00
	(per Wkst. B-2)						
207.00							207. 00
	Parts III and IV)						

Health Financial Systems	MASON DISTRICT HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-1313	Period: Worksheet C From 10/01/2022 Part I

					rom 10/01/2022 o 09/30/2023	Part I Date/Time Pre 2/26/2024 10:	
			Title	XVIII	Hospi tal	Cost	
	·		·		Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
20.00	03000 ADULTS & PEDIATRICS	2 10/ 770	I	2 10/ 770	8 0	0	30.00
	ł	3, 106, 778		3, 106, 778		0	
	O3100 INTENSIVE CARE UNIT ANCILLARY SERVICE COST CENTERS	1 0		<u> </u>)	0	31.00
	05000 OPERATING ROOM	880, 867	ĺ	000.047	0	0	50.00
50.00	05300 ANESTHESI OLOGY	1		880, 867		_	
53.00		363, 945		363, 945		0	
54.00	05400 RADI OLOGY - DI AGNOSTI C	2, 038, 893		2, 038, 893		0	54.00
	05401 RADI OLOGY-ULTRASOUND	214, 718		214, 718		0	54. 01
56. 00	05600 RADI OI SOTOPE	180, 695		180, 695		0	56. 00
58. 00	05800 MRI	201, 706		201, 706		0	58. 00
60.00	06000 LABORATORY	2, 973, 802		2, 973, 802		0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	173, 077		173, 077		0	62.00
64.00	06400 I NTRAVENOUS THERAPY	37, 392		37, 392		0	64.00
66.00	06600 PHYSI CAL THERAPY	1, 454, 938	0			0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	518, 550	0			0	67.00
68. 00	06800 SPEECH PATHOLOGY	163, 917	0	163, 917	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0			0	0	69. 00
69. 01	03160 CARDI OPULMONARY	942, 212		942, 212		0	69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	630, 883		630, 883		0	
	07300 DRUGS CHARGED TO PATIENTS	1, 310, 635		1, 310, 635		0	
76. 00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	572, 102		572, 102	2 0	0	
	03952 TELEMEDICINE PSYCH SERVICES	0		[C	0	0	
	03950 DIABETIC EDUCATION	26, 551		26, 551		0	
	03951 WOUND CARE	101, 160		101, 160		0	
	03953 ALLERGY 123	0		[C	1 1	0	76. 04
	07700 ALLOGENEIC HSCT ACQUISITION	0		C	١	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0		C	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS				, , , , , , , , , , , , , , , , , , , ,		
88. 00	08800 RURAL HEALTH CLINIC	6, 741, 270	ł .	6, 741, 270		0	
	08801 RURAL HEALTH CLINIC II	253, 130		253, 130		0	
88. 02	08802 RURAL HEALTH CLINIC III	1, 104, 172		1, 104, 172		0	
	09100 EMERGENCY	4, 295, 083		4, 295, 083		0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	687, 635		687, 635	5	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	855, 068		855, 068	0	0	95. 00
	10100 HOME HEALTH AGENCY	1, 199, 673		1, 199, 673	3		101. 00
102. 00	10200 OPIOID TREATMENT PROGRAM	0		[C)	0	102. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE						113. 00
200.00	Subtotal (see instructions)	31, 028, 852	0	31, 028, 852	0		200. 00
201.00	l	687, 635		687, 635			201. 00
202.00	Total (see instructions)	30, 341, 217	0	30, 341, 217	0	0	202. 00

Health Financial Systems	MASON DISTRICT HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-1313		Worksheet C
		From 10/01/2022	

Impatient Cost Center Description Impatient Outpatient Outpatient Cost Cost or Other Ratio Impatient Cost Cost or Other Ratio Impatient Ratio Cost Cost or Other Ratio Cost Cost or Other Impatient Ratio Cost Cost or Other Ratio Cost Cost or Other Impatient Ratio Cost Cost or Other Ratio Cost C					٦	From 10/01/2022 To 09/30/2023	Part I Date/Time Pre 2/26/2024 10:	
Inpati ent					XVIII	Hospi tal	Cost	
INPATIENT ROUTINE SERVICE COST CENTERS					1			
INPATIENT ROUTINE SERVICE COST CENTERS		Cost Center Description	I npati ent	Outpati ent				
NPATI ENT ROUTI NE SERVICE COST CENTERS					+ COI. /)	Ratio		
INPATIENT ROUTINE SERVICE COST CENTERS 2, 197, 279 30.00 310.00 3			4.00	7.00	0.00	0.00		
30.00 03000 ADULTS & PEDIATRICS 2,197,279 2,197,279 30.000 30.00 30.00 30.00 1 NTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0		INDATIENT DOUTINE SERVICE COST CENTERS	6.00	7.00	8.00	9.00	10.00	
31.00	20 00		2 107 270		2 107 270			20.00
ANCILLARY SERVICE COST CENTERS 3.000 Color			1					1
50.00 OSOOO OPERATI ING ROOM 33, \$21 1, 760, 955 1, 794, 476 0, 490877 0, 000000 50.00 53.00 OS300 AMESTHESI DLOGY 29, 888 1, 63, 848 1, 642 1, 646 1, 66 1, 60	31.00		ı o			<u>/</u>		31.00
53.00 0S300 AMESTHESI OLOCY 29, 888 1, 063, 843 1, 093, 731 0, 332755 0, 000000 54, 00	50 00		33 521	1 760 055	1 70/ /7/	0 400877	0.00000	50.00
54.00 0.5400 RADIOLOGY-DIAGNOSTIC 287.368 9, 482, 757 9, 770, 125 0. 208686 0. 0.00000 54.01 54.01 0.5401 RADIOLOGY-ULTRASOUND 22, 444 1, 16.6 600 1, 189, 104 0. 180571 0. 000000 54.01 55.00 0.5600 RADIOLOGYOPE 2, 955 454, 642 457, 597 0. 394878 0. 000000 54.01 56.00 0.5800 MRI 44, 041 1, 904, 913 1, 948, 954 0. 103474 0. 000000 58.00 58.00 0.5800 MRI 44, 041 1, 904, 913 1, 948, 954 0. 103474 0. 000000 58.00 56.00 0.5000 LABORATORY 521, 307 9, 823, 612 10, 344, 919 0. 287465 0. 000000 60.00 62.00 0.6200 WHOLE BLOOD & PACKED RED BLOOD CELL 14, 886 144, 249 159, 135 1.087611 0. 000000 62.00 64.00 0.6400 INTRAVENDUS THERAPY 409, 848 3, 742, 955 4, 152, 803 0. 350351 0. 000000 64.00 66.00 0.6600 PHYSI CAL THERAPY 409, 848 3, 742, 955 4, 152, 803 0. 350351 0. 000000 67.00 68.00 0.6800 SPEECH PATHOLOGY 28, 235 384, 245 412, 480 0. 397394 0. 000000 67.00 69.00 0.6900 ELECTROCARDIOLOGY 0 0 0 0. 000000 0. 000000 69.01 71.00 0.7100 MEDICAL SUPPLIES CHARGED TO PATIENT 216, 117 521, 473 737, 590 0. 855330 0. 000000 71.00 70.00 0.7000 DRUGS CHARGED TO PATIENT 216, 117 521, 473 737, 590 0. 855330 0. 000000 73.00 70.00 0.3955 PSYCHIATRI C/PSYCHOLOGI CAL SERVICES 0 1, 211, 455 1, 211, 455 0. 472244 0. 000000 76.01 70.00 0.3955 TELEMEDI CIN PEYSYCH SERVICES 0 713, 570 713, 570 0. 000000 0. 000000 76.02 70.00 0.7000 ALBORATORY 0 0 0 0 0. 000000 0. 000000 76.02 70.00 0.7000 ALBORATORY 0 0 0 0 0. 000000 76.02 70.00 0.7000 ALBORATORY 0 0 0 0. 000000 0. 000000 76.02 70.00 0.7000 ALBORATORY 0 0 0 0. 000000 0. 000000 76.02 70.00 0.7000 ALBORATORY 0 0 0 0. 000000 0. 000000 76.02 70.00 0.7000 ALBORATORY 0 0 0 0. 000000 0. 0000					· · ·			
54.01 05401 RADI OLOGY-ULTRASOUND 22, 444 1, 166, 660 1, 189, 104 0, 180571 0, 000000 54, 01					· · ·			1
56. 00 05600 RADI OI SOTOPE 2, 955 454, 642 457, 597 0, 394878 0, 000000 56. 00		l						1
S8. 00 05800 NR		l						
60.00 06000 LABORATORY 521, 307 9, 823, 612 10, 344, 919 0, 287465 0, 000000 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 14, 886 144, 249 159, 135 1, 087611 0, 000000 62.00 64.00 06400 INTRAVENOUS THERAPY 47, 168 562, 837 610, 005 0, 061298 0, 000000 64.00 66.00 06600 PHYSI CAL THERAPY 409, 848 3, 742, 955 4, 152, 803 0, 350351 0, 000000 66.00 66.00 66.00 06.00 0.00000 64.00 66.00 0.00000 66.00 0.00000 66.00 0.00000 66.00 0.00000 0.00000 0.00000 67.00 0.000000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000					·			
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 14,886 144,249 159,135 1,087611 0,000000 62.00 64.00 06400 INTRAVENOUS THERAPY 409,848 3,742,955 4,152,803 0,350351 0,000000 64.00 66.00 06600 PHYSI CAL THERAPY 409,848 3,742,955 4,152,803 0,350351 0,000000 66.00 67.00 06700 0CCUPATI ONAL THERAPY 382,077 1,297,882 1,679,959 0,38668 0,000000 67.00 68.00 06800 SPEECH PATHOLOGY 28,235 384,245 412,480 0,39734 0,000000 68.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0,000000 0,000000 69.00 69.01 03160 CARDIOPULMONARY 293,102 1,311,303 1,604,405 0,587266 0,00000 69.01 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 216,117 521,473 737,590 0,855330 0,00000 73.00 73.00 07300 RUGS CHARGED TO PATI ENTS 282,588 942,491 1,225,079 1,069837 0,000000 73.00 76.01 039550 PSYCHI ATRIC /PSYCHOLOGI CAL SERVI CES 0 1,211,455 1,211,455 0,472244 0,000000 76.00 76.02 039550 DALBETI C EDUCATION 0 587 587 45,231687 0,000000 76.00 76.02 039530 DIABETI C EDUCATION 0 587 587 45,231687 0,000000 76.00 76.03 03951 WOUND CARE 0 713,570 713,570 0,141766 0,000000 76.03 76.04 03953 ALLERGY 123 0 0 0 0,000000 0,000000 76.03 76.04 03953 ALLERGY 123 0 0 0 0,000000 0,000000 76.00 76.03 03950 CARRILLERGY 123 0 0 0 0,000000 0,000000 76.00 76.04 03950 RURAL HEALTH CLINI C 0 234,963 234,963 76.05 03800 RURAL HEALTH CLINI C 1 0 234,963 234,963 76.06 03800 RURAL HEALTH CLINI C 1 0 234,963 234,963 76.07 0700 0700 04LDEGENITO 0 0 0 0 0 0 0 76.00 0700 0700 0700 0700 0700 0700 0 77.00 0700 0700 0700 0700 0700 0700 0700 0700 77.00 0700 0700 0700 0700 0700 0700 0700 0700 0700 77.00 0700 0700 0700 0700 0700 0700 0700 0700 0700 0700 0700 0700 0700 070								
64.00 06400 INTRAVENOUS THERAPY 47, 168 562, 837 610, 005 0. 061298 0. 000000 64.00 66.00 06600 PHYSI CAL THERAPY 382, 077 372, 955 4, 152, 803 0. 350351 0. 000000 67.00 68.00 06700 OCCUPATI ONAL THERAPY 382, 077 382, 077 1, 297, 882 11, 679, 959 0. 308668 0. 000000 67.00 68.00 0. 000000 0. 00								
66.00 06600 PHYSI CAL THERAPY 409, 848 3,742, 955 4,152, 803 0,350351 0,000000 66.00 67.00 06700 0CCUPATI ONAL THERAPY 382, 077 1,297, 882 1,679, 959 0.308668 0.000000 68.00 68.00 06800 SPEECH PATHOLOGY 28,235 384,245 412,480 0.397394 0.000000 68.00 69.01 03160 CARDI OPULMONARY 293,102 1,311,303 1,604,405 0.587266 0.000000 69.00 69.01 03160 CARDI OPULMONARY 293,102 1,311,303 1,604,405 0.587266 0.000000 69.00 67.00 03700 DRUGS CHARGED TO PATI ENTS 282,588 942,491 1,225,079 1.069837 0.000000 71.00 67.00 033550 PSYCHI ATRIC C/PSYCHOLOGI CAL SERVI CES 0 1,211,455 1,211,455 0.472244 0.000000 76.00 67.01 03952 TELEMEDI CI NE PSYCH SERVI CES 0 0 0 0.000000 0.000000 76.00 67.03 03953 TOURD CARE 0 0 0 0.000000 0.000000 76.00 67.04 03953 ALLERGY 123 0 0 0 0 0.000000 0.000000 76.00 67.05 07700 ALLEGENIE C EDUCATI ON 0 0 0 0.000000 0.000000 76.00 68.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0.000000 0.000000 76.00 68.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0.000000 0.000000 76.00 68.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0.000000 0.000000 0.000000 76.00 68.00 08800 RURAL HEALTH CLINIC III 0 1,013,434 1,013,4			1		·			
67. 00 06700 06CUPATI ONAL THERAPY 382, 077 1,297, 882 1,679, 959 0,308668 0,000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 28, 235 384, 245 412, 480 0.397394 0.000000 68. 00 69. 01 03160 CARDI OPULMONARY 293, 102 1,311, 303 1,604, 405 0.587266 0.000000 69. 01 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 216, 117 521, 473 737, 590 0.855330 0.000000 71. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 282, 588 942, 491 1,225, 079 1.069837 0.000000 73. 00 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 1,211, 455 1,211, 455 0.472244 0.000000 76. 01 76. 01 03952 TELEMEDI CI NP PSYCH SERVI CES 0 0 0.000000 0.000000 76. 00 76. 02 03950 DI ABETI C EDUCATI ON 0 587 587 587 45, 231687 0.000000 76. 03 76. 04 03953 ALLERGY 123 0 0 0 0.000000 0.000000 76. 03 76. 04 03953 ALLERGY 123 0 0 0 0.000000 0.000000 76. 03 78. 00 0700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0.000000 0.000000 76. 03 78. 00 07800 CART T-CELL I IMMUNTHERAPY 0 0 0 0.000000 0.000000 76. 03 78. 00 08800 RURAL HEALTH CLINI C 11 0 0 234, 963 234, 963 79. 00 09100 EMERGENCY 18, 501 3, 130, 176 3, 148, 677 1, 364091 0.000000 75. 00 79. 00 09200 08SERVATI ON BEDS (NON-DI STI NCT PART 0 787, 956 787, 956 0.872682 0.000000 75. 00 79. 00 09200 08SERVATI ON BEDS (NON-DI STI NCT PART 0 787, 956 787, 956 0.872682 0.000000 75. 00 79. 00 09200 08SERVATI ON BEDS (NON-DI STI NCT PART 0 787, 956 787, 956 787, 956 0.872682 0.000000 75. 00 79. 00 09200 08SERVATI ON BEDS (NON-DI STI NCT PART 0 787, 956 787, 956 0.872682 0.000000 75. 00 79. 00 09200 08SERVATI ON BEDS (NON-DI STI NCT PART 0 787, 956 787, 956 787, 956 0.872682 0.000000 75. 00 79. 00 09200 08SERVATI ON BEDS (NON-DI STI NCT PART 0 787, 956 787, 956 787, 956 0.87					·			
68.00 06800 SPECCH PATHOLOGY 28, 235 384, 245 412, 480 0.397394 0.000000 68.00 69.00 0.0000000 69.00 0.000000 69.00 0.000000 69.00 0.0000000 69.00 0.0000000 69.00 0.0000000 69.00 0.0000000 69.00		l						
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0.000000 69. 00 69. 01 03160 CARDI OPULIMONARY 293, 102 1, 311, 303 1, 604, 405 0.587266 0.000000 69. 01 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 216, 117 521, 473 737, 590 0.855330 0.000000 71. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 282, 588 942, 491 1, 225, 079 1.069837 0.000000 73. 00 76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 1, 211, 455 0.472244 0.000000 76. 01 76. 01 03952 TELERBUI CINE PSYCH SERVI CES 0 0 0 0.000000 76. 01 76. 02 03950 DI ABETI C EDUCATI ON 0 587 587 45. 231687 0.000000 76. 01 76. 03 03951 WOUND CARE 0 0 0 0 0.000000 76. 02 76. 04 03953 ALLERGY 123 0 0 0 0 0.000000 76. 04 77. 00 07700 ALLOGENEI C HSCT ACQUI SITI ON 0 0 0 0.000000 0.000000 77. 00 78. 00 07800 CAR T-CELL I MMUNOTHERAPY 0 0 0 0.000000 0.000000 77. 00 78. 00 08800 RURAL HEALTH CLINIC 11 0 234, 963 234, 963 88. 01 88. 01 08801 RURAL HEALTH CLINIC 11 0 234, 963 234, 963 88. 02 88. 02 08802 RURAL HEALTH CLINIC 11 0 1, 013, 434 1, 013, 434 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0 787, 956 787, 956 0.872682 0.000000 92. 00 0710 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0 787, 956 787, 956 0.872682 0.000000 92. 00 0710 09200 0DSERVATION BEDS (NON-DISTINCT PART 0 787, 956 787, 956 0.872682 0.000000 92. 00 0710 09200 0DSERVATION BEDS (NON-DISTINCT PART 0 787, 956 787, 956 0.872682 0.000000 92. 00 0710 09200 0DSERVATION BEDS (NON-DISTINCT PART 0 787, 956 787, 956 0.872682 0.000000 92. 00 0710 09200 0DSERVATION BEDS (NON-DISTINCT PART 0 787, 956 787, 956 0.872682 0.000000 92. 00 0710 000000000000000000000000000000000	68. 00	06800 SPEECH PATHOLOGY					0.000000	68. 00
71. 00	69. 00		1				0. 000000	69.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 216, 117 521, 473 737, 590 0.855330 0.000000 71. 00 73. 00 74. 00 73. 00 74. 00		l	293, 102	1, 311, 303	1, 604, 405			
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 1, 211, 455 1, 211, 455 0. 472244 0. 000000 76. 00 76. 00 03952 TELEMEDI CI NE PSYCH SERVI CES 0 0 0 0. 000000 76. 01 0. 000000 76. 01 0. 000000 76. 01 0. 000000 76. 02 76. 03 03951 NOUND CARE 0 0 713, 570 713, 570 0. 141766 0. 000000 76. 03 76. 04 03953 ALLERGY 123 0 0 0 0 0. 000000 0. 000000 76. 04 77. 00 0. 000000 0. 000000 76. 04 77. 00 0. 000000 0. 000000 0. 000000 0. 000000 77. 00 0. 0000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	216, 117				0. 000000	71. 00
76. 01 03952 TELEMEDICINE PSYCH SERVICES 0 0 0 0 0.000000 76. 01 76. 02 03950 DIABETIC EDUCATION 0 587 587 45. 231687 0.000000 76. 02 76. 03 03951 WOUND CARE 0 713,570 713,570 0.141766 0.000000 76. 03 76. 04 03953 ALLERGY 123 0 0 0 0 0.000000 76. 04 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0.000000 0.000000 76. 04 77. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0.000000 0.000000 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0.000000 0.000000 78. 00 88. 00 08800 RURAL HEALTH CLINIC II 0 0 234, 963 234, 963 88. 01 08801 RURAL HEALTH CLINIC II 0 0 1, 013, 434 1, 013, 434 88. 02 88. 01 08802 RURAL HEALTH CLINIC III 0 18, 501 3, 130, 176 3, 148, 677 1.364091 0.000000 91. 00 92. 00 09200 09502 AMBULANCE SERVICES 5, 790 2, 781, 427 2, 787, 217 0.306782 0.00000 92. 00 101. 00 10100 HOME HEALTH AGENCY 0 2, 780, 777 2, 790, 777 101. 00 102. 00 10200 OPIOID TREATMENT PROGRAM 0 0 0 0 0 0 0 0 000000 95. 00 201. 00 Less Observation Beds 4, 837, 115 52, 254, 044 57, 091, 159 200. 00 201. 00 Less Observation Beds 5 133. 00 201. 00 Less Observation Beds 5 200. 00 201. 00 Le	73.00	07300 DRUGS CHARGED TO PATIENTS	282, 588	942, 491	1, 225, 079	1. 069837	0.000000	73. 00
76. 02 03950 DI ABETI C EDUCATION 0 587 587 45. 231687 0. 000000 76. 02 76. 03 03951 WOUND CARE 0 713, 570 713, 570 0. 141766 0. 000000 76. 03 76. 04 03953 ALLERGY 123 0 0 0 0 0. 000000 0. 000000 76. 03 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0. 000000 0. 000000 77. 00 0780 CAR T - CELL I IMUNOTHERAPY 0 0 0 0 0 0. 000000 0. 000000 78. 00 00000 0. 000000 0. 000000 78. 00 00000 0. 000000 0. 000000 0. 000000	76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	1, 211, 455	1, 211, 455	0. 472244	0.000000	76. 00
76. 03	76. 01	03952 TELEMEDICINE PSYCH SERVICES	0	0	(0. 000000	0.000000	76. 01
76. 04 03953 ALLERGY 123 0 0 0 0 0.000000 76. 04 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0.000000 77. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0.000000 0.000000 78. 00 0.000000 0.000000 78. 00 0.000000 0.000000 0.000000 78. 00 0.000000 0.000000 0.000000 0.000000	76. 02	03950 DIABETIC EDUCATION	0	587	587	45. 231687	0. 000000	76. 02
77. 00	76. 03	03951 WOUND CARE	0	713, 570	713, 570	0. 141766	0.000000	76. 03
78. 00	76.04	03953 ALLERGY 123	0	0	(0. 000000	0. 000000	76. 04
SECOND SUBSTITUTE SERVICE COST CENTERS SECOND SERVICE COST CENTERS SECOND SERVICE COST CENTERS SECOND SECOND SECOND SECOND SUBSTITUTE SERVICE SE	77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	(0. 000000	0. 000000	77. 00
88. 00	78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	(0. 000000	0. 000000	78. 00
88. 01 08801 RURAL HEALTH CLINIC II 0 234, 963 234, 963 88. 01 88. 02 08802 RURAL HEALTH CLINIC III 0 1,013, 434								
88. 02 08802 RURAL HEALTH CLINIC III 0 1,013,434 1,013,434 1,013,434 0.000000 91. 00 92. 00 09100 EMERGENCY 18,501 3,130,176 3,148,677 1.364091 0.000000 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 0 787,956 787,956 0.872682 0.000000 92. 00 07HER REI MBURSABLE COST CENTERS	88. 00		0	5, 024, 882	5, 024, 882	2		88. 00
91. 00			0					1
92. 00	88. 02	l	0	1, 013, 434	1, 013, 434	1		88. 02
OTHER REIMBURSABLE COST CENTERS 5,790 2,781,427 2,787,217 0.306782 0.000000 95.00			1		· · ·			
95. 00	92. 00		0	787, 956	787, 956	0. 872682	0. 000000	92. 00
101. 00								
102. 00 10200 OPI OI D TREATMENT PROGRAM O O O O O O O O O							0. 000000	
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 200.00 Subtotal (see instructions) 4,837,115 52,254,044 57,091,159 200.00 201.00 Less Observation Beds 201.00		l I	1					
113. 00	102.00		0	0	()		102.00
200.00 Subtotal (see instructions) 4,837,115 52,254,044 57,091,159 200.00 201.00 Less Observation Beds 200.00							140.00	
201.00 Less Observation Beds 201.00		l	4 007 445	E0 054 044	F7 001 15			
			4, 837, 115	52, 254, 044	57,091,159			
202.00 1018 (See 1151 0011 0015) 4, 657, 115 52, 254, 044 57, 071, 157		l	1 027 115	52 254 Q44	57 001 150			
	202.00	(See Histinctions)	4,037,115	52, 254, 044	37,071,135	7		1202.00

Heal th Financial Systems MASON DISTRICT HOSPITAL In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1313
Period: Worksheet C
From 10/01/2022
To 09/30/2023 Date/Time Prepared: Date/Time Pre

			10 07/30/2023	2/26/2024 10: 49 am
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
'	Rati o			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31. 00 03100 INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 000000			50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54. 00
54. 01 05401 RADI OLOGY-ULTRASOUND	0. 000000			54. 01
56. 00 05600 RADI 0I SOTOPE	0. 000000			56. 00
58. 00 05800 MRI	0. 000000			58. 00
60. 00 06000 LABORATORY	0. 000000			60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000			62.00
	0. 000000			64. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
69. 01 03160 CARDI OPULMONARY	0. 000000			69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000			76. 00
76. 01 03952 TELEMEDICINE PSYCH SERVICES	0. 000000			76. 01
76. 02 03950 DI ABETI C EDUCATI ON	0. 000000			76. 02
76. 03 03951 WOUND CARE	0. 000000			76. 03
76. 04 03953 ALLERGY 123	0. 000000			76. 04
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000			78. 00
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC				88. 00
88. 01 08801 RURAL HEALTH CLINIC II				88. 01
88. 02 08802 RURAL HEALTH CLINIC III				88. 02
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
101.00 10100 HOME HEALTH AGENCY	0.00000			101. 00
102. 00 10200 OPI OI D TREATMENT PROGRAM	1			102. 00
SPECIAL PURPOSE COST CENTERS				102.00
113. 00 11300 I NTEREST EXPENSE				113, 00
200.00 Subtotal (see instructions)				200. 00
201. 00 Less Observation Beds				200.00
202.00 Total (see instructions)				202. 00
202.00 Total (See Histractions)	1 1			₁ 202.00

ieu of Form CMS-2552-10
Worksheet C
22 Part I
0

					rom 10/01/2022 o 09/30/2023	Part I Date/Time Pre	pared:
			T: +1	e XIX	Hocni tal	2/26/2024 10: Cost	49 am_
			1111	e xi x	Hospi tal Costs	COST	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	cost center bescription	(from Wkst. B,	Adj.	10141 00313	Di sal I owance	10141 00313	
		Part I, col.	, , , , , , , , , , , , , , , , , , ,		Di Sai i olianee		
		26)					
		1.00	2, 00	3, 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	3, 106, 778		3, 106, 778	0	3, 106, 778	30.00
31.00	03100 INTENSIVE CARE UNIT	0		0	0	0	31. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	880, 867		880, 867	0	880, 867	50. 00
53.00	05300 ANESTHESI OLOGY	363, 945		363, 945	0	363, 945	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 038, 893		2, 038, 893	0	2, 038, 893	54. 00
54. 01	05401 RADI OLOGY-ULTRASOUND	214, 718		214, 718	0	214, 718	54. 01
56.00	05600 RADI 0I S0T0PE	180, 695		180, 695	0	180, 695	56. 00
58.00	05800 MRI	201, 706		201, 706		201, 706	
60.00	06000 LABORATORY	2, 973, 802		2, 973, 802		2, 973, 802	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	173, 077		173, 077		173, 077	1
64. 00	06400 I NTRAVENOUS THERAPY	37, 392		37, 392		37, 392	
66. 00	06600 PHYSI CAL THERAPY	1, 454, 938	l .	.,,		1, 454, 938	
67. 00	06700 OCCUPATI ONAL THERAPY	518, 550				518, 550	
68. 00	06800 SPEECH PATHOLOGY	163, 917	0	163, 917		163, 917	1
69. 00	06900 ELECTROCARDI OLOGY	0		0		0	
69. 01	03160 CARDI OPULMONARY	942, 212		942, 212		942, 212	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	630, 883		630, 883	-	630, 883	
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 310, 635		1, 310, 635		1, 310, 635	1
76. 00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	572, 102		572, 102		572, 102	
76. 01	03952 TELEMEDICINE PSYCH SERVICES	0		0		0	
	03950 DI ABETI C EDUCATI ON	26, 551		26, 551		26, 551	
	03951 WOUND CARE	101, 160		101, 160		101, 160	
	03953 ALLERGY 123	0		0	_	0	
	07700 ALLOGENEIC HSCT ACQUISITION	0		0	_	0	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	6, 741, 270	1	6, 741, 270	0	6, 741, 270	88. 00
	08801 RURAL HEALTH CLINIC II	253, 130	l .	253, 130		253, 130	1
88. 02	08802 RURAL HEALTH CLINIC III	1, 104, 172		1, 104, 172		1, 104, 172	
91. 00	09100 EMERGENCY	4, 295, 083		4, 295, 083		4, 295, 083	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	687, 635		687, 635		687, 635	
72.00	OTHER REIMBURSABLE COST CENTERS	007,033		007, 033		007,033	72.00
95 00	09500 AMBULANCE SERVICES	855, 068		855, 068	0	855, 068	95. 00
	10100 HOME HEALTH AGENCY	1, 199, 673		1, 199, 673		1, 199, 673	1
	10200 OPI OI D TREATMENT PROGRAM	0		0			102. 00
102.00	SPECIAL PURPOSE COST CENTERS					<u> </u>	102.00
113. 00	11300 NTEREST EXPENSE						113. 00
200.00		31, 028, 852	0	31, 028, 852	0	31, 028, 852	
201.00	,	687, 635		687, 635		687, 635	
202.00		30, 341, 217	0			30, 341, 217	
			'		-1		

Health Financial Systems	MASON DISTRICT HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-1313		Worksheet C
		From 10/01/2022	

					rom 10/01/2022 o 09/30/2023	Part I Date/Time Pre 2/26/2024 10:	
			Ti tl	e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	2, 197, 279		2, 197, 279			30. 00
31.00	03100 INTENSIVE CARE UNIT	0		C)		31.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	33, 521	1, 760, 955	1, 794, 476	0. 490877	0. 000000	50.00
53.00	05300 ANESTHESI OLOGY	29, 888	1, 063, 843	1, 093, 731	0. 332755	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	287, 368	9, 482, 757	9, 770, 125	0. 208686	0.000000	54.00
54. 01	05401 RADI OLOGY-ULTRASOUND	22, 444	1, 166, 660	1, 189, 104	0. 180571	0.000000	54. 01
56.00	05600 RADI 0I SOTOPE	2, 955	454, 642	457, 597	0. 394878	0.000000	56. 00
58.00	05800 MRI	44, 041	1, 904, 913	1, 948, 954	0. 103494	0.000000	58. 00
60.00	06000 LABORATORY	521, 307	9, 823, 612	10, 344, 919	0. 287465	0.000000	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	14, 886	144, 249	159, 135		0.000000	62. 00
64.00	06400 I NTRAVENOUS THERAPY	47, 168	562, 837	610, 005		0.000000	
66.00	06600 PHYSI CAL THERAPY	409, 848	3, 742, 955	4, 152, 803	0. 350351	0.000000	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	382, 077	1, 297, 882	1, 679, 959	0. 308668	0.000000	67. 00
68. 00	06800 SPEECH PATHOLOGY	28, 235	384, 245	412, 480	0. 397394	0.000000	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	C	0. 000000	0.000000	69. 00
69. 01	03160 CARDI OPULMONARY	293, 102	1, 311, 303	1, 604, 405	0. 587266	0.000000	69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	216, 117	521, 473	737, 590		0.000000	
	07300 DRUGS CHARGED TO PATIENTS	282, 588	942, 491	1, 225, 079		0.000000	73. 00
76. 00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	1, 211, 455	1, 211, 455	0. 472244	0.000000	76. 00
	03952 TELEMEDICINE PSYCH SERVICES	0	0	0		0.000000	
	03950 DIABETIC EDUCATION	0	587	587		0.000000	
	03951 WOUND CARE	0	713, 570	713, 570		0. 000000	
	03953 ALLERGY 123	0	0	0		0. 000000	
	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0		0. 000000	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	C	0.000000	0. 000000	78. 00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	5, 024, 882	5, 024, 882		0. 000000	
	08801 RURAL HEALTH CLINIC II	0	234, 963	234, 963		0. 000000	
	08802 RURAL HEALTH CLINIC III	0	1, 013, 434			0. 000000	
	09100 EMERGENCY	18, 501	3, 130, 176			0. 000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	787, 956	787, 956	0. 872682	0. 000000	92. 00
	OTHER REIMBURSABLE COST CENTERS				, , , , , , , , , , , , , , , , , , , ,		
	09500 AMBULANCE SERVI CES	5, 790	2, 781, 427	2, 787, 217	l l	0. 000000	
	10100 HOME HEALTH AGENCY	0	2, 790, 777	2, 790, 777			101. 00
102. 00	10200 OPI OI D TREATMENT PROGRAM	0	0	C			102. 00
	SPECIAL PURPOSE COST CENTERS	T			1		
	11300 I NTEREST EXPENSE						113. 00
200.00	1 /	4, 837, 115	52, 254, 044	57, 091, 159			200. 00
201.00	Less Observation Beds	4 007 115	E0 0E4 0	F7 004 150			201. 00
202. 00	Total (see instructions)	4, 837, 115	52, 254, 044	57, 091, 159	'I I		202. 00

Health Financial Systems MASON DISTRICT HOSPITAL In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1313
Period:
From 10/01/2022
To 09/30/2023 Date/Time Prepared:
Date/T

			10 07/30/2023	2/26/2024 10: 49 am
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 000000			50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
54. 01 05401 RADI OLOGY-ULTRASOUND	0. 000000			54. 01
56. 00 05600 RADI OI SOTOPE	0. 000000			56. 00
58. 00 05800 MRI	0. 000000			58. 00
60. 00 06000 LABORATORY	0. 000000			60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000			62. 00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000			64. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
	1			68. 00
	0. 000000 0. 000000			
69. 00 06900 ELECTROCARDI OLOGY				69. 00
69. 01 03160 CARDI OPULMONARY	0.000000			69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000			76. 00
76. 01 03952 TELEMEDI CI NE PSYCH SERVI CES	0. 000000			76. 01
76. 02 03950 DI ABETI C EDUCATION	0. 000000			76. 02
76. 03 03951 WOUND CARE	0. 000000			76. 03
76. 04 03953 ALLERGY 123	0. 000000			76. 04
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000			78. 00
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC	0. 000000			88. 00
88.01 08801 RURAL HEALTH CLINIC II	0. 000000			88. 01
88.02 08802 RURAL HEALTH CLINIC III	0. 000000			88. 02
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
101.00 10100 HOME HEALTH AGENCY				101. 00
102. 00 10200 OPI OI D TREATMENT PROGRAM				102. 00
SPECIAL PURPOSE COST CENTERS				192, 99
113. 00 11300 NTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
[10tal (300 Filati dott 613)	ı l			1202.00

Health Financial Systems	MASON DISTRI	CT HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE O	CAPITAL COSTS	Provi der C		Peri od: From 10/01/2022 To 09/30/2023	Worksheet D Part II Date/Time Pre 2/26/2024 10:	pared: 49 am
		Titl∈	XVIII	Hospi tal	Cost	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)		Program	Capital Costs (column 3 x column 4)	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 0PERATI NG ROOM 53. 00 05300 ANESTHESI OLOGY	180, 081 1, 326		1		3, 044 32	50. 00 53. 00

Cost Center Description	Capi tal	Total Charges	Ratio of Cost	Inpatient	Capital Costs	
'	Related Cost	(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col.	Charges	column 4)	
	Part II, col.	8)	2)	_		
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	180, 081	1, 794, 476	0. 100353	30, 330	3, 044	50. 00
53. 00 05300 ANESTHESI OLOGY	1, 326	1, 093, 731	0. 001212	26, 426	32	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	347, 688	9, 770, 125	0. 035587	78, 189	2, 783	54.00
54. 01 05401 RADI OLOGY-ULTRASOUND	6, 071	1, 189, 104	0. 005106	8, 666	44	54. 01
56. 00 05600 RADI 0I SOTOPE	7, 451	457, 597	0. 016283	0	0	56. 00
58. 00 05800 MRI	4, 337	1, 948, 954	0. 002225	16, 381	36	58. 00
60. 00 06000 LABORATORY	122, 473	10, 344, 919	0. 011839	186, 566	2, 209	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	3, 370	159, 135	0. 021177	8, 606	182	62.00
64.00 06400 INTRAVENOUS THERAPY	1, 188	610, 005	0. 001948	7, 656	15	64.00
66. 00 06600 PHYSI CAL THERAPY	95, 472	4, 152, 803	0. 022990	70, 279	1, 616	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	10, 237	1, 679, 959	0. 006094	58, 881	359	67. 00
68. 00 06800 SPEECH PATHOLOGY	3, 852	412, 480	0.009339	3, 497	33	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.000000	0	0	69. 00
69. 01 03160 CARDI OPULMONARY	57, 760	1, 604, 405	0. 036001	100, 109	3, 604	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	12, 444	737, 590	0. 016871	88, 245	1, 489	71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	50, 630	1, 225, 079	0. 041328	131, 138	5, 420	73.00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	11, 614	1, 211, 455	0. 009587	0	0	76. 00
76. 01 03952 TELEMEDICINE PSYCH SERVICES	0	0	0.000000	0	0	76. 01
76. 02 03950 DI ABETI C EDUCATI ON	324	587	0. 551959	0	0	76. 02
76. 03 03951 WOUND CARE	1, 877	713, 570	0. 002630	0	0	76. 03
76. 04 03953 ALLERGY 123	0	0	0.000000	0	0	76. 04
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	144, 836	5, 024, 882	0. 028824	0	0	88. 00
88.01 08801 RURAL HEALTH CLINIC II	4, 507	234, 963	0. 019182	0	0	88. 01
88.02 08802 RURAL HEALTH CLINIC III	13, 277	1, 013, 434	0. 013101	0	0	88. 02
91. 00 09100 EMERGENCY	114, 396	3, 148, 677	0. 036331	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	61, 060	787, 956	0. 077492	0	0	92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)	1, 256, 271	49, 315, 886		814, 969	20, 866	200. 00

Health Financial Systems	MASON DISTRICT HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT A	NCILLARY SERVICE OTHER PASS Provider CCN: 14-13	
THROUGH COSTS		From 10/01/2022 Part IV

Non Physician Anesthetist Cost	THROUGH COSTS				To 09/30/2023	Date/Time Pre 2/26/2024 10:	
Anesthetist Cost Program Program Program Adjustments Program Program Adjustments Program Program Adjustments Program Adjustments Program Program Adjustments Program Program Adjustments Program Program Program Adjustments Program Adjustments Program Program Program Adjustments Program P			Title	e XVIII	Hospi tal		
Cost	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
Adjustments		Anesthetist					
NOTE Content NOTE		Cost			Adjustments		
ANCI LLARY SERVICE COST CENTERS							
50.00		1.00	2A	2.00	3A	3. 00	
53. 00 05300 ANESTHESI OLOGY 349, 459 0 0 0 0 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 54. 01 05401 RADI OLOGY-ULTRASOUND 0 0 0 0 0 54. 01 05401 RADI OLOGY-ULTRASOUND 0 0 0 0 0 56. 00 05600 RADI OLOGY-ULTRASOUND 0 0 0 0 0 56. 00 05600 RADI OLOGY-ULTRASOUND 0 0 0 0 0 56. 00 05600 RADI OLOGY-ULTRASOUND 0 0 0 0 0 60. 00 06600 LABORATORY 0 0 0 0 0 0 60. 00 06600 LABORATORY 0 0 0 0 0 0 61. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 0 63. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 64. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 65. 00 06600 SPEECH PATHOLOGY 0 0 0 0 0 66. 00 06600 SPEECH PATHOLOGY 0 0 0 0 0 67. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 68. 00 06600 SPEECH PATHOLOGY 0 0 0 0 0 69. 01 03160 CARDI OPAULIONIANY 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENT 0 0 0 0 0 74. 00 03550 PSYCHI ATRI C./PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 75. 01 03950 DIABETI C EDUCATION 0 0 0 0 0 76. 02 03950 DIABETI C EDUCATION 0 0 0 0 0 76. 03 03951 WOUND CARE 0 0 0 0 0 0 76. 04 03953 ALLERGY 123 0 0 0 0 0 0 76. 05 0700 CARRESOUL CHARGED C CENTERS 0 0 0 0 0 88. 01 08800 RURAL HEALTH CLINI C 1 0 0 0 0 88. 02 08800 RURAL HEALTH CLINI C 1 0 0 0 0 99. 00 09520 DESERVATION BEDS (NON-DISTINCT PART 0 0 0 0 90. 000 000 000 000 000 0 90. 000 000 000 000 000 000 90. 000 000 000 000 000 90. 000 000 000 000 90. 000 000 000 000 90. 000 000 000 000 90. 000 000 000 000 90. 000 000 000 00							
54. 00 05400 RADI OLOGY-JULTRASOUND 0 0 0 0 0 54. 00 54. 01 05401 RADI OLOGY-JULTRASOUND 0 0 0 0 0 0 54. 01 05401 RADI OLOGY-JULTRASOUND 0 0 0 0 0 58. 00 05600 RADI OLOGY-JULTRASOUND 0 0 0 0 0 58. 00 05600 RADI OLOGY-JULTRASOUND 0 0 0 0 0 58. 00 05600 RADI OLOGY-JULTRASOUND 0 0 0 0 0 58. 00 05600 RADI OLOGY-JULTRASOUND 0 0 0 0 0 58. 00 05600 RADI OLOGY-JULTRASOUND 0 0 0 0 0 60. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 0 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 0 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 65. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 66. 00 06600 CAL THERAPY 0 0 0 0 0 0 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 68. 00 06600 PECCH PATHOLOGY 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 69. 01 03160 CARDI OPULMONARY 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 0 76. 01 03350 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 76. 01 03352 TELEMEDI CI NE PSYCH SERVI CES 0 0 0 0 0 76. 02 03950 DI ABETI C EDUCATI ON 0 0 0 0 76. 04 03953 ALLERGY 123 0 0 0 0 0 77. 00 0700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 78. 00 07800 CAR T-CELL IMMUNDTHERAPY 0 0 0 0 0 78. 00 07800 CAR T-CELL IMMUNDTHERAPY 0 0 0 0 88. 01 08801 RURAL HEALTH CLINI C 1 0 0 0 0 88. 02 08802 RURAL HEALTH CLINI C 1 0 0 0 0 90. 00 09100 EMERGENCY 0 0 0 0 90. 00 09100 EMERGENCY 0 0 0 90. 00 09100 EMERGENCY 0 0 90. 00 00 00		0 40 450	0)	0	0	
54.01 05401 RADI QLOGY-ULTRASQUND 0 0 0 0 0 0 54.01 56.00 05600 RADI OI SOTOPE 0 0 0 0 0 0 0 55.00 58.00 05800 MRI 0 0 0 0 0 0 0 55.00 60.00 06000 LABORATORY 0 0 0 0 0 0 0 0 0		349, 459	0)	0	0	
56. 00 05600 RADI OI SOTOPE 0 0 0 0 0 0 56. 00		0	0	2	0	0	
58. 00 05800 MRI 00 05800 MRI 01 00 05800 MRI 02 00 05000 LABORATORY 03 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0	2	0	0	
60. 00 06000 LABORATORY 0 0 0 0 0 0 0 0 60. 00 62. 00 62.00 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 0 0 0 0 62.00 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 64. 00 0660. 00 6400 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 0 0 66. 00 66		0	0	2	0	0	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 0 0 0 62. 00 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 64. 00 066. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 66. 00 0 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 0 66. 00 067. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 0 0 0 67. 00 06800 SPECCH PATHOLOGY 0 0 0 0 0 0 0 0 0 68. 00 06800 SPECCH PATHOLOGY 0 0 0 0 0 0 0 0 0 69. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0	2	0	0	1
64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 64. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 69. 01 03160 CARDI OPULMONARY 0 0 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 76. 01 03952 TELEMEDI CINE PSYCH SERVI CES 0 0 0 0 0 76. 02 03950 DI ABETI C EDUCATI ON 0 0 0 0 0 76. 03 03951 WOUND CARE 0 0 0 0 0 0 76. 04 03953 ALLERGY 123 0 0 0 0 0 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 88. 01 08800 RURAL HEALTH CLINIC 1 0 0 0 0 88. 01 08801 RURAL HEALTH CLINIC 1 0 0 0 0 88. 02 08802 RURAL HEALTH CLINIC 11 0 0 0 0 92. 00 OTHER REI MBURSABLE COST CENTERS		0	0)	0	0	
66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 66. 00 67. 00 67. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0)	0	0	
67. 00		0	0	(0	0	
68. 00		0	0	(0	0	1
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 69. 00 69. 01 03160 CARDI OPULMONARY 0 0 0 0 0 0 0 0 69. 01 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 0 71. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 73. 00 76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 76. 00 76. 01 03952 TELEMEDI CI NE PSYCH SERVI CES 0 0 0 0 0 0 0 76. 01 76. 02 03950 DI ABETI C EDUCATI ON 0 0 0 0 0 0 76. 02 76. 03 03951 WOUND CARE 0 0 0 0 0 0 0 76. 03 76. 04 03953 ALLERGY 123 0 0 0 0 0 0 76. 03 76. 04 03953 ALLERGY 123 0 0 0 0 0 0 76. 04 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 0 78. 00 00TATAIL HEALTH CLI NI C 1 0 0 0 0 0 0 88. 01 88. 00 08800 RURAL HEALTH CLI NI C 1 1 0 0 0 0 0 0 0 88. 01 88. 01 08801 RURAL HEALTH CLI NI C 1 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0		0	1	1
69. 01		0	0		0	1	
71. 00		0	0		0		
73. 00		0	0		0		
76. 00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 0 0 0 0 0 0 76. 00 76. 01 03952 TELEMEDICINE PSYCH SERVICES 0 0 0 0 0 0 76. 01 76. 02 03950 DI ABETIC EDUCATION 0 0 0 0 0 76. 02 76. 03 03951 WOUND CARE 0 0 0 0 0 0 0 76. 03 76. 04 03953 ALLERGY 123 0 0 0 0 0 0 0 76. 04 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 78. 00 OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 1 0 0 0 0 0 0 88. 00 88. 01 08801 RURAL HEALTH CLINIC 1 1 0 0 0 0 0 0 88. 01 88. 02 08802 RURAL HEALTH CLINIC 1 1 0 0 0 0 0 0 0 88. 01 91. 00 09100 EMERGENCY 0 0 0 0 0 0 0 0 0 992.00 OTHER REIMBURSABLE COST CENTERS		0			0		1
76. 01 03952 TELEMEDICINE PSYCH SERVICES 0 0 0 0 0 0 76. 01 76. 02 03950 DI ABETIC EDUCATION 0 0 0 0 0 0 76. 02 76. 03 03951 WOUND CARE 0 0 0 0 0 0 0 76. 03 76. 04 03953 ALLERGY 123 0 0 0 0 0 0 76. 04 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 77. 00 00 0 0 0 0 78. 00 00 0 0 0 0 0 0 78. 00 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					0		1
76. 02 03950 DI ABETI C EDUCATION 0 0 0 0 0 0 76. 02 76. 03 03951 WOUND CARE 0 0 0 0 0 0 0 76. 03 76. 04 03953 ALLERGY 123 0 0 0 0 0 0 0 76. 04 77. 00 07700 ALLOGENEI C HSCT ACQUI SITION 0 0 0 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 78. 00 OUTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINI C 0 0 0 0 0 0 88. 00 88. 01 08801 RURAL HEALTH CLINI C II 0 0 0 0 0 0 88. 01 88. 02 08802 RURAL HEALTH CLINI C III 0 0 0 0 0 0 88. 02 91. 00 09100 EMERGENCY 0 0 0 0 0 0 91. 00 OTHER REI MBURSABLE COST CENTERS		0			0		1
76. 03 03951 WOUND CARE		0			0		1
76. 04 03953 ALLERGY 123 0 0 0 0 0 0 76. 04 77. 00 07700 ALLOGENEI C HSCT ACQUISITION 0 0 0 0 0 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 88. 01 08801 RURAL HEALTH CLINIC II 0 0 0 0 0 88. 02 08802 RURAL HEALTH CLINIC III 0 0 0 0 0 88. 01 08902 RURAL HEALTH CLINIC III 0 0 0 0 891. 00 09100 EMERGENCY 0 0 0 0 90100 EMERGENCY 0 0 0 0 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 OTHER REIMBURSABLE COST CENTERS					0 0		1
77. 00 07700 ALLOGENEI C HSCT ACQUISITION 0 0 0 0 0 0 77. 00 0 0 0 0 0 0 0 0 0					0		1
78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 0 0					0 0		
SECTION SURVICE COST CENTERS SECTION S				1	0 0		
88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 88. 00 88. 01 88. 01 88. 02 08802 RURAL HEALTH CLINIC III 0 0 0 0 0 0 0 88. 01 88. 02 91. 00 09100 EMERGENCY 0 0 0 0 0 0 0 0 91. 00 92. 00 00 00 0 0 0 0 0 0 0 0 0 0 0 0 0				′1	0		70.00
88. 01 08801 RURAL HEALTH CLINIC II 0 0 0 0 0 0 88. 01 88. 02 08802 RURAL HEALTH CLINIC III 0 0 0 0 0 0 88. 02 91. 00 09100 EMERGENCY 0 0 0 0 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				1	0 0	0	88 00
88. 02 08802 RURAL HEALTH CLINIC III 0 0 0 0 0 0 88. 02 91. 00 09100 EMERGENCY 0 0 0 0 0 91. 00 92. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 0 0 92. 00 OTHER REIMBURSABLE COST CENTERS					0 0	1 0	
91. 00 09100 EMERGENCY 0 0 0 0 91. 00 92. 00 0 0 0 92. 00 0 0 0 0 0 0 0 0 0					0 0	1 0	
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 92. 00 OTHER REIMBURSABLE COST CENTERS		0	0		0 0	l o	1
OTHER REI MBURSABLE COST CENTERS		0	Ĭ	1	n		
			l	1	<u> </u>		1 /2.00
							95. 00
200.00 Total (lines 50 through 199) 349, 459 0 0 0 200.00	1	349, 459	0		0 0	0	

APPORT	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER SH COSTS	MASON DISTRIC			In Lie Period: From 10/01/2022 To 09/30/2023		
			Ti tl e	XVIII	Hospi tal	Cost	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	•	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4.00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	C		0 1, 794, 476	0.000000	50. 00
53.00	05300 ANESTHESI OLOGY	0	349, 459		0 1, 093, 731	0. 319511	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 9, 770, 125	0.000000	54.00
54. 01	05401 RADI OLOGY-ULTRASOUND	0	0		0 1, 189, 104	0.000000	54. 01
56.00	05600 RADI OI SOTOPE	0	0		0 457, 597	0.000000	56.00
58.00	05800 MRI	0	0		0 1, 948, 954	0.000000	58. 00
60.00	06000 LABORATORY	0	l o		0 10, 344, 919	0.000000	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0			0 159, 135	0.000000	62.00
64.00	06400 I NTRAVENOUS THERAPY	0	l		0 610,005	0.000000	64.00
66.00	06600 PHYSI CAL THERAPY	0	l		0 4, 152, 803	0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	l		0 1, 679, 959	0.000000	67.00
68. 00	06800 SPEECH PATHOLOGY	0	l		0 412, 480	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	l		0 0	0.000000	69. 00
69. 01	03160 CARDI OPULMONARY	0	l		0 1, 604, 405	0.000000	69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			0 737, 590		
73. 00	07300 DRUGS CHARGED TO PATIENTS	0			0 1, 225, 079		73.00
76. 00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0			0 1, 211, 455		
76. 01	03952 TELEMEDICINE PSYCH SERVICES	0	0		0 0	0.000000	
76. 02	03950 DI ABETI C EDUCATI ON	0	l o		0 587	0.000000	
76. 03	03951 WOUND CARE	0	0		0 713, 570		
	03953 ALLERGY 123	0	l o		0 0	0. 000000	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	ĺ		0 0	0. 000000	
	07800 CAR T-CELL IMMUNOTHERAPY	0	l o		0 0	0. 000000	
. 5. 50	OUTPATIENT SERVICE COST CENTERS			1	-1	2. 223000	
88. 00	08800 RURAL HEALTH CLINIC	1 0	0		0 5, 024, 882	0.000000	88. 00
	00000 ROBAL HEALTH CLINIC II				0 224 062		

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349, 459

5, 024, 882 234, 963 1, 013, 434

3, 148, 677

49, 315, 886

787, 956

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88. 01

88. 02

91.00

92.00

95.00

200. 00

08801 RURAL HEALTH CLINIC II 08802 RURAL HEALTH CLINIC III

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS

Total (lines 50 through 199)

88. 01 88. 02

200.00

91. 00 09100 EMERGENCY

95. 00 09500 AMBULANCE SERVICES

Health Financial Systems	MASON DISTRICT	HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS	Provider CO		Period: From 10/01/2022 To 09/30/2023	Worksheet D Part IV Date/Time Pre 2/26/2024 10:	pared: 49 am
			XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS			ı	ما ما		
50. 00 05000 OPERATI NG ROOM	0. 000000	30, 330		0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	26, 426			0	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0. 000000	78, 189		0	0	54.00
54. 01 05401 RADI OLOGY-ULTRASOUND	0. 000000	8, 666		0	0	54. 01
56. 00 05600 RADI OI SOTOPE	0. 000000	4 . 224		0	0	56. 00
58. 00 05800 MRI	0. 000000	16, 381		0	0	58.00
60. 00 06000 LABORATORY	0.000000	186, 566		0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 64.00 06400 INTRAVENOUS THERAPY	0.000000	8, 606		0	0	62. 00 64. 00
64. 00 06400 I NTRAVENOUS THERAPY 66. 00 06600 PHYSI CAL THERAPY	0. 000000 0. 000000	7, 656 70, 279		0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			0	0	67.00
68. 00 06700 OCCUPATIONAL THERAPY	0. 000000	58, 881 3, 497		0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	3, 497		0	0	69.00
69. 01 03160 CARDI OPULMONARY		100 100		0	0	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000 0. 000000	100, 109 88, 245		0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	131, 138		0	0	73.00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	131, 138		0	0	76.00
76. 01 03952 TELEMEDI CI NE PSYCH SERVI CES	0. 000000	0		0	0	76.00
76. 02 03950 DI ABETI C EDUCATION	0. 000000	0		0	0	76. 01
76. 03 03950 DI ABETT C'EDUCATTON 76. 03 03951 WOUND CARE	0. 000000	0		0	0	76. 02
76. 04 03953 ALLERGY 123	0. 000000	0			0	76. 03
77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON	0. 000000	0		0	0	77.00
78. 00 07/00 ALLOGENETC HSCT ACQUISITION 78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0 0	0	78.00
OUTPATIENT SERVICE COST CENTERS	0.000000			<u>υ</u> υ	U	70.00
88. 00 08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88. 00
00. 00 00000 RURAL HEALTH CLINIC	0.000000	0			0	

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8, 443

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0

814, 969

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88. 01 88. 02

91.00

92.00 95.00

0 200. 00

0 0

0

92. 00 09200 | 0BSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS
95. 00 09500 | AMBULANCE SERVICES

Total (lines 50 through 199)

09100 EMERGENCY

91.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 14-1313 Peri od: Worksheet D From 10/01/2022 Part V 09/30/2023 Date/Time Prepared: 2/26/2024 10:49 am Title XVIII Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 490877 486, 890 0 50.00 53.00 05300 ANESTHESI OLOGY 0. 332755 305, 267 53.00 05400 RADI OLOGY-DI AGNOSTI C 54 00 0.208686 0 3 060 530 54 00 0 05401 RADI OLOGY-ULTRASOUND 54.01 0.180571 0 363, 321 0 54.01 56.00 05600 RADI OI SOTOPE 0.394878 155, 576 0 56.00 58.00 05800 MRI 0.103494 0 473, 603 0 58.00 06000 LABORATORY 0 60.00 0.287465 3, 151, 060 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 1.087611 54, 107 0 62.00 06400 I NTRAVENOUS THERAPY 64.00 0.061298 195, 326 0 64.00 06600 PHYSI CAL THERAPY 1, 251, 587 0.350351 66 00 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.308668 127, 770 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.397394 0 68.00 44, 134 69.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 0 03160 CARDI OPULMONARY 0.587266 0 498, 561 69 01 0 69.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.855330 0 145, 788 0 71.00 07300 DRUGS CHARGED TO PATIENTS 1.069837 686, 813 73.00 73.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0. 472244 0 895, 142 0 76.00 76.00 03952 TELEMEDICINE PSYCH SERVICES 0.000000 0 76.01 C 0 76.01 76. 02 03950 DIABETIC EDUCATION 45. 231687 219 0 76.02 03951 WOUND CARE 0 350, 007 76.03 76.03 0.141766 0 03953 ALLERGY 123 76.04 0.000000 0 0 76.04 C 07700 ALLOGENEIC HSCT ACQUISITION Ω 0 77.00 0.000000 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0 0 78.00 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 88.01 08801 RURAL HEALTH CLINIC II 88.01 08802 RURAL HEALTH CLINIC III 88.02 88.02 09100 EMERGENCY 91.00 1.364091 724, 022 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.872682 Λ 255, 353 0 92.00 Λ 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0. 306782 95.00 Subtotal (see instructions) 0 200.00 200.00 0 13, 225, 076 0 Less PBP Clinic Lab. Services-Program 0 201.00 201. 00

13, 225, 076

0 202.00

Only Charges

Net Charges (line 200 - line 201)

09/30/2023 Date/Time Prepared: 2/26/2024 10:49 am Title XVIII Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 239, 003 0 50.00 53.00 05300 ANESTHESI OLOGY 101, 579 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 638, 690 54 00 05401 RADI OLOGY-ULTRASOUND 0 54.01 65,605 54.01 56. 00 | 05600 RADI OI SOTOPE 61, 434 0 56.00 58.00 05800 MRI 49, 015 0 58.00 06000 LABORATORY 905, 819 0 60.00 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 58, 847 0 62.00 06400 I NTRAVENOUS THERAPY 0 64.00 11, 973 64.00 06600 PHYSI CAL THERAPY 438. 495 0 66 00 66 00 06700 OCCUPATIONAL THERAPY 67.00 39, 439 0 67.00 68.00 06800 SPEECH PATHOLOGY 17, 539 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 03160 CARDI OPULMONARY 0 292, 788 69.01 69.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 124, 697 0 71.00 07300 DRUGS CHARGED TO PATIENTS 734, 778 73.00 73.00 76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 76.00 422, 725 03952 TELEMEDICINE PSYCH SERVICES 0 76.01 76.01 76.02 03950 DIABETIC EDUCATION 9,906 0 76.02 03951 WOUND CARE 0 76.03 76.03 49,619 03953 ALLERGY 123 0 76.04 76.04 0 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 08801 RURAL HEALTH CLINIC II 88.01 88.01 88. 02 08802 RURAL HEALTH CLINIC III 88.02 09100 EMERGENCY 91.00 987, 632 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 222, 842 0 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 95.00 Subtotal (see instructions) 200.00 5, 472, 425 0 200.00 Less PBP Clinic Lab. Services-Program 201.00 201. 00

5, 472, 425

0

202.00

Only Charges

Net Charges (line 200 - line 201)

Health Financial Systems	MASON DISTRICT HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING	COST Provi der CCN: 14-1313	Peri od: From 10/01/2022 To 09/30/2023	Worksheet D-1 Date/Time Prepared: 2/26/2024 10:49 am
	Title XVIII	Hospi tal	Cost

1.00			Title XVIII	Hospi tal	2/26/2024 10: Cost	49 am_
INPATIENT DAYS INPA		Cost Center Description		noop: tu		
Impartient days (including private room days and saing-bed days, excluding newborn) 1,280 1,00		PART I - ALL PROVIDER COMPONENTS			1. 00	
Impatient days (including private room days, excluding safing-bed and newborn days) 17 3.00 Private room days (secularing safing-bed and observation bed days) 17 3.00 18 3.00 18 3.00 18 3.00 18 3.00 18 3.00 18 3.00 3.00 18 3.00 3.0						
Private room days (excluding swing-bed and observation bed days). If you have only private room days. 17 3.0						
do not complete this line. 4. OS Self-private room days (excluding swing-bed and observation bed days) 5. Diatal swing-bed SW type inpatient days (including private room days) after December 31 of the cost reporting period (if callendary year, enter 0 on this line) 7. Diatal swing-bed SW type inpatient days (including private room days) after December 31 of the cost reporting period (if callendary year, enter 0 on this line) 7. Diatal swing-bed SW type inpatient days (including private room days) through December 31 of the cost reporting period (if callendary year, enter 0 on this line) 8. Diatal swing-bed SW type inpatient days (including private room days) after December 31 of the cost in the cost reporting period (if callendary year, enter 0 on this line) 9. Diatal inputient days including private room days applicable to the Program (excluding swing-bed and next period in the cost instructions) 8. Diatal inputient days including private room days applicable to this line) 10. Diatal inputient days applicable to it tile xVIII only (including private room days) 11. Diatal inputient days applicable to tile xVIII only (including private room days) 12. Diatal inputient days applicable to tile xVIII only (including private room days) 13. Diatal swing-bed SW type inpatient days applicable to tile xVIII only (including private room days) 14. Diatal swing-bed SW type inpatient days applicable to tile xVIII only (including private room days) 15. Diatal swing-bed SW type inpatient days applicable to tile xVIII only (including private room days) 16. Diatal swing-bed SW type inpatient days applicable to tile xVIII only (including private room days) 17. Diatal swing-bed SW type inpatient days applicable to tile xVIII only (including private room days) 18. Diatal swing-bed SW type inpatient days applicable to tile xVIII only (including private room days) 18. Diatal swing-bed SW type inpatient days applicable to tile xVIII only (including private room days) 18. Diatal swing-bed by type inpatient days applic			<i>3</i> ,	vato room days		
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 7.0 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 8.0 Lots swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 9.0 Total inpatient days including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 10. SNIng-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 11.0 SNIng-bed SNF type inpatient days applicable to the Program (excluding swing-bed and possible of the program (excluding private room days) 11.0 SNIng-bed SNF type inpatient days applicable to dise instructions) 12.0 SNing-bed SNF type inpatient days applicable to dise instructions 13.0 SNing-bed SNF type inpatient days applicable to titles V or XIX enly (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 13.0 SNing-bed SNF type inpatient days applicable to titles V or XIX enly (including private room days) 13.0 SNing-bed SNF type inpatient days applicable to the Program (excluding swing-bed days) 14.0 Medically in personally of the cost reporting period (if cal endar year, enter 0 on this line) 15.0 SNing-bed SNF type inpatient days applicable to the Program (excluding swing-bed days) 15.0 Total nursery days (title V or XIX only) 16.0 Newspray days (title V or XIX only) 17.0 Medically in personal period (if cal endar year, enter 0 on this line) 18.0 Wedical rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (if cal endar year) 18.0 Wedical rate for swing-bed SNF services applicable to services after Dec	3.00		75). The you have only pro	vate room days,	17	3.00
reporting period (1 cal calary very netro 0 on this line) 7.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (1 cal calary very netro) on this line) 8.00 reporting period (1 cal calary very netro) on this line) 9.00 Total inpatient days (including private room days) after December 31 of the cost reporting period (1 cal endary very netro) on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see Instructions) 10.00 Swing-bed SNF type inpatient days applicable to this line) 10.00 Swing-bed SNF type inpatient days applicable to till eXVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to till eXVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to till eXVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to till eXVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 12.00 Swing-bed SNF type inpatient days applicable to till eXVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 13.00 Swing-bed NF type inpatient days applicable to till eXVIII only (including private room days) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 North program (excluding swing-bed days) 16.00 North program (excluding swing-bed days) 17.00 North program (excluding swing-bed days) 18.00 North program (exc						
Total swing-bed NN type inpatient days (including private room days) after becember 31 of the cost reporting period (if ceil endar years, enter 0 on this line)	5. 00		om days) through December	31 of the cost	68	5. 00
reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed Mr type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days after December 31 of the cost of the cost reporting period (if calendar year, enter 0 on this line) 10.00 Swing-bed SMr type inpatient days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 11.00 Swing-bed SMr type inpatient days applicable to title XVIII only (including private room days) after 0 becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed SMr type inpatient days applicable to title XVIII only (including private room days) after 0 becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed SMr type inpatient days applicable to title XV or XX only (including private room days) 12.00 Swing-bed SMr type inpatient days applicable to title XV or XX only (including private room days) 12.00 Swing-bed SMr type inpatient days applicable to title XV or XX only (including private room days) 12.00 Swing-bed SMr type inpatient days applicable to title XV or XX only (including private room days) 13.00 Swing-bed SMr type inpatient days applicable to title XV or XX only (including private room days) 14.00 Medically necessary private room days applicable to title XV or XX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medical prevail inpatient days applicable to services through December 31 of the cost reporting period (including private room days) 18.00 Medical crate for swing-bed SMF services applicable to services through December 31 of the cost reporting period (line 6 Nedical crate for swing-bed SMF services applicable to services after December 31 of the cost reporting period (line 6 Nedical crate for swing-bed MF services applicable to services	6 00		om davs) after December :	R1 of the cost	204	6.00
reporting period 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) 9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 12. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (ir calendar year, enter 0 on this line) 12. 00 Swing-bed SNF type inpatient days applicable to titles XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13. 00 After December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 13. 00 After December 31 of the cost reporting period 14. 00 Medically necessary private room days applicable to services through December 31 of the cost reporting period 15. 00 After December 31 of the cost reporting period 15. 00 After December 31 of the cost reporting period 15. 00 After December 31 of the cost reporting period 15. 00 After December 31 of the cost reporting period 15. 00 After December 31 of the cost reporting period (line 8 x 1 in 19. 00 After December 31 of the cost reporting period (line 8 x 1 in 19. 00 After December 31 of the cost reporting period (line 8 x 1 in 19. 00 After December 31 of the cost reporting period (line 8 x 1 in 19. 00 After December 31 December 31 of the cost reporting period (line 8 x 1 in 19. 00	0.00		daye, a. te. becembe.		20.	0.00
Total sexing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line)	7. 00		n days) through December	31 of the cost	40	7. 00
reporting period (if calendar year, enter 0 on this line) 10.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after otherwise the private room days applicable to title XVIII only (including private room days) 12.00 Swing-bed SNF type inpatient days applicable to title SV or XIX only (including private room days) 13.00 Swing-bed SNF type inpatient days applicable to title SV or XIX only (including private room days) 14.00 Medically necessary private room days applicable to the Program (excluding private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 SWING BED ADUSHINENT 18.00 Medically necessary private room days applicable to services through December 31 of the cost reporting period (including private room days) 18.00 Pedicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days) 18.00 Pedicare rate for swing-bed SNF services applicable to services after December 31 of the cost (20.70 to Nedical drate for swing-bed NF services applicable to services after December 31 of the cost (20.70 to Nedical drate for swing-bed NF services applicable to services after December 31 of the cost (20.70 to Nedical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 6 to NF type services through December 31 of the cost reporting period (line 6 to NF type services through December 31 of the cost reporting period (line 8 to NF type services through December 31 of the cost re	8 00		n davs) after December 3	of the cost	118	8 00
newborn days) (see Instructions) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 bying-bed SNF type inpatient days applicable to titlet XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 12.00 Swing-bed SNF type inpatient days applicable to titlet XVIII only (including private room days) after through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13.00 Swing-bed NF type inpatient days applicable to titlet V or XIX only (including private room days) 14.00 Edically increasary private room days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Nursery days (title V or XIX only) 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period of the Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (increasary private room days) 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (increasary private room days) 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (increasary private room days applicable to services after December 31 of the cost reporting period (increasary private room days applicable to services after December 31 of the cost reporting period (increasary private room days applicable to services after December 31 of the cost reporting period (increasary private room days applicable to services after December 31 of the cost reporting period (line 6 varied private room days applicable to services after December 31 of the cost reporting period (line 6 varied private room days applicable to services after December 31 of the cost reporting period (line 6 varied private room days applicable to s			,			
10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 66 10.00	9. 00		the Program (excluding	swing-bed and	250	9. 00
through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNT type inpatient days applicable to title XVIII only (including private room days) after pecember 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NT type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NT type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Early and the cost reporting period (if calendar year, enter 0 on this line) 15.00 All the cost reporting period (if calendar year, enter 0 on this line) 16.00 All the cost reporting period (if calendar year, enter 0 on this line) 17.00 All the cost reporting period (if calendar year, enter 0 on this line) 18.00 All the cost reporting period (if calendar year, enter 0 on this line) 18.00 All the cost reporting period (if calendar year, enter 0 on this line) 18.00 All the cost reporting period (if calendar year, enter 0 on this line) 18.00 All the cost reporting period (if calendar year, enter 0 on this line) 18.00 All the cost reporting period (if calendar year, enter 0 on this line) 18.00 All the cost reporting period (if calendar year, enter 0 on this line) 18.00 All the cost reporting period (if calendar year, enter 0 on this line) 18.00 All the cost reporting period (if calendar year, enter 0 on this line) 18.00 Medicare rate for swing-bed SNF services applicable to services after becember 31 of the cost reporting period (if the cost period period period period period (if the cost period (if the cost period period (if the cost period period (if	10 00		nlv (including private ro	nom days)	66	10 00
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24. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 7 x line 19) 25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 24, 627 25. 00 x line 20) 26. 00 Total swing-bed cost (see instructions) 27. 00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 Semi-private room per diem charge (line 29 ÷ line 3) 31. 00 Average per diem private room per diem charge (line 30 + line 4) 32. 00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 32. 00 Average per diem private room cost differential (line 3 x line 31) 29. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (23.00		31 of the cost reporting	period (line 6	Ü	23.00
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x line 20) Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 27.00 PRI VATE ROOM DIFFERENTI AL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.01 Pri vate room charges (excluding swing-bed charges) 30.02 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average private room per diem charge (line 29 + line 3) 33.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Ajusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 38.00 Ajusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 38.00 Ajusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 38.00 Ajusted general inpatient routine service cost (line 9 x line 38) 38.00 Ajusted general inpatient routine service cost (line 9 x line 38) 38.00 Ajusted general inpatient routine service cost (line 9 x line 38) 38.00 Ajusted general inpatient routine service cost (line 9 x li	25.00	,)1 of the cost reporting	nominal (line O	24 (27	25 00
Total swing-bed cost (see instructions) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERNTIAL ADJUSTMENT Reneral inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) Reneral inpatient routine service cost/charge ratio (line 27 + line 28) Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 + line 4) Average per diem private room cost differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Reneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 278, 260) PRAT II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 27.00 27.00 27.00 27.00 29.00 29.00 29.00 29.00 29.01 29.00 29.01 29.00 29.01 29.00 29.01 29.00 20.00	25.00		or the cost reporting	perrou (Trie 8	24, 027	25.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 992, 177 28.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Average per diem private room cost differential (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 278, 260) 37.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 670, 078 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 28.00 Aoo Medically necessary private room cost applicable to the Program (line 14 x line 35) 28.00 Aoo Medically necessary private room cost applicable to the Program (line 14 x line 35)	26. 00				778, 138	26. 00
28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29. 00 Pri vate room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 General inpatient routine service cost/charge ratio (line 27 ± line 28) 30. 00 Average private room per diem charge (line 29 ± line 3) 30. 00 Average semi-private room per diem charge (line 30 ± line 4) 31. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 32. 00 Average per diem private room cost differential (line 34 x line 31) 33. 00 Average per diem private room cost differential (line 34 x line 31) 35. 00 Average per diem private room cost differential (line 34 x line 35) 36. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 278, 260) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 278, 260) 37. 00 Adjusted general inpatient routine service cost per diem (see instructions) 38. 00 Adjusted general inpatient routine service cost (line 9 x line 38) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 38. 50 Average per diem private room cost applicable to the Program (line 14 x line 35)	27. 00		(line 21 minus line 26)		2, 328, 640	27. 00
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 278, 260) 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 (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 38.50 Ao.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 38.50 Ao.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 39.00 Ao.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	28 00		l and observation hed ch	rnes)	992 177	28 00
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 2. 347001 31.00 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 278, 260) 2. 347001 31.00 31.00 Average per diem private room cost differential (line 34 x line 31) 2. 963.53 35.00 35.00 Private room cost differential adjustment (line 3 x line 35) 36.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 278, 260) 2. 278, 260 37.00 2. 347001 31.00 35.00 Program Inpatient routine service cost per diem (see instructions) 36.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 38.00 Average per diem charge (line 29 + line 3) 38.00 Average per diem private room per diem charge (line 30 + line 3) 39.00 Program general inpatient routine service cost (line 9 x line 38) 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)			and observation bed en	ii gcs)		
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 278, 260) 27 minus line 36) 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) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 38.50 Average per diem charge (line 30 ÷ line 3) 32.00 Average per diem charge (line 30 ÷ line 3) 32.00 Average per diem private room cost differential (line 2, 263.53) 35.00 Average per diem private room cost differential (line 2, 278, 260) 36.00 Average per diem private room cost differential (line 3 x line 35) 37.00 Constant of the program (line 14 x line 35) 38.00 Average per diem private room per diem charge (line 3) and constant of the program (line 14 x line 35) 38.00 Average per diem private room per diem charge (line 3) and constant of the program (line 14 x line 35) 38.00 Average per diem private room per diem charge (line 3) and constant of the program (line 14 x line 35)	30.00	Semi -pri vate room charges (excluding swing-bed charges)				
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 278, 260) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 38.50 Average semi-private room per diem charge (line 30 ÷ line 4) 1, 620.55 33.00 1, 262.69 34.00 2, 963.53 35.00 50, 380 36.00 2, 278, 260 37.00 2, 278, 260 37.00 2, 680.31 38.00 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 38.526 40.00	31. 00	General inpatient routine service cost/charge ratio (line 27	- line 28)		2. 347001	31. 00
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 1, 262.69 34.00 35.00 Average per diem private room cost differential (line 34 x line 31) 2, 963.53 35.00 37.00 Private room cost differential adjustment (line 3 x line 35) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 278, 260 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 (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 34.00 Average per diem private room cost differential (line 2, 980.53) 50, 380 36.00 70, 000 2, 278, 260 37.00 71, 262.69 34.00 72, 963.53 35.00 73, 00 2, 278, 260 37.00 74, 000 2, 278, 260 37.00 75, 000 2, 278, 260 37.00 76, 000 38, 000 77, 000 2, 278, 260 37.00 77, 000 2, 278, 260 37.00 78, 000 2, 278, 260 37.00 79, 000 2, 278, 260 37.00 70, 000 2, 278, 260 37.00 70, 000 2, 278, 260 37.00 70, 000 2, 278, 260 37.00 70, 000 2, 278, 260 37.00 71, 262.69 34.00						
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 278, 260 37.00 27 minus line 36) 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) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 38.50 Average per diem private room cost differential (line 2, 963.53 35.00 50, 380 36.00 37.00 2						
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 278, 260 27 minus line 36) 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) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 36.00 2, 278, 260 37.00 2, 278, 260 2, 278, 260 37.00 2, 278, 260 2, 2		, , ,		ions)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 278, 260 27 minus line 36) 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) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37.00 2, 278, 260 37.00		,	ne 31)			
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 2, 680. 31 38.00 Program general inpatient routine service cost (line 9 x line 38) 670, 078 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 38, 526 40.00		,				
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 2,680.31 38.00 Program general inpatient routine service cost (line 9 x line 38) 670,078 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 38,526 40.00	37.00		and private room cost di	Terentiai (iine	2, 278, 260	37.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 38.526 40.00						
38.00Adjusted general inpatient routine service cost per diem (see instructions)2,680.3138.0039.00Program general inpatient routine service cost (line 9 x line 38)670,07839.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)38,52640.00			ISTMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 670,078 39.00 38,526 40.00	38. 00				2, 680. 31	38. 00
	39. 00	, , , , , , , , , , , , , , , , , , , ,	•			
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 708,604 41.00		, , , , , , , , , , , , , , , , , , , ,	•			
	41. 00	lotal Program general inpatient routine service cost (line 39	+ IIne 40)	l	708, 604	41.00

COMPUT	Financial Systems ATION OF INPATIENT OPERATING COST	MASON DISTRIC		CCN: 14-1313	Period: From 10/01/2022	worksheet D-1	
					To 09/30/2023	Date/Time Pre 2/26/2024 10:	
	Coot Conton Decement on	Total	Ti tl o	e XVIII	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Cost			Program Days ÷	Program Cost (col. 3 x col.	
		1.00	2. 00	col. 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)						42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	O	(0.0	0 0	0	43. 00
	CORONARY CARE UNIT						44. 00
	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
17. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
	Program inpatient ancillary service cost (Wk: Program inpatient cellular therapy acquisition			III lino 10	column 1)	425, 471 0	1
	Total Program inpatient costs (sum of lines				COI ullil 1)	1, 134, 075	
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	atient routine s	ervices (from	m Wkst D sum	of Parts I and	0	50.00
	III)		·				
51. 00	Pass through costs applicable to Program inpa and IV)	atient ancillary	services (fi	rom Wkst. D, s	um of Parts II	0	51.00
	Total Program excludable cost (sum of lines!					0	
3. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line !		ated, non-pny	ysician anestn	etist, and	0	53. 00
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge					0.00	
	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor o	ico only)				0. 00 0. 00	
	Target amount (line 54 x sum of lines 55, 55.					0.00	
	Difference between adjusted inpatient operati	ng cost and tar	get amount (I	line 56 minus	line 53)	0	
	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54, o	or line 55 from	the cost repo	ortina period	endi na 1996.	0 0. 00	
0. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,		·	0.	3	0.00	
	market basket)			•			
51. 00	Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less					0	61.00
	53) are less than expected costs (lines 54 \times enter zero. (see instructions)						
52. 00	Relief payment (see instructions)					0	62. 00
53. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruc	tions)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	e cost reporti	ng period (See	176, 900	64. 00
55. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decembe	r 31 of the d	cost reporting	period (See	533, 382	65. 00
56. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line 6	Anlus line /	45)(title XVII	l only): for	710, 282	66. 00
	CAH, see instructions	•	•		3,		
57. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 (of the cost re	porting period	0	67. 00
58. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after De	ecember 31 of	the cost repo	rting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient (0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili						70.00
71. 00	Adjusted general inpatient routine service co	-					71. 00
	Program routine service cost (line 9 x line 'Medically necessary private room cost applications)	*	(line 14 v li	ine 35)			72.00
74. 00	Total Program general inpatient routine servi	•	•				74. 00
75. 00	Capital-related cost allocated to inpatient (26, line 45)	routine service	costs (from \	Worksheet B, Pa	art II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess		ovi der record	ds)			79. 00
30. 00 31. 00	Total Program routine service costs for compa		st limitation	n (line 78 min	us line 79)		80. 00 81. 00
	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (li						82.00
3. 00	Reasonable inpatient routine service costs (see instructions					83.00
	Program inpatient ancillary services (see insutilization review - physician compensation		ıs)				84. 00 85. 00
36. 00	Total Program inpatient operating costs (sum	of lines 83 thr					86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS						
37. 00	Total observation bed days (see instructions))				251	87.00

251 87.00 2,739.58 88.00 687,635 89.00

87.00 Total observation bed days (see instructions)
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)
89.00 Observation bed cost (line 87 x line 88) (see instructions)

Health Financial Systems	MASON DISTRIC	CT HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 10/01/2022 To 09/30/2023	Date/Time Prep 2/26/2024 10:	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH O	COST					
90.00 Capital -related cost	275, 872	3, 106, 778	0. 08879	7 687, 635	61, 060	90.00
91.00 Nursing Program cost	0	3, 106, 778	0.00000	0 687, 635	0	91.00
92.00 Allied health cost	0	3, 106, 778	0.00000	0 687, 635	0	92.00
93.00 All other Medical Education	0	3, 106, 778	0. 00000	0 687, 635	0	93. 00

	I CT HOSPI TAL	ON 14 1010		u of Form CMS-1	
NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Peri od: From 10/01/2022	Worksheet D-3	
			To 09/30/2023	Date/Time Pre 2/26/2024 10:	
	Ti tl e	XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2. 00	2) 3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
0. 00 03000 ADULTS & PEDI ATRI CS			588, 486		30.0
1. 00 03100 NTENSI VE CARE UNIT			0		31. 0
ANCI LLARY SERVI CE COST CENTERS					
O. OO O5000 OPERATING ROOM		0. 49087	77 30, 330	14, 888	50.00
3. 00 05300 ANESTHESI OLOGY		0. 33275		8, 793	
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 20868	78, 189	16, 317	54.0
4. 01 05401 RADI OLOGY-ULTRASOUND		0. 18057	71 8, 666	1, 565	54.0
6. 00 05600 RADI 0I SOTOPE		0. 39487	78 0	0	56. 0
8. 00 05800 MRI		0. 10349		1, 695	58. 0
0. 00 06000 LABORATORY		0. 28746		53, 631	1
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		1. 08761		9, 360	
4. 00 06400 I NTRAVENOUS THERAPY		0. 06129		469	
6. 00 06600 PHYSI CAL THERAPY		0. 35035		24, 622	
7. 00 06700 OCCUPATI ONAL THERAPY		0. 30866		18, 175	
8. 00 06800 SPEECH PATHOLOGY		0. 39739		1, 390	
9. 00 06900 ELECTROCARDI OLOGY		0.00000		0	
.9. 01 03160 CARDI OPULMONARY 1. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT		0. 58726		58, 791	1
3.00 07300 DRUGS CHARGED TO PATIENTS		0. 85533 1. 06983		75, 479 140, 296	
6. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 47224		140, 290	1
6. 01 03952 TELEMEDICINE PSYCH SERVICES		0. 00000		0	1
6. 02 03950 DI ABETI C EDUCATION		45. 23168		0	
6. 03 03951 WOUND CARE		0. 14176		0	
6. 04 03953 ALLERGY 123		0.00000		0	
7.00 07700 ALLOGENEIC HSCT ACQUISITION		0.00000		0	77. 0
8. 00 07800 CAR T-CELL IMMUNOTHERAPY		0.00000	00	0	78.0
OUTPATIENT SERVICE COST CENTERS					
8. 00 08800 RURAL HEALTH CLINIC		0.00000	00	0	88. 0
8.01 08801 RURAL HEALTH CLINIC II		0.00000		0	1
8.02 08802 RURAL HEALTH CLINIC III		0.00000		0	
1. 00 09100 EMERGENCY		1. 36409		0	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 87268	32 0	0	92. 0
OTHER REI MBURSABLE COST CENTERS					4
15. 00 09500 AMBULANCE SERVI CES			044.040	105 131	95.0
Total (sum of lines 50 through 94 and 96 through 98)	(1: (4)		814, 969	425, 471	
O1.00 Less PBP Clinic Laboratory Services-Program only cha	rges (line 61)		014.00		201. 0
02.00 Net charges (line 200 minus line 201)			814, 969		202. 0

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CC		Peri od:	Worksheet D-3	j
	Component C		From 10/01/2022 To 09/30/2023		nared
	•			2/26/2024 10:	
	Title		Swing Beds - SNF		
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
	-	1. 00	2.00	2) 3. 00	-
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3.00	1
0. 00 03000 ADULTS & PEDIATRICS					30.0
1.00 03100 INTENSIVE CARE UNIT					31. (
ANCILLARY SERVICE COST CENTERS] 31. \
D. OO OSOOO OPERATING ROOM		0. 49087	77 0	0	50.
B. 00 05300 ANESTHESI OLOGY		0. 33275		_	1
1. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 20868		_	
4. 01 05401 RADI OLOGY-ULTRASOUND		0. 18057		l .	
5. 00 05600 RADI OI SOTOPE		0. 39487			1
3. 00 05800 MRI		0. 10349		_	
0. 00 06000 LABORATORY		0. 28746			
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		1. 08761		l	1
1. 00 06400 I NTRAVENOUS THERAPY		0. 06129		182	1
5. 00 06600 PHYSI CAL THERAPY		0. 35035	155, 927	54, 629	66.
7. 00 06700 OCCUPATI ONAL THERAPY		0. 30866	148, 309	45, 778	67.
3. 00 06800 SPEECH PATHOLOGY		0. 39739	94 0	0	68.
P. 00 06900 ELECTROCARDI OLOGY		0.00000	00	0	69.
P. 01 03160 CARDI OPULMONARY		0. 58726	13, 833	8, 124	69.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 85533	21, 220	18, 150	71.
3.00 07300 DRUGS CHARGED TO PATIENTS		1. 06983	31, 407	33, 600	73.
5. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 47224	14 0	0	76.
5. 01 03952 TELEMEDICINE PSYCH SERVICES		0.00000	00	0	76.
5. 02 03950 DI ABETI C EDUCATI ON		45. 23168	37 0	0	76.
5. 03 03951 WOUND CARE		0. 14176		0	76.
5. 04 03953 ALLERGY 123		0.00000	00	0	76.
7.00 07700 ALLOGENEIC HSCT ACQUISITION		0.00000			
3.00 07800 CAR T-CELL IMMUNOTHERAPY		0. 00000	00	0	78.
OUTPATIENT SERVICE COST CENTERS					4
B. 00 08800 RURAL HEALTH CLINIC		0.00000		0	
B. 01 08801 RURAL HEALTH CLINIC II		0.00000		0	
3. 02 08802 RURAL HEALTH CLINIC III		0. 00000		0	
1. 00 09100 EMERGENCY		1. 36409			1
2.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS		0. 87268	32 0	0	92.

418, 920

418, 920

95. 00 173, 147 200. 00

201. 00 202. 00

201.00

202.00

95. 00 | 09500 | AMBULANCE SERVICES | Total (sum of lines 50 through 94 and 96 through 98)

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201)

	Title XVIII	Hospi tal	2/26/2024 10: Cost	49 am
			1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)		5, 472, 425	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2. 00
3.00	OPPS or REH payments		0	3. 00
4.00	Outlier payment (see instructions)		0	4.00
4. 01 5. 00	Outlier reconciliation amount (see instructions)		0.000	4. 01 5. 00
6. 00	Enter the hospital specific payment to cost ratio (see instructions) Line 2 times line 5		I 0.000	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)		0.00	8. 00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		Ō	9. 00
10.00			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)		5, 472, 425	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable charges			
12. 00			0	
13. 00			0	13.00
14. 00			0	14. 00
15. 00	Customary charges Aggregate amount actually collected from patients liable for payment for services on a	chargo hacis	0	15. 00
16. 00			0	16. 00
10.00	had such payment been made in accordance with 42 CFR §413.13(e)	a chargebasis		10.00
17. 00			0. 000000	17. 00
18. 00			0	18. 00
19. 00		e 11) (see	0	19. 00
	instructions)			
20.00		e 18) (see	0	20. 00
	instructions)			
21. 00			5, 527, 149	
22. 00	· · · · · · · · · · · · · · · · · · ·		0	22. 00
23. 00 24. 00			0	23. 00 24. 00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT		0	24.00
25. 00			25, 750	25. 00
26. 00	· · · · · · · · · · · · · · · · · · ·	ctions)	1, 989, 265	
27. 00	, , ,	,	3, 512, 134	
	instructions)	- `		
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28. 00
28. 50				28. 50
29. 00	,		0	29. 00
30. 00			3, 512, 134	
31.00			169	
32. 00			3, 511, 965	32. 00
33. 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11)		0	33. 00
34. 00			88, 921	
35. 00	· · · · · · · · · · · · · · · · · · ·		57, 799	
36. 00	, , , , , , , , , , , , , , , , , , , ,		88, 921	
37. 00			3, 569, 764	
38. 00			0	38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			39. 50
39. 75	1 1 3 3		0	39. 75
39. 97	Demonstration payment adjustment amount before sequestration		0	39. 97
39. 98	· · · · · · · · · · · · · · · · · · ·	ons)	0	39. 98
39. 99			0	39. 99
40. 00			3, 569, 764	40. 00
40. 01			71, 395	
40. 02	, , , , , , , , , , , , , , , , , , , ,		0	40. 02
40. 03			2 22/ 504	40. 03
41.00			3, 226, 594	
41. 01 42. 00			0	41. 01 42. 00
42. 01	3,		l o	42. 01
43. 00	, , , , , , , , , , , , , , , , , , , ,		271, 775	
43. 01			27.1,770	43. 01
44. 00		napter 1,	0	44.00
	§115. 2	<u> </u>		
	TO BE COMPLETED BY CONTRACTOR			
90.00	, , ,		0	90. 00
91.00			0	91.00
92.00	· · · · · · · · · · · · · · · · · · ·		0.00	
93.00			0	93.00
94. 00	Total (sum of lines 91 and 93)		0	94. 00

Health Financial Systems	MASON DISTRICT	HOSPI TAL	In Lie	u of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1313	Peri od:	Worksheet E	
			From 10/01/2022		
			To 09/30/2023	Date/Time Pr	repared:
				2/26/2024 10):49 am
		Title XVIII	Hospi tal	Cost	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days					0 200. 00

Health Financial Systems MASTANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1
From 10/01/2022 Part I
To 09/30/2023 Date/Ti me Prepared: 2/26/2024 10: 49 am Provider CCN: 14-1313

					2/26/2024 10: 2	49 am_
	· · · · · · · · · · · · · · · · · · ·		XVIII	Hospi tal	Cost	
		Inpatien	t Part A	Par	rt 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		779, 62		3, 226, 594	1.00
2.00	Interim payments payable on individual bills, either		(O	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	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) Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	06/22/2023	65, 10	06/22/2023	0	3. 01
3. 02	ADJUSTINIENTS TO TROVIDER	00/ 22/ 2023	•	0072272023	0	3. 02
3. 03					0	3. 03
3. 04					0	3. 04
3. 05					0	3. 05
	Provider to Program			-1		
3.50	ADJUSTMENTS TO PROGRAM		(D	0	3. 50
3.51			()	0	3. 51
3.52			(O	0	3. 52
3.53			(O	0	3. 53
3.54			(O	0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		65, 10)	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		844, 72	9	3, 226, 594	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		(D	0	5. 01
5.02			(o	o	5. 02
5.03			(O	0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		(O	0	5. 50
5. 51				O	0	5. 51
5. 52				O	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		(O	0	5. 99
/ 00	5. 50-5. 98)					/ 00
6. 00	Determined net settlement amount (balance due) based on					6. 00
6. 01	the cost report. (1) SETTLEMENT TO PROVIDER		187, 75		271, 775	6. 01
6. 01	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		•		2/1, //5	6. 01
7. 00	Total Medicare program liability (see instructions)		1, 032, 48		3, 498, 369	7. 00
7.00	Total medicale program frability (see Histructions)		1, 032, 40	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	'			•	. '	

Health Financial Systems MASTANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

		Component	CCN. 14-Z313 1	0 09/30/2023	2/26/2024 10:	
		Title	XVIII S	wing Beds - SNF		
		Inpatien	it Part A	Par	t 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		654, 517		0	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	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)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	06/22/2023	39, 600)	0	3. 0°
3. 02			0		0	3. 02
3.03			[C		0	3. 0
3.04			[C		0	3.0
3.05			C		0	3. 0!
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			C		0	3. 5
3. 52			0		0	3. 5.
3. 53			C		0	3. 5
3. 54			C		0	3. 5
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		39, 600)	0	3. 9
4 00	3. 50-3. 98)		(04.117			4.00
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		694, 117		0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
5.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER				0	5.01
5. 02					Ö	5. 02
5. 03					Ö	5. 03
	Provider to Program	•		'		
5.50	TENTATI VE TO PROGRAM		C		0	5. 50
5. 51)	0	5. 5 ⁻
5. 52)	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines)	0	5. 9
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		177, 949		0	6.0
6. 02	SETTLEMENT TO PROGRAM		[C		0	6. 0
7. 00	Total Medicare program liability (see instructions)		872, 066		0	7. 0
				Contractor	NPR Date	
			•	Number	(Mo/Day/Yr)	
0.00	Name of Continents	()	1. 00	2. 00	0.0
8.00	Name of Contractor			Į.		8.00

		Component Con. 14-2313	10 04/30/2023	2/26/2024 10:	
		Title XVIII	Swing Beds - SNF	r'	
			Part A	Part B	
	COMPUTATION OF NET COST OF COVERED SERVICES		1.00	2. 00	
1.00	COMPUTATION OF NET COST OF COVERED SERVICES Inpatient routine services - swing bed-SNF (see instructions)		717, 385	0	1.00
2. 00	Inpatient routine services - swing bed-NF (see instructions)		717,303	Ĭ	2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part	t A, and sum of Wkst. D,	174, 878	0	3. 00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swir	ng-bed pass-through, see			
	instructions)				
3. 01	Nursing and allied health payment-PARHM (see instructions)				3. 01
4. 00	Per diem cost for interns and residents not in approved teachi	ng program (see		0.00	4. 00
5.00	instructions) Program days		265	0	5. 00
6. 00	Interns and residents not in approved teaching program (see in	nstructions)	200	Ö	
7.00	Utilization review - physician compensation - SNF optional met		0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	3	892, 263	0	8. 00
9.00	Primary payer payments (see instructions)		0	0	
10.00	Subtotal (line 8 minus line 9)		892, 263		
11. 00	Deductibles billed to program patients (exclude amounts applic	cable to physician	0	0	11. 00
12. 00	professional services) Subtotal (line 10 minus line 11)		892, 263	0	12. 00
13. 00	Coinsurance billed to program patients (from provider records)	(exclude coinsurance	2, 400		13.00
13.00	for physician professional services)	(exertiac corristrationec	2, 400		13.00
14. 00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		889, 863	0	15. 00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16. 00
16. 50	Pioneer ACO demonstration payment adjustment (see instructions				16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstr	ration) payment	0		16. 55
16. 99	adjustment (see instructions) Demonstration payment adjustment amount before sequestration		0	0	16. 99
17. 00	Allowable bad debts (see instructions)		0	0	
17. 01	Adjusted reimbursable bad debts (see instructions)		0	Ö	17. 00
18. 00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)	0	Ō	
19.00	Total (see instructions)		889, 863	0	19.00
19. 01	Sequestration adjustment (see instructions)		17, 797	0	
19. 02	Demonstration payment adjustment amount after sequestration)		0	0	19. 02
19. 03	Sequestration adjustment-PARHM pass-throughs				19. 03
19. 25	Sequestration for non-claims based amounts (see instructions)		(04 117	0	
20. 00 20. 01	Interim payments Interim payments-PARHM		694, 117	0	20. 00 20. 01
21. 00	Tentative settlement (for contractor use only)		0	0	21.00
21. 01	Tentative settlement-PARHM (for contractor use only)			Ĭ	21. 01
22. 00	Balance due provider/program (line 19 minus lines 19.01, 19.02	2, 19.25, 20, and 21)	177, 949	0	22. 00
22. 01	Balance due provider/program-PARHM (see instructions)	,			22. 01
23. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2,	0	0	23. 00
	chapter 1, §115.2				
200 00	Rural Community Hospital Demonstration Project (§410A Demonstr				200. 00
200.00	Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.	Tod under the 21st			200.00
	Cost Reimbursement		I		İ
201.00	Medicare swing-bed SNF inpatient routine service costs (from V	Wkst. D-1, Pt. II, line			201. 00
	66 (title XVIII hospital))				
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from	m Wkst. D-3, col. 3, lin	е		202. 00
202 00	200 (title XVIII swing-bed SNF))				202 00
	Total (sum of lines 201 and 202) Medicare swing-bed SNF discharges (see instructions)				203. 00 204. 00
204.00	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-year demonst	l tration	1204. 00
	period)	Trist year or the earle	iit 5 year demonst	tration	
205.00	Medicare swing-bed SNF target amount				205. 00
	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti	mes line 204)			206. 00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs	sement			
	Program reimbursement under the §410A Demonstration (see instr				207. 00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2	2, col. 1, sum of lines	1		208. 00
200 00	and 3)	etions)			200 00
	Adjustment to Medicare swing-bed SNF PPS payments (see instruc Reserved for future use				209. 00 210. 00
Z 10. UC	Comparision of PPS versus Cost Reimbursement				اک این اور ا
215. 00	Total adjustment to Medicare swing-bed SNF PPS payment (line 2	209 plus line 210) (see			215. 00
	instructions)				" - "
			•	-	-

Health Financial Systems	MASON DISTRICT HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-1313	From 10/01/2022	Worksheet E-3 Part V Date/Time Prepared: 2/26/2024 10:49 am
	T' 11 \ \A\(1) 1	11 1 1	0 1

				2/26/2024 10: 4	49 am_
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	REIMBURSEMENT		
1.00	Inpatient services			1, 134, 075	1. 00
2.00	Nursing and Allied Health Managed Care payment (see instructi	ons)		0	2. 00
3.00	Organ acquisition	•		0	3. 00
3. 01	Cellular therapy acquisition cost (see instructions)			0	3. 01
4.00	Subtotal (sum of lines 1 through 3.01)			1, 134, 075	
5. 00	Primary payer payments			0	5. 00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1, 134, 075	6. 00
0.00	COMPUTATION OF LESSER OF COST OR CHARGES			1, 101, 070	0.00
	Reasonable charges				
7.00	Routi ne servi ce charges			0	7. 00
8. 00	Ancillary service charges			0	8. 00
9. 00	Organ acquisition charges, net of revenue			0	9. 00
10. 00	Total reasonable charges			0	
10.00				U	10.00
11. 00	Customary charges Aggregate amount actually collected from patients liable for	normant for convices on	s charge backs	0	11. 00
12. 00	Amounts that would have been realized from patients liable fo			0	12. 00
12.00	l l	1 3	i a charge basis	U	12.00
12 00	had such payment been made in accordance with 42 CFR 413.13(e)		0. 000000	12 00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)				
14. 00	Total customary charges (see instructions)	l ! & l! 14	() (0	14. 00
15. 00	Excess of customary charges over reasonable cost (complete on	Ty IT Time 14 exceeds III	ne 6) (See	0	15. 00
1/ 00	instructions)	ly if lime (avecade lim	14) (000	0	17 00
16. 00	Excess of reasonable cost over customary charges (complete on	ry it time 6 exceeds time	e 14) (See	0	16. 00
17 00	instructions)			0	17.00
17. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	17. 00
40.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			-	40.00
18. 00	Direct graduate medical education payments (from Worksheet E-	4, line 49)		0	
19. 00	Cost of covered services (sum of lines 6, 17 and 18)			1, 134, 075	
20. 00	Deductibles (exclude professional component)			88, 896	
21. 00	Excess reasonable cost (from line 16)			0	21. 00
22. 00	Subtotal (line 19 minus line 20 and 21)			1, 045, 179	
23. 00	Coinsurance			0	
24. 00	Subtotal (line 22 minus line 23)			1, 045, 179	
25. 00	Allowable bad debts (exclude bad debts for professional servi	ces) (see instructions)		12, 891	
26. 00	Adjusted reimbursable bad debts (see instructions)			8, 379	
27. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		12, 891	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)			1, 053, 558	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29. 00
29. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	29. 50
29. 98	Recovery of accelerated depreciation.			0	29. 98
29. 99	Demonstration payment adjustment amount before sequestration			0	29. 99
30.00	Subtotal (see instructions)			1, 053, 558	30. 00
30. 01	Sequestration adjustment (see instructions)			21, 071	30. 01
30. 02	Demonstration payment adjustment amount after sequestration			0	30. 02
30. 03	Sequestration adjustment-PARHM				30. 03
31.00	Interim payments			844, 729	31. 00
31. 01	Interim payments-PARHM			•	31. 01
32. 00	Tentative settlement (for contractor use only)			0	
32. 01	Tentative settlement-PARHM (for contractor use only)				32. 01
33. 00	Balance due provider/program (line 30 minus lines 30.01, 30.0	2 31 and 32)		187, 758	
33. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, m		and 32 01)	107, 730	33. 00
34. 00	Protested amounts (nonallowable cost report items) in accorda		′ ′	0	
5 1. 00	§115. 2	1 U.D. 1 U.D. 10-2, (aptoi 1,	O	31.00
	13				

Health Financial Systems

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

Provider CCN: 14-1313

Peri od: Worksheet G From 10/01/2022 To 09/30/2023 Date/Time Prepared: 2/26/2024 10: 49 am

O	oni y)					2/26/2024 10:	
Display Capt on hand in benics 1,00 2,00 3,00 4,00 1,00 2,00 3,00 4,00 1,00 2,00 3,00 4,00 2,00 3,00 4,00 2,00 3,00 4,00 2,00 3,00 4,00 3,00 4,00 4,00 4,00 6,00 6,00 6,00 6,00 6,00 6,00 4,00 6,00			General Fund		Endowment Fund	Plant Fund	
Cash on hand in banks			1.00		3. 00	4. 00	
2.00 Comparary investments							
3.00				1	0	•	
4.00 Accounts receivable 6.029,588 0 0 0 4.00 4.00 Accounts receivable 6.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 1	074, 250	i	-		
5.00 Commons for uncol lectible notes and accounts receivable 0 0 0 0 0 0 0 0 0			6, 029, 588	1			
1.00 1.00 1.00 1.00 0.0			0		o o		
1.00 Pregaid éxpenses 201,240 0 0 0 8.00	6.00	Allowances for uncollectible notes and accounts receivable	0		0		
9.00 Other current assets 0 0 0 0 9.00 11.00 Diger from other finds 0 0 0 0 10.00 12.00 Diger from other finds 0 0 0 0 10.00 12.00 Diger from other finds 0 0 0 0 10.00 13.00 Diger from other finds 0 0 0 0 10.00 14.00 Accumulated depreciation 0 0 0 0 14.00 15.00 Buildings 0 0 0 0 0 0 14.00 15.00 Buildings 0 0 0 0 0 0 14.00 15.00 Diger from other finds 0 0 0 0 0 14.00 15.00 Diger from other finds 0 0 0 0 0 14.00 15.00 Diger from other finds 0 0 0 0 0 14.00 15.00 Diger from other finds 0 0 0 0 0 14.00 15.00 Diger from other finds 0 0 0 0 0 14.00 15.00 Diger from other finds 0 0 0 0 0 14.00 15.00 Diger from other finds 0 0 0 0 0 16.00 15.00 Diger from other finds 0 0 0 0 0 16.00 15.00 Diger from other finds 0 0 0 0 0 16.00 15.00 Diger from other finds 0 0 0 0 0 16.00 15.00 Diger from other finds 0 0 0 0 0 16.00 15.00 Diger from other finds 0 0 0 0 0 16.00 15.00 Diger from other finds 0 0 0 0 0 0 16.00 15.00 Diger from other finds 0 0 0 0 0 0 0 0 0 15.00 Diger from other finds 0 0 0 0 0 0 0 0 0				1	0		
10.00 Due from other funds			201, 240		0	l .	
11.00 Company Compan			0				
FIXED ASSETS			23 859 100		-	1	1
12.00 Land Iaprovements	11.00		20,007,100		51 0		11.00
14.00 Accumulated depreciation 0 0 0 14.00	12. 00		0	(0	0	12. 00
15.00 Bail dings	13.00	Land improvements	0		0		
16.00 Accumul ated depreciation 0 0 0 0 16.00			0			l	1
17.00 Leasehol d Improvements			10, 415, 223	1	-		
18.00 Accumul ated depreciation 0 0 0 0 18.00			0	1	-	•	1
19.00 Fixed equipment		•					
20.00 Accumulated depreciation 0 0 0 0 0 20.00		•	ĺ		o o		
22.00 Accumulated depreciation 0 0 0 0 22.00		1	0		0	l	
Sample S	21. 00		0		0		
24.00 Accumul ated depreciation 0 0 0 0 0 0 24.00 26.00 A Inter equipment depreciable 0 0 0 0 0 0 0 25.00 26.00 A Accumul ated depreciation 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		•	0	1	-		
25.00 Minor equipment depreciable 0 0 0 0 25.00 27.00 HIT designated Assets 0 0 0 0 0 27.00 27.00 HIT designated Assets 0 0 0 0 0 27.00 27.00 HIT designated Assets 0 0 0 0 0 27.00 27.00 Minor equipment-nondepreciable 0 0 0 0 0 29.00 27.00 Minor equipment-nondepreciable 0 0 0 0 0 29.00 27.00 Minor equipment-nondepreciable 0 0 0 0 0 0 29.00 27.00 Minor equipment-nondepreciable 0 0 0 0 0 0 0 27.00 Minor equipment-nondepreciable 0 0 0 0 0 0 0 27.00 Assets 0 0 0 0 0 0 0 0 0 27.00 Assets 0 0 0 0 0 0 0 0 0		1 -	0		0	•	
26.00 Accumul ated depreciation		•	0		0		
27.00 All T designated Assets 0 0 0 0 27.00							
28. 00 Accumula fed depreciation		•	Ö		o o		
30. 00 Total fixed assets (sum of lines 12-29) 10,415,223 0 0 0 30. 00	28. 00		0		0	0	28. 00
OTHER ASSETS Investments 0 0 0 0 0 0 0 31.00 32.00 Deposits on leases 0 0 0 0 0 0 32.00 33.00 Due from owners/officers 0 0 0 0 0 0 33.00 33.00 Due from owners/officers 0 0 0 0 0 0 33.00 33.00 Due from owners/officers 0 0 0 0 0 0 34.00 34.00 35.00 Total other assets (sum of lines 31-34) 10,388,194 0 0 0 35.00 35.00 Total other assets (sum of lines 11, 30, and 35) 44,662,517 0 0 0 35.00 36.00 Total assets (sum of lines 11, 30, and 35) 44,662,517 0 0 0 35.00 36.00 Total assets (sum of lines 31-34) 10,388,194 0 0 0 35.00 36.00 Total assets (sum of lines 31-34) 10,388,194 0 0 0 0 35.00 36.00 Total counts payable 0 0 0 0 0 36.00 Total counts payable 331,019 0 0 0 0 38.00 39.00 Payroli taxes payable 0 0 0 0 0 0 39.00 39.00 Payroli taxes payable 0 0 0 0 0 0 0 0 0	29. 00	Mi nor equi pment-nondepreci abl e	0	(0		
31.00 Investments	30. 00		10, 415, 223	(0	0	30.00
32.00 Deposits on leases	21 00			J			21 00
33 00 Due from owners/officers 0 0 0 0 0 0 0 0 0			0				
34.00 Other assets 10,388,194 0 0 0 0 0 34.00 35.00 Total other assets (sum of lines 31-34) 36.00 Total assets (sum of lines 31-34) 37.00 Accounts payable 38.00 Salaries, wages, and fees payable 38.00 Salaries, wages, and fees payable 39.00 Payroll taxes payable 30.00 Payroll taxe		· ·		`	1		
35.00 Total other assets (sum of lines 31-34) 10, 388, 194 0 0 0 35.00			10, 388, 194		o o	1	1
CURRENT LIABILITIES	35.00	Total other assets (sum of lines 31-34)		1	0	0	35. 00
37.00 Accounts payable	36. 00		44, 662, 517		0	0	36. 00
38.00 Salaries, wages, and fees payable 331,019 0 0 0 38.00 39.00 Payroll taxes payable 0 0 0 0 39.00 0 0 0 0 0 0 0 0 0			1 001 017			_	
39.00 Payroll taxes payable 0 0 0 0 39.00				1			
40.00 Notes and Loans payable (short term) 958,952 0 0 0 0 40.00 41.00 Deferred income 0 0 0 0 0 41.00 42.00 Accelerated payments 0 0 0 0 0 0 43.00 43.00 Due to other funds 1,748,061 0 0 0 0 43.00 44.00 Other current liabilities 1,577,464 0 0 0 0 0 44.00 64.00 Other current liabilities (sum of lines 37 thru 44) 5,996,563 0 0 0 0 0 45.00 LONG TERM LIABILITIES 46.00 Mortgage payable 0 0 0 0 0 0 46.00 67.00 Notes payable 2,636,577 0 0 0 0 47.00 68.00 Unsecured Loans 0 0 0 0 0 48.00 69.00 Other Long term Liabilities (sum of lines 46 thru 49) 11,328,253 0 0 0 50.00 70 Total long term Liabilities (sum of lines 46 thru 49) 11,324,816 0 0 0 51.00 6APITAL ACCOUNTS 52.00 General fund balance 52.00 General fund balance - restricted 55.00 Donor created - endowment fund balance - restricted 55.00 Specific purpose fund 55.00 56.00 Governing body created - endowment fund balance - restricted 55.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total liabilities (sum of lines 52 thru 58) 27, 337, 701 0 0 0 59.00 Total liabilities and fund balances (sum of lines 51 and 44, 662, 517 0 0 0 0 50.00			331,019	1	-		
41.00 Deferred income 0 0 0 0 42.00			958, 952	1		•	
43.00 Due to other funds 1,748,061 0 0 0 43.00 44.00 Other current liabilities (sum of lines 37 thru 44) 5,996,563 0 0 0 45.00 LONG TERM LIABILITIES			0		o o		
44.00 Other current liabilities 1,577,464 0 0 0 44.00 45.00 Total current liabilities (sum of lines 37 thru 44) 5,996,563 0 0 0 45.00 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 8,691,676 0 0 0 49.00 50.00 Total long term liabilities (sum of lines 46 thru 49) 11,328,253 0 0 0 50.00 51.00 Total liabilities (sum of lines 45 and 50) 17,324,816 0 0 0 51.00 60.00 Specific purpose fund 0 0 52.00 52.00 52.00 General fund balance 27,337,701 0 52.00 54.00 Donor created - endowment fund balance - unrestricted 0 54.00 55.00 Governing body created - endowment fund balance 0 55.00	42.00	Accel erated payments	0				42. 00
45.00 Total current liabilities (sum of lines 37 thru 44) 5,996,563 0 0 0 45.00				1	0	l	
LONG TERM LIABILITIES				1	-		
46.00 Mortgage payable 0 0 0 0 46.00 47.00 Notes payable 2,636,577 0 0 0 47.00 48.00 Unsecured Loans 0 0 0 0 48.00 49.00 Other Long term Liabilities 8,691,676 0 0 0 49.00 50.00 Total Liabilities (sum of Lines 46 thru 49) 11,328,253 0 0 0 50.00 0 50.00 0 0 50.00 0 0 50.00 0 0 50.00 0 0 50.00 0 0 51.00 0 0 51.00 0 0 51.00 0 0 51.00 0 52.00 0 0 52.00 0 52.00 53.00 52.00 53.00 52.00 53.00 52.00 53.00 54.00 0 55.00 55.00 55.00 55.00 55.00 55.00 56.00 55.00 56.00 56.00 56.00 56.00 57.00 57.00 58.00 57.00 58.00 60.00 <t< td=""><td>45. 00</td><td></td><td>5, 996, 563</td><td></td><td>) 0</td><td>0</td><td>45.00</td></t<>	45. 00		5, 996, 563) 0	0	45.00
47.00 Notes payable 2,636,577 0 0 0 47.00 48.00 Unsecured Loans 0 0 0 0 0 49.00 Other Long term Liabilities Sum of Lines 46 thru 49 11,328,253 0 0 0 50.00 Total Liabilities (sum of Lines 45 and 50) 17,324,816 0 0 51.00 CAPITAL ACCOUNTS 52.00 General fund balance Specific purpose fund 53.00 54.00 Donor created - endowment fund balance - restricted 55.00 55.00 Donor created - endowment fund balance 55.00 56.00 Governing body created - endowment fund balance 56.00 57.00 Plant fund balance - invested in plant 0 57.00 58.00 Total Liabilities (sum of Lines 52 thru 58) 27,337,701 0 0 0 59.00 Total Liabilities and fund balances (sum of Lines 51 and 44,662,517 0 0 0 50.00 Total Liabilities and fund balances (sum of Lines 51 and 51.00 50.00 Total Liabilities and fund balances (sum of Lines 51 and 51.00 50.00 Total Liabilities and fund balances (sum of Lines 51 and 51.00 50.00 Total Liabilities 51.00 0 0 50.00 0 0 0 50.00 0 0 0 50.00 0 0 0 50.00 0 0 0 50.00 0 0 0 50.00 0 0 50.00 0 0 50.00 0 0 50.00 0 0 50.00 0 0 50.00 0 0 50.00 0 0 50.00 0 0 50.00 0 50.00 0 0 50.00 0	46 00		1			Γ 0	46 00
48.00 Unsecured Loans 0 0 0 0 0 48.00 49.00 Other Long term Liabilities 50.00 Total Long term Liabilities (sum of Lines 46 thru 49) 11, 328, 253 0 0 0 0 50.00 51.00 Total Liabilities (sum of Lines 45 and 50) 17, 324, 816 0 0 0 51.00 CAPITAL ACCOUNTS 52.00 General fund balance 53.00 Bonor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total Liabilities and fund balances (sum of Lines 51 and 44, 662, 517 0 0 0 0 60.00			2, 636, 577	`	٦		
50. 00 Total long term liabilities (sum of lines 46 thru 49) 11, 328, 253 0 0 0 50. 00 51. 00 Total liabilities (sum of lines 45 and 50) 17, 324, 816 0 0 0 51. 00 CAPITAL ACCOUNTS 52. 00 53. 00 Specific purpose fund 0 53. 00 54. 00 Donor created - endowment fund balance - restricted 0 54. 00 55. 00 Donor created - endowment fund balance - unrestricted 0 55. 00 56. 00 Governing body created - endowment fund balance 0 56. 00 57. 00 Plant fund balance - invested in plant 0 57. 00 58. 00 Plant fund balance - reserve for plant improvement, replacement, and expansion 0 58. 00 59. 00 Total fund balances (sum of lines 52 thru 58) 27, 337, 701 0 0 0 59. 00 60. 00 Total liabilities and fund balances (sum of lines 51 and 44, 662, 517 0 0 60. 00		1	0	1		l .	
51.00 Total liabilities (sum of lines 45 and 50) 17, 324, 816 0 0 0 51.00 CAPITAL ACCOUNTS 52.00 General fund balance 27, 337, 701 52.00 52.00 53.00 52.00 53.00 52.00 53.00 53.00 50.00 53.00 53.00 53.00 54.00 55.00 0.00 54.00 55.00 0.00 0.00 55.00 0.00 0.00 57.00 0.00 0.00 57.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00	49.00	Other long term liabilities	8, 691, 676	(0	0	49. 00
CAPITAL ACCOUNTS Seneral fund balance 27, 337, 701 52.00 Specific purpose fund 0 53.00 Specific purpose fund 0 53.00 Specific purpose fund 0 54.00 Donor created - endowment fund balance - restricted 0 54.00 Specific purpose fund 0 55.00 Spe							
53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 57.00 Country of the purpose fund 58.00 Country of the purpose fund 59.00 Total liabilities and fund balances (sum of lines 51 and 59.00 Total liabilities and fund balances (sum of lines 51 and on the purpose fund on the purpose f	51. 00	CAPI TAL ACCOUNTS	17, 324, 816	(0	0	51.00
54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 27, 337, 701 0 0 0 59.00 0 0 60.00			27, 337, 701	1			52. 00
55.00 Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance Flant fund balance - invested in plant Flant fund balance - reserve for plant improvement, replacement, and expansion Flant fund balances (sum of lines 52 thru 58) Total fund balances (sum of lines 51 and Flant fund				(1
56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 27, 337, 701 0 0 0 56.00 57.00 0 58.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					0		
57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 44,662,517 0 0 57.00 58.00 0 0 59.00 0 0 0 60.00					0		1
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 44,662,517 0 0 0 60.00						_	
replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 27,337,701 0 0 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and 44,662,517 0 0 0 60.00		· ·					
60.00 Total liabilities and fund balances (sum of lines 51 and 44,662,517 0 0 60.00		repl acement, and expansion					
				1	0		
المحوا	60. 00		44, 662, 517		0	0	60.00
		(^{לכ} ין	I	I	1	I	I

Provider CCN: 14-1313

					10 09/30/2023	2/26/2024 10:	
		General	Fund	Special P	urpose Fund	Endowment Fund	17 dill
		1.00	2.00	3. 00	4. 00	5. 00	
1. 00	Fund balances at beginning of period	1.00	2. 00 26, 748, 595		4.00	5.00	1. 00
2. 00	Net income (loss) (from Wkst. G-3, line 29)		589, 106				2. 00
3.00	Total (sum of line 1 and line 2)		27, 337, 701		0		3. 00
4.00	Additions (credit adjustments) (specify)	o	27,007,701		o	o	4. 00
5. 00	(, (, (, (, (, (o			Ö	Ö	5. 00
6.00		O			o	0	6. 00
7.00		0			o	0	7. 00
8.00		O			0	0	8. 00
9.00		0			0	0	9. 00
10.00	Total additions (sum of line 4-9)		0		0		10. 00
11. 00	Subtotal (line 3 plus line 10)		27, 337, 701		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	Total deductions (sum of lines 12 17)	U	0		0	0	17. 00 18. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance		27, 337, 701		0		18.00
19.00	sheet (line 11 minus line 18)		21, 331, 101		0		19.00
	Janeer (Trine Trimings Trine To)	Endowment Fund	PI ant	Fund			
		6.00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2. 00
3.00	Total (sum of line 1 and line 2)	0	_		0		3. 00
4.00	Additions (credit adjustments) (specify)		0				4. 00
5.00			0				5. 00
6.00			0				6. 00
7. 00 8. 00			0				7. 00 8. 00
9. 00			0				9. 00
10. 00	Total additions (sum of line 4-9)		U		o		10.00
11. 00	Subtotal (line 3 plus line 10)				0		11. 00
12. 00	Deductions (debit adjustments) (specify)		0				12.00
13. 00	beddetrons (debrt day detiments) (specify)		0				13. 00
14. 00			0				14. 00
15. 00			0				15. 00
16.00			0				16. 00
17. 00			o				17. 00
18.00	Total deductions (sum of lines 12-17)	0			О		18. 00
19. 00	Fund balance at end of period per balance	0			0		19. 00
	sheet (line 11 minus line 18)						

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 14-1313

			0 09/30/2023	2/26/2024 10:	
	Cost Center Description	I npati ent	Outpati ent	Total	17 (
	'	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	2, 814, 485		2, 814, 485	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVI DER - I RF				3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF	746, 586		746, 586	5.00
6.00	Swing bed - NF	7, 176	1	7, 176	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)	3, 568, 247		3, 568, 247	10. 00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT			0	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			0	16.00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	3, 568, 247		3, 568, 247	17. 00
18. 00	Ancillary services	2, 619, 815		40, 847, 577	18. 00
19. 00	Outpati ent servi ces	21, 314		5, 930, 052	19. 00
20. 00	RURAL HEALTH CLINIC		-,,	5, 024, 882	20. 00
20. 01	RURAL HEALTH CLINIC II		,	234, 963	20. 01
20. 02	RURAL HEALTH CLINIC III		.,	1, 013, 434	
21. 00	FEDERALLY QUALIFIED HEALTH CENTER			0	21. 00
22. 00	HOME HEALTH AGENCY		2, 790, 777	2, 790, 777	22. 00
23. 00	AMBULANCE SERVICES	5, 790	2, 754, 071	2, 759, 861	23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE	_	_	_	26. 00
27. 00	OTHER (SPECIFY)	()		0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	6, 215, 166	55, 954, 627	62, 169, 793	28. 00
	G-3, line 1)				
20.00	PART II - OPERATING EXPENSES		22.0/5.407		20.00
29. 00 30. 00	Operating expenses (per Wkst. A, column 3, line 200) ADD (SPECIFY)		32, 965, 497		29. 00 30. 00
30.00	ADD (SPECIFY)				30.00
31.00					31.00
					32.00
33. 00 34. 00					34. 00
35. 00					35. 00
36. 00	Total additions (sum of lines 20.25)				36. 00
37. 00	Total additions (sum of lines 30-35) EMPLOYEE PHYSICALS -DEDUCTION	35, 300	,		37. 00
38. 00	EMPLOTEE PHISICALS -DEDUCTION	35, 300			38.00
39. 00					39. 00
40. 00					40. 00
40.00					40.00
41.00	Total deductions (sum of lines 37-41)		35, 300		41.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transf	-or	32, 930, 197		43. 00
43.00	to Wkst. G-3, line 4)	E1	32, 930, 197		43.00
	10 MGC. 0 0, 1116 4)	I .	1	l	

Heal th	Financial Systems MASON DI	STRI CT HOSPI TAL	In Lie	u of Form CMS-2	2552-10
STATE	IENT OF REVENUES AND EXPENSES	Provider CCN: 14-1313	Peri od:	Worksheet G-3	
			From 10/01/2022 To 09/30/2023	Date/Time Pre	nared:
			10 07/30/2023	2/26/2024 10: 4	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column			62, 169, 793	
2.00	Less contractual allowances and discounts on patients'	accounts		31, 745, 340	
3.00	Net patient revenues (line 1 minus line 2)			30, 424, 453	
4.00	Less total operating expenses (from Wkst. G-2, Part II			32, 930, 197	
5.00	Net income from service to patients (line 3 minus line	4)		-2, 505, 744	5. 00
6. 00	OTHER INCOME Contributions, donations, bequests, etc			442, 199	6.00
7. 00	Income from investments			442, 199	
8. 00	Revenues from telephone and other miscellaneous commun	ication sorvices		401,009	
9. 00	Revenue from television and radio service	i cati oii sei vi ces		0	
10.00	Purchase di scounts			0	
11. 00	Rebates and refunds of expenses			0	
12. 00	Parking lot receipts			0	
	Revenue from Laundry and Linen service			0	
14. 00	Revenue from meals sold to employees and quests			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	
21. 00	Rental of vending machines			0	
22. 00	Rental of hospital space			0	
23. 00	Governmental appropriations			981, 008	
24. 00	OTHER REVENUE			1, 258, 196	
	COVI D-19 PHE Fundi ng			12, 438	
	Total other income (sum of lines 6-24)			3, 094, 850	
	Total (line 5 plus line 25)			589, 106	
	OTHER EXPENSES (SPECIFY)			0	
	Total other expenses (sum of line 27 and subscripts)	00)		0	
29. 00	Net income (or loss) for the period (line 26 minus lin	e 28)		589, 106	29.00

0

891, 572

0

0

891, 572

23.50

24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

Tel emedi ci ne

24.00 Total (sum of lines 1-23)

Heal th	Financial Systems		MASON DISTRIC	T HOSPITAL		In Lie	u of Form CMS-:	2552-10
	LLOCATION - HHA GENERAL SERVICE	COST			CN: 14-1313	Peri od:	Worksheet H-1	
				HHA CCN:	14-7202	From 10/01/2022 To 09/30/2023	Part Date/Time Pre	pared:
							2/26/2024 10:	49 am_
						Home Health Agency I	PPS	
			Capital Rela	ated Costs				
		Net Expenses	BI dgs &	Movabl e	l Plant	Transportati on	Subtotal	
		for Cost	Fixtures	Equi pment	Operation &		(col s. 0-4)	
		Allocation (from Wkst. H,			Mai ntenance	>		
		col. 10)						
		0	1.00	2.00	3.00	4. 00	4A. 00	
1. 00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	0	0		I		0	1.00
1.00	Fixtures		O				0	1.00
2.00	Capital Related - Movable	0		0			0	2. 00
3. 00	Equipment Plant Operation & Maintenance	0	0	0		0	0	3. 00
4. 00	Transportation	O	0	0		0 0	· ·	4. 00
5.00	Administrative and General	305, 371	0	0		0 0	305, 371	5. 00
6. 00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	535, 545	0	0		0 0	535, 545	6.00
7. 00	Physical Therapy	0	0	O		0 0	0	7. 00
8.00	Occupational Therapy Speech Pathology	0	0	0		0 0	0	8. 00
9. 00 10. 00	Medical Social Services	5, 872	0	0		0 0	5, 872	9. 00 10. 00
11. 00	Home Health Aide	44, 784	0	0		0 0	44, 784	11. 00
12.00	Supplies (see instructions) Drugs	0	0	0		0 0	0	
13. 00 14. 00	DME	0	0	0		0 0	0	13. 00 14. 00
	HHA NONREIMBURSABLE SERVICES		-					
15. 00 16. 00	Home Dialysis Aide Services Respiratory Therapy	0	0	0		0 0	0	15. 00 16. 00
17. 00	Private Duty Nursing	0	0	0		0 0	0	17. 00
18. 00	Clinic	O	0	0		0 0	0	18. 00
19. 00 20. 00	Health Promotion Activities Day Care Program	0	0	0		0 0	0	19. 00 20. 00
21. 00	Home Delivered Meals Program	0	0	0		0 0	0	21. 00
22. 00	Homemaker Service	0	0	0		0 0	0	22. 00
23. 00 23. 50	All Others (specify) Telemedicine	0	0	0			0	23. 00 23. 50
24. 00	Total (sum of lines 1-23)	891, 572	o	Ö		0 0	891, 572	1
		Admi ni strati ve	`					
		& General 5.00	4A + 5) 6.00					
	GENERAL SERVICE COST CENTERS							
1. 00	Capital Related - Bldg. & Fixtures							1. 00
2.00	Capital Related - Movable							2. 00
0.00	Equi pment							0.00
3. 00 4. 00	Plant Operation & Maintenance Transportation							3. 00 4. 00
5. 00	Administrative and General	305, 371						5. 00
6. 00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	278, 983	814, 528					6. 00
7. 00	Physical Therapy	276, 463	0 14, 528					7. 00
8.00	Occupational Therapy	O	0					8. 00
9. 00 10. 00	Speech Pathology Medical Social Services	0 3, 059	0 8, 931					9. 00 10. 00
11. 00	Home Heal th Ai de	23, 329	68, 113					11. 00
12.00	Supplies (see instructions)	0	0					12.00
13. 00 14. 00	Drugs DME	0	0					13. 00 14. 00
11.00	HHA NONREI MBURSABLE SERVI CES		0					1 11 00
15.00	Home Dialysis Aide Services	0	0					15. 00
16. 00 17. 00	Respiratory Therapy Private Duty Nursing	0	0					16. 00 17. 00
18. 00	Clinic	0	o					18. 00
19.00	Health Promotion Activities	0	O					19.00
20. 00 21. 00	Day Care Program Home Delivered Meals Program	0	0					20. 00 21. 00
22. 00	Homemaker Service	Ö	ő					22. 00
23. 00	All Others (specify)	0	0					23. 00
23. 50 24. 00	Telemedicine Total (sum of lines 1-23)		0 891, 572					23. 50 24. 00
00	1.11. (34 3. 11103 1 20)	1	371, 372					, 00

COST A	<u>Financial Systems</u> LLOCATION - HHA STATISTICAL BAS	SLS	MASON DISTRIC	Provider C	CN: 14-1313	Peri od:	eu of Form CMS-2 Worksheet H-1	
		0		HHA CCN:	14-7202	From 10/01/2022 To 09/30/2023	Part II	pared:
						Home Health	PPS	.,
		I 0 D.				Agency I		
		Capital Rei	ated Costs					
		BI dgs &	Movabl e	PI ant	Transportati	on Reconciliation	Admi ni strati ve	
		Fixtures	Equi pment	Operation &	(MI LEAGE)		& General	
		(SQUARE FEET)	(DOLLAR VALUE)	Maintenance (SQUARE FEET)			(ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS							
1. 00	Capital Related - Bldg. &	0				0		1. 00
2 00	Fixtures		0			0		2 00
2. 00	Capital Related - Movable Equipment		U			0		2. 00
3. 00	Plant Operation & Maintenance	0	0	0	,	0		3.00
4. 00	Transportation (see	0	0	0		0		4.00
	instructions)							
5.00	Administrative and General	0	0	0)	0 -305, 371	586, 201	5. 00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	_	0	1	0 0	535, 545	
7. 00	Physi cal Therapy	0	0	0	1	0 0	0	
8.00	Occupational Therapy	0	0	0	1	0 0	0	1 0.00
9. 00	Speech Pathology	0	0	0	1	0 0	0	9.00
10.00	Medical Social Services	0	0	0	1	0 0	5, 872	
	Home Health Aide	0	0	0	1	0 0	44, 784	
12.00	Supplies (see instructions)	0	0	0		0 0	0	1
13.00	Drugs	0	0	0	1	0	0	
14. 00	DME HHA NONREI MBURSABLE SERVI CES	0	0	0		0 0	0	14. 00
15. 00	Home Dialysis Aide Services	l 0	0	0	d .	0 0	0	15. 00
16. 00	Respiratory Therapy	0	0	0	1	0 0	0	
17. 00	Private Duty Nursing	0	0	0		0 0	0	
18. 00	Clinic	0	0	0	,	0 0	0	1
	Health Promotion Activities	l o	0	0	,	0 0	Ö	
	Day Care Program	0	0	0)	0 0	0	20.00
21. 00	Home Delivered Meals Program	0	0	0	1	0 0	0	21.00
22. 00	Homemaker Service	0	0	0	1	0 0	0	22.00
23. 00	All Others (specify)	0	0	0	1	0 0	0	23.00
23. 50	Tel emedi ci ne	0	0	0)	0 0	0	23.50
24. 00	Total (sum of lines 1-23)	0	0	0)	0 -305, 371	586, 201	24.00
25. 00	Cost To Be Allocated (per	0	0	0)	0	305, 371	25. 00
	Worksheet H-1, Part I)				1			
26.00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0.0000	000	0. 520932	26.00

							2/26/2024 10:	49 am
						Home Health Agency I	PPS	
			CAPI TAL			Agency		
	0 0	1111A T: -1	RELATED COSTS	NEW CLINIC	NEW NEW MED	NEW CAR DEL	MVDLE FOULD	
	Cost Center Description	HHA Trial Balance (1)	BLDG & FIXT	NEW CLINIC BUILDING	NEW NEW MED SURG	NEW CAP REL COSTS - WEST	MVBLE EQUIP	
		barance (1)		DOT EDT NO	30110	CAMPUS BUI		
1.00		0	1.00	1. 01	1. 02	1. 03	2. 00	1 00
1. 00 2. 00	Administrative and General Skilled Nursing Care	0 814, 528	0	3, 777 0		0	7, 747 0	1. 00 2. 00
3.00	Physical Therapy	0 , 525	0	Ö	l c	0	Ö	3. 00
4.00	Occupational Therapy	0	0	0	C	0	0	4. 00
5.00	Speech Pathology	0	0	0	C	0	0	5. 00
6. 00 7. 00	Medical Social Services Home Health Aide	8, 931 68, 113	0		C	_	0	6. 00 7. 00
8.00	Supplies (see instructions)	0	0	1	C	_	Ö	8. 00
9.00	Drugs	0	0	0	C	0	0	9. 00
10. 00 11. 00	DME Home Dialysis Aide Services	0	0	0		0	0	10. 00 11. 00
12. 00	Respiratory Therapy	0	0	ő	ď	0	ő	12. 00
13. 00	Private Duty Nursing	0	0		C	_	0	13. 00
14. 00 15. 00	Clinic Health Promotion Activities	0	0	· ·	C	_	0	14. 00 15. 00
16. 00	Day Care Program	0	0				0	16. 00
17. 00	Home Delivered Meals Program	0	0	0	C	0	0	17. 00
18. 00 19. 00	Homemaker Service All Others (specify)	0	0	0	0	0	0	18. 00 19. 00
19. 50	Tel emedi ci ne	0	0	0		0	0	19. 50
20. 00	Total (sum of lines 1-19) (2)	891, 572	0	3, 777	0	0	7, 747	20. 00
21. 00	Unit Cost Multiplier: column 26, line 1 divided by the sum							21. 00
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places. Cost Center Description	EMPLOYEE	Subtotal	ADMI NI STRATI VE	Subtotal	A&G HOSPITAL	MAINTENANCE &	
	oost conton beschiptren	BENEFITS	ous coca.	AND GENERAL	oub to tu.	ONLY	REPAI RS	
		DEPARTMENT 4.00	4A	5. 01	5A. 01	5. 02	6. 00	
1. 00	Administrative and General	140, 691	152, 215				17, 789	1. 00
2.00	Skilled Nursing Care	0	814, 528	1			0	2. 00
3.00	Physical Therapy	0	0	0	C	0	0	3.00
4. 00 5. 00	Occupational Therapy Speech Pathology	0	0	0		0	0	4. 00 5. 00
6.00	Medical Social Services	0	8, 931	863	9, 794	0	0	6. 00
7.00	Home Heal th Ai de	0	68, 113	6, 581	74, 694	0	0	7. 00
8. 00 9. 00	Supplies (see instructions) Drugs	0	0	0		0	0	8. 00 9. 00
10.00	DME	Ö	0	ő	C	0	ő	10. 00
11.00	Home Dialysis Aide Services	0	0	0	C	0	0	11.00
12. 00 13. 00	Respiratory Therapy Private Duty Nursing	0	0	0		0	0	12. 00 13. 00
14. 00		Ö	0	Ö	ď	0	ő	
15. 00	Health Promotion Activities	0	0	0	C	0	0	15. 00
16. 00 17. 00	Day Care Program Home Delivered Meals Program	0	0	0	C	0	0	16. 00 17. 00
18. 00	Homemaker Service	0	0	0		0	0	18. 00
19. 00	All Others (specify)	0	0	0	C	0	0	19. 00
19. 50				1 0	1 0	0	1 0	19. 50
	Telemedicine	140 401	1 0/2 707	100 057	1 111 411	^	17 700	
20. 00 21. 00	Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column	140, 691	1, 043, 787 0. 000000		1, 144, 644 0. 000000		17, 789	
	Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	140, 691					17, 789	20. 00
	Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus	0 140, 691					17, 789	20. 00
	Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	140, 691					17, 789	20. 00

⁽¹⁾ Column O, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

HHA CCN: 14-7202

						Home Health	PPS	
	Cost Center Description	MAINTENANCE &	OPERATION OF	OPERATION OF	OPERATION OF	Agency I LAUNDRY &	HOUSEKEEPI NG	
	2001 2011101 20001 1 211 011	REPAIRS - WEST	PLANT	PLANT-CLINIC	PLANT - WEST	LINEN SERVICE	11000EREEL TRO	
		CAMPUS			CAMPUS BU			
	,	6. 01	7. 00	7. 01	7. 02	8. 00	9. 00	
1.00	Administrative and General	0	0		1		16, 519	1. 00
2.00	Skilled Nursing Care	0	0	1		را ا	0	2. 00
3.00	Physi cal Therapy	0	0	0		0	0	3. 00
4.00	Occupational Therapy	0	0			0	0	4.00
5. 00 6. 00	Speech Pathology Medical Social Services		0				0	5. 00 6. 00
7. 00	Home Heal th Ai de		0				0	7. 00
8. 00	Supplies (see instructions)		0				0	8. 00
9. 00	Drugs	l ő	0			o o	ő	9. 00
10. 00	DME	l o	0	ĺ		o o	ő	10. 00
11. 00	Home Dialysis Aide Services	0	0	l c		0	0	11. 00
12.00	Respi ratory Therapy	0	0	0) (0	0	12.00
13.00	Private Duty Nursing	0	0	0)	0	0	13.00
14. 00	Clinic	0	0	0) (0	0	14.00
15. 00	Health Promotion Activities	0	0	0)	0	0	15. 00
16. 00	Day Care Program	0	0	0		0	0	16. 00
17. 00	Home Delivered Meals Program	0	0	0		0	0	17. 00
18.00	Homemaker Service	0	0	0		0	0	18.00
19. 00 19. 50	All Others (specify) Telemedicine	0	0				0	19. 00 19. 50
20. 00	Total (sum of lines 1-19) (2)		0	· -		145	16, 519	20. 00
21. 00	Unit Cost Multiplier: column		0	٥		143	10, 319	21. 00
21.00	26, line 1 divided by the sum							21.00
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							
		LIQUIDEL/EERI NO	DI ETABLI	0.4557551.4		OFNERAL	DUI 4 D1 4 4 6 1 /	
	Cost Center Description	HOUSEKEEPING -	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
		WEST CAMPUS	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	SERVICES &	PHARMACY	
			DI ETARY 10. 00	CAFETERI A 11. 00			PHARMACY 15.00	
1.00		WEST CAMPUS BUILDING		11.00	ADMI NI STRATI ON 13. 00	SERVI CES & SUPPLY 14. 00		1.00
2.00	Cost Center Description Administrative and General Skilled Nursing Care	WEST CAMPUS BUILDING 9.01	10. 00	11.00	ADMI NI STRATI ON 13. 00	SERVI CES & SUPPLY 14. 00	15. 00 0 0	2. 00
2. 00 3. 00	Cost Center Description Administrative and General Skilled Nursing Care Physical Therapy	WEST CAMPUS BUILDING 9.01	10.00	11.00	ADMI NI STRATI ON 13. 00	SERVI CES & SUPPLY 14. 00	15. 00 0 0	2. 00 3. 00
2. 00 3. 00 4. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy	WEST CAMPUS BUILDING 9.01	10. 00 0 0 0	11.00	ADMI NI STRATI ON 13. 00	SERVI CES & SUPPLY 14. 00	15. 00 0 0 0	2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	WEST CAMPUS BUILDING 9.01	10. 00 0 0 0 0	11.00	ADMI NI STRATI ON 13. 00	SERVI CES & SUPPLY 14. 00	15. 00 0 0 0 0	2. 00 3. 00 4. 00 5. 00
2.00 3.00 4.00 5.00 6.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	WEST CAMPUS BUILDING 9.01	10.00 0 0 0 0 0	11. 00 0 0 0 0	ADMI NI STRATI ON 13. 00	SERVI CES & SUPPLY 14. 00	15. 00 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	WEST CAMPUS BUILDING 9.01	10.00 0 0 0 0 0	11. 00 0 0 0 0 0	13.00	SERVI CES & SUPPLY	15. 00 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	WEST CAMPUS BUILDING 9.01	10.00 0 0 0 0 0 0	11. 00 0 0 0 0 0 0	ADMI NI STRATI ON 13. 00	SERVI CES & SUPPLY 14. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15. 00 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	WEST CAMPUS BUILDING 9.01	10.00 0 0 0 0 0	11. 00 0 0 0 0 0 0	13.00	SERVI CES & SUPPLY 14. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15. 00 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	WEST CAMPUS BUILDING 9.01	10.00 0 0 0 0 0 0 0	11. 00 0 0 0 0 0 0	13.00	SERVI CES & SUPPLY 14. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15. 00 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	WEST CAMPUS BUILDING 9.01	10. 00 0 0 0 0 0 0 0	11. 00 0 0 0 0 0 0	13.00	SERVI CES & SUPPLY 14. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15. 00 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services	WEST CAMPUS BUILDING 9.01	10. 00 0 0 0 0 0 0 0	11. 00 0 0 0 0 0 0	13.00	SERVI CES & SUPPLY 14. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15. 00 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	WEST CAMPUS BUILDING 9.01	10. 00 0 0 0 0 0 0 0 0 0 0	11. 00 0 0 0 0 0 0	13.00	SERVI CES & SUPPLY 14. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15. 00 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	WEST CAMPUS BUILDING 9.01	10.00 0 0 0 0 0 0 0 0 0 0 0 0 0	11. 00 0 0 0 0 0 0	13.00	SERVI CES & SUPPLY 14. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15. 00 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	WEST CAMPUS BUILDING 9.01	10.00 0 0 0 0 0 0 0 0 0 0 0 0	11. 00 0 0 0 0 0 0	13.00	SERVI CES & SUPPLY 14. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15. 00 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	WEST CAMPUS BUILDING 9.01	10.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	11.00 00 00 00 00 00 00 00 00 00 00 00 00	13. 00	SERVI CES & SUPPLY 14.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service	WEST CAMPUS BUILDING 9.01	10.00 0 0 0 0 0 0 0 0 0 0 0 0 0	11.00 00 00 00 00 00 00 00 00 00 00 00 00	13.00	SERVI CES & SUPPLY 14.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	WEST CAMPUS BUILDING 9.01	10.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	11.00 00 00 00 00 00 00 00 00 00 00 00 00	13. 00	SERVI CES & SUPPLY 14.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine	WEST CAMPUS BUILDING 9.01	10.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	11.00 00 00 00 00 00 00 00 00 00 00 00 00	13. 00	SERVI CES & SUPPLY 14.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2)	WEST CAMPUS BUILDING 9.01	10.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	11.00 00 00 00 00 00 00 00 00 00 00 00 00	13. 00	SERVI CES & SUPPLY 14.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	WEST CAMPUS BUILDING 9.01	10.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	11.00 00 00 00 00 00 00 00 00 00 00 00 00	13. 00	SERVI CES & SUPPLY 14.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus	WEST CAMPUS BUILDING 9.01	10.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	11.00 00 00 00 00 00 00 00 00 00 00 00 00	13. 00	SERVI CES & SUPPLY 14.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	WEST CAMPUS BUILDING 9.01	10.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	11.00 00 00 00 00 00 00 00 00 00 00 00 00	13. 00	SERVI CES & SUPPLY 14.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00

⁽¹⁾ Column O, line 20 must agree with Wkst. A, column 7, line 101.(2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

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	Total (Sull of Titles 1-19) (2)	20, 370	Ч	1, 177, 0/3	١	1, 199, 073	221, 932	
21. 00	· •						0. 227010	21. 00
	26, line 1 divided by the sum							
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							
	Cost Center Description	Total HHA						
		Costs						
		28. 00						
1.00	Administrative and General							1. 00
2.00	Skilled Nursing Care	1, 096, 006						2. 00
3.00	Physi cal Therapy	0						3. 00
4.00	Occupational Therapy	0						4.00
5.00	Speech Pathology	0						5. 00
6.00	Medical Social Services	12, 017						6.00
7.00	Home Health Aide	91, 650						7.00
8.00	Supplies (see instructions)	0						8. 00
9.00	Drugs	0						9. 00
10.00	DME	0						10.00
11. 00	Home Dialysis Aide Services	0						11. 00
12.00	Respiratory Therapy	0						12.00
13.00	1	0						13.00
14.00	Clinic	0						14. 00
15. 00	Health Promotion Activities	0						15. 00
16. 00	Day Care Program	0						16.00
17. 00	Home Delivered Meals Program	0						17. 00
18. 00	Homemaker Service	0						18. 00
19. 00	All Others (specify)	0						19. 00
19. 50		0						19. 50
20. 00	Total (sum of lines 1-19) (2)	1, 199, 673						20. 00
21. 00	, , , ,	., .,,, .,,						21. 00
	26, line 1 divided by the sum							
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							
	1	'					'	

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Speech Pathology

Home Health Aide

Respiratory Therapy

Private Duty Nursing

Day Care Program

Homemaker Service

Tel emedi ci ne

All Others (specify)

Drugs

Clinic

DMF

Medical Social Services

Supplies (see instructions)

Home Dialysis Aide Services

Health Promotion Activities

Home Delivered Meals Program

Total (sum of lines 1-19) (2)

⁽¹⁾ Column O, line 20 must agree with Wkst. A, column 7, line 101. (2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

					Home Health Agency I	PPS	17 uiii
		CAP	TAL RELATED CO	STS	rigonoy :		
Cost Center Description	BLDG & FIXT (SQUARE FEET)	NEW CLINIC BUILDING (SQUARE FEET)	NEW NEW MED SURG (SQUARE FEET)	NEW CAP REL COSTS - WEST CAMPUS BUI (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALA RIE)	
	1.00	1. 01	1. 02	1. 03	2. 00	4. 00	
1.00 Administrative and General 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Services 7.00 Home Health Aide 8.00 Supplies (see instructions) 9.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Homemaker Service 19.00 All Others (specify) 19.50 Telemedicine 20.00 Total (sum of lines 1-19) 21.00 Total cost to be allocated	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 594 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8, 363 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	695, 694 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	21. 00
22.00 Unit cost multiplier Cost Center Description	0.000000 Reconciliation	2. 369511 ADMI NI STRATI VE AND GENERAL (ACCUM. COST)	0.000000 Reconciliation		MAINTENANCE &	0. 202231 MAI NTENANCE & REPAI RS - WEST CAMPUS	22. 00
	54.01		54.00		, ,	(SQUARE FEET)	
1.00 Administrative and General 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Services 7.00 Home Health Aide 8.00 Supplies (see instructions) 9.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Homemaker Service 19.00 All Others (specify) 19.50 Telemedicine 20.00 Total (sum of lines 1-19) 21.00 Total cost to be allocated 22.00 Unit cost multiplier	5A. 01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5. 01 152, 215 814, 528 0 0 0 8, 931 68, 113 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 -9, 794 -74, 694 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00 21. 00

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Home Health PPS Agency I OPERATION OF OPERATION OF HOUSEKEEPI NG HOUSEKEEPI NG Cost Center Description OPERATION OF LAUNDRY & PLANT-CLI NI C LINEN SERVICE (SQUARE FEET) WEST CAMPUS PLANT PLANT - WEST (SQUARE FEET) CAMPUS BU (POUNDS OF (SQUARE FEET) BUI LDI NG (SQUARE FEET) (SQUARE FEET) LAUNDRY) 7.00 7.01 7.02 8.00 9.00 9.01 Administrative and General 1.00 0 0 0 0000000 80 1, 594 1. 00 Skilled Nursing Care 0 2.00 2.00 C 0 0 0 0 3.00 Physical Therapy 3.00 4.00 Occupational Therapy 0 0 0 4.00 Speech Pathology 5.00 0 0 0 5.00 0 0 6.00 Medical Social Services Ω 6.00 0 7.00 Home Health Aide C 7.00 0 8.00 Supplies (see instructions) 8.00 Drugs 0 00000000000 0 0 0 9.00 9 00 0 0 10.00 DMF 0 10.00 11.00 Home Dialysis Aide Services 11.00 0 12.00 Respiratory Therapy 0 0 12.00 0 0 13 00 Private Duty Nursing 13 00 14.00 Clinic 0 14.00 15.00 Health Promotion Activities 15.00 0 Day Care Program 16.00 16,00 0 0 17.00 17.00 Home Delivered Meals Program 18.00 Homemaker Service 0 0 0 18.00 All Others (specify) 19.00 19.00 Tel emedi ci ne 0 0 0 19.50 0 19.50 Total (sum of lines 1-19) 0 0 80 1, 594 20.00 20 00 C 21.00 Total cost to be allocated 145 16, 519 21.00 1.812500 10. 363237 22.00 Unit cost multiplier 0.000000 0.000000 0.000000 0.000000 22.00 CAFETERI A NURSI NG CENTRAL PHARMACY MEDI CAL Cost Center Description DIFTARY (MEALS SERVED) ADMI NI STRATI ON SERVICES & (COSTED REQ RECORDS & (FTE'S) **SUPPLY** UISI) LI BRARY (HOURS OF (COSTED REQ (GROSS REVE SERVI CE) UISI) NUE) 10. 00 11. 00 13.00 14.00 15. 00 16. 00 Administrative and General 1.00 2, 790, 777 0 0 0 1 00 000000000000000000000 0 0 2.00 Skilled Nursing Care 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 2.00 3.00 Physical Therapy 0 0 3.00 0 0 0 0 0 4.00 Occupational Therapy 4.00 0 0 5.00 Speech Pathology C 5 00 6.00 Medical Social Services 6.00 7.00 Home Health Aide 0 0 0 7.00 0 0 Supplies (see instructions) 8.00 0 8.00 0 0 9.00 Drugs Ω 9.00 10.00 0 0 10.00 DME 11.00 Home Dialysis Aide Services 11.00 0 0 12.00 Respiratory Therapy 0 12.00 13.00 Private Duty Nursing C 0 13.00 14.00 Clinic 14.00 Health Promotion Activities 0 15.00 0 0 15.00 0 0 16.00 Day Care Program 0 16.00 0 17.00 Home Delivered Meals Program 0 17.00 0 Homemaker Service 0 0 18.00 0 18.00 All Others (specify) 0 0 19.00 19.00 0 0 0 0 19.50 Tel emedi ci ne C 19.50 20.00 Total (sum of lines 1-19) 0 0 C 0 0 2, 790, 777 20.00

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Total cost to be allocated

22.00 Unit cost multiplier

	Financial Systems		MASON DISTRICT				u of Form CMS-2	2552-10
	ATION OF GENERAL SERVICE COSTS 1	O HHA COST CENT	TERS STATISTICAL	Provi der CCN:	14-1313	Peri od:	Worksheet H-2	
BASIS				HHA CCN:	14-7202	From 10/01/2022 To 09/30/2023	Part II Date/Time Pre	nared·
				111111 0011.	11 7202	077 007 2020	2/26/2024 10:	49 am
						Home Health	PPS	
						Agency I		
	Cost Center Description	NONPHYSI CI AN						
		ANESTHETI STS						
		(ASSI GNED						
		TIME)						-
1 00	Administrative and Comment	19. 00						1 00
1.00	Administrative and General	0						1. 00 2. 00
2.00	Skilled Nursing Care	0						
3.00	Physical Therapy	0						3. 00 4. 00
4. 00 5. 00	Occupational Therapy Speech Pathology	0						5.00
6. 00	Medical Social Services	0						6.00
7.00	Home Health Aide	0						7.00
8.00	Supplies (see instructions)							8.00
9. 00								9.00
10.00	Drugs DME							10.00
11. 00	Home Dialysis Aide Services							11.00
12.00	Respiratory Therapy							12.00
13. 00	Private Duty Nursing							13. 00
14. 00	Clinic							14. 00
15. 00	Health Promotion Activities							15. 00
16. 00	Day Care Program							16.00
17. 00	Home Delivered Meals Program							17. 00
18. 00	Homemaker Service							18.00
19. 00	All Others (specify)							19.00
19. 50	Tel emedi ci ne							19. 50
	Total (sum of lines 1-19)							20.00
21. 00	Total cost to be allocated							21.00
22. 00	Unit cost multiplier	0. 000000						22. 00

	Financial Systems	-0	MASON DISTRIC		ON 14 1010		u of Form CMS-2	
PPORT	FIONMENT OF PATIENT SERVICE COST	S		Provi der C	UN: 14-1313	Peri od: From 10/01/2022	Worksheet H-3 Part I	
				HHA CCN:	14-7202	To 09/30/2023	Date/Time Pre 2/26/2024 10:	
				Title	· XVIII	Home Health	PPS	
	Cost Center Description	From, Wkst.	Facility Costs	Shared	Total HHA	Agency I Total Visits	Average Cost	
	oost conten beschiptron	H-2, Part I,	(from Wkst.	Ancillary	Costs (cols.		Per Vi si t	
		col. 28, line		Costs (from	+ 2)		(col. 3 ÷ col.	
			·	Part II)			4)	
		0	1.00	2. 00	3.00	4. 00	5. 00	
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	OF AGGREGATE F	PROGRAM COSI, A	GGREGATE OF TH	E PROGRAM LIM	ITATION COST, OF	₹	
	Cost Per Visit Computation							1
00	Skilled Nursing Care	2. 00	1, 096, 006		1, 096, 00	6 4, 718	232. 30	1.
00	Physi cal Therapy	3. 00		254, 922			126. 83	2.
00	Occupational Therapy	4. 00		110, 732	110, 73	2 991	111. 74	3.
00	Speech Pathology	5. 00		16, 238			143. 70	
00	Medical Social Services	6. 00			12, 01		222. 54	
00	Home Heal th Ai de	7. 00		004 000	91, 65		271. 15	1
00	Total (sum of lines 1-6)		1, 199, 673	381, 892	1,581,56 Program Visit			7.
			1			rt B		1
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject t			
	2001 2011101 20001 Pt. 011	0000 21 1111 10	05071 1101 (1)		Deductibles 8			
					Coi nsurance			
		0	1.00	2.00	3. 00	4. 00	5. 00	
	Limitation Cost Computation	T	07000		1 -	.T		
00	Skilled Nursing Care		37900	0		6		8.
01 02	Skilled Nursing Care Skilled Nursing Care		44100 99914	0	2, 43	8		8. 8.
00	Physical Therapy		37900	0	2, 43			9.
01	Physical Therapy		44100	0	•	ó		9.
02	Physical Therapy		99914	0	1, 15	8		9.
. 00	Occupational Therapy		37900	0	1	5		10.
. 01	Occupational Therapy		44100	0		0		10.
. 02	Occupati onal Therapy		99914	0	49			10.
. 00	Speech Pathology		37900	0		0		11.
. 01	Speech Pathology		44100 99914	0		0		11.
. 02	Speech Pathology Medical Social Services		37900	0	4	7		11. 12.
2. 01	Medical Social Services		44100	0		0		12.
. 02	Medical Social Services		99914	0		2		12.
. 00	Home Heal th Ai de		37900	0		ō		13.
. 01	Home Health Aide		44100	0		О		13.
. 02	Home Health Aide		99914	0	22	9		13.
. 00	Total (sum of lines 8-13)			0	4, 54			14.
	Cost Center Description		Facility Costs	Shared	Total HHA	Total Charges	•	
		Part I, col. 28, line	(from Wkst.		Costs (cols.		÷ col. 4)	
		20, 11116	H-2, Part I)	Costs (from Part II)	+ 2)	Records)		
		0	1. 00	2.00	3.00	4. 00	5. 00	
	Supplies and Drugs Cost Computa	ations			•	<u> </u>		
. 00	•	8. 00		27, 495	27, 49	5 32, 145	0. 855343	1
. 00	Cost of Drugs	9. 00		0		0 0	0. 000000	16.
			Program Visits		Cost of			
			Dow	+ D	Servi ces	Dont D		
	Cost Center Description	Part A	Par Not Subject to		Part A	Part B Not Subject to	Subject to	
	cost center bescription	I dit A	Deductibles &		l lait A	Deductibles &		
			Coi nsurance	Coi nsurance		Coi nsurance	Coi nsurance	
		6. 00	7. 00	8. 00	9. 00	10.00	11. 00	
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	OF AGGREGATE F	PROGRAM COST, A	GGREGATE OF TH	E PROGRAM LIM	ITATION COST, OF	?	
	Cost Per Visit Computation	1	1		ı	_T		
00	Skilled Nursing Care	0	2, 579			0 599, 102		1.
00	Physical Therapy	0	1, 175			0 149, 025		2.
00	Occupational Therapy		514			0 57, 434		3.
00 00	Speech Pathology Medical Social Services		47			0 6, 754 0 445		4. 5.
UU			229			0 62, 093		6.
00	Home Health Aide	11						

Health Financial Systems APPORTIONMENT OF PATIENT SERVICE COS		MASON DISTRICT		Provider CO	CN: 14-1313 14-7202 • XVIII	Period: From 10/01/2022 To 09/30/2023 Home Health Agency I	w of Form CMS-2552-10 Worksheet H-3 Part I Date/Ti me Prepared: 2/26/2024 10: 49 am PPS	
	Cost Center Description	6.00	7.00	8. 00	9. 00	10.00	11. 00	
	Limitation Cost Computation							
8. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 02 11. 00 11. 01 11. 02 12. 00 12. 01 13. 00 13. 01 13. 02 14. 00	Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Medical Social Services Home Health Aide Home Health Aide Total (sum of lines 8-13)							8. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 11. 00 11. 01 11. 02 12. 00 12. 01 12. 02 13. 00 13. 01 13. 02 14. 00
		Prog	ram Covered Cha	rges	Cost of			
					Servi ces			
	Cost Center Description	Part A	Part Not Subject to Deductibles & Coinsurance 7.00	Subject to	Part A	Part B Not Subject to Deductibles & Coinsurance 10.00		
	Supplies and Drugs Cost Computa		7.00	6.00	9.00	10.00	11.00	
15.00	Cost of Medical Supplies	O	-,	0	•	0 7, 017	0	
16.00	Cost of Drugs Cost Center Description	Total Program	0	0		0	0	16. 00
		Cost (sum of						
		cols. 9-10)	-					-
	PART I - COMPUTATION OF LESSER	12. 00	PROGRAM COST, AG	GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR	<u> </u>	
	BENEFICIARY COST LIMITATION	12. 00	PROGRAM COST, AG	GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR	}	
1 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation	12.00 OF AGGREGATE I		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR	2	1 00
1. 00	BENEFICIARY COST LIMITATION	12. 00	•	GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR	2	1.00
	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care	12. 00 OF AGGREGATE I		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR	2	1
2.00 3.00 4.00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	12. 00 OF AGGREGATE I 599, 102 149, 025 57, 434 6, 754		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR	2	2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	12. 00 OF AGGREGATE I 599, 102 149, 025 57, 434 6, 754 445		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR	2	2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00 5. 00 6. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	12. 00 OF AGGREGATE I 599, 102 149, 025 57, 434 6, 754 445 62, 093		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR	R	2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6)	12. 00 OF AGGREGATE I 599, 102 149, 025 57, 434 6, 754 445		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR	2	2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00 5. 00 6. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	12. 00 OF AGGREGATE I 599, 102 149, 025 57, 434 6, 754 445 62, 093 874, 853		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR	2	2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6)	12. 00 OF AGGREGATE I 599, 102 149, 025 57, 434 6, 754 445 62, 093		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR	2	2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care	12. 00 OF AGGREGATE I 599, 102 149, 025 57, 434 6, 754 445 62, 093 874, 853		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR	2	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 8. 01	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care	12. 00 OF AGGREGATE I 599, 102 149, 025 57, 434 6, 754 445 62, 093 874, 853		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR	2	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 8. 01
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 8. 01 8. 02	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care	12. 00 OF AGGREGATE I 599, 102 149, 025 57, 434 6, 754 445 62, 093 874, 853		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR	2	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 01 8. 02
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 8. 01 8. 02 9. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Physical Therapy	12. 00 OF AGGREGATE I 599, 102 149, 025 57, 434 6, 754 445 62, 093 874, 853		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR	2	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 01 8. 02 9. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 8. 01 8. 02 9. 00 9. 01	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy	12. 00 OF AGGREGATE I 599, 102 149, 025 57, 434 6, 754 445 62, 093 874, 853		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR	2	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 01 8. 02 9. 00 9. 01
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 8. 01 8. 02 9. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy	12. 00 OF AGGREGATE I 599, 102 149, 025 57, 434 6, 754 445 62, 093 874, 853		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR	2	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 01 8. 02 9. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 01 8. 02 9. 00 9. 01 9. 02	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy	12. 00 OF AGGREGATE I 599, 102 149, 025 57, 434 6, 754 445 62, 093 874, 853		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR	2	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 01
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 01	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy	12. 00 OF AGGREGATE I 599, 102 149, 025 57, 434 6, 754 445 62, 093 874, 853		SGREGATE OF TH	E PROGRAM LI	MITATION COST, OR	2	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 10. 02
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 10. 02 11. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology	12. 00 OF AGGREGATE I 599, 102 149, 025 57, 434 6, 754 445 62, 093 874, 853		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR	2	8. 00 8. 01 9. 00 9. 01 9. 02 10. 00 10. 01 11. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 10. 02 11. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology	12. 00 OF AGGREGATE I 599, 102 149, 025 57, 434 6, 754 445 62, 093 874, 853		GREGATE OF TH	E PROGRAM LI	MITATION COST, OR	2	8. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 10. 02 11. 00 11. 01
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 01 8. 02 9. 01 9. 02 10. 00 10. 01 11. 02 11. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology	12. 00 OF AGGREGATE I 599, 102 149, 025 57, 434 6, 754 445 62, 093 874, 853		GREGATE OF TH	E PROGRAM LI	MITATION COST, OR	2	8. 00 8. 01 8. 02 9. 00 10. 01 10. 01 11. 02 11. 00 11. 01 11. 02
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 11. 00 11. 01 11. 02 12. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services	12. 00 OF AGGREGATE I 599, 102 149, 025 57, 434 6, 754 445 62, 093 874, 853		GREGATE OF TH	E PROGRAM LI	MITATION COST, OR		8. 00 8. 00 9. 01 9. 02 10. 00 11. 01 11. 02 12. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 01 8. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 11. 01 11. 02 11. 00 12. 00 12. 01	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Medical Social Services	12. 00 OF AGGREGATE I 599, 102 149, 025 57, 434 6, 754 445 62, 093 874, 853		GREGATE OF TH	E PROGRAM LI	MITATION COST, OR		8. 00 8. 01 9. 02 10. 00 11. 00 11. 01 11. 02 12. 00 12. 01
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 11. 00 11. 01 11. 02 12. 00 12. 01 12. 02	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services	12. 00 OF AGGREGATE I 599, 102 149, 025 57, 434 6, 754 445 62, 093 874, 853		SGREGATE OF TH	E PROGRAM LI	MITATION COST, OR		8. 00 8. 01 8. 02 9. 00 9. 01 10. 02 11. 00 11. 01 12. 01 12. 02
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 01 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 11. 01 11. 00 11. 00 12. 00 12. 01	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Medical Social Services Home Health Aide	12. 00 OF AGGREGATE I 599, 102 149, 025 57, 434 6, 754 445 62, 093 874, 853		SGREGATE OF TH	E PROGRAM LI	MITATION COST, OR	2	8. 00 8. 01 9. 02 10. 00 11. 00 11. 01 11. 02 12. 00 12. 01
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 11. 01 11. 02 12. 00 12. 01 12. 02 13. 00 13. 01	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Medical Social Services Home Health Aide	12. 00 OF AGGREGATE I 599, 102 149, 025 57, 434 6, 754 445 62, 093 874, 853		SGREGATE OF TH	E PROGRAM LI	MITATION COST, OR	2	8. 00 8. 01 8. 00 9. 00 9. 01 9. 02 10. 00 10. 01 11. 02 11. 00 11. 01 11. 02 12. 00 12. 01 12. 02 13. 00

Health Financial Systems		MASON DISTRICT HOSPITAL				In Lieu of Form CMS-2552-10			
APP0R1	TIONMENT OF PATIENT SERVICE COST	S		Provider Co		Peri od:	Worksheet H-3		
						From 10/01/2022			
		HHA CCN:	14-7202	To 09/30/2023	Date/Time Pre 2/26/2024 10:				
				Home Health	PPS	49 alli			
							PP3		
						Agency I			
	Cost Center Description	From Wkst. C,	Cost to Charge	Total HHA	HHA Shared	Transfer to			
		Part I, col.	Ratio	Charge (from	Ancillary	Part I as			
		9, line		provi der	Costs (col.	1 Indicated			
				records)	x col. 2)				
		0	1. 00	2. 00	3. 00	4. 00			
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS									
1.00	Physical Therapy	66. 00	0. 350351	727, 620	254, 92	22 col. 2, line 2	. 00	1.00	
2.00	Occupational Therapy	67. 00	0. 308668	358, 742	110, 73	32 col. 2, line 3	. 00	2.00	
3.00	Speech Pathology	68. 00	0. 397394	40, 861	16, 23	88 col. 2, line 4	. 00	3.00	
4.00	Cost of Medical Supplies	71. 00	0. 855330	32, 145	27, 49	95 col. 2, line 1	5. 00	4.00	
5.00	Cost of Drugs	73. 00	1. 069837	0		0 col. 2, line 1	6. 00	5. 00	

	Financial Systems MASON DISTRICT TION OF HHA REIMBURSEMENT SETTLEMENT	Provi der CC	CN: 14-1313		eri od:	u of Form CMS-2 Worksheet H-4	
		HHA CCN:	14-7202	Fr To	rom 10/01/2022 0 09/30/2023	Part - Date/Time Prep 2/26/2024 10:4	
		Title	XVIII		Home Health	PPS	47 (
					Agency I Par	t B	
			Part A		Not Subject to Deductibles &		
					Coi nsurance	Coi nsurance	
	DART I COMPUTATION OF THE LEGGER OF DEACONARIE COST OR CUCTUM	OMADY OHADOE	1.00		2. 00	3. 00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTO Reasonable Cost of Part A & Part B Services	JMARY CHARGES	5				
00	Reasonable cost of services (see instructions)			0	0	0	1
-	Total charges			0	0	0	2
	Customary Charges	r 00m/1000		0	ol	0	,
	Amount actually collected from patients liable for payment foon a charge basis (from your records)	i services		U	U	U	3
	Amount that would have been realized from patients liable for	payment		0	0	0	4
	for services on a charge basis had such payment been made in	accordance					
1	with 42 CFR §413.13(b) Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	000	0. 000000	0. 000000	
	Total customary charges (see instructions)		0.0000	0	0. 000000	0.000000	
	Excess of total customary charges over total reasonable cost	(complete		0	0	0	-
	only if line 6 exceeds line 1)						
	Excess of reasonable cost over customary charges (complete on 1 exceeds line 6)	ry ii line		U	٩	0	8
	Primary payer amounts			0	0	0	(
					Part A	Part B	
				ŀ	Servi ces 1.00	Servi ces 2. 00	
F	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				1.00	2.00	
- 1	Total reasonable cost (see instructions)				0	0	
- 1	Total PPS Reimbursement - Full Episodes without Outliers				0	607, 851	
- 1	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes				O O	153, 829 4, 548	
	Total PPS Reimbursement - PEP Episodes				0	4, 548	14
	Total PPS Outlier Reimbursement - Full Episodes with Outliers				O	67, 833	
1	Total PPS Outlier Reimbursement - PEP Episodes				0	0	10
1	Total Other Payments				0	0	1
1	DME Payments Oxygen Payments				0	0	18
	Prosthetic and Orthotic Payments				0	0	20
- 1	Part B deductibles billed to Medicare patients (exclude coins	urance)				0	2
	Subtotal (sum of lines 10 thru 20 minus line 21)				0	834, 061	
	Excess reasonable cost (from line 8)				O	0	23
	Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records)				٩	834, 061 0	2:
	Net cost (line 24 minus line 25)				o	834, 061	
	Allowable bad debts (from your records)]	0	2
	Adjusted reimbursable bad debts (see instructions)					0	-
	Allowable bad debts for dual eligible (see instructions)	`				0	
	Total costs - current cost reporting period (see instructions OTHER ADJUSTMENT	J			0	834, 061 -1	
	Pioneer ACO demonstration payment adjustment (see instruction	s)			ol	0	
	Demonstration payment adjustment amount before sequestration	•			O	Ō	30
	Subtotal (see instructions)				0	834, 060	
	Sequestration adjustment (see instructions)				0	16, 681	
	Demonstration payment adjustment amount after sequestration Sequestration adjustment for non-claims based amounts (see in	structions)			0	0	3
	sequestration augustment for hon-craims based amounts (see fit Interim payments (see instructions)	3 (1 UC (1 UHS)			0	817, 379	
	Tentative settlement (for contractor use only)				o	0	33
. 00	Balance due provider/program (line 31 minus lines 31.01, 31.0		. ,		0	0	34
. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS	Pub 15-2		ol	0	35

Health Financial Systems MASON DISTRICATION ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED In Lieu of Form CMS-2552-10 MASON DISTRICT HOSPITAL

Peri od: From 10/01/2022 To 09/30/2023 Date/Ti me Prepared: 2/26/2024 10:49 am PPS Provider CCN: 14-1313 TO PROGRAM BENEFICIARIES HHA CCN: 14-7202

				Home Health Agency I	PPS	
		Inpatien	t Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
1.00	Total interim payments paid to provider			0	817, 379	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,			O	0	2. 00
3.00	write "NONE" or enter a zero 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		<u> </u>			
3.01				0	0	3. 01
3.02				0	0	3. 02
3.03				0	0	3. 03
3.04				0	0	3. 04
3. 05				0	0	3. 05
3. 50	Provider to Program		I	0		3. 50
3. 50				0		3. 51
3. 52				0		3. 52
3. 53				0	0	3. 53
3. 54				0	l ol	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)			0	817, 379	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	0	5. 01
5. 02 5. 03				0	0	5. 02 5. 03
5.03	Provider to Program			U	0	5. 03
5. 50	1 Tovi dei 10 1 Togi alli			0	0	5. 50
5. 51				0	l ol	5. 51
5.52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
6. 00	5.50-5.98) Determined net settlement amount (balance due) based on					6. 00
/ O1	the cost report. (1) SETTLEMENT TO PROVIDER				0	/ 01
6. 01 6. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM			0		6. 01 6. 02
7.00	Total Medicare program liability (see instructions)			0	817, 379	7. 00
7.00	1.0.tal. modified by ogram i rability (See Thatroctions)			Contractor Number	NPR Date (Mo/Day/Yr)	,. 00
		()	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	•	•		•	. '	

llool +h	Financial Systems	MACON DICTRI	CT LIOCOL TAI		la lia	u of Form CMS (DEE2 10
	Financial Systems SIS OF HOSPITAL-BASED RHC/FQHC COSTS	MASON DISTRIC	Provider C	N: 14_1313	Peri od:	eu of Form CMS-2 Worksheet M-1	
AWALIS	NO OF TIOSET THE BASED KITCH QUE GOSTS				From 10/01/2022		
			Component	CCN: 14-3457	To 09/30/2023		
-					RHC I	2/26/2024 10: Cost	49 alli
		Compensation	Other Costs	Total (col.	1 Reclassificati	Recl assi fi ed	
		oomponoutron	0 11101 00010	+ col . 2)	ons	Trial Balance	
				ĺ		(col. 3 + col.	
						4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	1, 857, 041		1, 857, 04	1 -47, 875		1. 00
2.00	Physician Assistant	0			0	0	
3.00	Nurse Practitioner	513, 556	0	513, 55	6 0	513, 556	3. 00
4.00	Visiting Nurse	405 407	0	405.40	0	0	
5.00	Other Nurse	485, 136	0	485, 13	6 0	485, 136	1
6.00	Clinical Psychologist	0	0		0	0	
7.00	Clinical Social Worker	0	0		0	0	1
8. 00 9. 00	Laboratory Technician	0	0		0	0	8. 00 9. 00
10.00	Other Facility Health Care Staff Costs Subtotal (sum of lines 1 through 9)	2, 855, 733	0	2, 855, 73	3 -47, 875		
11. 00	Physician Services Under Agreement	2,000,700	778, 454	778, 45	•	778, 454	11. 00
12. 00	Physician Supervision Under Agreement	0	776, 434	770,43	0 0	778, 434	1
13. 00	Other Costs Under Agreement	0	12, 530	12, 53	9	12, 530	1
14. 00	Subtotal (sum of lines 11 through 13)	0	790, 984	790, 98		790, 984	14. 00
15. 00	Medical Supplies	0	124, 134	124, 13		124, 134	1
16. 00	Transportation (Health Care Staff)	0	0	12.7.10	0 0	0	16. 00
17. 00	Depreciation-Medical Equipment	0	0		0 0	0	
18. 00	Professional Liability Insurance	0	120, 900	120, 90	0 0	120, 900	
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	245, 034	245, 03	4 0	245, 034	21. 00
22.00	Total Cost of Health Care Services (sum of	2, 855, 733	1, 036, 018	3, 891, 75	1 -47, 875	3, 843, 876	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	Pharmacy	0	0		0	0	
24. 00	Dental	0	0		0	0	24. 00
25. 00	Optometry	0	0		0	0	25. 00
25. 01	Tel eheal th	13, 166		13, 16		13, 166	1
25. 02	Chronic Care Management	28, 340		28, 34		28, 340	1
26. 00	All other nonreimbursable costs	0	0		0	0	20.00
27. 00	Nonallowable GME costs	44 507	_	44 50	,	44 50/	27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	41, 506		41, 50	6 0	41, 506	28. 00

410, 124

410, 124

3, 307, 363

9, 257

1, 080, 627

1, 089, 884

5, 023, 141

9, 257 1, 080, 627

1, 089, 884

4, 975, 266

0

-47, 875

29.00

30.00

31.00

32.00

9, 257 670, 503 679, 760

1, 715, 778

through 27)
FACILITY OVERHEAD
29.00 Facility Costs
30.00 Administrative Costs

and 31)

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28

31.00

32.00

Health Financial Systems	MASON DISTRICT HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 14-1313	Peri od: From 10/01/2022	Worksheet M-1
	Component CCN: 14-3457	To 09/30/2023	Date/Time Prepared: 2/26/2024 10:49 am

RHC I	6/2024 10:49 am Cost
Adjustments Net Expenses	
for Allocation	
(col. 5 + col.	
6)	
6.00 7.00	
FACILITY HEALTH CARE STAFF COSTS	
1. 00 Physi ci an 0 1, 809, 166	1.00
2.00 Physician Assistant 0 0	2. 00
3.00 Nurse Practitioner 0 513,556	3. 00
4.00 Visiting Nurse 0 0	4. 00
5.00 Other Nurse 0 485, 136	5. 00
6.00 Clinical Psychologist 0 0	6. 00
7.00 Clinical Social Worker 0 0	7. 00
8.00 Laboratory Technician 0 0	8. 00
9.00 Other Facility Health Care Staff Costs 0 0	9. 00
10.00 Subtotal (sum of lines 1 through 9) 0 2,807,858	10.00
11.00 Physician Services Under Agreement 0 778, 454	11. 00
12.00 Physician Supervision Under Agreement 0 0	12. 00
13.00 Other Costs Under Agreement 0 12,530	13. 00
14.00 Subtotal (sum of lines 11 through 13) 0 790,984	14. 00
15.00 Medical Supplies 0 124, 134	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 0 120,900	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) 0 245,034	21. 00
22.00 Total Cost of Health Care Services (sum of 0 3,843,876	22. 00
li nes 10, 14, and 21)	
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 Tel eheal th 0 13, 166	25. 01
25.02 Chronic Care Management 0 28,340	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 0 41,506	28. 00
through 27)	
FACILITY OVERHEAD	
29. 00 Facility Costs 0 9, 257	29. 00
30.00 Administrative Costs 0 1,080,627	30.00
31.00 Total Facility Overhead (sum of lines 29 and 0 1,089,884	31. 00
30)	
32.00 Total facility costs (sum of lines 22, 28 0 4,975,266	32. 00
and 31)	I

Heal th	Financial Systems	MASON DISTRIC	CT HOSPITAL		In lie	eu of Form CMS-2	2552-10
	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der Co	CN: 14-1313	Peri od:	Worksheet M-1	
					From 10/01/2022 To 09/30/2023		
					RHC II	Cost	
		Compensation	Other Costs	Total (col. 1	Reclassi fi cati	Reclassi fied	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS	,					
1.00	Physi ci an	44, 412	0	44, 41	2 0	44, 412	1. 00
2.00	Physician Assistant	0	0		0	0	2. 00
3.00	Nurse Practitioner	25, 882	0	25, 88	2 0	25, 882	3. 00
4.00	Visiting Nurse	0	0		0	0	4. 00
5.00	Other Nurse	17, 865	0	17, 86	5 0	17, 865	1
6.00	Clinical Psychologist	0	0		0	0	6. 00
7.00	Clinical Social Worker	0	0		0	0	7. 00
8.00	Laboratory Techni ci an	0	0		0	0	8. 00
9.00	Other Facility Health Care Staff Costs	0	0		0	0	9. 00
	Subtotal (sum of lines 1 through 9)	88, 159	0	88, 15		88, 159	
	Physician Services Under Agreement	0	4, 002	4, 00	2 0	4, 002	
	Physician Supervision Under Agreement	0	0		0	0	12. 00
	Other Costs Under Agreement	0	5, 532			5, 532	
	Subtotal (sum of lines 11 through 13)	0	9, 534			9, 534	•
	Medical Supplies	0	4, 462			4, 462	
16. 00	Transportation (Health Care Staff)	0	5, 282	5, 28	2 0	5, 282	
	Depreciation-Medical Equipment	0	0		0	0	17. 00
	Professional Liability Insurance	0	3, 722	3, 72	2 0	3, 722	
	Other Health Care Costs	0	0		0	0	
	Allowable GME Costs						20. 00
	Subtotal (sum of lines 15 through 20)	0	13, 466			13, 466	
22. 00	Total Cost of Health Care Services (sum of	88, 159	23, 000	111, 15	9 0	111, 159	22. 00
	lines 10, 14, and 21)						
00.00	COSTS OTHER THAN RHC/FQHC SERVICES	1 5		1	0 0		00.00
	Pharmacy	0	0		0	0	

40, 964

40, 964

129, 123

0

2, 965 46, 303

49, 268

72, 268

0

24.00

25.00

0 25.02

26.00

27. 00

29.00

30.00

31.00

32.00

0 25. 01

0 28.00

2, 965 87, 267

90, 232

201, 391

0

2, 965 87, 267

90, 232

201, 391

24.00

25.00

25.01

25. 02

27. 00

28.00

30.00

31.00

32.00

Dental

Optometry

29.00 Facility Costs

and 31)

Tel eheal th

Chronic Care Management

Nonallowable GME costs

through 27) FACILITY OVERHEAD

Administrative Costs

26.00 All other nonreimbursable costs

Total Nonreimbursable Costs (sum of lines 23

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28

Health Financial Systems	MASON DISTRICT HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 14-1313	Period: Worksheet M-1 From 10/01/2022
	Component CCN: 14-3462	To 09/30/2023 Date/Time Prepared: 2/26/2024 10:49 am

			Component	CON. 14	3402	10	0 97 307 2023	2/26/2024 10	
							RHC II	Cost	
		Adjustments	Net Expenses						
		İ	for Allocation	า					
			(col. 5 + col.						
			6)						
		6. 00	7. 00						
	FACILITY HEALTH CARE STAFF COSTS								
1. 00	Physi ci an	0	44, 412	1					1. 00
2.00	Physi ci an Assi stant	0		0					2. 00
3.00	Nurse Practitioner	0	25, 882	2					3. 00
4.00	Visiting Nurse	0	(0					4. 00
5. 00	Other Nurse	0	17, 86	5					5. 00
6.00	Clinical Psychologist	0	(0					6. 00
7.00	Clinical Social Worker	0	(0					7. 00
8.00	Laboratory Techni ci an	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	88, 159						10. 00
11. 00	Physician Services Under Agreement	0	4, 002	1					11. 00
12.00	Physician Supervision Under Agreement	0		0					12. 00
13. 00	Other Costs Under Agreement	0	5, 532						13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0	9, 53						14. 00
15. 00	Medical Supplies	0	4, 462						15. 00
16. 00	Transportation (Health Care Staff)	0	5, 282						16. 00
17. 00	Depreciation-Medical Equipment	0		0					17. 00
18. 00	Professional Liability Insurance	0	3, 722	2					18. 00
19. 00	Other Health Care Costs	0	()					19. 00
20. 00	Allowable GME Costs								20. 00
21. 00	Subtotal (sum of lines 15 through 20)	0	13, 460						21. 00
22. 00	Total Cost of Health Care Services (sum of	0	111, 159	9					22. 00
	lines 10, 14, and 21)								_
22.00	COSTS OTHER THAN RHC/FQHC SERVICES	٥		٦.					
23. 00	1	0		C					23. 00
24. 00	Dental	0							24. 00
25. 00	Optometry	0	(C					25. 00
25. 01	Tel eheal th	0	(2					25. 01
25. 02	Chronic Care Management	0	(3					25. 02
26. 00	All other nonreimbursable costs	٩	(ا					26. 00 27. 00
27. 00	Nonallowable GME costs		,						
28. 00	Total Nonreimbursable Costs (sum of lines 23	U	(ال					28. 00
	through 27) FACILITY OVERHEAD								-
29. 00	Facility Overhead Facility Costs	ما	2, 96!	5					29. 00
30.00	Administrative Costs	0	2, 90: 87, 26:						30.00
31.00	Total Facility Overhead (sum of lines 29 and)	90, 232						31.00
31.00	30)	٩	90, 232	4					31.00
32. 00	Total facility costs (sum of lines 22, 28	0	201, 39°	1					32. 00
32.00	and 31)	٩	201, 37	'					32.00
	10.10 0.7	I		1					1

Heal th	Financial Systems	MASON DISTRIC	T HOSPITAL		In Lie	u of Form CMS-2	2552-10
	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der Co		Peri od:	Worksheet M-1	
			Component (From 10/01/2022 To 09/30/2023	Date/Time Pre 2/26/2024 10:	
					RHC III	Cost	
		Compensation	Other Costs	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS	1					
1.00	Physi ci an	282, 430	0	282, 430	0	282, 430	
2.00	Physician Assistant	0	0		0	0	
3.00	Nurse Practitioner	126, 322	0	126, 322	2 0	126, 322	3. 00
4.00	Visiting Nurse	0	0	150.10	0	0	1
5.00	Other Nurse	158, 436	0	158, 436	0	158, 436	
6.00	Clinical Psychologist	0	0	9	0	0	6.00
7.00	Clinical Social Worker	0	0	9	0	0	7.00
8. 00 9. 00	Laboratory Technician	0	0	9	0	0	8. 00 9. 00
10.00	Other Facility Health Care Staff Costs	F 4 7 100	0	E/7 100		U E47 100	
11. 00	,	567, 188	7, 545	567, 188		567, 188 7, 545	
	Physician Supervision Under Agreement	0	7, 545	7, 54!	0	7, 545 0	1
	Other Costs Under Agreement	0	5, 943	5, 94		5, 943	
	Subtotal (sum of lines 11 through 13)		13, 488			13, 488	
	Medical Supplies		72, 726			72, 726	
	Transportation (Health Care Staff)		72, 720 514			514	
	Depreciation-Medical Equipment		0	31.	0	0	
	Professional Liability Insurance		8, 328	8, 328	3	8, 328	
19. 00			0, 320	0, 320		0, 320	
	Allowable GME Costs		O	`			20.00
	Subtotal (sum of lines 15 through 20)		81, 568	81, 568	0	81, 568	
22. 00		567, 188	95, 056			662, 244	
22. 50	lines 10, 14, and 21)	337,100	, 5, 000	332,21		332,211	

0

1, 231

1, 231

67, 999

67, 999

636, 418

23.00

25.00

25. 01

25. 02

26.00

27. 00

28.00

29.00

30.00

31.00

32.00

0 24.00

0

1, 231

1, 231

7, 731

156, 558

164, 289

827, 764

0

1, 231

1, 231

7, 731

156, 558

164, 289

827, 764

0

0

7, 731 88, 559

96, 290

191, 346

COSTS OTHER THAN RHC/FQHC SERVICES

All other nonreimbursable costs

Total Nonreimbursable Costs (sum of lines 23

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28

23.00

24.00

25.00

25. 01

25. 02

26.00

27. 00

28.00

29.00

30.00

31.00

32.00

Pharmacy

Optometry

Tel eheal th

Chronic Care Management

Nonallowable GME costs

through 27)
FACILITY OVERHEAD

Administrative Costs

Facility Costs

and 31)

Dental

Health Financial Systems	MASON DISTRICT HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 14-1313	Period: Worksheet M-1 From 10/01/2022
	Component CCN: 14-8592	To 09/30/2023 Date/Ti me Prepared: 2/26/2024 10:49 am

			Component	CCN. 14-0372	. 10 07/30/2	2/26/2024 10	
					RHC III	Cost	
		Adjustments	Net Expenses				
			for Allocation				
			(col. 5 + col.				
			6)				
		6.00	7. 00				
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	0	282, 430				1. 00
2.00	Physician Assistant	0	0				2. 00
3.00	Nurse Practitioner	0	126, 322				3. 00
4.00	Visiting Nurse	0	0				4. 00
5.00	Other Nurse	0	158, 436				5. 00
6.00	Clinical Psychologist	0	0				6. 00
7.00	Clinical Social Worker	0	0				7. 00
8.00	Laboratory Techni ci an	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	567, 188				10. 00
11. 00	Physician Services Under Agreement	0	7, 545				11. 00
12.00	Physician Supervision Under Agreement	0	0				12. 00
13.00	Other Costs Under Agreement	0	5, 943				13. 00
14.00	Subtotal (sum of lines 11 through 13)	0	13, 488				14. 00
15.00	Medical Supplies	0	72, 726				15. 00
16.00	Transportation (Health Care Staff)	0	514				16. 00
17.00	Depreciation-Medical Equipment	0	0	1			17. 00
18. 00	Professional Liability Insurance	0	8, 328				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	81, 568				21. 00
22.00	Total Cost of Health Care Services (sum of	0	662, 244				22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES			1			_
23. 00	Pharmacy	0	0	1			23. 00
24. 00	Dental	O	0	•			24. 00
25. 00	Optometry	0	0	•			25. 00
25. 01	Tel eheal th	0	1, 231	1			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	0	1, 231				28. 00
	through 27)						_
	FACILITY OVERHEAD	_1		1			
29. 00	Facility Costs	0	7, 731				29. 00
30. 00	Administrative Costs	-300		1			30. 00
31. 00	Total Facility Overhead (sum of lines 29 and	-300	163, 989				31. 00
22.22	30)	222	007				22.00
32. 00	Total facility costs (sum of lines 22, 28	-300	827, 464				32. 00
	and 31)	ı		I			I

	Financial Systems TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	MASON DISTRIC	Provi der Co		Peri od:	u of Form CMS-2 Worksheet M-2	
			Component		From 10/01/2022 To 09/30/2023	Date/Time Prep 2/26/2024 10:4	
					RHC I	Cost	
		Number of FTE	Total Visits	Producti vi ty	/ Minimum Visits	Greater of	
		Personnel		Standard (1)	(col. 1 x col.	col. 2 or col.	
					3)	4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1.00	Physi ci an	3. 26			1 3		1.00
2.00	Physician Assistant	0. 00	0	2, 10	00		2. 00
3.00	Nurse Practitioner	3. 38	7, 124		1 3		3. 00
4.00	Subtotal (sum of lines 1 through 3)	6. 64	17, 475		6	17, 475	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	0. 00	0			0	7. 02
	onl y)						
8.00	Total FTEs and Visits (sum of lines 4	6. 64	17, 475			17, 475	8. 00
	through 7)						
9. 00	Physician Services Under Agreements		0			0	9. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO			VICES			
	Total costs of health care services (from Wk					3, 843, 876	
	Total nonreimbursable costs (from Wkst. M-1,					41, 506	
12. 00	Cost of all services (excluding overhead) (s					3, 885, 382	
13. 00	Ratio of hospital -based RHC/FQHC services (I			>		0. 989317	
14. 00	Total hospital-based RHC/FQHC overhead - (fr			ne 31)		1, 089, 884	
15.00	Parent provider overhead allocated to facili	ty (see instruc	ctions)			1, 766, 004	
16.00	Total overhead (sum of lines 14 and 15)					2, 855, 888	
17.00	Allowable GME overhead (see instructions)					0	17. 00
	Enter the amount from line 16			2)		2, 855, 888	
	Overhead applicable to hospital-based RHC/FQ					2, 825, 379	
20.00	Total allowable cost of hospital-based RHC/F	UHC services (s	sum of lines 10	and 19)		6, 669, 255	20.00

	Financial Systems TION OF OVERHEAD TO HOSPITAL-BASED RHC/FOHC S	MASON DISTRIC	Provider C	CN: 14-1313	In Lie Period:	u of Form CMS-2 Worksheet M-2	
					From 10/01/2022		
			Component	CCN: 14-3462	To 09/30/2023	Date/Time Pre 2/26/2024 10:	
					RHC II	Cost	
		Number of FTE	Total Visits	Producti vi ty	/ Minimum Visits	Greater of	
		Personnel		Standard (1)	(col. 1 x col.		
					3)	4	
	h	1.00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons	1 0 44		1	-		
1.00	Physi ci an	0. 16			1 0		1.00
2.00	Physician Assistant	0.00			0		2.00
3.00	Nurse Practitioner	0. 14	l .		0	057	3.00
4.00	Subtotal (sum of lines 1 through 3)	0. 30		•	0	957	4. 00
5.00	Visiting Nurse	0.00				0	
6.00	Clinical Psychologist Clinical Social Worker	0.00	l e			0	6. 00 7. 00
7. 00 7. 01		0. 00 0. 00	l e			0	7.00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	l e			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	U			Ü	7.02
8. 00	Total FTEs and Visits (sum of lines 4	0. 30	957			957	8.00
0.00	through 7)	0. 50	/5/			757	0.00
9.00	Physician Services Under Agreements		0			0	9. 00
7.00	The oral convices that high coments						7.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	HOSPI TAL-BASE	D RHC/FQHC SER	VI CES			
10.00	Total costs of health care services (from Wk	st. M-1, col. 7	7, line 22)			111, 159	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line 2	28)			0	11. 00
12.00	Cost of all services (excluding overhead) (s	um of lines 10	and 11)			111, 159	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I	ine 10 divided	by line 12)			1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (fr	om Worksheet. M	1-1, col. 7, li	ne 31)		90, 232	14.00
15.00	Parent provider overhead allocated to facili	ty (see instruc	ctions)			51, 739	15.00
16.00	Total overhead (sum of lines 14 and 15)					141, 971	16. 00
17.00	Allowable GME overhead (see instructions)					0	
	Enter the amount from line 16					141, 971	
	Overhead applicable to hospital-based RHC/FQ					141, 971	
20.00	Total allowable cost of hospital-based RHC/F	QHC services (s	sum of lines 10	and 19)		253, 130	20.00

	Financial Systems TION OF OVERHEAD TO HOSPITAL-BASED RHC/FOHC S	MASON DISTRI	CT HOSPITAL Provider C	CN: 14 1212	In Lie	eu of Form CMS-: Worksheet M-2	
ALLUCA	TITON OF OVERHEAD TO HOSPITAL-BASED KHC/FUHC S	DERVICES	Provider C		From 10/01/2022		
			Component	CCN: 14-8592	To 09/30/2023		
					RHC III	Cost	
		Number of FTE	Total Visits		/ Minimum Visits		
		Personnel		Standard (1)			
		1.00			3)	4	
	VII CLITC AND DECENDED IN THE	1.00	2.00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						-
1 00	Posi ti ons	0.00	2 20/		1 1		1.00
1.00	Physician	0. 80 0. 00			1		2.00
2. 00 3. 00	Physician Assistant Nurse Practitioner	0. 00		_,	1 1		3.00
4.00	Subtotal (sum of lines 1 through 3)	1. 40			1 1	4, 046	
5.00	Visiting Nurse	0. 00		1		0 4,040	1
6. 00	Clinical Psychologist	0.00				0	
7. 00	Clinical Social Worker	0.00				0	
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	
7. 02	Di abetes Self Management Training (FQHC	0.00				0	7. 02
7.02	only)	0.00					
8.00	Total FTEs and Visits (sum of lines 4	1. 40	4, 046	,		4, 046	8. 00
	through 7)						
9.00	Physician Services Under Agreements		0			0	9. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO			VI CES		T	-
10.00	Total costs of health care services (from Wk					662, 244	
11.00						1, 231	
12.00	Cost of all services (excluding overhead) (s					663, 475	
13.00	Ratio of hospital -based RHC/FQHC services (I			24)		0. 998145	
14.00	Total hospital-based RHC/FQHC overhead - (fr			ne 31)		163, 989	
15.00						276, 708	
16.00	Total overhead (sum of lines 14 and 15)					440, 697	
17.00	Allowable GME overhead (see instructions) Enter the amount from line 16					0 440, 697	
	Overhead applicable to hospital-based RHC/FQ	UC corvices (Li	no 12 v lino 1	0)		439, 880	
	Total allowable cost of hospital-based RHC/Fu					1, 102, 124	
20.00	Trotal allowable cost of hospital-based kilo/i	wile services (s	Juni OI IIIIGS IC	and 17)		1, 102, 124	1 20.00

Heal th	Financial Systems MASON DISTRICT HO	SPI TAL	In Lie	u of Form CMS-2	2552-10
		Provider CCN: 14-1313	Peri od:	Worksheet M-3	
SERVI (ES C	Component CCN: 14-3457	From 10/01/2022 To 09/30/2023	Date/Time Prep 2/26/2024 10:4	
		Title XVIII	RHC I	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from	Wkst. M-2, line 20)		6, 669, 255	1. 00
2.00	Cost of injections/infusions and their administration (from Wks			144, 909	2. 00
3.00	Total allowable cost excluding injections/infusions (line 1 min	us line 2)		6, 524, 346	3. 00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	no ()		17, 475	
5. 00 6. 00	Physicians visits under agreement (from Wkst. M-2, column 5, lill Total adjusted visits (line 4 plus line 5)	ne 9)		0 17, 475	5. 00 6. 00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			373. 35	7. 00
7.00	That district of the order of the order of		Cal cul ati on		7.00
			Rate Period 1		
			(10/01/2022	(01/01/2023	
			through 12/31/2022)	through 09/30/2023)	
			1. 00	2.00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6	or your contractor)	388. 19	366. 71	8. 00
9.00	Rate for Program covered visits (see instructions)		373. 35	366. 71	9. 00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from co		989	2, 990	10.00
11. 00 12. 00	Program cost excluding costs for mental health services (line 9 Program covered visits for mental health services (from contrac		369, 243 0	1, 096, 463 0	11. 00 12. 00
13. 00	Program covered cost from mental health services (line 9 x line		0	0	13.00
14. 00	Limit adjustment for mental health services (see instructions)	12)	o	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 a	0	1, 465, 706	16. 00	
16. 01	Total program charges (see instructions)(from contractor's reco	*		1, 032, 366	
16. 02	Total program preventive charges (see instructions)(from provide			64, 691	16. 02
16. 03 16. 04	Total program preventive costs ((line 16.02/line 16.01) times I Total Program non-preventive costs ((line 16 minus lines 16.03)			91, 846 1, 022, 626	
10. 04	(Titles V and XIX see instructions.)	and 10) trilles . 80)		1, 022, 020	10.04
16. 05	Total program cost (see instructions)		0	1, 114, 472	16. 05
17. 00	Pri mary payer amounts			0	17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor		95, 577	18. 00
40.00	records)) (6		474 040	40.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instructions records)) (from contractor		174, 318	19. 00
20. 00	Net Medicare cost excluding vaccines (see instructions)			1, 114, 472	20. 00
21. 00	Program cost of vaccines and their administration (from Wkst. M	-4, line 16)		26, 100	
22. 00	Total reimbursable Program cost (line 20 plus line 21)			1, 140, 572	
23. 00	Allowable bad debts (see instructions)			42, 773	
23. 01	Adjusted reimbursable bad debts (see instructions)			27, 802	
24. 00 25. 00	Allowable bad debts for dual eligible beneficiaries (see instru	CTI ONS)		0	24. 00 25. 00
25. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)			0	
25. 99	Demonstration payment adjustment amount before sequestration		0		
26. 00	Net reimbursable amount (see instructions)		1, 168, 374		
26. 01	Sequestration adjustment (see instructions)		23, 367	26. 01	
26. 02	Demonstration payment adjustment amount after sequestration			0	26. 02
27. 00	Interim payments			1, 155, 541	27. 00
28. 00 29. 00	Tentative settlement (for contractor use only) Balance due component/program (line 26 minus lines 26.01, 26.02	27 and 201		-10, 534	28. 00 29. 00
30.00	Protested amounts (nonallowable cost report items) in accordance	•		-10, 554	30.00
00	chapter I, §115.2				
			. '	!	-

Heal th Financial Systems	MASON DISTRICT			u of Form CMS-2	
CALCULATION OF REIMBURSEMENT S SERVICES	ETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 14-1313	Peri od: From 10/01/2022	Worksheet M-3	
JERVI GEO		Component CCN: 14-3462	To 09/30/2023	Date/Time Prep 2/26/2024 10:	
		Title XVIII	RHC I I	Cost	
				1. 00	
DETERMINATION OF RATE FO	R HOSPITAL-BASED RHC/FQHC SERVICES				
	hospital-based RHC/FQHC Services (from			253, 130	
1	sions and their administration (from W			10, 859	1
	cluding injections/infusions (line 1 m	inus line 2)		242, 271	3.00
4.00 Total Visits (from Wkst.		line ()		957	4.00
5.00 Physicians visits under 6.00 Total adjusted visits (1	agreement (from Wkst. M-2, column 5,	Title 9)		0 957	5. 00 6. 00
1	(line 3 divided by line 6)			253. 16	1
7.00 Aujusteu cost per visit	(Trie 3 di vided by Trie 0)		Cal cul ati on		7.00
			54.54.41.5		
			Rate Period 1		
			(10/01/2022	(01/01/2023	
			through 12/31/2022)	through 09/30/2023)	
			1. 00	2. 00	
8.00 Per visit payment limit	(from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	345. 47	358. 61	8. 00
9.00 Rate for Program covered	253. 16	253. 16			
CALCULATION OF SETTLEMEN	Т				
	excluding mental health services (from		27	129	
	costs for mental health services (line	*	6, 835	32, 658	1
	for mental health services (from contr	•	0	0	
	om mental health services (line 9 x li	•	0	0	
1	ntal health services (see instructions on Pass Through Cost (see instruction	•	0	0	14. 00 15. 00
	of lines 11, 14, and 15, columns 1, 2		0	39, 493	
	see instructions)(from contractor's re			41, 764	
' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	charges (see instructions)(from prov	•		2, 870	
	e costs ((line 16.02/line 16.01) times	•		2, 714	1
	ntive costs ((line 16 minus lines 16.0	3 and 18) times .80)		25, 336	16. 04
(Titles V and XIX see in					
16.05 Total program cost (see	e instructions)		0	28, 050	
17.00 Primary payer amounts	stible for DUC only (see instructions)	(from contractor		0 F 100	17.00
18.00 Less: Beneficiary deduction records)	ctible for RHC only (see instructions)	(from contractor		5, 109	18.00
	for RHC/FQHC services (see instruction	ns) (from contractor		6, 757	19.00
records)	(, (2, . 2 .	
20.00 Net Medicare cost exclud	ding vaccines (see instructions)			28, 050	20.00
	s and their administration (from Wkst.	M-4, line 16)		7, 909	
1	ram cost (line 20 plus line 21)			35, 959	
23.00 Allowable bad debts (see	The state of the s			2, 573	
	ad debts (see instructions) dual eligible beneficiaries (see inst	rustions)		1, 672	
•	•	ructions)		0	
. 99 Demonstration payment adjustment amount before sequestration				0	
. 00 Net reimbursable amount (see instructions)				37, 631	
. 01 Sequestration adjustment (see instructions)				753	
Demonstration payment adjustment amount after sequestration				0	
7.00 Interim payments				40, 065	
28.00 Tentative settlement (fo		00 07 100		0	
	rogram (line 26 minus lines 26.01, 26.			-3, 187	
0.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2				0	30.00

ealth Financial Systems MASON DISTRICT			u of Form CMS-2	2552-1
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 14-1313	Peri od: From 10/01/2022	Worksheet M-3	
SERVI CES	Component CCN: 14-8592	To 09/30/2023	Date/Time Prep 2/26/2024 10:4	
	Title XVIII	RHC III	Cost	
			1. 00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
.00 Total Allowable Cost of hospital-based RHC/FQHC Services (from			1, 102, 124	1.00
2.00 Cost of injections/infusions and their administration (from Wi			57, 534	2.00
7.00 Total allowable cost excluding injections/infusions (line 1 mi	nus line 2)		1, 044, 590	3.00
1.00 Total Visits (from Wkst. M-2, column 5, line 8) 1.00 Physicians visits under agreement (from Wkst. M-2, column 5, l	line (l)		4, 046 0	4. 00 5. 00
5.00 Total adjusted visits (line 4 plus line 5)	111e <i>4)</i>		4, 046	6.00
7.00 Adjusted cost per visit (line 3 divided by line 6)			258. 18	7.00
		Cal cul ati on	of Limit (1)	
		Rate Period 1	Rate Period 2	
		(10/01/2022	(01/01/2023	
		through	through	
		12/31/2022)	09/30/2023)	
00 Den vielt germant Hait (6-2 000 D.L. 100 04 L.L. 100 000	()	1. 00	2.00	0.00
B.OO Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20. P.OO Rate for Program covered visits (see instructions)	6 or your contractor)	285. 66 258. 18	275. 79 258. 18	8. 00 9. 00
CALCULATION OF SETTLEMENT		230. 10	200. 10	9.00
0.00 Program covered visits excluding mental health services (from	contractor records)	73	209	10.00
1.00 Program cost excluding costs for mental health services (line	•	18, 847	53, 960	11.00
2.00 Program covered visits for mental health services (from contra	*	0	0	12.00
3.00 Program covered cost from mental health services (line 9 x lines)	•	0	0	13.00
4.00 Limit adjustment for mental health services (see instructions)		0	0	14.00
5.00 Graduate Medical Education Pass Through Cost (see instructions 6.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	72, 807	15. 00 16. 00
6.01 Total program charges (see instructions)(from contractor's red			76, 396	
6.02 Total program preventive charges (see instructions) (from provi	•		14, 994	
6.03 Total program preventive costs ((line 16.02/line 16.01) times	•		14, 290	
6.04 Total Program non-preventive costs ((line 16 minus lines 16.03	3 and 18) times .80)		39, 766	16. 04
(Titles V and XIX see instructions.)			E4 0E/	4 . 0
6.05 Total program cost (see instructions) 7.00 Primary payer amounts		0	54, 056 0	16. 05 17. 00
7.00 Primary payer amounts 8.00 Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		8, 809	18.00
records)	(11 om contractor		0,007	10.00
9.00 Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		10, 519	19. 00
10.00 Net Medicare cost excluding vaccines (see instructions)			54, 056	20.00
11.00 Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		10, 624	21.00
22.00 Total reimbursable Program cost (line 20 plus line 21)			64, 680	
3.00 Allowable bad debts (see instructions)			1, 697	23. 00
23.01 Adjusted reimbursable bad debts (see instructions) 24.00 Allowable bad debts for dual eligible beneficiaries (see insti	quati ana)		1, 103	
	uctions)		0	24. 00 25. 00
25.50 Pioneer ACO demonstration payment adjustment (see instructions				
. 99 Demonstration payment adjustment before sequestration			0	25. 9
b. 00 Net reimbursable amount (see instructions)			65, 783	
.01 Sequestration adjustment (see instructions)			1, 316 0	
Demonstration payment adjustment amount after sequestration				26. 02
17.00 Interim payments			58, 899	
18.00 Tentative settlement (for contractor use only) 19.00 Balance due component/program (line 26 minus lines 26.01, 26.0	12 27 and 28)		0 5, 568	28. 00 29. 00
19.00 Barance due component/program (The 26 minus Thes 26.01, 26.00) Protested amounts (nonallowable cost report items) in accordance			0, 500	30.00
chapter I, §115.2			o o	55.00

OMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CC	CN: 14-1313	Peri od:	Worksheet M-4	
		Component (CCN: 14-3457	From 10/01/2022 To 09/30/2023		
		Title		RHC I	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2. 02	
. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	2, 807, 858 0. 000854	2, 807, 89 0. 00179			
. 00	Injection/infusion health care staff cost (line 1 x line 2)	2, 398	4, 92	28 0	0	3. (
. 00	Injections/infusions and related medical supplies costs (from your records)	65, 964	10, 23	30 0	0	4. (
. 00	Direct cost of injections/infusions (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	68, 362 3, 843, 876	15, 15 3, 843, 8		0 3, 843, 876	5. 6.
. 00 . 00	Total overhead (from Wkst. M-2, line 19) Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	2, 825, 379 0. 017785	2, 825, 3 0. 0039			7. 8.
. 00 0. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	50, 249 118, 611	11, 14 26, 29		0	9. 10.
1. 00 2. 00 3. 00	Total number of injections/infusions (from your records) Cost per injection/infusion (line 10/line 11) Number of injection/infusion administered to Program	259 457. 96 19	49. 4	32 0 43 0.00 52 0	0 0.00 0	12.
3. 01	beneficiaries Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.
4. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	8, 701	17, 39	99 0	0	14.
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
				1. 00	2.00	
. 00	Total cost of injections/infusions and their administration 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		columns 1,		144, 909	15.
6. 00	Total Program cost of injections/infusions and their admin		(sum of		26, 100	16.

	Financial Systems MASON DISTRI TATION OF HOSPITAL-BASED RHC/FOHC VACCINE COST	CT HOSPITAL Provider CO	CN: 14-1313	Peri od:	eu of Form CMS-2 Worksheet M-4	
301111 0 1	ATTOW OF HOSPITAL BROLD KING/TONG WAGGINE GOOT			From 10/01/2022		
		Component	CCN: 14-3462	To 09/30/2023	Date/Time Prep 2/26/2024 10:	
			XVIII	RHC II	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1. 00	2. 00	2. 01	2. 02	
1.00 2.00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	88, 159 0. 000666				1. 00 2. 00
3. 00	<pre>Injection/infusion health care staff cost (line 1 x line 2)</pre>	59	1	10 0	0	3.00
1. 00	Injections/infusions and related medical supplies costs (from your records)	4, 023		77 0	0	4.00
5. 00 6. 00	Direct cost of injections/infusions (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	4, 082 111, 159		87 0 59 111, 159	0 111, 159	5. 00 6. 00
7. 00 3. 00	Total overhead (from Wkst. M-2, line 19) Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	141, 971 0. 036722				7. 00 8. 00
9. 00 10. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	5, 213 9, 295		77 0 64 0		9. 00 10. 00
11. 00 12. 00 13. 00	Total number of injections/infusions (from your records) Cost per injection/infusion (line 10/line 11) Number of injection/infusion administered to Program	16 580. 94 12	52.	30 0 13 0. 00 18 0		12.00
3. 01	beneficiaries Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 0 ⁻
4. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	6, 971	9:	38 0	0	14.00
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
				1. 00	2. 00	
5. 00	Total cost of injections/infusions and their administration 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		columns 1,		10, 859	15. 00
16. 00			(sum of		7 000	16.00

	Financial Systems MASON DISTRI ATION OF HOSPITAL-BASED RHC/FOHC VACCINE COST	Provider CC	N. 14 1010	Period:	eu of Form CMS-2	
JUMPU I	ATTON OF HOSPITAL-RASED KHC/FOHC VACCINE COST	Provider CC	N: 14-1313	From 10/01/2022	Worksheet M-4	
		Component C		To 09/30/2023	Date/Time Pre 2/26/2024 10:	
			XVIII	RHC III	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2. 02	
1. 00 2. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	567, 188 0. 001263	567, 18 0. 00283		l	
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	716	1, 60	0	0	3.00
4. 00	Injections/infusions and related medical supplies costs (from your records)	27, 915	4, 33	34 0	0	4.00
5. 00	Direct cost of injections/infusions (line 3 plus line 4)	28, 631	5, 94		0	5. 00
5. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	662, 244	662, 24	662, 244	662, 244	6. 00
7. 00	Total overhead (from Wkst. M-2, line 19)	439, 880	439, 88			
3. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 043233	0. 00897			
9. 00	Overhead cost - injection/infusion (line 7 x line 8)	19, 017	3, 94		0	9. 0
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	47, 648			0	
11.00	Total number of injections/infusions (from your records)	70	15		0	
2. 00	Cost per injection/infusion (line 10/line 11)	680. 69	62. 9			12. 0
3. 00	Number of injection/infusion administered to Program beneficiaries	12	3	39 0	0	
3. 01	Number of COVID-19 vaccine injections/infusions			0	0	13.0
14. 00	administered to MA enrollees Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13	8, 168	2, 45	56 0	0	14.0
	and 13.01, as applicable)					
		<u>'</u>			COST OF	
					INJECTIONS /	
					INFUSIONS AND	
					ADMI NI STRATI ON	
	T	. , -		1. 00	2.00	4
	Total cost of injections/infusions and their administration 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.	M-3, line 2)			57, 534	
6.00	Total Program cost of injections/infusions and their admin	istration costs	(sum of		10, 624	16.0

Health Financial Systems	MASON DISTRICT	HOSPI TAL		In Lie	u of Form CN	MS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAR		Provider (Component		10/01/2022 09/30/2023	Date/Time F	Prepared:
					2/26/2024	10:49 am

				2/26/2024 10:	49 am
			RHC I	Cost	
			Par	rt B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			1, 155, 541	1. 00
2.00	Interim payments payable on individual bills, either submit	ted or to be submitted to		0	2.00
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero	•			
3.00	List separately each retroactive lump sum adjustment amount	based on subsequent			3.00
	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)				
	Program to Provider				
3.01				0	3. 0
3.02				0	3. 02
3.03				0	3. 0
3.04				0	3.04
3.05				0	3. 0
	Provider to Program				[
3.50				0	3. 5
3.51				0	3. 5
3. 52				0	3. 5.
3.53				0	3.5
3.54				0	3.5
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		0	3.9
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	fer to Worksheet M-3, line		1, 155, 541	4.0
	27)				
	TO BE COMPLETED BY CONTRACTOR				ĺ
5.00	List separately each tentative settlement payment after des	k review. Also show date of	,		5.0
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
5.01				0	5.0
5.02				0	5. 0
5.03				0	5.03
	Provider to Program				
5.50				0	5. 50
5. 51				0	5. 5
5. 52				0	5. 5.
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		0	5. 9
6.00	Determined net settlement amount (balance due) based on the	cost report. (1)			6.0
6. 01	SETTLEMENT TO PROVIDER	,		0	6.0
6. 02	SETTLEMENT TO PROGRAM			10, 534	6.0
7.00	Total Medicare program liability (see instructions)			1, 145, 007	7. 0
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	

Health Financial Systems	MASON DISTRICT	HOSPI TAL		In Lie	u of Form CMS	-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAL		Provider (Component		10/01/2022	Date/Time Pr	epared:
					2/26/2024 10): 49 am

	Component Con. 14-3402	10 097 307 2023	2/26/2024 10: 4	
		RHC II	Cost	
		Par	t B	
		mm/dd/yyyy	Amount	
		1. 00	2.00	
Total interim payments paid to hospital-based RHC/FQHC			40, 065	1
On Interim payments payable on individual bills, either submi	tted or to be submitted to		0	2
the contractor for services rendered in the cost reporting				
"NONE" or enter a zero				
DO List separately each retroactive lump sum adjustment amour	nt based on subsequent			3
revision of the interim rate for the cost reporting period	d. Also show date of each			
payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider				
01			0	3
02			0	3
03			0	3
04			o	1
05			o	1
Provider to Program				
50			0	1
51			0	1
52			0	1
53			o	:
54			ol	:
99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3	3. 98)		0	1
Total interim payments (sum of lines 1, 2, and 3.99) (tran	nsfer to Worksheet M-3, line		40, 065	4
27)				
TO BE COMPLETED BY CONTRACTOR				
DO List separately each tentative settlement payment after de	esk review. Also show date of			5
each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider				
01			0	
02			0	
03			0	5
Provider to Program				
50			0	
51			0	
52			0	
99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5			0	
Determined net settlement amount (balance due) based on th	ne cost report. (1)			6
O1 SETTLEMENT TO PROVIDER			0	6
D2 SETTLEMENT TO PROGRAM			3, 187	6
Total Medicare program liability (see instructions)			36, 878	7
		Contractor	NPR Date	
		Number	(Mo/Day/Yr)	
	0	1. 00	2. 00	
Name of Contractor				l 8

Health Financial Systems	MASON DISTRICT	HOSPI TAL		In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIA			CN: 14-1313 CCN: 14-8592	10/01/2022 09/30/2023	Date/Time Prepared:
					2/26/2024 10:49 am

				2/26/2024 10: 4	49 am
			RHC III	Cost	_
			Par	rt B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
1. 00	Total interim payments paid to hospital-based RHC/FQHC			58, 899	1. 0
2. 00	Interim payments payable on individual bills, either submit		0	2.0	
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero				
3. 00	List separately each retroactive lump sum adjustment amount			3.0	
	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)]
	Program to Provider				
. 01				0	3. (
3. 02				0	3.0
3. 03			0	3. (
3. 04				0	3. (
3. 05				0	3.
	Provider to Program				
. 50				0	3.
. 51				0	3.
. 52				0	3.
. 53				0	3.
. 54				0	3.
. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		0	3.
. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans		58, 899	4.	
	27)				
	TO BE COMPLETED BY CONTRACTOR				
. 00	List separately each tentative settlement payment after des	k review. Also show date of	'		5.
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
. 01				0	
. 02				0	5.
. 03				0	5.
	Provider to Program				
. 50				0	5.
. 51				0	
. 52			0	5.	
99				0	5.
. 00					6.
01	SETTLEMENT TO PROVI DER			5, 568	6.
. 02	SETTLEMENT TO PROGRAM			0	6.
. 00	Total Medicare program liability (see instructions)			64, 467	7.
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2. 00	
3. 00	Name of Contractor			1	8. (