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: 14-1329 Worksheet S Peri od: From 07/01/2022 Parts I-III AND SETTLEMENT SUMMARY 06/30/2023 Date/Time Prepared: 11/29/2023 3:45 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 11/29/2023 3:45 pm] 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] Initial 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 Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

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

(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 MORRISON COMMUNITY HOSPITAL (14-1329) for the cost reporting period beginning 07/01/2022 and ending 06/30/2023 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	Ca	mi Megli	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	Cami Megli			2
3	Signatory Title	CF0			3
4	Date	(Dated when report is electronica			4

			Title	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	-16, 351	350, 445	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	-246, 913	0		0	5. 00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		107, 281		0	10.00
10. 01	RURAL HEALTH CLINIC (RHC) ERIE II	0		0		0	10. 01
200.00	TOTAL	0	-263, 264	457, 726	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

							From 07/01/ To 06/30/		Part I Date/Ti	me Pre	pared:
	1.00	2.00		3. 00				1. 00	11/29/2	2023 3:	45 pm
	Hospital and Hospital Health Care Co			3. 00				, 00			
1.00	Street: 303 JACKSON City: MORRISON	PO Box:	7in Cod	lo. 413	20	Count	y: WHITESIDI	E			1.00
2. 00	City: MORRISON	State: IL Component Name	Zip Cod	CBS		rovi der	Date		nt Syst	em (P.	2. 00
			Number	Numl		Type	Certi fi ed	Ť,	0, or	N)	
		1.00	2.00	3. (00	4. 00	5. 00	V 6. 00	7. 00	XI X 8. 00	-
	Hospital and Hospital-Based Componer		2.00] 3. (00	4.00	3.00	0.00	7.00	0.00	
3.00	Hospi tal	MORRISON COMMUNITY	141329	999	14	1	08/01/2003	N	0	0	3.00
4. 00	Subprovider - IPF	HOSPI TAL									4. 00
5. 00	Subprovi der - IRF										5. 00
6.00	Subprovider - (Other)										6. 00
7. 00 8. 00	Swing Beds - SNF Swing Beds - NF	MORRISON SWING BED	14Z329	999	714		08/01/2003	N	0	N	7. 00 8. 00
9. 00	Hospi tal -Based SNF										9. 00
10.00	Hospital -Based NF										10.00
11. 00 12. 00	Hospi tal -Based OLTC Hospi tal -Based HHA										11. 00 12. 00
13. 00	Separately Certified ASC										13. 00
14.00	Hospi tal -Based Hospi ce	HODDI OOL OOLUUU TV	440004				07 (04 (400)				14.00
15. 00	Hospital-Based Health Clinic - RHC	MORRISON COMMUNITY HOSPITAL CLINIC	143981	999	714		07/01/1996	N	0	0	15. 00
15. 01	Hospital-Based Health Clinic - RHC	MORRISON COMMUNITY ERIE	148657	999	14		06/30/2023	N	0	0	15. 01
14 00	Haspital Pasad Haalth Clinic FOHC	CLINIC									14 00
16. 00 17. 00	Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I										16. 00 17. 00
18. 00	Renal Dialysis										18. 00
19. 00	Other										19. 00
							From: 1.00		To		_
	Cost Reporting Period (mm/dd/yyyy)						07/01/20	022	06/30/		20. 00
21. 00	Type of Control (see instructions)						11				21. 00
						1. 00	2. 00		3. (00	_
	Inpatient PPS Information										
22. 00	Does this facility qualify and is it disproportionate share hospital adju					N	N				22. 00
	§412. 106? In column 1, enter "Y" for										
	facility subject to 42 CFR Section §		endment								
22. 01	hospital?) In column 2, enter "Y" fo Did this hospital receive interim UC		al IICPs	for		N	N				22. 01
22.01	this cost reporting period? Enter in										22.0.
	for the portion of the cost reportin										
	1. Enter in column 2, "Y" for yes or cost reporting period occurring on co		TON OF T	ne							
	instructions)	·									
22. 02	Is this a newly merged hospital that			Lumm		N	N				22. 02
	determined at cost report settlement 1, "Y" for yes or "N" for no, for th			ullin							
	period prior to October 1. Enter in	column 2, "Y" for yes or	"N" for	no,							
22 02	for the portion of the cost reportin Did this hospital receive a geograph			2		N	N		N		22. 03
22. 03	rural as a result of the OMB standar					IN			14		22.03
	adopted by CMS in FY2015? Enter in c										
	for the portion of the cost reporting in column 2, "Y" for yes or "N" for			er							
	reporting period occurring on or aft										
	Does this hospital contain at least counted in accordance with 42 CFR 41										
	yes or "N" for no.	Z. 100): EILLEI IN COLUMN	υ, τ Γ(JI							
22. 04	Did this hospital receive a geograph										22. 04
	rural as a result of the revised OME adopted by CMS in FY 2021? Enter in										
	for the portion of the cost reporting										
	in column 2, "Y" for yes or "N" for	no for the portion of th	ne cost								
	reporting period occurring on or aft Does this hospital contain at least			as							
	counted in accordance with 42 CFR 41										
22 00	yes or "N" for no.	dicaid days on lines 24	and/or 2	5			2 N				23. 00
∠3.00	Which method is used to determine Me below? In column 1, enter 1 if date						Z IN				23.00
	if date of discharge. Is the method	of identifying the days	in this								
	reporting period different from the reporting period? In column 2, enter										
		J					1				

beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4. If line 56 is yes, did this facility elect cost reimbursement for physicians' services as

defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.

Ν

58.00

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	AIA	Provi der CC		Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part I Date/Time Pre 11/29/2023 3:	pared:
				V	XVIII XIX	
2.00 Are costs claimed on line 100 of Worksheet A? If ye	s compl	ete Wkst D-2	. Pt. I.	1. 00 N	2.00 3.00	59. 00
	<u>0, 00mp.</u>	ete interior b 2	NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
0.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413 instructions) Enter "Y" for yes or "N" for no in co is "Y", are you impacted by CR 11642 (or subsequent adjustment? Enter "Y" for yes or "N" for no in colu	.85? (s lumn 1. CR) NAHE	see If column 1	1.00 N	2.00	3. 00	60.00
adjustilient? Enter Y for yes of N for no fil coru	Y/N	I ME	Direct GME	I ME	Direct GME	
	1. 00	2. 00	3. 00	4. 00	5. 00	
 .00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) .01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) .02 Enter the current year total unweighted primary care FTE count (excluding 0B/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of 	N			0.00	0.00	61. 00
ACA). (see instructions) 1.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61. 0
 .04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). .05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's 						61. 0
primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) .06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61. 0
, , , , , , , , , , , , , , , , , , ,	Pro	ogram Name	Program Code		Unweighted Direct GME FTE Count	
		1.00	2. 00	3.00	4.00	
 .10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. .20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 				0. 00		61. 10
			(UDCA)		1.00	
ACA Provisions Affecting the Health Resources and Se 2.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instru	trai nec			riod for which		62.00
2.01 Enter the number of FTE residents that rotated from during in this cost reporting period of HRSA THC pro Teaching Hospitals that Claim Residents in Nonprovid	gram. (s	see instructio		your hospital	0.00	62. 01

Health Financial Systems	MORRI SON	COMMUNITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	TA Provider CO		eriod: fom 07/01/2022 0 06/30/2023	Worksheet S-2 Part I Date/Time Prep 11/29/2023 3:4	
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1. 00	2. 00	3.00	
Section 5504 of the ACA Base Year			This base year	is your cost r	eporti ng	
64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to rosettings. Enter in column 2 the resident FTEs that trained in your of (column 1 divided by (column)	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter ir 1 + column 2)). (see	ry trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio instructions)	0. 00	0. 00		64.00
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1. 00	2.00	3. 00	4. 00	5. 00	
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00		65. 00
			FTEs Nonprovi der Si te	FTEs in Hospital	(col. 1 + col. 2))	
			1. 00	2.00	3.00	
Section 5504 of the ACA Current		n Nonprovider Setting	sEffective fo	r cost reporti	ng peri ods	
beginning on or after July 1, 20 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	unweighted non-primar ccurring in all nonpr unweighted non-primar	rovider settings. Ty care resident	0.00	0. 00	0. 000000	66. 00
(column 1 divided by (column 1 +	column 2)). (see ins	tructions)				
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3. 00	4. 00	5.00	
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.00000	67. 00

Health Financial Systems MORRISON COMMUNITY HOSPITAL		In L	ieu of Form	n CMS-2	552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider		Period: From 07/01/202	Workshee 2 Part I	et S-2	
		To 06/30/202	?3 Date/Tin		
			11/29/20)23 3: 4	15 pm
Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-	10072 (August 10	2022)	1.00)	
68.00 For a cost reporting period beginning prior to October 1, 2022, did you MAC to apply the new DGME formula in accordance with the FY 2023 IPPS F (August 10, 2022)?	obtain permissi	on from your	N		68. 00
		1	00 2.00	3.00	
Inpatient Psychiatric Facility PPS				0.00	
70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it con Enter "Y" for yes or "N" for no.	ntain an IPF sub	provi der?	N		70. 00
71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teach			N N	0	71. 00
recent cost report filed on or before November 15, 2004? Enter "Y" for 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residen					
program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for	yes or "N" for	no.			
Column 3: If column 2 is Y, indicate which program year began during th (see instructions)	s cost reportin	g period.			
Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it	contain on LDE		N I		75. 00
subprovider? Enter "Y" for yes and "N" for no.			N		
76.00 If line 75 is yes: Column 1: Did the facility have an approved GME teach recent cost reporting period ending on or before November 15, 2004? Enti-				0	76. 00
no. Column 2: Did this facility train residents in a new teaching progra	am in accordance	with 42			
CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: indicate which program year began during this cost reporting period. (so		,			
	,		1.00	_	
Long Term Care Hospital PPS			1.00	J	
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" fo 81.00 Is this a LTCH co-located within another hospital for part or all of the		noriada Enta	n N		80. 00 81. 00
"Y" for yes and "N" for no.	e cost reporting	perrou: Litte	IN IN		81.00
TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? En	er "V" for ves	or "N" for no	. N		85. 00
86.00 Did this facility establish a new Other subprovider (excluded unit) und	1		86. 00		
§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 87.00 Is this hospital an extended neoplastic disease care hospital classifie	lunder section		N		87. 00
1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.				-	
		Approved fo Permanent	r Number Approv		
		Adjustment	Perman Adjustm		
		(Y/N) 1.00	2. 00		
88.00 Column 1: Is this hospital approved for a permanent adjustment to the T amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete	FRA target			0	88. 00
89. (see instructions)	cor. 2 and rine				
Column 2: Enter the number of approved permanent adjustments.	Wkst Alina	Effective Da	te Approv	hav	
	No.	Lifective ba	Perman	ent	
			Adjustr Amount		
			Di scha		
89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number	1.00	2.00	3.00		89. 00
on which the per discharge permanent adjustment approval was based.	0.0			٩	U7. UU
Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount					
per di scharge.					
Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.					
		V 1. 00	XI X 2. 00		
Title V and XIX Services		1.00	2.00	J	
90.00 Does this facility have title V and/or XIX inpatient hospital services? yes or "N" for no in the applicable column.	Enter "Y" for	N	N		90. 00
91.00 Is this hospital reimbursed for title V and/or XIX through the cost rep		N	N		91. 00
full or in part? Enter "Y" for yes or "N" for no in the applicable colu 92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certific	N		92. 00		
instructions) Enter "Y" for yes or "N" for no in the applicable column.					
93.00 Does this facility operate an ICF/IID facility for purposes of title V "Y" for yes or "N" for no in the applicable column.	N		93. 00		
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for applicable column.	no in the	N	N		94. 00
95.00 If line 94 is "Y", enter the reduction percentage in the applicable col		0.00	0.00	о	95. 00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for applicable column.	no in the	N	N		96. 00
97.00 If line 96 is "Y", enter the reduction percentage in the applicable col	ımn.	0. 00	0.00	o	97. 00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der Co	^N: 1/1_1220	Peri od:	Worksheet S	3_2
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider Co	JN: 14-1329	From 07/01/2022 To 06/30/2023	2 Part I	Prepared:
			V	XI X	3. 43 piii
			1. 00	2.00	
Does title V or XIX follow Medicare (title XVIII) for the instepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for column 1 for title V, and in column 2 for title XIX.			N	Y	98. 0
Does title V or XIX follow Medicare (title XVIII) for the report of the control of the contro				Y	98. 0
Does title V or XIX follow Medicare (title XVIII) for the cal bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or for title V, and in column 2 for title XIX.			N	Y	98. 0
Does title V or XIX follow Medicare (title XVIII) for a critical reimbursed 101% of inpatient services cost? Enter "Y" for yes for title V, and in column 2 for title XIX.	cal access he s or "N" for i	ospital (CAH) no in column	1 N	N	98. 0
Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in in column 2 for title XIX.			N	N	98. 0
P8.05 Does title V or XIX follow Medicare (title XVIII) and add bac Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in co				Y	98. 0
column 2 for title XIX. 188.06 Does title V or XIX follow Medicare (title XVIII) when cost in the Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			N	Y	98. 0
Rural Providers					
05.00 Does this hospital qualify as a CAH? 06.00 If this facility qualifies as a CAH, has it elected the all-i for outpatient services? (see instructions)	nclusive met	hod of paymen	y Y		105. 0 106. 0
07.00 Column 1: If line 105 is Y, is this facility eligible for costraining 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 yapproved medical education program in the CAH's excluded IPI Enter "Y" for yes or "N" for no in column 2. (see instruction	1. (see ins you train L&R: and/or LRF	tructions) s in an	N		107. (
08.00 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				108. 0
	Physi cal 1.00	Occupationa 2.00	Speech 3.00	Respirator 4.00	У
09.00 of this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N N	N N	Y	N N	109. 0
				1.00	_
10.00 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 Workapplicable.	" for yes or	"N" for no.	If yes,	1. 00 N	110. 0
			1. 00	2.00	
11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to col integration prong of the FCHIP demo in which this CAH is participated all that apply: "A" for Ambulance services; "B" for additional for tele-health services.	st reporting pumn 1 is Y, of ticipating in	period? Enter enter the column 2.	. N		111. C
		1. 00	2. 00	3.00	
12.00 Did 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 col "Y", enter in column 2, the date the hospital began participate demonstration. In column 3, enter the date the hospital cease participation in the demonstration, if applicable.	oorting umn 1 is ating in the	N			112. (
Miscellaneous Cost Reporting Information 15.00 s this an all-inclusive rate provider? Enter "Y" for yes or	"N" for no	N			0115. (
in column 1. If column 1 is yes, enter the method used (A, B, in column 2. If column 2 is "E", enter in column 3 either "9" for short term hospital or "98" percent for long term care (in psychiatric, rehabilitation and long term hospitals providers the definition in CMS Pub. 15-1, chapter 22, §2208. 1.	or E only) 3" percent ncludes	N			U 115. (
16.00 Is this facility classified as a referral center? Enter "Y"	for yes or	N			116. (
"N" for no.	-				
17.00 Is this facility legally-required to carry malpractice insura		Y			117. (

117. 00 118. 00

117.00 s this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.

118.00 s the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.

Health Financial Systems	MORRISON COMMUNIT				u of Form CM	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIF	CATION DATA	Provider CCN	l: 14-1329	Peri od: From 07/01/2022 To 06/30/2023	Worksheet S Part I Date/Time P	repared:
			Premi ums	Losses	11/29/2023 Insurance	3: 45 pm
					2.22	
118.01 List amounts of mal practice premiums and pa	id losses:		1. 00 247, 5	2. 00 522 0	3.00	0118.01
				1. 00	2.00	
118.02 Are mal practice premiums and paid losses re	ported in a cost ce	nter other th	nan the	1. 00 N	2.00	118. 02
Administrative and General? If yes, submit and amounts contained therein.	supporting schedul	e listing cos	st centers			110.00
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for th	e Outpatient Hold H	armless provi	sion in ACA	A N	N	119. 00 120. 00
§3121 and applicable amendments? (see instr	uctions) Enter in c	olumn 1, "Y"	for yes or			
"N" for no. Is this a rural hospital with < Hold Harmless provision in ACA §3121 and ap				-		
Enter in column 2, "Y" for yes or "N" for n 121.00 Did this facility incur and report costs fo		able dovices	charged to	Y		121. 00
patients? Enter "Y" for yes or "N" for no.			J			
122.00 Does the cost report contain healthcare rel Act?Enter "Y" for yes or "N" for no in colu	mn 1. If column 1 i					122. 00
the Worksheet A line number where these tax 123.00 Did the facility and/or its subproviders (i		ase professio	onal			123. 00
services, e.g., legal, accounting, tax prep management/consulting services, from an unr						
for yes or "N" for no.	erated organization	i? III Corumii	i, eiitei i			
If column 1 is "Y", were the majority of the professional services expenses, for service						
located in a CBSA outside of the main hospi				-		
"N" for no. Certified Transplant Center Information						
125.00 Does this facility operate a Medicare-certi			/" for yes	N		125. 00
and "N" for no. If yes, enter certification 126.00 If this is a Medicare-certified kidney tran			fication dat	:e		126. 00
in column 1 and termination date, if applic 127.00 If this is a Medicare-certified heart trans		r the certifi	cation date	2		127. 00
in column 1 and termination date, if applic 128.00 If this is a Medicare-certified liver trans		r the certifi	cation date	7		128. 00
in column 1 and termination date, if applic	able, in column 2.					
129.00 If this is a Medicare-certified lung transp in column 1 and termination date, if applic		the certific	cation date			129. 00
130.00 If this is a Medicare-certified pancreas tr	ansplant program, e		ti fi cati on			130. 00
date in column 1 and termination date, if a 131.00 If this is a Medicare-certified intestinal			erti fi cati or	n		131. 00
date in column 1 and termination date, if a 132.00 If this is a Medicare-certified islet trans			cation date	3		132. 00
in column 1 and termination date, if applic			outron dure			
133.00 Removed and reserved 134.00 If this is a hospital-based organ procureme	nt organization (OF	0), enter the	e OPO number	-		133. 00 134. 00
in column 1 and termination date, if application All Providers	able, in column 2.					
140.00 Are there any related organization or home				N		140. 00
chapter 10? Enter "Y" for yes or "N" for no are claimed, enter in column 2 the home off				6		
1.00	2. 00			3.00	6.11	
If this facility is part of a chain organize home office and enter the home office contributions.				name and address	or the	
141.00 Name: Cont 142.00 Street: PO B	ractor's Name:		Contract	or's Number:		141. 00 142. 00
143. 00 Ci ty: Stat			Zi p Code	: :		143. 00
					1.00	
144.00 Are provider based physicians' costs includ	ed in Worksheet A?				Y Y	144. 00
				1. 00	2.00	
145.00 If costs for renal services are claimed on						145. 00
inpatient services only? Enter "Y" for yes no, does the dialysis facility include Medi	care utilization fo					
period? Enter "Y" for yes or "N" for no in	col umn 2.			N		146 00
146.00 Has the cost allocation methodology changed Enter "Y" for yes or "N" for no in column 1	. (See CMS Pub. 15-			- N		146. 00
yes, enter the approval date (mm/dd/yyyy) i	n column 2.			I		I

Health Financial Systems	MORRI SON CO	MMUNITY HOSPI	I TAL			In Lie	u of Form CMS	5-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE					riod: om 07/01/2022	Worksheet S	-2 repared:	
							1, 00	
147.00 Was there a change in the statist	ical basis? Enter "Y" f	or ves or "N	" for	no.			N N	147. 00
148.00 Was there a change in the order o							N	148. 00
149.00 Was there a change to the simplif					for no).	N	149. 00
		Part		Part		Title V	Title XIX	
		1.00		2.00		3. 00	4. 00	
Does this facility contain a prov or charges? Enter "Y" for yes or							3. 13)	
155. 00 Hospi tal		N		N		N	N	155. 00
156.00 Subprovider - IPF		N		N		N	N	156. 00
157. 00 Subprovi der - I RF 158. 00 SUBPROVI DER		N		N		N	N	157. 00
158. 00 S0BPR0V1DER 159. 00 SNF		N		N		N	N	158. 00 159. 00
160.00HOME HEALTH AGENCY		N N		N N		N N	N N	160.00
161. OOICMHC		IN.		N N		N N	N N	161. 00
TOT. SOJOWITE		<u> </u>		14		10	1.00	101.00
Multicampus							1.00	
165.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that has	one or more	campu	ses in di	fferer	nt CBSAs?	N	165. 00
Entesi i isi yee si n isi iisi	Name	County		State	Zip (Code CBSA	FTE/Campus	
	0	1. 00		2.00	3. (5. 00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							0.	00 166. 00
							1.00	
Health Information Technology (HI	T) incentive in the Ame	eri can Recove	ery and	Rei nvest	ment	Act	1.00	
167.00 Is this provider a meaningful use 168.00 If this provider is a CAH (line 1	r under §1886(n)? Ente O5 is "Y") and is a mea	er "Y" for ye nningful user	s or "	N" for no			N	167. 00 168. 00
reasonable cost incurred for the 168.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)	not a meaningful user,	does this pr				hardshi p		168. 01
169.00 If this provider is a meaningful transition factor. (see instruction	user (line 167 is "Y")), enter the	0.	00169.00
	·					Begi nni ng	Endi ng	
						1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	peginning date and endi	ng date for	the re	porting				170. 00
						1. 00	2.00	
171.00 If line 167 is "Y", does this prosection 1876 Medicare cost plans "Y" for yes and "N" for no in col 1876 Medicare days in column 2.	reported on Wkst. S-3, umn 1. If column 1 is y	Pt. I, line	2, col	. 6? Ente		N		0171.00

### PROVIDED FOR THE PROVIDED TO THE PROVIDED CONTROL OF THE PROPERTY OF THE PROVIDED CONTROL OF THE PROVIDED CONTROL OF THE PROPERTY OF THE PROVIDED CONTROL OF THE PROVIDED	Heal th	Financial Systems MORRISON COMMUN	NITY HOSPITAL		In Lie	eu of Form CMS-	2552-10
PART 11 - MSPITAL AND MSPITAL HEATHCARE CONFLEX RETIREURSPERT QUESTIONNAISE General Trestruction: Patter Y for all YS responses. Enter N For all MD responses. Finter all dates in the control of the provider demand of the provider of the provider of the provider demand of the provider o				CN: 14-1329	Peri od:	Worksheet S-2	
BAST 11 - MOSPITAL AND MOSPITAL HEATMONE COMPLEX RETINUARSEMENT OVESTTONNAISE 1.00 2.00						Date/Time Pre	
PART II - MOSP TAL AND MOSP TAL METHICARE COMPLEX RELIMINESSEMENT QUESTIONNAIRE Concredit Instruction in Enter Y for all IVS responses. Enter N for all No responses. Enter all dates in the middle Veyor Enter. 1.00 New York of Control of Co					Y/N		45 pili
Someral Instruction: Enter Y for all YES responses. Enter N for all N0 responses. Enter all dates in the mandaty yeyy format. SOMELIES BY ALL TILLON AND SPERTAL ON THE CONTROL OF THE CO		DART II. HOCDITAL AND HOCDITAL HEATHCARE COMPLEY DELMBHRCE	MENT OUESTLONK	IALDE	1. 00	2. 00	
1.00 Has the provider changed covership i mediately prior to the beginning of the cost N		General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS			er all dates in t	the	
2.00 last the provider terminated participation in the Medicare Program? If 1,00 2.00 3.00 2.00 yes, enter in column 2 the date of termination and in column 3, "Y" for yes, enter in column 2 the date of termination and in column 3, "Y" for yes, enter in column 2 the date of termination and in column 3, "Y" for one of the column 2 the date of termination and in column 3, "Y" for one of the column 2 the date of termination and in column 3, "Y" for one of the column 2 the date of the column 3, 3.00 or medical supply companies) that are related to the provider or its officers, medical start, management personnel, on members of the band of directors through ownership, control, or family and other similar of directors, medical start, management personnel, on members of the band of directors through ownership, control, or family and other similar or late of directors. In the column 2 through ownership, control, or family and other similar or late of directors. In the column 3, 3.00 or directors through ownership, control, or family and other similar or late of the column 3, 3.00 or directors through ownership, control, or family and other similar or late of the column 3, 3.00 or directors and state of the column 3, 3.00 or directors and state of the column 3, 3.00 or directors and state of the column 3, 3.00 or directors and state of the column 3, 3.00 or directors and state of the column 3, 3.00 or directors and state of the column 3, 3.00 or directors and state of the column 3, 3.00 or directors and state of the column 3, 3.00 or directors and state of the column 3, 3.00 or directors and state of the column 3, 3.00 or directors and state of the column 3, 3.00 or directors and state of the column 3, 3.00 or directors and state of the column 3, 3.00 or directors and state of the column 3, 3.00 or directors and state of the column 3, 3.00 or directors and state of the column 3, 3.00 or directors and state of the column 3, 3.00 or directors and state of the column 3, 3.00 or directors and state of the column 3, 3.00 o	1. 00	Has the provider changed ownership immediately prior to the					1.00
2.00 Has the provider terminated participation in the Medicare Program? If N		reporting period? If yes, enter the date of the change in c	olumn 2. (see			V/I	
yes, enter In column 2 the date of termination and in column 3, "V" for voluntary or "1" for involuntary or "1" fo				1. 00			
contracts, with individuals or entitles (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) 4.00 [Column 1: Were the Financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Revolveds 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 N Legal Oper. 5.00 [Column 1: Are costs call and for a nursing program? Column 2: If yes, is the provider the legal operator of the program? "Y" Legal Oper. 5.00 [Column 1: Are costs call med for a nursing program? Column 2: If yes, is the provider the legal operator of the program? "Y" Legal Oper. 6.00 [Column 1: Are costs call med for a nursing program? Polumn 2: If yes, is the provider the legal operator of the program? "Y" See Instructions. N 7.00 7.00 [Are costs call med for All Ice Meal th programs approved and/or renewed during the cost cost reporting period? If yes, see instructions N 9.00 7.00 [Operation of Are costs call med for Interns and Residents in an approved graduate medical education N 9.00 7.00 [Operation of Program on Norksheet A? If yes, see instructions. N 10.00 8.00 [Operation of Program on Norksheet A? If yes, see instructions. Y 1.00 8.01 [Internation of Program on Norksheet A? If yes, see instructions. Y 1.00 8.02 [Internation of Program on Norksheet A? If yes, see instructions. N 1.00 9.03 [Internation of Program on Norksheet A? If yes, see instructions N 1.00 1.00 [Internation of Program on Norksheet A? If yes, see instructions N 1.00 1.00 [Internation of Program on Norksheet A? If yes, see instructions N 1.00 1.00 [Internation of Program on		yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	n 3, "V" for				
Financial Data and Reports Column 1: Were the Financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from N Incorporation 1.00 2.00 Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the programs? Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the programs? 7.00 Are costs claimed for Allied Health Programs? If "V" see Instructions. 8.00 Were nursing programs and/or allied health programs approved and/or renewed during the N 8.00 Were nursing programs and/or allied health programs approved and/or renewed during the N 9.00 Are costs claimed for Interns and Residents in an approved graduate medical education N 9.00 Was an approved intern and Resident fole program initiated or renewed in the current cost reporting period? If yes, see instructions. 10.00 Was an approved intern and Resident fole program initiated or renewed in the current cost reporting period? If yes, see instructions. 11.00 Are obtained the provider of cost centres scher than I & R in an Approved N 11.00 If all the provider of cost centres scher than I & R in an Approved N 11.00 If all the provider is bad debt collection policy change during this cost reporting N 13.00 If I ine 12 is yes, did the provider's bad debt collection policy change during this cost reporting N 14.00 If the column 1 or 3 is yes, enter the pald-through date of the PS&R Report used to renew the provider's records for all ocation? If the column 2 and 4. (see instructions) 17.00 Was the cost report prepared using the PS&R Report for totals and the provider's records for all ocation? If either column 1 or 3 is yes, enter the pa	3. 00	contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of directors through ownership, control, or family and other	s, with individuals or entities (e.g., chain home offices, drug all supply companies) that are related to the provider or its medical staff, management personnel, or members of the board tors through ownership, control, or family and other similar				3.00
Financial Data and Reports 4.00 Column 1: Were the financial statements prepared by a Certified Public Y A Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit compilete copy or enter data evaliable in column 3. (see instructions) If no, see instructions. Y/N Legal Oper.							
A. 00 Column 1: Were the financial statements prepared by a Certified Public Y A A A. 00 Accountant? Column 2: If yes, enter "A" for Adulted, "C" for Compiled, or "R" for Reviewed. Subalit complete copy or enter date available in column 3. (see instructions). If no, see instructions. Y/N Legal Oper.		Financial Data and Reports		1.00	2.00	3.00	
those on the filed financial statements? If yes, submit reconciliation. Y/N Legal Oper.	4.00	Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date ava	or Compiled,	Y	A		4. 00
Approved Educational Activities 1.00 2.00	5.00			N			5. 00
Approved Educational Activities Approved Educational Activities Approved Educational Activities Approved Educational Activities Approved Education N		Those on the fired financial statements: If yes, saum tired	Oner i att on.	L			
the legal operator of the program? 7.00 8.00 Were nursing programs and/or allied health programs approved and/or renewed during the costs claimed for Allied Health Programs approved and/or renewed during the cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions. 10.00		Approved Educational Activities			1.00	2.00	
Section Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	6. 00		2: If yes, is	the provider	- N		6. 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 cost reporting period? If yes, see instructions. 11.00 Are GME cost directly assigned to cost centers other than I & R in an Approved N Teaching Program on Worksheet A? If yes, see instructions. 1.00		Were nursing programs and/or allied health programs approve		ed during the			7. 00 8. 00
Cost reporting period? If yes, see instructions. A	9. 00	l ··	•	al education	N		9. 00
11.00 Are GME cost directly assigned to cost centers other than I & R in an Approved N 11.00	10. 00		r renewed in t	he current	N		10.00
Bad Debts 1.00 1.	11. 00	Are GME cost directly assigned to cost centers other than I	& R in an App	proved	N	V /N	11. 00
12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 13.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see N 14.00 If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see N 14.00 Did total beds available change from the prior cost reporting period? If yes, see instructions. N 15.00 Part A Part B Y/N Date Y/N Date 1.00 2.00 3.00 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 17.00 Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4 . (see instructions) 18.00 If line 16 or 17 is yes, were adjustments made to PS&R N Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. N 12.00 If line 16 or 17 is yes, were adjustments made to PS&R N N N N N N N N N N N N N							
13.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see N 14.00 If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see N 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions. N 15.00 Part A Part B Y/N Date Y/N Date 1.00 2.00 3.00 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions) 17.00 Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 18.00 If line 16 or 17 is yes, were adjustments made to PS&R Report used to file this cost report? If yes, see instructions. 19.00 If line 16 or 17 is yes, were adjustments made to PS&R Report N 19.00 Report data for corrections of other PS&R Report	12.00		soo instruct	Long		l v	12.00
14.00 If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see 14.00 Instructions. Bed Complement		If line 12 is yes, did the provider's bad debt collection p			ost reporting	l .	13. 00
15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions. N 15.00	14. 00	If line 12 is yes, were patient deductibles and/or coinsura instructions.	nce amounts wa	nived? If yes,	see	N	14. 00
PS&R Data PS&R Data	15. 00						15. 00
PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) 17.00 Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 18.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. 19.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report							
16.00 Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 17.00 Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 18.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. 19.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report		DSVD Data	1.00	2.00	3. 00	4. 00	
17.00 Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 18.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. 19.00 Report data for corrections of other PS&R Report 17.00 10/03/2023 Y 10/03/2023 17.00 N N N 18.00 N N 18.00	16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	N		N		16. 00
18.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. 19.00 If line 16 or 17 is yes, were adjustments made to PS&R N Report data for corrections of other PS&R Report	17. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Υ	10/03/2023	Y	10/03/2023	17. 00
19.00 If line 16 or 17 is yes, were adjustments made to PS&R N N Report data for corrections of other PS&R Report	18. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18. 00
	19. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		N		19. 00

Heal th	Financial Systems MORRISON COMMUN	NITY HOSPITAL		In Lie	u of Form CMS	-2552-10		
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider Co	CN: 14-1329	Peri od: From 07/01/2022 To 06/30/2023	Worksheet S- Part II Date/Time Pr 11/29/2023 3	epared:		
		Descri	ption	Y/N	Y/N	. 45 piii		
				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 1.00	Date 2.00	Y/N 3. 00	Date 4.00			
21. 00	Was the cost report prepared only using the provider's	N N	2.00	N N	4.00	21. 00		
	records? If yes, see instructions.							
					1. 00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	OSPI TALS)					
22. 00	Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see	instructions			N	22. 00		
23. 00	have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		als made dur	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?	Y	24. 00		
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	If yes, see	Y	25. 00		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	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 en	N	28. 00					
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	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	N	30. 00					
31. 00	<pre>instructions. Has debt been recalled before scheduled maturity without is instructions.</pre>	, see	N	31. 00				
32. 00	<u>Purchased Services</u> Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru		d through co	ntractual	Υ	32. 00		
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		g to competi	tive bidding? If	Υ	33. 00		
	Provi der-Based Physi ci ans							
34. 00	Were services furnished at the provider facility under an a lf 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			
	Home Office Costs			1. 00	2. 00			
36. 00	Home Office Costs Were home office costs claimed on the cost report?			N		36.00		
	If line 36 is yes, has a home office cost statement been pr	repared by the	home office?			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 othe see instructions.			, N		39. 00		
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	N		40. 00		
	1.00 2							
	Cost Report Preparer Contact Information							
41. 00	held by the cost report preparer in columns 1, 2, and 3,	JI LL		NELSON		41. 00		
42. 00	respectively. Enter the employer/company name of the cost report preparer.	RSM US LLP				42. 00		
43. 00	1' '	612-455-9706		JI LL. NELSON@RSI	MUS. COM	43. 00		

Health Financial Systems	MORRI SON COMMUI	NITY HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIM	BURSEMENT QUESTIONNALRE	Provider CCN:	F	Period: From 07/01/2022 Fo 06/30/2023		pared:
		3.00				
Cost Report Preparer Contact Inf	ormati on					
41.00 Enter the first name, last name	and the title/position	DI RECTOR				41.00
held by the cost report preparer	in columns 1, 2, and 3,					
respecti vel y.						
42.00 Enter the employer/company name	of the cost report					42.00
preparer.						
43.00 Enter the telephone number and 6	email address of the cost					43.00
report preparer in columns 1 and	l 2, respectively.					

| Peri od: | Worksheet S-3 | From 07/01/2022 | Part | To 06/30/2023 | Date/Time Prepared: Health Financial Systems MORRISON HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 14-1329

				1	o 06/30/2023	Date/Time Prep 11/29/2023 3:4	
						I/P Days / 0/P	+5 piii
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	Title V	
	35p3.112	Li ne No.		Avai I abl e	or any recent rious of		
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	25	9, 125	5, 088. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and						
	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					0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7.00	Total Adults and Peds. (exclude observation		25	9, 125	5, 088. 00	0	7. 00
	beds) (see instructions)						
8. 00	I NTENSI VE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		٥٦	0 10	F 000 00		13.00
14. 00	Total (see instructions)		25	9, 125	5, 088. 00	0	14. 00
15.00	CAH visits					U	15. 00
15. 10 16. 00	REH hours and visits SUBPROVIDER - IPF						15. 10 16. 00
17. 00	SUBPROVIDER - IPF						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						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 (RHC) ERIE	88. 01				0	26. 01
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 Tri ps						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	()		32. 00
32. 01	Total ancillary labor & delivery room						32. 01
00.00	outpatient days (see instructions)						00.00
33. 00	LTCH non-covered days						33. 00
33. 01	LTCH site neutral days and discharges	20.00	_	,	,		33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care	30. 00	0	(기	0	34. 00

						11/29/2023 3:	45 pm
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interne	Employees On	
	Component	I II LI E AVIII	II tie xix	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	77	19	212			1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	0	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	921	0				4.00
5. 00 6. 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF	921	0				5. 00 6. 00
7. 00	Total Adults and Peds. (exclude observation	998	19				7.00
7.00	beds) (see instructions)	770	1 7	1, 770			7.00
8.00	INTENSIVE CARE UNIT						8.00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13. 00
14.00	Total (see instructions)	998	19			153. 99	14. 00
15. 00	CAH visits	3, 638	2, 713	8, 289			15. 00
15. 10	REH hours and visits						15. 10
16. 00	SUBPROVIDER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18.00
19. 00 20. 00	SKILLED NURSING FACILITY NURSING FACILITY						19. 00 20. 00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)			0			24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC	5, 805	428	32, 367	0.00	44. 86	26. 00
26. 01	RURAL HEALTH CLINIC (RHC) ERIE	0	0	1	0.00	0. 01	26. 01
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26. 25
27. 00	Total (sum of lines 14-26)				0.00	198. 86	•
28. 00	Observation Bed Days		1	379			28. 00
29. 00	Ambul ance Tri ps	257					29. 00
30.00	Employee discount days (see instruction)			0			30.00
31. 00	Employee discount days - IRF		0	0			31.00
32. 00	Labor & delivery days (see instructions)	0	0	0			32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32. 01
33. 00	LTCH non-covered days	٥					33. 00
33. 01	LTCH site neutral days and discharges						33. 01
	Temporary Expansion COVID-19 PHE Acute Care	o	0	0			34. 00
	. 5	, -1		'	T.	'	

| Peri od: | Worksheet S-3 | From 07/01/2022 | Part | To 06/30/2023 | Date/Time Prepared: Health Financial Systems MORRISON HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 14-1329

				To	06/30/2023	Date/Time Prep 11/29/2023 3:4	
		Full Time Equivalents		Di sch	arges	111/27/2020 01	10 p
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	30	13	81	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2. 00	for the portion of LDP room available beds) HMO and other (see instructions)			0	0		2. 00
3. 00	HMO IPF Subprovider			l o	o		3. 00
4. 00	HMO IRF Subprovider				o		4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF				Ĭ		5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13.00
14. 00	Total (see instructions)	0. 00	0	30	13	81	14. 00
15. 00	CAH visits						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 19. 00	SUBPROVI DER						18. 00 19. 00
20. 00	SKILLED NURSING FACILITY NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						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 (RHC) ERIE	0.00					26. 01
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
22 00	outpatient days (see instructions)						22 00
33. 00 33. 01	LTCH non-covered days LTCH site neutral days and discharges			0			33. 00 33. 01
	Temporary Expansi on COVID-19 PHE Acute Care			١			34. 00
34.00	Tremporary Expansion Covid-19 File Acute Care				I		34.00

Heal th	Financial Systems	MORRISON COMMU	NITY HOSPITAL		In Lie	eu of Form CMS	S-2552	2-10
	AL-BASED RHC/FQHC STATISTICAL DATA		Provi der (CCN: 14-1329	Peri od:	Worksheet S	-8	
			Component	CCN: 14-3981	From 07/01/2022 To 06/30/2023			
					RHC I	Cost		РШ
	Clinic Address and Identification				1.	. 00		
1.00	Clinic Address and Identification Street				303 NORTH JACK	SON STREET	1	1. 00
1.00	511 661		C	ity	State	ZIP Code		. 00
				. 00	2. 00	3. 00		
2.00	City, State, ZIP Code, County		MORRI SON		IL	61270	2	2. 00
						1.00		
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ento	er "R" for rura	al or "U" for	urban		1.00	0 3	3. 00
	, <u>, , , , , , , , , , , , , , , , , , </u>				nt Award	Date		
	0.5.1.1.5.1				1. 00	2. 00		
4. 00	Source of Federal Funds Community Health Center (Section 330(d), PHS	Act)		T				1. 00
5.00	Mi grant Health Center (Section 329(d), PHS A							+. 00 5. 00
6.00	Health Services for the Homeless (Section 34)							5. OC
7. 00	Appalachian Regional Commission							7. 00
8. 00 9. 00	Look-Alikes OTHER (SPECIFY)						- 1	3. OC 9. OC
9.00	OTHER (SPECIFT)						9	<i>r</i> . 00
					1. 00	2.00		
10. 00	Does this facility operate as other than a house or "N" for no in column 1. If yes, indical. (Enter in subscripts of line 11 the type of hours.)	ate number of d	other operatio	ns in column	N		0 10). OC
	Tiloui S.)	Sur	nday		Monday	Tuesday		
		from	to	from	to	from		
	T	1.00	2.00	3. 00	4. 00	5. 00		
11 00	Facility hours of operations (1)	08: 00	18: 00	08: 00	18: 00	08: 00		1. 00
11.00	CETNIC	08.00	110.00	08.00	18.00	08.00	11	. 00
					1. 00	2.00		
12. 00 13. 00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colonumber of providers included in this report. In numbers below.	d in CMS Pub. 1 umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the	N N		0 13	2. OC 3. OC
				Prov	ider name	CCN		
11.00	DUO (FOLIO OON				1. 00	2. 00	14	
14.00	RHC/FQHC name, CCN	Y/N	V	XVIII	XIX	Total Visits		1. 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	5. OC
				unty				
2.00	City Ctata 71D Cata C			. 00				
2.00	City, State, ZIP Code, County	Tuesday	WHI TESI DE	nesday	Thu	rsday	1 2	2. 00
		to	from	to	from	to		
		6.00	7.00	8.00	9. 00	10.00		
	Facility hours of operations (1)							
11. 00	CLI NI C	18: 00	08: 00	18: 00	08: 00	18: 00	11	1. (

Health Financial Systems	MORRI SON COMMU	NITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 14-1329	Peri od:	Worksheet S-8	
		Component	CCN: 14-3981	From 07/01/2022 To 06/30/2023	Date/Time Pre	
		· ·			11/29/2023 3:	45 pm_
				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	18: 00		11. 00

Heal th	Financial Systems	MORRISON COMMU	NITY HOSPITAL		In Lie	eu of Form CMS	S-25	52-10
HOSPI T	AL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-1329	Peri od:	Worksheet S-	-8	
			Component	CCN: 14-8657	From 07/01/2022 To 06/30/2023			
					RHC II	11/29/2023 3 Cost		5 pm
					KHC II	LOST		
					1.	00		
1 00	Clinic Address and Identification				FOO AOTH CTREE	-		4 00
1.00	Street		Ci	ty	530 12TH STREE State	ZIP Code	+	1. 00
				00	2.00	3.00	+	
2. 00	City, State, ZIP Code, County		ERI E			61250		2. 00
						4 00	_	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ento	er "R" for rur:	al or "II" for i	ırhan		1. 00	0	3. 00
0.00	THOSE THE BROCK FRIES ONET. BOST GRACTION ENT.	CI IK TOI TUIT	01 0 101 0		nt Award	Date		0.00
					1. 00	2. 00		
4 00	Source of Federal Funds	A 13				Γ		4 00
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	Does this facility operate as other than a he	ospi tal -based I	RHC or FQHC? Er	nter "Y" for	N		0	10. 00
	yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of							
	hours.)	Sur	nday	T	 Monday	Tuesday		
		from	to	from	to	from		
		1. 00	2. 00	3. 00	4. 00	5. 00		
44 00	Facility hours of operations (1)			loo .oo	17.00	00.00		44 00
11.00	CLINIC			08: 00	17: 00	08: 00		11. 00
					1. 00	2.00		
	Have you received an approval for an exception				N			12. 00
13. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	umn 1. If yes,	enter in colum	nn 2 the	N		0	13. 00
	numbers below.			Prov	ider name	CCN		
				FIOV	1. 00	2. 00	+	
14. 00	RHC/FQHC name, CCN							14. 00
		Y/N	V	XVIII	XIX	Total Visits	3	
1E 00	Have you provided all or substantially all	1.00	2.00	3.00	4. 00	5. 00	-	15. 00
13.00	GME cost? Enter "Y" for yes or "N" for no in							15.00
	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)						\perp	
				inty				
2.00	City, State, ZIP Code, County		WHITESIDE COUN	00				2.00
2.00	Colly, State, ZIP Code, County	Tuesday		esday	Thur	sday		2. 00
		to	from	to	from	to		
		6. 00	7. 00	8. 00	9. 00	10.00		
44.00	Facility hours of operations (1)	17.00	loo 00	47.00	00.00	47.00		44.00
11.00	CLI NI C	17: 00	08: 00	17: 00	08: 00	17: 00		11. 00

Health Financial Systems	MORRI SON COMMUN	NITY HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-1329	Peri od:	Worksheet S-8	
				From 07/01/2022		
		Component	CCN: 14-8657	To 06/30/2023	Date/Time Pre	
					11/29/2023 3:	45 pm_
				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	08: 00	17: 00				11. 00

SPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA Pr	rovider CC	N: 14-1329	Peri od:	Worksheet S-10	0
				From 07/01/2022 To 06/30/2023	Date/Time Pre	naro
				10 00/30/2023	11/29/2023 3:	
					1. 00	
	Uncompensated and indigent care cost computation					
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	ded by lir	ne 202 column	8)	0. 513552	1.
00	Medicaid (see instructions for each line) Net revenue from Medicaid				9, 524, 783	2.
00	Did you receive DSH or supplemental payments from Medicaid?				9, 524, 765 Y	3
00	If line 3 is yes, does line 2 include all DSH and/or supplemental	al payments	from Medica	i d?	Ϋ́	4.
00	If line 4 is no, then enter DSH and/or supplemental payments from				0	5.
00	Medicaid charges				14, 728, 684	6.
00	Medicaid cost (line 1 times line 6)				7, 563, 945	
00	Difference between net revenue and costs for Medicaid program (li < zero then enter zero)	ine / minu	is sum of lir	es 2 and 5; If	0	8.
	Children's Health Insurance Program (CHIP) (see instructions for	each Line	.)			
00	Net revenue from stand-alone CHIP	0.0.011 11110	<i>,</i>		0	9
00	Stand-alone CHIP charges				0	10
. 00	Stand-alone CHIP cost (line 1 times line 10)				0	11
. 00	Difference between net revenue and costs for stand-alone CHIP (li	ine 11 mir	nus line 9; i	f < zero then	0	12
	enter zero) Other state or local government indigent care program (see instru	ructions fo	r oach line)			
00	Net revenue from state or local indigent care program (Not included in the inc				0	13
00	Charges for patients covered under state or local indigent care p				0	
	10)					
00	State or local indigent care program cost (line 1 times line 14)				0	
. 00	Difference between net revenue and costs for state or local indig	gent care	program (lir	e 15 minus line	0	16
. 00	13; if < zero then enter zero)					16
. 00						16
. 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to func	and state	ty care		ns (see	17
. 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to func Government grants, appropriations or transfers for support of hos	and state	ty care	ent care program	os (see 0 11, 938	17. 18.
. 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to func Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i	and state	ty care	ent care program	os (see 0 11, 938	17. 18.
. 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to func Government grants, appropriations or transfers for support of hos	and state	ty care	ent care program	os (see 0 11, 938	16. 17. 18. 19.
. 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to func Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i	and state	ty care erations eare programs Uninsured patients	ent care program (sum of lines Insured patients	0 11,938 0 Total (col. 1 + col. 2)	17. 18.
00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16)	and state	ty care erations care programs Uninsured	ent care program (sum of lines	0 11,938 0 Total (col. 1	17 18
00 00 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line)	and state	ty care erations care programs Uninsured patients 1.00	ent care program (sum of lines Insured patients 2.00	0 11,938 0 Total (col. 1 + col. 2) 3.00	17 18 19
00 00 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to func Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil	and state	ty care erations eare programs Uninsured patients	ent care program (sum of lines Insured patients 2.00	0 11,938 0 Total (col. 1 + col. 2) 3.00	17 18 19
00 00 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line)	P and state adding chari spital ope indigent c	ty care erations care programs Uninsured patients 1.00	ent care program (sum of lines Insured patients 2.00	Total (col. 1 + col. 2) 3.00	17 18 19
00 00 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local image is a serious for the entered cost for Medicaid image. Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discountinstructions)	P and state adding chari pspital ope indigent c	ty care erations care programs Uninsured patients 1.00	ent care program (sum of lines Insured patients 2.00 12,404	Total (col. 1 + col. 2) 3.00	177 18 19 20 21
00 00 00 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local image and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discountinstructions) Payments received from patients for amounts previously written of	P and state adding chari pspital ope indigent c	ty care erations care programs Uninsured patients 1.00	ent care program (sum of lines Insured patients 2.00 12,404	Total (col. 1 + col. 2) 3.00	177 18 19 20 21
00 00 00 00 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local image and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care	P and state adding chari pspital ope indigent c	ty care trations care programs Uninsured patients 1.00 5,02 2,58	ent care program (sum of lines Insured patients 2.00 12,404 12,404 1,550	Total (col. 1 + col. 2) 3.00 17,432 14,986 2,088	17 18 19 20 21 22
00 00 00 00 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local image and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care	P and state adding chari pspital ope indigent c	ty care erations care programs Uninsured patients 1.00 5,02	ent care program (sum of lines Insured patients 2.00 12,404 12,404 1,550	Total (col. 1 + col. 2) 3.00 17,432 14,986 2,088	17 18 19 20 21 22
00 00 00 00 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local image and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care	P and state adding chari pspital ope indigent c	ty care trations care programs Uninsured patients 1.00 5,02 2,58	ent care program (sum of lines Insured patients 2.00 12,404 12,404 1,550	Total (col. 1 + col. 2) 3.00 17,432 14,986 2,088	17 18 19 20 21 22
00 00 00 00 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to func Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discountinstructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient	P and state adding chari- pspital ope indigent control lity ats (see off as	ty care erations care programs Uninsured patients 1.00 5,02 2,58 53	Insured patients 2.00 12,404 12,404 1,550 10,854	Total (col. 1 + col. 2) 3.00 17, 432 14, 986 2, 088 12, 898	17 18 19 20 21 22
00 00 00 00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local image is a series of the series of	P and state I and state I and state I and state I i ty I	ty care trations care programs Uninsured patients 1.00 5,02 2,58 53 2,04	ent care program (sum of lines Insured patients 2.00 12,404 12,404 13,550 14,0854	Total (col. 1 + col. 2) 3.00 17,432 14,986 2,088 12,898	20 21 22 23
00 00 00 00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local image image is a support of the	P and state I and state I and state I and state I i ty I	ty care trations care programs Uninsured patients 1.00 5,02 2,58 53 2,04	ent care program (sum of lines Insured patients 2.00 12,404 12,404 13,550 14,0854	Total (col. 1 + col. 2) 3.00 17, 432 14, 986 2, 088 12, 898	20 21 22 23
00 00 00 00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local image is a series of the series of	P and state adding chari spital ope indigent c lity ats (see off as	ty care trations care programs Uninsured patients 1.00 5,02 2,58 53 2,04	ent care program (sum of lines Insured patients 2.00 12,404 12,404 13,550 14,0854	Total (col. 1 + col. 2) 3.00 17,432 14,986 2,088 12,898	20 21 22 23 24 25
000000000000000000000000000000000000000	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care provided in the stay limit.	P and state adding chari- pspital ope- indigent of lity ats (see off as c days beyon orogram? e indigent cructions)	ty care erations care programs Uninsured patients 1.00 5,02 2,58 2,04 and a length care program	ent care program (sum of lines Insured patients 2.00 12,404 12,404 13,550 14,0854	11, 938 0 11, 938 0 Total (col. 1 + col. 2) 3.00 17, 432 14, 986 2, 088 12, 898 1.00 N 0 2, 115, 001 108, 678	20 21 22 23 24 25 26 27
00 00 00 00 00 00 00 00 00 00 01	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local image and the state and local image and local image and the state and local image and local ima	P and state adding chari aspital ope indigent of lity ats (see aff as adding chari aspital ope indigent of adding chari aspital ope indigent of adding chari aspital ope indigent aructions) (see instr	ty care erations are programs Uninsured patients 1.00 5,02 2,58 2,04 and a length care program	ent care program (sum of lines Insured patients 2.00 12,404 12,404 13,550 14,0854	Total (col. 1 + col. 2) 3.00 17, 432 14, 986 2, 088 12, 898 1.00 N 0 2, 115, 001 108, 678 167, 197	20 21 22 23 24 25 26 27 27
.000	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local image and the state and local image and local image and the state and local image a	P and state Iding chari Indigent control Iity Its (see off as	ty care erations care programs Uninsured patients 1.00 5,02 2,58 2,04 and a length care program cuctions)	ent care program (sum of lines Insured patients 2.00 12,404 12,404 1,550 14,10,854 of stay limit 's length of	11, 938 0 11, 938 0 Total (col. 1 + col. 2) 3.00 17, 432 14, 986 2, 088 12, 898 1.00 N 0 2, 115, 001 108, 678 167, 197 1, 947, 804	20 21 22 23 24 25 26 27 27 28
. 00 . 00 . 00 . 00 . 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local image and the state and local image and local image and the state and local image and local ima	P and state Iding chari Indigent control Iity Its (see off as	ty care erations care programs Uninsured patients 1.00 5,02 2,58 2,04 and a length care program cuctions)	ent care program (sum of lines Insured patients 2.00 12,404 12,404 1,550 14,10,854 of stay limit 's length of	Total (col. 1 + col. 2) 3.00 17, 432 14, 986 2, 088 12, 898 1.00 N 0 2, 115, 001 108, 678 167, 197	20 21 22 23 24 25 26 27 27 28 29

Health Financial Systems	MORRISON COMMUNITY HOSPITAL			In Lieu of Form CMS-2552-10			
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provider CO		Peri od:	Worksheet A		
				rom 07/01/2022	Doto/Time Dro	aanad.	
				To 06/30/2023	Date/Time Prep 11/29/2023 3:4		
Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati	Reclassi fi ed	TO PIII	
odst denter beserretten	our ur res	Other	+ col . 2)	ons (See A-6)	Trial Balance		
			' ' ' ' ' ' ' '	(()	(col. 3 +-		
					col . 4)		
	1.00	2.00	3. 00	4. 00	5. 00		
GENERAL SERVICE COST CENTERS							
1.00 00100 CAP REL COSTS-BLDG & FLXT		2, 321, 903	2, 321, 903	64, 550	2, 386, 453	1.00	
2.00 O0200 CAP REL COSTS-MVBLE EQUIP		446, 711	446, 711	653, 283	1, 099, 994	2.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	5, 235, 190	5, 235, 190	-1, 203, 318	4, 031, 872	4.00	
5.01 00560 PURCHASING RECEIVING AND STORES	95, 093	-25, 864			69, 229	5. 01	
5. 02 00591 PERSONNEL	83, 767	17, 646			101, 413	5. 02	
5. 03 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	747, 372	199, 759			947, 131	5. 03	
5. 05 00590 ADMINISTRATIVE & GENERAL	889, 527	793, 244				5. 05	
7.00 O0700 OPERATION OF PLANT	175, 344	481, 874				7. 00	
8.00 00800 LAUNDRY & LINEN SERVICE	0	67, 854			67, 854	8. 00	
9. 00 00900 HOUSEKEEPI NG	199, 359	31, 709			231, 068	9. 00	
10. 00 01000 DI ETARY	269, 042	92, 808	1			10. 00	
11. 00 01100 CAFETERI A	0	0	(-	0	11. 00	
13. 00 O1300 NURSING ADMINISTRATION	241, 345	37, 881	279, 226			13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY	90, 267	156, 010			246, 277	14. 00	
16.00 01600 MEDICAL RECORDS & LIBRARY	430, 366	203, 621			633, 987	16. 00	
17. 00 01700 SOCI AL SERVI CE	60, 636	1, 769			62, 405	17. 00	
19. 00 01900 NONPHYSICIAN ANESTHETISTS	772, 884	40, 101	812, 985	5 0	812, 985	19. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1 (11 100	1 010 051			0.710.100		
30. 00 03000 ADULTS & PEDI ATRI CS	1, 644, 130	1, 042, 851	2, 686, 981	23, 201	2, 710, 182	30. 00	
ANCILLARY SERVICE COST CENTERS	1 204 200	4 450 407	0.045.005	-1	0.045.404	F0 00	
50. 00 05000 OPERATI NG ROOM	1, 394, 899	1, 450, 436				50.00	
53. 00 05300 ANESTHESI OLOGY	0	65, 904				53.00	
54. 00 05400 RADI OLOGY - DI AGNOSTI C	711, 344	612, 981	1, 324, 325			54.00	
60. 00 06000 LABORATORY	496, 911	1, 527, 976				60.00	
64. 00 06400 I NTRAVENOUS THERAPY	0	122, 763				64. 00	
65. 00 06500 RESPIRATORY THERAPY	64, 718	113, 339				65. 00	
66. 00 06600 PHYSI CAL THERAPY	306, 108	32, 424			338, 532	66.00	
67. 00 06700 OCCUPATI ONAL THERAPY	155, 398	681	156, 079		156, 079	67.00	
68. 00 06800 SPEECH PATHOLOGY	1 104	4, 000			4, 000	68. 00	
69. 00 06900 ELECTROCARDI OLOGY	1, 106	32, 819			33, 925	69. 00 71. 00	
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS	0	240, 900			344, 046 3, 293, 644	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS		3, 293, 644				72.00	
75. 00 07300 DRUGS CHARGED TO PATTENTS 76. 00 03950 NEUROLOGY	205, 082 11, 410	1, 181, 402 92, 521	1, 386, 484 103, 931		1, 386, 646 103, 931	76. 00	
77. 00 07700 ALLOGENEI C HSCT ACQUISITION	11,410	92, 521	1		103, 931	78. 00 77. 00	
OUTPATIENT SERVICE COST CENTERS	J O	0		<u>) </u>	0	77.00	
88. 00 08800 RURAL HEALTH CLINIC	7, 484, 153	1, 516, 454	9, 000, 607	387, 181	9, 387, 788	88. 00	
88. 01 08801 RURAL HEALTH CLINIC (RHC) ERIE	7, 404, 133	1, 310, 434				88. 01	
91. 00 09100 EMERGENCY	796, 796	2, 334, 274				91. 00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	770,770	2, 334, 214	3, 131, 070	00, 737	3, 044, 131	92. 00	
93. 00 04950 WOUND CARE	71, 051	1, 485	72, 536	0	72, 536	93. 00	
OTHER REI MBURSABLE COST CENTERS	71,001	1, 100	12,000	J	72,000	70.00	
95. 00 09500 AMBULANCE SERVI CES	120, 832	81, 076	201, 908	-9, 747	192, 161	95. 00	
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0				102. 00	
SPECIAL PURPOSE COST CENTERS							
113. 00 11300 NTEREST EXPENSE		638, 617	638, 617	-638, 617	0	113. 00	
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	17, 518, 940	24, 489, 840					
NONREI MBURSABLE COST CENTERS	, , , , , , ,	.,,					
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	(0	0	190. 00	
194. 00 07950 DI XON CLINI C		0		59, 280			
194. 01 07951 RENTAL SPACE		0		0		194. 01	
194.02 07952 OTHER NON-REIMBURSABLE COST CENTERS		0		35, 063	35, 063	194. 02	
194.03 07953 MORRISON ORTHOPEDIC CLINIC		1, 340	1, 340	339, 437	340, 777	194. 03	
194. 04 07954 CLINTON CLINIC	J 0	0	(280, 345	280, 345	194. 04	
200.00 TOTAL (SUM OF LINES 118 through 199)	17, 518, 940	24, 491, 180	42, 010, 120				
	·			•	•		

Peri od: Worksheet A From 07/01/2022 To 06/30/2023 Date/Time Prepared:

					10 00/ 30/ 2023	11/29/2023 3:	
	Cost Center Description	Adjustments	Net Expenses				
	·	(See A-8)	For Allocation	1			
		6. 00	7. 00				
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	-7, 891	2, 378, 562	1			1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0	1, 099, 994	·			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-637, 899	3, 393, 973	3			4. 00
5. 01	00560 PURCHASING RECEIVING AND STORES	0	69, 229)			5. 01
5.02	00591 PERSONNEL	0	101, 413	3			5. 02
5.03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	-67, 971	879, 160)			5. 03
5.05	00590 ADMINISTRATIVE & GENERAL	-15, 051	1, 672, 872				5. 05
7.00	00700 OPERATION OF PLANT	0	657, 218	3			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	67, 854	·			8. 00
9.00	00900 HOUSEKEEPI NG	0	231, 068	3			9. 00
10.00	01000 DI ETARY	-67, 148	294, 702	2			10.00
11. 00	01100 CAFETERI A	0	0)			11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	280, 750)			13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	246, 277	'			14. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	-3, 701	630, 286	b			16. 00
17. 00	01700 SOCIAL SERVICE	0	62, 405	5			17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	-812, 985	0				19. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	-676, 450	2, 033, 732	2			30.00
	ANCILLARY SERVICE COST CENTERS	,					
50. 00	05000 OPERATING ROOM	-31, 920		1			50.00
53. 00	05300 ANESTHESI OLOGY	0	68, 750	1			53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-52, 775		1			54. 00
60. 00	06000 LABORATORY	-12, 350	2, 012, 702	1			60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	184, 039	1			64. 00
65. 00	06500 RESPI RATORY THERAPY	0	77, 302				65. 00
66. 00	06600 PHYSI CAL THERAPY	-6, 500	332, 032	1			66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	156, 079	1			67. 00
68. 00	06800 SPEECH PATHOLOGY	0	4, 000	1			68. 00
69. 00	06900 ELECTROCARDI OLOGY	-23, 747	10, 178	1			69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	344, 046	1			71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	3, 293, 644	1			72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	-95, 478		1			73. 00
76. 00	03950 NEUROLOGY	-85, 725	18, 206				76. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0)			77. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	9, 387, 788	1			88. 00
88. 01	08801 RURAL HEALTH CLINIC (RHC) ERIE	0	1, 539	1			88. 01
91. 00	09100 EMERGENCY	-510, 276	2, 533, 855				91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	_					92. 00
93. 00	04950 WOUND CARE	0	72, 536				93. 00
	OTHER REIMBURSABLE COST CENTERS		404 7/4				
95. 00	09500 AMBULANCE SERVICES	-400	191, 761	1			95.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0)			102. 00
112 00	SPECIAL PURPOSE COST CENTERS		0	<u></u>			112 00
118.00	11300 INTEREST EXPENSE	2 109 247	0	1			113.00
110.00		-3, 108, 267	38, 186, 388	PI			118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0				190. 00
	07950 DIXON CLINIC	0	59, 280	1			194. 00
	07951 RENTAL SPACE	0	39, 200	1			194. 00
	07951 RENTAL SPACE 07952 OTHER NON-REIMBURSABLE COST CENTERS	0	35, 063	1			194. 01
	07952 OTHER NON-REI MBURSABLE COST CENTERS	0	340, 777				194. 02
	107954 CLINTON CLINIC	0	280, 345	1			194. 03
200.00		-3, 108, 267					200.00
200.00	TOTAL (SOM OF LINES THE UNIONS 199)	3, 100, 207	30, 701, 000	1			1200.00

					10	1/29/2023 3:45 pm
		Increases			<u> </u>	
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4.00	5. 00		
	INTEREST	1, 00	ما	(02.250		1.0
	REL COSTS-BLDG & FIXT	5. 05	0	602, 258 4, 523		1. 0
	SING ADMINISTRATION	13. 00	0	1, 524		3. 0
	RATING ROOM	50.00	0	1, 524		4. 0
•	STHESI OLOGY	53. 00	0	2, 846		5. 0
	I OLOGY-DI AGNOSTI C	54. 00	0	22, 234		6. 0
	ORATORY	60.00	0	165		7. 0
	PIRATORY THERAPY	65.00	0	772		8.0
	IGS CHARGED TO PATIENTS	73.00	0	162		9. 0
	AL HEALTH CLINIC	88. 00	Ö	2, 668		10.0
	RGENCY	91.00	Ö	1, 396		11. 0
0		— — /11. 00	 	638, 617		11.0
В -	INSURANCE	<u></u>		222, 211		
	REL COSTS-BLDG & FLXT	1.00	0	97, 413		1. 0
2.00 CAP	REL COSTS-MVBLE EQUIP	2.00	o	18, 162		2. 0
3.00 ADM	IINISTRATIVE & GENERAL	5. 05	О	68, 912		3. 0
4.00		0.00	O	0		4. 0
0				184, 487		
	DEPRECIATION					
1.00 CAP	REL COSTS-MVBLE EQUIP		0	63 <u>5, 1</u> 21		1.0
0			0	635, 121		
	MEDICAL SUPPLIES					
	I CAL SUPPLIES CHARGED TO	71. 00	0	103, 146		1.0
	TENT	0.00				2.0
2.00		0.00	0	0		2.0
3.00				103, 146		3. 0
- E	IV THERAPY SALARIES		U	103, 140		
	RAVENOUS THERAPY	64. 00	61, 276	0		1.0
0		— — "" +	61, 276	0		
G -	RHC PROVIDER BENEFITS	<u> </u>	5.7 = . 5	-1		
	AL HEALTH CLINIC	88.00	0	1, 103, 373		1.0
0				1, 103, 373		
H -	DIXON CLINIC					
1.00 DIX	ON CLINIC	194. 00	45, 641	13, 639		1. 0
2. 00			0	0		2. 0
0			45, 641	13, 639		
	MARKETING					
	ER NON-REIMBURSABLE COST	194. 02	0	35, 063		1. 0
CEN	ITERS	+				
0	DAVENDODE OPTHODEDLO CLIM	1.0	0	35, 063		
	DAVENPORT ORTHOPEDIC CLIN	194. 03	294, 434	45, 003		1.0
2. 00	RISON ORTHOPEDIC CLINIC	0.00	294, 434	45, 003		2.0
2.00	$\cdot +$			45, 003		2.0
K -	CLINTON CLINIC		274, 434	43, 003		
	NTON CLINIC	194. 04	239, 042	41, 303		1.0
2. 00		0.00	0	0		2. 0
	ALS		239, 042	41, 303		
L -	SALARY RECLASS					
1.00 ADU	LTS & PEDIATRICS	30.00	25, 577	7, 643		1. 0
ТОТ	ALS		25, 577	7, 643		
	ERIE CLINIC RECLASS					
	AL HEALTH CLINIC (RHC)	88. 01	462	0		1. 0
ERI						
	ALS		462	0		
500.00 Gra	nd Total: Increases		666, 432	2, 807, 395		500. 0

Health Financial Systems RECLASSIFICATIONS Peri od: From 07/01/2022 To 06/30/2023 Date/Ti me Prepared: 11/29/2023 3:45 pm Provider CCN: 14-1329

						11/29/2023 3:	45 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7.00	8. 00	9. 00	10.00		
	A - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	638, 617	11		1. 00
2.00		0.00	o	0	ol		2. 00
3.00		0.00	o	0	o		3. 00
4.00		0.00	0	0			4. 00
5. 00		0.00	o	0	0		5. 00
6. 00		0.00	o	0	0		6. 00
7. 00		0.00	0	0			7. 00
8.00		0.00	0	0	0		8. 00
9.00	1	0.00	0	0	0	-	9. 00
			-1	0			
10.00		0.00	0	0	0		10.00
11. 00	<u> </u>	0.00		0	0		11. 00
	0		0	638, 617			
	B - I NSURANCE						
1. 00	ADULTS & PEDIATRICS	30.00	0	9, 179			1. 00
2.00	RURAL HEALTH CLINIC	88. 00	0	139, 281	12		2. 00
3.00	EMERGENCY	91.00	0	26, 280	0		3. 00
4.00	AMBULANCE SERVICES	95.00	0	9, 747	0		4. 00
	0	T		184, 487			
	C - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	635, 121	9		1.00
			₀	635, 121			
	D - MEDICAL SUPPLIES		-				
1.00	ADULTS & PEDIATRICS	30.00	0	840	0		1. 00
2. 00	RESPIRATORY THERAPY	65. 00	0	101, 527	0		2. 00
3.00	EMERGENCY	91. 00	o	779			3. 00
3.00	O	— - 71. 00	— — — —				3.00
	F - IV THERAPY SALARIES		U U	103, 140			
1.00	EMERGENCY	01 00	(1.27/		0		1. 00
1.00	EMERGENCY	<u>91.</u> 00	6 <u>1, 2</u> 76	0			1.00
	0		61, 276	0			
	G - RHC PROVIDER BENEFITS		_1				
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	<u>1, 103, 3</u> 73			1. 00
	0		0	1, 103, 373			
	H - DIXON CLINIC						
1. 00	RURAL HEALTH CLINIC	88. 00	45, 641	0			1. 00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1 <u>3, 6</u> 39	0		2. 00
	0		45, 641	13, 639			
	I - MARKETING						
1.00	ADMINISTRATIVE & GENERAL	5. 05	0	35, 063	0		1. 00
		T	₀	35, 063			
	J - DAVENPORT ORTHOPEDIC CLIN	II C					ĺ
1.00	RURAL HEALTH CLINIC	88. 00	294, 434	0	0		1. 00
2. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45, 003			2. 00
2.00	0	— — °†	294, 434	45, 003			2.00
	K - CLINTON CLINIC		274, 434	43, 003			
1.00	RURAL HEALTH CLINIC	88.00	239, 042	0	0		1. 00
2. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	239, 042	41, 303			2.00
2.00	TOTALS						2.00
			239, 042	41, 303			
	L - SALARY RECLASS						
1. 00	ADMINISTRATIVE & GENERAL		2 <u>5, 5</u> 77	<u>7, 6</u> 43			1. 00
	TOTALS		25, 577	7, 643			
	M - ERIE CLINIC RECLASS						
1.00	RURAL HEALTH CLINIC		<u>4</u> 62	0	0		1. 00
	TOTALS		462	0			
500.00	Grand Total: Decreases		666, 432	2, 807, 395			500.00
			- 1		. '		•

				To	06/30/2023	Date/Time Prep 11/29/2023 3:4	oared: 45 pm
				Acqui si ti ons			
		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						
1.00	Land	230, 584	184, 334		184, 334		1.00
2.00	Land Improvements	2, 664, 334	162, 879		162, 879	0	2.00
3.00	Buildings and Fixtures	30, 431, 717	244, 691		244, 691	0	3.00
4.00	Building Improvements	458, 729	2, 509, 267	0	2, 509, 267	0	4.00
5.00	Fixed Equipment	2, 709, 623	0	0	0	398, 223	5.00
6.00	Movable Equipment	8, 301, 922	2, 214, 153	0	2, 214, 153	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	44, 796, 909	5, 315, 324	0	5, 315, 324	398, 223	8.00
9.00	Reconciling Items	458, 729	2, 509, 267	0	2, 509, 267	0	9.00
10.00	Total (line 8 minus line 9)	44, 338, 180	2, 806, 057	0	2, 806, 057	398, 223	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	414, 918	0				1.00
2.00	Land Improvements	2, 827, 213	0				2.00
3.00	Buildings and Fixtures	30, 676, 408	0				3.00
4.00	Building Improvements	2, 967, 996	0				4.00
5.00	Fixed Equipment	2, 311, 400	0				5.00
6.00	Movable Equipment	10, 516, 075	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	49, 714, 010	0				8.00
9.00	Reconciling Items	2, 967, 996	0				9.00
10.00	Total (line 8 minus line 9)	46, 746, 014	0				10.00

Heal th	Financial Systems	MORRI SON COMMUN	NITY HOSPITAL		In Lieu of Form CMS-2552		
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 14-1329	Peri od:	Worksheet A-7	
					From 07/01/2022		
					To 06/30/2023		
						11/29/2023 3: 4	45 pm
			SL	JMMARY OF CAP	'I I AL		
				ı			
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	,	
					instructions)	instructions)	
		9. 00	10.00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	2, 321, 903	0		0 0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	446, 711	0		0 0	0	2. 00
3.00	Total (sum of lines 1-2)	2, 768, 614	0		0 0	0	3. 00
		SUMMARY 0	F CAPITAL		<u> </u>		
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	2, 321, 903				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	446, 711				2. 00
3.00	Total (sum of lines 1-2)	0	2, 768, 614	•			3. 00
		-	,	1			

Health Financial Systems	MORRI SON COMMU	NITY HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 07/01/2022 To 06/30/2023	Worksheet A-7 Part III Date/Time Pre 11/29/2023 3:4	pared:
	COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
		Leases	for Ratio	instructions)		
			(col . 1 - col 2)			
	1.00	2.00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00 CAP REL COSTS-BLDG & FLXT	39, 197, 935		39, 197, 93		0	1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	10, 516, 075				0	2. 00
3.00 Total (sum of lines 1-2)	49, 714, 010		49, 714, 01			3. 00
	ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY C	OF CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Relate				
		d Costs	through 7)			
DART III DECONOLILIATION OF CARLTAL COCTO	6. 00	7. 00	8. 00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS		1	0 1, 686, 782	0	1. 00
2.00 CAP REL COSTS-BLDG & FIXT				0 1, 081, 832		2.00
3.00 Total (sum of lines 1-2)				0 2, 768, 614	0	3.00
3.00 Total (Suil of Titles 1-2)		SI	JMMARY OF CAPI		0	3.00
		50	JIMINATE OF CALL	IAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see	through 14)	
				instructions)		
DADT III DECONCILIATION OF CARLTAL COSTS O	11. 00	12.00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C	594, 367	97, 413		0 0	2, 378, 562	1. 00
2.00 CAP REL COSTS-BLDG & FIXT	594, 367	18, 162		0 0	1, 099, 994	2.00
3.00 Total (sum of lines 1-2)	594, 367			0 0		
3. 00 10tal (3uiii 01 1111e3 1-2)	374,307	113,575	ı	0	J 3, 470, 550	J. 00

					From 07/01/2022 Fo 06/30/2023		
				Expense Classification on	Worksheet A	11/29/2023 3: 4	45 pm
				To/From Which the Amount is			
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1. 00 B	2. 00 -7. 891	3.00 CAP REL COSTS-BLDG & FLXT	4. 00	5. 00 11	1. 00
	COSTS-BLDG & FIXT (chapter 2)						
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		Ü	CAP REL COSTS-MVBLE EQUIP	2.00	0	2. 00
3. 00	Investment income - other (chapter 2)		0		0.00	0	3. 00
4. 00	Trade, quantity, and time		0		0.00	0	4. 00
5. 00	di scounts (chapter 8) Refunds and rebates of		0		0.00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6. 00
	suppliers (chapter 8)		0				
7. 00	Telephone services (pay stations excluded) (chapter 21)	A	-2, 049	ADMINISTRATIVE & GENERAL	5. 05	0	7. 00
8. 00	Television and radio service (chapter 21)		0		0.00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -1, 380, 868		0.00	0	
11. 00	adjustment Sale of scrap, waste, etc.	A-0-2	-1, 300, 000		0. 00		
12. 00	(chapter 23) Related organization	A-8-1	0			0	12. 00
	transactions (chapter 10)	A-0-1	0				
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	В В	0 -65, 301	DI ETARY	0.00		
15. 00	Rental of quarters to employee		0		0.00	1	15. 00
16. 00	and others Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
17. 00	patients Sale of drugs to other than patients		0		0. 00	O	17. 00
18. 00	Sale of medical records and	В	-3, 701	MEDICAL RECORDS & LIBRARY	16. 00	О	18. 00
19. 00	abstracts Nursing and allied health education (tuition, fees,		0		0. 00	0	19. 00
20. 00	books, etc.) Vending machines		0		0.00	0	20. 00
21. 00	Income from imposition of		0		0.00		21. 00
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0. 00	o	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	therapy costs in excess of						
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSICAL 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 COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27. 00
28. 00	Non-physician Anesthetist	А	-812, 985	NONPHYSICIAN ANESTHETISTS	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	0. 00 67. 00	1	29. 00 30. 00
	therapy costs in excess of						
30. 99	limitation (chapter 14) Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of limitation (chapter 14)						
32. 00	CAH HIT Adjustment for Depreciation and Interest	А	0	CAP REL COSTS-MVBLE EQUIP	2.00	9	32. 00
33. 00	CATERI NG REVENUE	В	-1, 847	DI ETARY	10.00	0	33. 00

Health Financial Systems	MORRISON COMMUNITY HOSPITAL	In Lie	In Lieu of Form CMS-2552-10		
ADJUSTMENTS TO EXPENSES	Provi der CCN:	: 14-1329 Peri od: From 07/01/2022	Worksheet A-8		
		To 06/30/2023	Date/Time Prepared: 11/29/2023 3:45 pm		
		ification on Worksheet A ne Amount is to be Adjusted			

Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted To/From Which the Amount is to be Adjusted							11/29/2023 3:	45 pm
Cost Center Description					Expense Classification on	Worksheet A		
1.00 2.00 3.00 4.00 5.00 3.01 3.01 LAB OTHER REVENUE B -12, 350 LABORATORY 60.00 0 33.01 33.02 REHAB MI SC REV B -6, 500 PHYSI CAL THERAPY 66.00 0 33.02 33.03 0THER REV-A&G B -240 ADMI NI STRATI VE & GENERAL 5.05 0 33.03 33.04 NONALLOWABLE DUES B -6, 707 ADMI NI STRATI VE & GENERAL 5.05 0 33.04 33.05 PATI ENT TELEPHONE - SALARI ES A -2, 586 ADMI NI STRATI VE & GENERAL 5.05 0 33.05 33.06 PATI ENT TELEPHONE - BENEFITS A -779 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 33.06 33.07 20.00 20.					To/From Which the Amount is	to be Adjusted		
1.00 2.00 3.00 4.00 5.00								
1.00 2.00 3.00 4.00 5.00								
1.00 2.00 3.00 4.00 5.00 3.01 3.01 LAB OTHER REVENUE B -12, 350 LABORATORY 60.00 0 33.01 33.02 REHAB MI SC REV B -6, 500 PHYSI CAL THERAPY 66.00 0 33.02 33.03 0THER REV-A&G B -240 ADMI NI STRATI VE & GENERAL 5.05 0 33.03 33.04 NONALLOWABLE DUES B -6, 707 ADMI NI STRATI VE & GENERAL 5.05 0 33.04 33.05 PATI ENT TELEPHONE - SALARI ES A -2, 586 ADMI NI STRATI VE & GENERAL 5.05 0 33.05 33.06 PATI ENT TELEPHONE - BENEFITS A -779 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 33.06 33.07 20.00 20.								
1.00 2.00 3.00 4.00 5.00								
33. 01 LAB OTHER REVENUE B -12, 350 LABORATORY 60. 00 0 33. 01 33. 02 REHAB MI SC REV B -6, 500 PHYSI CAL THERAPY 66. 00 0 33. 02 33. 03 OTHER REV-A&G B -6, 500 PHYSI CAL THERAPY 66. 00 0 33. 02 33. 04 NONALLOWABLE DUES B -6, 707 ADMIN IN STRATI VE & GENERAL 5. 05 0 33. 04 33. 05 PATI ENT TELEPHONE - SALARI ES A -2, 586 ADMIN IN STRATI VE & GENERAL 5. 05 0 33. 05 33. 06 PATI ENT TELEPHONE - BENEFITS A -779 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 06 33. 07 PHYSI CI AN BI LLI NG SALARI ES A -779 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 07 33. 08 PHYSI CI AN BI LLI NG EMPLOYEE A -20, 312 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 08 33. 10 CRNA EMPLOYEE BENEFITS A -230, 961 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 10 33. 11 SELF-I NSURANCE EXPENSE A -230, 961 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 11 33. 12 TELEVI SI ON DEPRECI ATI ON A -1, 284 ADMIN IN STRATI VE & GENERAL 5. 05 0 33. 12 33. 13 OTHER REVENUE EDUCATI ON B -136 ADMIN IN STRATI VE & GENERAL 5. 05 0 33. 13 33. 14 OTHER REVENUE EDUCATI ON B -250 ADMIN IN STRATI VE & GENERAL 5. 05 0 33. 14 33. 15 OTHER REVENUE EDUCATI ON B -400 ADMIN IN STRATI VE & GENERAL 5. 05 0 33. 15 33. 16 PATI ENT TELEPHONE - OTHER A -2, 049 ADMIN IN STRATI VE & GENERAL 5. 05 0 33. 16 33. 16 PATI ENT TELEPHONE - OTHER A -2, 049 ADMIN IN STRATI VE & GENERAL 5. 05 0 33. 16 33. 16 PATI ENT TELEPHONE - OTHER A -2, 049 ADMIN IN STRATI VE & GENERAL 5. 05 0 33. 16 33. 16 PATI ENT TELEPHONE - OTHER A -2, 049 ADMIN IN STRATI VE & GENERAL 5. 05 0 33. 16 33. 16 PATI ENT TELEPHONE - OTHER A -2, 049 ADMIN IN STRATI VE & GENERAL 5. 05 0 33. 16 33. 16 PATI ENT TELEPHONE - OTHER A -2, 049 ADMIN IN STRATI VE & GENERAL 5. 05 0 33. 16 33. 16		Cost Center Description						
33. 02 REHAB MI SC REV		T						
33. 03 OTHER REV-A&G B -240 ADMI NI STRATI VE & GENERAL 5. 05 0 33. 03 33. 04 NONALLOWABLE DUES B -6, 707 ADMI NI STRATI VE & GENERAL 5. 05 0 33. 04 33. 05 PATI ENT TELEPHONE - SALARI ES A -2, 586 ADMI NI STRATI VE & GENERAL 5. 05 0 33. 05 33. 06 PATI ENT TELEPHONE - BENEFI TS A -779 EMPLOYEE BENEFI TS DEPARTMENT 4. 00 0 33. 06 33. 07 PHYSI CI AN BI LLI NG SALARI ES A -67, 971 CASHI ERI NG/ACCOUNTS 5. 03 0 33. 07 33. 08 PHYSI CI AN BI LLI NG EMPLOYEE A -20, 312 EMPLOYEE BENEFI TS DEPARTMENT 4. 00 0 33. 08 33. 09 PHARMACY DRUG RETAI L 340B A -95, 478 DRUGS CHARGED TO PATI ENTS 73. 00 0 33. 09 33. 10 CRNA EMPLOYEE BENEFI TS A -230, 961 EMPLOYEE BENEFI TS DEPARTMENT 4. 00 0 33. 10 33. 11 SELF-I NSURANCE EXPENSE A -385, 847 EMPLOYEE BENEFI TS DEPARTMENT 4. 00 0 33. 11 33. 12 TELEVI SI ON DEPRECI ATI ON A -1, 284 ADMI NI STRATI VE & GENERAL 5. 05 0 33. 12 33. 13 OTHER REVENUE EDUCATI ON B -136 ADMI NI STRATI VE & GENERAL 5. 05 0 33. 13 33. 14 OTHER DEPT REV RADI OLOGY B -25 RADI OLOGY -10 AGNOSTI C 54. 00 0 33. 16 33. 16 PATI ENT TELEPHONE - OTHER A -2, 049 ADMI NI STRATI VE & GENERAL 5. 05 0 33. 16 33. 16 PATI ENT TELEPHONE - OTHER A -2, 049 ADMI NI STRATI VE & GENERAL 5. 05 0 33. 16 34. 16 PATI ENT TELEPHONE - OTHER A -2, 049 ADMI NI STRATI VE & GENERAL 5. 05 0 33. 16 35. 16 PATI ENT TELEPHONE - OTHER A -2, 049 ADMI NI STRATI VE & GENERAL 5. 05 0 33. 16 35. 20 PATI ENT TELEPHONE - OTHER A -2, 049 ADMI NI STRATI VE & GENERAL 5. 05 0 33. 16 36. 20 PATI ENT TELEPHONE - OTHER A -2, 049 ADMI NI STRATI VE & GENERAL 5. 05 0 33. 16 37. 20 PATI ENT TELEPHONE - OTHER A -2, 049 ADMI NI STRATI VE & GENERAL 5. 05 0 33. 16 38. 20 PATI ENT TELEPHONE - OTHER A -2, 049 ADMI NI STRATI VE			_		1			•
33. 04 NONALLOWABLE DUES B -6, 707 ADMINISTRATIVE & GENERAL 5. 05 0 33. 04 33. 05 PATIENT TELEPHONE - SALARIES A -2, 586 ADMINISTRATIVE & GENERAL 5. 05 0 33. 05 33. 06 PATIENT TELEPHONE - BENEFITS A -779 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 06 33. 07 PHYSICIAN BILLING SALARIES A -67, 971 CASHIERING/ACCOUNTS 5. 03 0 33. 07 RECEIVABLE A -20, 312 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 08 BENEFITS 73. 00 0 33. 09 33. 10 CRNA EMPLOYEE BENEFITS A -230, 961 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 10 33. 11 SELF-INSURANCE EXPENSE A -385, 847 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 11 33. 12 TELEVISION DEPRECIATION A -1, 284 ADMINISTRATIVE & GENERAL 5. 05 0 33. 12 33. 14 OTHER REVENUE EDUCATION B -25 RADIOLOGY B -25 RADIOLOGY-DIAGNOSTIC 54. 00 0 33. 14 33. 15 OTHER REV-AMBULANCE B -400 AMBULANCE SERVICES 95. 00 0 33. 15 33. 16 PATIENT TELEPHONE - OTHER A -2, 049 ADMINISTRATIVE & GENERAL 5. 05 0 33. 16			_	· ·	1			
33. 05 PATI ENT TELEPHONE - SALARI ES A -2, 586 ADMI NI STRATI VE & GENERAL 5. 05 0 33. 05 06 33. 06 9ATI ENT TELEPHONE - BENEFITS A -779 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 06 33. 07 PHYSI CI AN BI LLI NG SALARI ES A -67, 971 CASHI ERI NG/ACCOUNTS RECEI VABLE 5. 03 0 33. 07 RECEI VABLE 5. 03 0 33. 07 RECEI VABLE 6 SENEFITS DEPARTMENT 5. 03 0 33. 08 BENEFITS 5. 03 0 33. 09 PHARMACY DRUG RETAIL 340B A -95, 478 DRUGS CHARGED TO PATI ENTS 73. 00 0 33. 09 33. 10 CRNA EMPLOYEE BENEFITS A -230, 961 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 10 33. 11 SELF-I NSURANCE EXPENSE A -385, 847 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 11 33. 12 TELEVI SI ON DEPRECI ATI ON A -1, 284 ADMI NI STRATI VE & GENERAL 5. 05 0 33. 12 33. 14 OTHER REVENUE EDUCATION B -25 RADI OLOGY DI AGNOSTI C 54. 00 0 33. 14 33. 15 OTHER REV-AMBULANCE B -400 AMBULANCE SERVI CES 95. 00 0 33. 16 0 33. 16		7.7	_					
33. 06 PATI ENT TELEPHONE - BENEFITS			В	·	1			
33. 07 PHYSICIAN BILLING SALARIES A -67, 971 CASHIERING/ACCOUNTS RECEIVABLE 33. 08 PHYSICIAN BILLING EMPLOYEE A -20, 312 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 08 33. 09 PHARMACY DRUG RETAIL 340B A -95, 478 DRUGS CHARGED TO PATIENTS 73. 00 0 33. 09 33. 10 CRNA EMPLOYEE BENEFITS A -230, 961 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 10 33. 11 SELF-INSURANCE EXPENSE A -385, 847 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 11 33. 12 TELEVISION DEPRECIATION A -1, 284 ADMINISTRATIVE & GENERAL 5. 05 0 33. 12 33. 13 OTHER REVENUE EDUCATION B -136 ADMINISTRATIVE & GENERAL 5. 05 0 33. 13 33. 14 OTHER DEPT REV RADIOLOGY B -25 RADIOLOGY-DIAGNOSTIC 54. 00 0 33. 15 33. 16 PATIENT TELEPHONE - OTHER A -2, 049 ADMINISTRATIVE & GENERAL 5. 05 0 33. 16			A	·	1			
RECEI VABLE RECEI VABLE RECEI VABLE RECEI VABLE A -20, 312 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 33.08								
33. 08 PHYSI CI AN BILLING EMPLOYEE A -20, 312 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 08 BENEFITS 33. 09 PHARMACY DRUG RETAIL 340B A -95, 478 DRUGS CHARGED TO PATIENTS 73. 00 0 33. 09 33. 10 CRNA EMPLOYEE BENEFITS A -230, 961 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 10 33. 11 SELF-INSURANCE EXPENSE A -385, 847 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 11 33. 12 TELEVISION DEPRECIATION A -1, 284 ADMINISTRATIVE & GENERAL 5. 05 0 33. 12 33. 13 OTHER REVENUE EDUCATION B -136 ADMINISTRATIVE & GENERAL 5. 05 0 33. 13 33. 14 OTHER DEPT REV RADIOLOGY B -25 RADIOLOGY-DIAGNOSTIC 54. 00 0 33. 14 33. 15 OTHER REV-AMBULANCE B -400 AMBULANCE SERVICES 95. 00 0 33. 16 33. 16 PATIENT TELEPHONE - OTHER A -2, 049 ADMINISTRATIVE & GENERAL 5. 05 0 33. 16	33. 07	PHYSICIAN BILLING SALARIES	A	· ·		5. 03	0	33. 07
BENEFITS					1			
33. 09 PHARMACY DRUG RETAIL 340B A -95, 478 DRUGS CHARGED TO PATIENTS 73. 00 0 33. 09 33. 10 CRNA EMPLOYEE BENEFITS A -230, 961 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 10 33. 11 SELF-I NSURANCE EXPENSE A -385, 847 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 11 33. 12 TELEVISION DEPRECIATION A -1, 284 ADMINISTRATIVE & GENERAL 5. 05 0 33. 12 33. 14 OTHER REVENUE EDUCATION B -136 ADMINISTRATIVE & GENERAL 5. 05 0 33. 14 33. 15 OTHER DEPT REV RADIOLOGY B -25 RADIOLOGY-DIAGNOSTIC 54. 00 0 33. 14 33. 16 PATIENT TELEPHONE - OTHER A -2, 049 ADMINISTRATIVE & GENERAL 5. 05 0 33. 15	33. 08		A	-20, 312	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 08
33. 10 CRNA EMPLOYEE BENEFITS A -230, 961 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 10 33. 11 SELF-INSURANCE EXPENSE A -385, 847 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 11 33. 12 TELEVISION DEPRECIATION A -1, 284 ADMINISTRATIVE & GENERAL 5. 05 0 33. 12 33. 13 OTHER REVENUE EDUCATION B -136 ADMINISTRATIVE & GENERAL 5. 05 0 33. 13 33. 14 OTHER DEPT REV RADIOLOGY B -25 RADIOLOGY-DIAGNOSTIC 54. 00 0 33. 14 33. 15 OTHER REV-AMBULANCE B -400 AMBULANCE SERVICES 95. 00 0 33. 15 33. 16 PATIENT TELEPHONE - OTHER A -2, 049 ADMINISTRATIVE & GENERAL 5. 05 0 33. 16								
33. 11 SELF-I NSURANCE EXPENSE A -385, 847 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 11 33. 12 TELEVI SI ON DEPRECIATION A -1, 284 ADMI NI STRATI VE & GENERAL 5. 05 0 33. 12 33. 13 OTHER REVENUE EDUCATION B -136 ADMI NI STRATI VE & GENERAL 5. 05 0 33. 13 33. 14 OTHER DEPT REV RADIOLOGY B -25 RADIOLOGY-DI AGNOSTI C 54. 00 0 33. 14 33. 15 OTHER REV-AMBULANCE B -400 AMBULANCE SERVI CES 95. 00 0 33. 15 33. 16 PATI ENT TELEPHONE - OTHER A -2, 049 ADMI NI STRATI VE & GENERAL 5. 05 0 33. 16		II	A					
33. 12 TELEVISION DEPRECIATION A -1, 284 ADMINISTRATIVE & GENERAL 5. 05 0 33. 12 33. 13 OTHER REVENUE EDUCATION B -136 ADMINISTRATIVE & GENERAL 5. 05 0 33. 13 33. 14 OTHER DEPT REV RADIOLOGY B -25 RADIOLOGY-DIAGNOSTIC 54. 00 0 33. 14 33. 15 OTHER REV-AMBULANCE B -400 AMBULANCE SERVICES 95. 00 0 33. 15 33. 16 PATIENT TELEPHONE - OTHER A -2, 049 ADMINISTRATIVE & GENERAL 5. 05 0 33. 16			A					
33. 13 OTHER REVENUE EDUCATION B -136 ADMINISTRATIVE & GENERAL 5. 05 0 33. 13 33. 14 OTHER DEPT REV RADIOLOGY B -25 RADIOLOGY-DIAGNOSTIC 54. 00 0 33. 14 33. 15 OTHER REV-AMBULANCE B -400 AMBULANCE SERVICES 95. 00 0 33. 15 33. 16 PATIENT TELEPHONE - OTHER A -2, 049 ADMINISTRATIVE & GENERAL 5. 05 0 33. 16			A	· ·	1			
33. 14 OTHER DEPT REV RADIOLOGY B -25 RADIOLOGY-DIAGNOSTIC 54. 00 0 33. 14 33. 15 OTHER REV-AMBULANCE B -400 AMBULANCE SERVICES 95. 00 0 33. 15 33. 16 PATIENT TELEPHONE - OTHER A -2, 049 ADMINISTRATIVE & GENERAL 5. 05 0 33. 16		II	A	· ·	1			
33. 15 OTHER REV-AMBULANCE B -400 AMBULANCE SERVICES 95. 00 0 33. 15 33. 16 PATI ENT TELEPHONE - OTHER A -2, 049 ADMI NI STRATI VE & GENERAL 5. 05 0 33. 16	33. 13		1					
33. 16 PATI ENT TELEPHONE - OTHER A -2, 049 ADMI NI STRATI VE & GENERAL 5. 05 0 33. 16	33. 14	OTHER DEPT REV RADIOLOGY	В	-25	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 14
	33. 15	OTHER REV-AMBULANCE	В	-400	AMBULANCE SERVICES	95.00	0	33. 15
EXPENSE	33. 16	PATIENT TELEPHONE - OTHER	A	-2, 049	ADMINISTRATIVE & GENERAL	5. 05	0	33. 16
		l -						
50. 00 TOTAL (sum of lines 1 thru 49) -3, 108, 267 50. 00	50.00			-3, 108, 267				50.00
(Transfer to Worksheet A,								
column 6, line 200.)		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.

						10 06/30/2023	3 Date/IIMe Pre 11/29/2023 3:	
	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, 823, 965	510, 276	1, 313, 689	0	0	1. 00
2.00	30. 00	ADULTS & PEDIATRICS	697, 792	676, 450	21, 342	0	0	2. 00
3.00	50. 00	OPERATING ROOM	31, 920	31, 920	0	0	0	3. 00
4.00	54. 00	RADI OLOGY-DI AGNOSTI C	52, 750	52, 750	0	0	0	4. 00
5.00	69. 00	ELECTROCARDI OLOGY	23, 747	23, 747	0	0	0	5. 00
6.00	76. 00	NEUROLOGY	85, 725	85, 725	0	0	0	6. 00
7. 00	0.00		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	l 0	0	10.00
200.00			2, 715, 899	1, 380, 868	1, 335, 031		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		Identifier	Limit	Unadjusted RCE	Memberships &	Component	of Mal practice	
				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		EMERGENCY	0			-		
2.00		ADULTS & PEDIATRICS	0	· ·	0	0	0	
3. 00		OPERATING ROOM	0	0	0	0	0	
4. 00		RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	
5. 00		ELECTROCARDI OLOGY	0	0	0	0	0	
6. 00		NEUROLOGY	0	0	0	0	0	1
7. 00	0. 00		0	0	0	0	0	
8. 00	0. 00		0	0	0	0	0	
9. 00	0. 00		0	0	0	0	0	
10. 00	0. 00		0	0	0	0	0	
200.00			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.					
	1. 00	2.00	14 15. 00	16. 00	17. 00	18. 00	+	
1. 00		EMERGENCY	15.00	10.00	17.00			1, 00
2. 00		ADULTS & PEDIATRICS						2.00
3. 00		OPERATING ROOM		0	0	31, 920		3. 00
4. 00		RADI OLOGY-DI AGNOSTI C		0	0	52, 750		4.00
5. 00		ELECTROCARDI OLOGY		0	0	23, 747	•	5. 00
6. 00		NEUROLOGY		0	0	85, 725		6. 00
7. 00	0.00			0	0	05, 725	1	7. 00
7. 00 8. 00	0.00							8.00
	0.00			0	0			
9. 00 10. 00	0.00] 0] 0				9. 00 10. 00
	0.00					1 200 040		200.00
200. 00	I	I	0	ı	ı	1, 380, 868	יו	200.00

	<i>J</i>	MORRI SON COMMUNI	-		u of Form CMS-2		
	NABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	FURNI SHED BY	Provider CCN: 14-1329	Peri od: From 07/01/2022 To 06/30/2023	Worksheet A-8- Parts I-VI Date/Time Prep 11/29/2023 3:4	pared:	
				Speech Pathology			
					1. 00		
1. 00	PART I - GENERAL INFORMATION Total number of weeks worked (excluding aide:	s) (see instruct	i ons)		32	1.00	
2. 00	Line 1 multiplied by 15 hours per week	, ,	,		480	2. 00	
3. 00 4. 00	Number of unduplicated days in which supervisions Number of unduplicated days in which therapy nor therapist was on provider site (see institute).	assistant was o			28	3. 00 4. 00	
5. 00 6. 00	Number of unduplicated offsite visits - super Number of unduplicated offsite visits - there assistant and on which supervisor and/or the instructions)	rvisors or thera apy assistants (include only visits made		0	5. 00 6. 00	
7.00	Standard travel expense rate				6. 48	7.00	
8. 00	Optional travel expense rate per mile	s Ai des	0.65 Trai nees	8. 00			
0.00	I r	1.00	2.00 3.00	4.00	5. 00	0.00	
9. 00 10. 00	Total hours worked AHSEA (see instructions)	0. 00 108. 34		. 00 0. 00 . 69 0. 00	0. 00 0. 00		
11. 00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	41. 13	41. 13 30	. 85		11. 00	
12. 00	Number of travel hours (provider site)	0	0	0		12.00	
12. 01 13. 00	Number of travel hours (offsite) Number of miles driven (provider site)	0	0	0		12. 0° 13. 00	
13. 01	· · · · · · · · · · · · · · · · · · ·	Ö	0	Ö		13. 0	
					1. 00		
14. 00	Part II - SALARY EQUIVALENCY COMPUTATION Supervisors (column 1, line 9 times column 1,	Line 10)			0	14. 00	
15. 00					2, 320		
16. 00 17. 00	Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 a		atory thorany or lines 1	1 16 for all	0 2, 320	16. 00 17. 00	
	others)	•	atory therapy or filles in	+-10 101 all			
18. 00 19. 00			0	18. 00 19. 00			
20. 00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others) 2,320						
	If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete	n line 2, make n					
21. 00	Weighted average rate excluding aides and tra	ainees (line 17		s 1 and 2, line 9	82. 27	21.00	
22. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and trained				39, 490	22. 00	
23. 00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	VANCE AND TRAVEL	EVDENCE COMPLITATION DI	DOWN DED. CLIFE	39, 490	23. 00	
	Standard Travel Allowance	VANCE AND TRAVEL	EXPENSE COMPUTATION - Pr	ROVIDER SITE			
24. 00 25. 00	Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11)				1, 152 0		
26. 00	Subtotal (line 24 for respiratory therapy or	sum of lines 24	and 25 for all others)		1, 152		
27. 00	Standard travel expense (line 7 times line 3 others)	for respiratory	therapy or sum of lines	3 and 4 for all	181	27. 00	
28. 00	Total standard travel allowance and standard 27)	travel expense	at the provider site (sur	n of lines 26 and	1, 333	28. 00	
29. 00	Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of		2 line 12)		0	29. 00	
30. 00	Assistants (column 3, line 10 times column 3,	line 12)			0	30.00	
31. 00 32. 00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns			ov or sum of	0	31. 00 32. 00	
32.00	columns 1-3, line 13 for all others)	3 I dild 2, Title	13 for respiratory therap	by or sum or		32.00	
33. 00 34. 00	Standard travel allowance and standard travel Optional travel allowance and standard travel				1, 333 0	33. 00 34. 00	
35. 00	Optional travel allowance and optional travel	expense (sum o	flines 31 and 32)		0		
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense	ANCE AND TRAVEL	EXPENSE COMPUTATION - SER	RVICES OUTSIDE PRO	OVIDER SITE		
36. 00	Therapists (line 5 times column 2, line 11)				0		
37. 00 38. 00					0		
39. 00	Standard travel expense (line 7 times the sur		6)		0		
40. 00	Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0		2. line 10)		0	40.00	
41. 00	Assistants (column 3, line 12.01 times column		,		0	41.00	
42. 00 43. 00	Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sur	m of columns 1-3	, line 13.01)		0	42. 00 43. 00	
	Total Travel Allowance and Travel Expense - 0			lowing three line			
44. 00	or 46, as appropriate. Standard travel allowance and standard travel	expense (sum o	f lines 38 and 39 - see i	nstructions)	0	44.00	
	Optional travel allowance and standard travel		C 1 ' 00 1 40 '	notructions)	0	45. 0	

EASONABLE COST DETERMINATION FOR THERAPY SERVICES UTSIDE SUPPLIERS	FURNI SHED BY	Provi der CC	CN: 14-1329	Peri od: From 07/01/2022 To 06/30/2023 Speech Pathology	11/29/2023 3:	pared:
				Speech Pathology	Cost	
					1. 00	
6.00 Optional travel allowance and optional travel					0	46. 00
	Therapi sts	Assi stants	Ai des	Trai nees	Total	
PART V - OVERTIME COMPUTATION	1.00	2. 00	3. 00	4. 00	5. 00	
7.00 Overtime hours worked during reporting	0.00	0.00	0	00 0.00	0.00	47. 00
period (if column 5, line 47, is zero or						
equal to or greater than 2,080, do not						
complete lines 48-55 and enter zero in each						
column of line 56) 8.00 Overtime rate (see instructions)	0. 00	0. 00	0	0.00		48. 00
9.00 Total overtime (including base and overtime	0.00	0.00		00 0.00		49.00
allowance) (multiply line 47 times line 48)	0.00	0.00	0.	0.00		17.00
CALCULATION OF LIMIT						
0.00 Percentage of overtime hours by category	0. 00	0. 00	0.	0.00	0. 00	50.00
(divide the hours in each column on line 47						
by the total overtime worked - column 5, line 47)						
1.00 Allocation of provider's standard work year	0. 00	0.00	0.	0.00	0.00	51.00
for one full-time employee times the						
percentages on line 50) (see instructions)						
DETERMINATION OF OVERTIME ALLOWANCE	00.04	(4 (0		00 000		F0 00
2.00 Adjusted hourly salary equivalency amount (see instructions)	82. 26	61. 69	0.	0.00		52. 00
3.00 Overtime cost limitation (line 51 times line	0	0		0 0		53.00
52)		Ĭ				00.00
4.00 Maximum overtime cost (enter the lesser of	0	o		0 0		54.00
line 49 or line 53)						FF 00
5.00 Portion of overtime already included in hourly computation at the AHSEA (multiply	0	0		0 0		55. 00
line 47 times line 52)						
6.00 Overtime allowance (line 54 minus line 55 -	О	О		0 0	0	56. 00
if negative enter zero) (Enter in column 5						
the sum of columns 1, 3, and 4 for						
respiratory therapy and columns 1 through 3 for all others.)						
Tot all others.)						
					1. 00	
Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST A	DJUSTMENT				
7.00 Salary equivalency amount (from line 23)	/C !! 00	0.5			39, 490	
8.00 Travel allowance and expense - provider site 9.00 Travel allowance and expense - Offsite service			`		1, 333 0	1
0.00 Overtime allowance (from column 5, line 56)	es (ITOIII ITIIes 2	14, 45, 01 40)		0	
1.00 Equipment cost (see instructions)					Ö	
2.00 Supplies (see instructions)					0	
3.00 Total allowance (sum of lines 57-62)					40, 823	63.00
4.00 Total cost of outside supplier services (from						64. 00
5.00 Excess over limitation (line 64 minus line 63	B - if negative,	enter zero)			0	65.00
LINE 33 CALCULATION 00.00 Line 26 = line 24 for respiratory therapy or	sum of lines 24	and 25 for a	II others		1 152	100. 00
00.01 Line 27 = line 7 times line 3 for respiratory				others	'	100.00
00.02 Line 33 = line 28 = sum of lines 26 and 27						100. 02
LINE 34 CALCULATION						
01.00 Line 27 = line 7 times line 3 for respiratory				others		101. 00
01.01 Line 31 = line 29 for respiratory therapy or	sum of lines 29	and 30 for a	II others			101. 01
01.02 Line 34 = sum of lines 27 and 31					181	101. 02
LINE 35 CALCULATION 02.00 Line 31 = line 29 for respiratory therapy or	sum of lines 20	and 30 for a	II others		n	102. 00
02.01 Line 32 = line 8 times columns 1 and 2, line				umns 1-3. line		102. 00
13 for all others		J		,		
						102. 02

Health Financial Systems	MORRISON COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10		
COCT ALLOCATION CENEDAL CEDVICE COCTS	Dray i dan CCN, 14 1220	Doni od.	Waskahaat D	

COST ALLOCATION – GENERAL SERVICE COSTS Peri od: From 07/01/2022 Part I 06/30/2023 Date/Time Prepared: 11/29/2023 3:45 pm CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP EMPLOYEE **PURCHASI NG** RECEIVING AND for Cost **BENEFITS** DEPARTMENT **STORES** Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 5. 01 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 2, 378, 562 2, 378, 562 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 1,099,994 1, 099, 994 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 3, 393, 973 3, 393, 973 4.00 00560 PURCHASING RECEIVING AND STORES 5 01 69 229 48, 689 149, 355 5 01 0 31, 437 5.02 00591 PERSONNEL 101, 413 12,055 0 27, 693 148 5.02 5.03 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 879, 160 38, 515 9, 235 224, 608 3, 254 5.03 5.05 00590 ADMINISTRATIVE & GENERAL 1, 672, 872 107, 184 105, 421 284, 764 5, 510 5.05 00700 OPERATION OF PLANT 7 00 657, 218 517, 652 57, 968 296 7 00 702 8.00 00800 LAUNDRY & LINEN SERVICE 67,854 44, 727 0 37 8.00 00900 HOUSEKEEPI NG 65, 907 9.00 231, 068 18,670 0 74 9.00 88, 944 01000 DI ETARY 53, 726 10.00 294, 702 0 887 10.00 19, 912 11.00 01100 CAFETERI A 0 0 11.00 01300 NURSING ADMINISTRATION 280, 750 14, 405 16,035 79, 788 111 13.00 13.00 246, 277 01400 CENTRAL SERVICES & SUPPLY 13, 588 14.00 53, 861 29,842 33, 909 14.00 01600 MEDICAL RECORDS & LIBRARY 142, 278 630, 286 50, 133 172 148 16, 00 16,00 17 00 01700 SOCIAL SERVICE 62, 405 5, 138 Ω 20, 046 0 17 00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 2, 033, 732 30.00 03000 ADULTS & PEDIATRICS 310, 370 41,655 552, 006 5, 769 30.00 ANCILLARY SERVICE COST CENTERS 45, 296 05000 OPERATING ROOM 2, 813, 484 142, 341 273, 217 461, 149 50.00 53.00 05300 ANESTHESI OLOGY 68, 750 82, 673 3, 032 53.00 54 00 05400 RADI OLOGY-DI AGNOSTI C 1, 293, 784 72.866 270, 300 235, 168 4, 216 54.00 60.00 06000 LABORATORY 2, 012, 702 69, 173 33,070 164, 277 4, 216 60.00 64.00 06400 I NTRAVENOUS THERAPY 184, 039 20, 258 64.00 65.00 06500 RESPIRATORY THERAPY 77, 302 9, 451 21, 396 65.00 0 66.00 06600 PHYSI CAL THERAPY 332, 032 81, 798 256 101, 198 2,071 66.00 06700 OCCUPATIONAL THERAPY 156, 079 9, 369 67.00 51, 374 67.00 68.00 06800 SPEECH PATHOLOGY 4,000 3, 727 0 O 68.00 06900 ELECTROCARDI OLOGY 69 00 10.178 0 366 Ω 69 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 344, 046 r 0 1, 442 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 3, 293, 644 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 67, 799 73.00 1, 291, 168 12.323 7.770 814 73.00 03950 NEUROLOGY 76.00 18, 206 0 3, 772 37 76.00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 OUTPATIENT SERVICE COST CENTERS 9. 387. 788 355, 185 88 00 08800 RURAL HEALTH CLINIC 459 662 135, 639 21 041 88 00 88.01 08801 RURAL HEALTH CLINIC (RHC) ERIE 1,539 153 Ω 88.01 91.00 09100 EMERGENCY 2, 533, 855 149, 997 53, 534 243, 161 13,090 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 04950 WOUND CARE 259 93.00 72.536 93.00 5, 541 23, 489 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 47, 276 39, 947 3, 698 95.00 191, 761 76, 728 102.00 10200 OPI OI D TREATMENT PROGRAM 0 102. 00 0 0 0 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 SUBTOTALS (SUM_OF_LINES_1 through 117) 2, 378, 562 1, 099, 994 3, 393, 973 149, 355 118. 00 38, 186, 388 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 190, 00 194.00 07950 DIXON CLINIC 59, 280 0 0 194.00 0 0 0 194. 01 194. 01 07951 RENTAL SPACE 0 194. 02 07952 OTHER NON-REIMBURSABLE COST CENTERS 0 0 0 194 02 35,063 Ω 194.03 07953 MORRISON ORTHOPEDIC CLINIC 340,777 0 0 0 0 194. 03 194. 04 07954 CLINTON CLINIC 0 0 194. 04 280.345 Cross Foot Adjustments 200.00 200. 00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118 through 201) 38, 901, 853 2, 378, 562 1, 099, 994 3, 393, 973 149, 355 202. 00

				T T	06/30/2023	Date/Time Pre 11/29/2023 3:	
	Cost Center Description	PERSONNEL	CASHI ERI NG/ACC	Subtotal	ADMI NI STRATI VE	OPERATION OF	45 piii
	oost center bescriptron	1 ENGONNEE	OUNTS	Subtotal	& GENERAL	PLANT	
			RECEI VABLE		u oenerote	1 27 11 11	
		5. 02	5. 03	5A. 03	5. 05	7. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00560 PURCHASING RECEIVING AND STORES						5. 01
5. 02	00591 PERSONNEL	141, 309					5. 02
5. 03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	6, 090	1				5. 02
5. 05	00590 ADMINISTRATIVE & GENERAL	7, 040		2, 182, 791	2, 182, 791		5. 05
7. 00	00700 OPERATION OF PLANT	1, 429	1	1, 235, 265	73, 432	1, 308, 697	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	1, 427		112, 618	6, 695	35, 380	8. 00
9. 00	00900 HOUSEKEEPING	1, 625		317, 344	18, 865	14, 768	9. 00
10.00	01000 DI ETARY	2, 192		440, 451	26, 183	42, 498	10.00
11. 00	01100 CAFETERI A	2, 192		19, 912	1, 184	15, 751	11. 00
13. 00	01300 NURSING ADMINISTRATION	_					13. 00
14. 00	1 1	1, 967		393, 056	23, 366	11, 395	
	01400 CENTRAL SERVICES & SUPPLY	736	· -	378, 213	22, 483	42, 604	14.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	3, 507	0	826, 524	49, 134	39, 656	16. 00
17. 00	01700 SOCI AL SERVI CE	494	0	88, 083	5, 236	4, 064	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	6, 298	0	6, 298	374	0	19. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	40.707	04.400	0.004.070	477 040	0.45 505	00.00
30. 00	03000 ADULTS & PEDI ATRI CS	13, 606	34, 130	2, 991, 268	177, 819	245, 505	30. 00
F0 00	ANCILLARY SERVICE COST CENTERS	44.0/7	074 404	4 440 055	044 044	440 500	F0 00
50.00	05000 OPERATI NG ROOM	11, 367	371, 401	4, 118, 255	244, 814	112, 593	50.00
53. 00	05300 ANESTHESI OLOGY	0	47, 548	202, 003	12, 008	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	5, 797	157, 911	2, 040, 042	121, 272	57, 638	54. 00
60.00	06000 LABORATORY	4, 049		2, 398, 336	142, 571	54, 716	60.00
64. 00	06400 I NTRAVENOUS THERAPY	499	29, 236	234, 032	13, 912	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	527	2, 602	111, 278	6, 615	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	2, 494		545, 653	32, 437	64, 703	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 266		225, 764	13, 421	7, 411	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	98	7, 825	465	2, 948	68. 00
69. 00	06900 ELECTROCARDI OLOGY	9	4, 413	14, 966	890	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	13, 527	359, 015	21, 342	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	109, 485	3, 403, 129	202, 302	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 671	79, 225	1, 460, 770	86, 837	9, 748	73. 00
76.00	03950 NEUROLOGY	93	3, 539	25, 647	1, 525	0	76. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	56, 272	111, 384	10, 526, 971	625, 777	363, 595	88. 00
88. 01	08801 RURAL HEALTH CLINIC (RHC) ERIE	4	0	1, 696	101	0	88. 01
91.00	09100 EMERGENCY	5, 994	38, 947	3, 038, 578	180, 631	118, 649	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART			0			92. 00
93.00	04950 WOUND CARE	579	2, 233	104, 637	6, 220	4, 383	93. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	985	10, 854	371, 249	22, 069	60, 692	95. 00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	o	0	O	0	102. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 I NTEREST EXPENSE						113. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	136, 590	1, 160, 862	38, 181, 669	2, 139, 980	1, 308, 697	118. 00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	07950 DIXON CLINIC	372	o	59, 652	3, 546		194. 00
194. 01	07951 RENTAL SPACE	0	ol	0	O		194. 01
194. 02	07952 OTHER NON-REIMBURSABLE COST CENTERS	0	ol	35, 063	2, 084	0	194. 02
	07953 MORRISON ORTHOPEDIC CLINIC	2, 399	o	343, 176	20, 400		194. 03
	07954 CLINTON CLINIC	1, 948		282, 293	16, 781		194. 04
200.00		., . 10		0	,	ŭ	200. 00
201.00		0	ol	0	o		201. 00
202.00		141, 309		38, 901, 853	2, 182, 791		

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 07/01/2022 | Part I | To 06/30/2023 | Date/Time Prepared: 11/29/2023 3: 45 pm

						11/29/2023 3:	45 pm_
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
	·	LINEN SERVICE				ADMI NI STRATI ON	
		8. 00	9. 00	10.00	11. 00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2. 00							2. 00
	00200 CAP REL COSTS-MVBLE EQUIP						
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00560 PURCHASING RECEIVING AND STORES						5. 01
5. 02	00591 PERSONNEL						5. 02
5.03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 03
5.05	00590 ADMINISTRATIVE & GENERAL						5. 05
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	154, 693					8. 00
		134, 093	250 077				
9. 00	00900 HOUSEKEEPI NG	0	350, 977				9. 00
10. 00	01000 DI ETARY	0	12, 377	521, 509			10. 00
11. 00	01100 CAFETERI A	0	4, 587	361, 374	402, 808		11. 00
13.00	01300 NURSING ADMINISTRATION	0	0	0	6, 664	434, 481	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	12, 415	0	6, 477	0	14.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	6, 389	0	24, 891	0	16. 00
17. 00	01700 SOCI AL SERVI CE	j o	1, 184	0	3, 158		17. 00
		-	1, 104	-	3, 130		
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	49, 489	70, 253	147, 757	74, 754	175, 295	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	60, 088	32, 806	4, 441	44, 697	104, 838	50.00
53.00	05300 ANESTHESI OLOGY	0	0	0	8, 083	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 049	15, 556	0	26, 979	0	54.00
60.00	06000 LABORATORY	0,011	15, 935	0	22, 803	Ō	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	13, 733	0		Ö	64. 00
		0	0	-	964		
65. 00	06500 RESPI RATORY THERAPY	0	0	0	2, 730	6, 406	65. 00
66. 00	06600 PHYSI CAL THERAPY	3, 669	18, 843	0	10, 974	25, 730	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	2, 158	0	5, 246	12, 311	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	859	0	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	Ō	o	0	54	0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	Ö	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	2, 236	0	6, 397	15, 000	73. 00
		_	2, 230	0	0, 397		
76. 00	03950 NEUROLOGY	0	0	0	0	0	76. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	8, 810	119, 534	0	116, 479	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC (RHC) ERIE	0	0	0	0	0	88. 01
91.00	09100 EMERGENCY	27, 264	34, 569	7, 937	34, 633	81, 223	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1	·	•	·		92. 00
93. 00	04950 WOUND CARE	0	1, 276	0	2, 676	6, 249	93. 00
70.00	OTHER REIMBURSABLE COST CENTERS		1,270	J	2,070	0,217	70.00
05 00	09500 AMBULANCE SERVICES	324	0	0	4, 149	0	95. 00
					4, 147		
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	U	0	102. 00
	SPECIAL PURPOSE COST CENTERS	1					
	11300 INTEREST EXPENSE						113. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	154, 693	350, 977	521, 509	402, 808	434, 481	118. 00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
	07950 DIXON CLINIC	0	o	0	0	n	194. 00
	07951 RENTAL SPACE	0	n	n	n		194. 01
	207952 OTHER NON-REIMBURSABLE COST CENTERS		٥	0	0		194. 01
		0		0	0		194. 02
	3 O7953 MORRI SON ORTHOPEDIC CLINIC	0	0	0	0		
	07954 CLINTON CLINIC	0	이	0	0	0	194. 04
200.00]					200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	154, 693	350, 977	521, 509	402, 808	434, 481	202. 00
						•	

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 07/01/2022 | Part | | To 06/30/2023 | Date/Time Prepared: Provider CCN: 14-1329

				T	06/30/2023	Date/Time Pre 11/29/2023 3:	
	Cost Center Description	CENTRAL	MEDI CAL	SOCIAL SERVICE	NONPHYSI CI AN	Subtotal	45 piii
		SERVICES &	RECORDS &		ANESTHETI STS		
		SUPPLY	LIBRARY				
CENE	DAL CEDULCE COCT CENTERS	14. 00	16. 00	17. 00	19. 00	24. 00	
	RAL SERVICE COST CENTERS OO CAP REL COSTS-BLDG & FIXT						1.00
	OO CAP REL COSTS-MVBLE EQUIP						2.00
	O EMPLOYEE BENEFITS DEPARTMENT			•			4. 00
	DO PURCHASING RECEIVING AND STORES						5. 01
	PI PERSONNEL						5. 02
	O CASHIERING/ACCOUNTS RECEIVABLE						5. 03
5. 05 0059	OO ADMINISTRATIVE & GENERAL						5. 05
7.00 0070	OO OPERATION OF PLANT						7. 00
	OO LAUNDRY & LINEN SERVICE						8. 00
	00 HOUSEKEEPI NG						9. 00
	OO DI ETARY						10.00
	OO CAFETERI A						11.00
	00 NURSING ADMINISTRATION 00 CENTRAL SERVICES & SUPPLY	442 102					13. 00 14. 00
	00 MEDICAL RECORDS & LIBRARY	462, 192	946, 594				16.00
	00 SOCIAL SERVICE	0	940, 594				17. 00
	00 NONPHYSICIAN ANESTHETISTS		0				19.00
	TIENT ROUTINE SERVICE COST CENTERS	<u> </u>			0, 072		17.00
	00 ADULTS & PEDIATRICS	0	25, 280	109, 154	0	4, 066, 574	30.00
	LLARY SERVICE COST CENTERS	,					1
	OO OPERATING ROOM	310, 437	325, 216	0	0	5, 358, 185	50. 00
	OO ANESTHESI OLOGY	0	59, 028		6, 672	287, 794	1
	OO RADI OLOGY-DI AGNOSTI C	0	118, 315		0	2, 384, 851	1
	OO LABORATORY	0	82, 109		0	2, 716, 470	1
	00 I NTRAVENOUS THERAPY	0	21, 656		0	270, 564	1
	00 RESPI RATORY THERAPY 00 PHYSI CAL THERAPY	0	1, 927		_	128, 956	1
	00 OCCUPATIONAL THERAPY	0	19, 114 5, 686			721, 123 271, 997	1
	00 SPEECH PATHOLOGY		73		0	12, 170	1
	00 ELECTROCARDI OLOGY	0	4, 165		0	20, 075	1
	O MEDICAL SUPPLIES CHARGED TO PATIENT		10, 020		0	390, 377	1
	OO IMPL. DEV. CHARGED TO PATIENTS	o o	81, 097	1	Ö	3, 686, 528	1
	DO DRUGS CHARGED TO PATIENTS	o	58, 683		o	1, 639, 671	1
	50 NEUROLOGY	0	3, 411	1	O	30, 583	1
77. 00 0770	OO ALLOGENEIC HSCT ACQUISITION	O	0	1	О	0	1
OUTP	PATIENT SERVICE COST CENTERS						
	OO RURAL HEALTH CLINIC	147, 084	82, 504	1		11, 990, 754	1
	NI RURAL HEALTH CLINIC (RHC) ERIE	0	0	0	_	1, 797	1
	OO EMERGENCY	4, 671	38, 616	0	0	3, 566, 771	91.00
	OO OBSERVATION BEDS (NON-DISTINCT PART		4 (54			407.005	92.00
	50 WOUND CARE	0	1, 654	. 0	0	127, 095	93. 00
	R REIMBURSABLE COST CENTERS OO AMBULANCE SERVICES	ol	8, 040	0	O	466, 523	95. 00
	00 OPLOLD TREATMENT PROGRAM	o	8, 040				102. 00
	TIAL PURPOSE COST CENTERS	<u> </u>		<u> </u>	<u> </u>		102.00
	OO I NTEREST EXPENSE						113. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	462, 192	946, 594	109, 154	6, 672	38, 138, 858	
NONR	EIMBURSABLE COST CENTERS	· · · · ·					1
190. 00 1900	OO GIFT FLOWER COFFEE SHOP & CANTEEN	0	C	0	0		190. 00
194. 00 0795	50 DIXON CLINIC	0	0	0	0		194. 00
	RENTAL SPACE	0	0	0	_		194. 01
	52 OTHER NON-REIMBURSABLE COST CENTERS	이	0	0			194. 02
	MORRISON ORTHOPEDIC CLINIC	이	0	0	0	363, 576	
	54 CLINTON CLINIC	이	0	0	0	299, 074	
200.00	Cross Foot Adjustments		_	_	0		200.00
201.00	Negative Cost Centers	442 102	044 504	100 154	4 472		201. 00
202.00	TOTAL (sum lines 118 through 201)	462, 192	946, 594	109, 154	6, 672	38, 901, 853	12U2. UU

Health Financial Systems MORRISON COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-1329 Period: Worksheet B

Provider CCN: 14-1329 From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 11/29/2023 3:45 pm Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00560 PURCHASING RECEIVING AND STORES 5.01 5.01 00591 PERSONNEL 5.02 5.02 5.03 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.03 5.05 00590 ADMINISTRATIVE & GENERAL 5.05 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13 00 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17 00 17 00 19.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 -180, 856 3, 885, 718 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 5, 358, 185 50.00 05300 ANESTHESI OLOGY 0 287, 794 53.00 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 2, 384, 851 54.00 06000 LABORATORY 0 60 00 60 00 2, 716, 470 64.00 06400 I NTRAVENOUS THERAPY 180, 856 451, 420 64.00 06500 RESPIRATORY THERAPY 128, 956 65.00 0 65.00 06600 PHYSI CAL THERAPY 0 721, 123 66.00 66, 00 06700 OCCUPATIONAL THERAPY 271, 997 67.00 67.00 0 68.00 06800 SPEECH PATHOLOGY 12, 170 68.00 06900 ELECTROCARDI OLOGY 69 00 20,075 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 390, 377 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 3, 686, 528 72 00 07300 DRUGS CHARGED TO PATIENTS 1, 639, 671 73.00 73.00 03950 NEUROLOGY 0 76.00 30, 583 76.00 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 11, 990, 754 88.00 88. 01 08801 RURAL HEALTH CLINIC (RHC) ERIE 0 1, 797 88.01 0 91.00 09100 EMERGENCY 3, 566, 771 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 93.00 04950 WOUND CARE 0 127, 095 93.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0 466, 523 95.00 102.00 10200 OPIOID TREATMENT PROGRAM 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 38, 138, 858 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GLFT FLOWER COFFEE SHOP & CANTEEN 190.00 00000 194.00 07950 DIXON CLINIC 63, 198 194.00 194. 01 07951 RENTAL SPACE C 194. 01 194. 02 07952 OTHER NON-REIMBURSABLE COST CENTERS 37, 147 194. 02 194. 03 07953 MORRI SON ORTHOPEDIC CLINIC 363 576 194. 03 194. 04 07954 CLINTON CLINIC 299, 074 194.04 200.00 Cross Foot Adjustments 200.00 0 201.00 Negative Cost Centers 201.00 38, 901, 853 202.00 TOTAL (sum lines 118 through 201) 202.00

| Period: | Worksheet B | From 07/01/2022 | Part II | To 06/30/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1329

					To	06/30/2023	Date/Time Pre 11/29/2023 3:	
				CAPI TAL REI	ATED COSTS		11/29/2023 3.	45 PIII
	0-		D:+1	DIDC & FLVT	MVDLE FOLLID	Ch. + - + - 1	EMDL OVEE	
	Co	ost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			Capi tal				DEPARTMENT	
			Related Costs		0.00			
	CENEDAL	SERVI CE COST CENTERS	0	1. 00	2.00	2A	4. 00	
1.00		AP REL COSTS-BLDG & FLXT						1. 00
2.00		AP REL COSTS-MVBLE EQUIP						2. 00
4.00		MPLOYEE BENEFITS DEPARTMENT	0	0	1	0	0	4. 00
5. 01 5. 02	00560 PU 00591 PE	JRCHASING RECEIVING AND STORES	0	48, 689 12, 055		48, 689 12, 055	0	5. 01 5. 02
5. 02		ASHI ERI NG/ACCOUNTS RECEI VABLE	0	38, 515		47, 750	0	5. 02
5. 05		OMINISTRATIVE & GENERAL	0	107, 184		212, 605	0	5. 05
7.00	1	PERATION OF PLANT	0	517, 652		518, 354	0	7. 00
8.00		AUNDRY & LINEN SERVICE	0	44, 727		44, 727	0	8. 00
9. 00 10. 00	01000 DI	DUSEKEEPI NG	0	18, 670 53, 726		18, 670 53, 726	0	9. 00 10. 00
11. 00	01000 DI		0	19, 912		19, 912	0	11.00
13. 00		JRSI NG ADMI NI STRATI ON	Ö	14, 405		30, 440	0	13. 00
14.00		ENTRAL SERVICES & SUPPLY	0	53, 861	13, 588	67, 449	0	14. 00
16. 00		EDICAL RECORDS & LIBRARY	0	50, 133		50, 305	0	16. 00
17. 00 19. 00		OCIAL SERVICE ONPHYSICIAN ANESTHETISTS	0	5, 138 0		5, 138 0	0	17. 00 19. 00
19.00		NT ROUTINE SERVICE COST CENTERS	U _I	0	<u> </u>	<u> </u>	0	19.00
30. 00		OULTS & PEDIATRICS	0	310, 370	41, 655	352, 025	0	30. 00
	ANCI LLAR	RY SERVICE COST CENTERS						
50.00		PERATING ROOM	0	142, 341	273, 217	415, 558	0	50.00
53. 00 54. 00		IESTHESI OLOGY ADI OLOGY-DI AGNOSTI C	0	0 72, 866	,	82, 673 343, 166	0	53. 00 54. 00
60.00		ABORATORY	0	69, 173		102, 243	0	60.00
64. 00	1 1	ITRAVENOUS THERAPY	Ö	0,,,,,0	1	0	0	64. 00
65. 00		SPI RATORY THERAPY	0	0	.,	9, 451	0	65. 00
66. 00		HYSI CAL THERAPY	0	81, 798		82, 054	0	66. 00
67. 00 68. 00		CCUPATIONAL THERAPY PEECH PATHOLOGY	0	9, 369 3, 727	0	9, 369 3, 727	0	67. 00 68. 00
69. 00		LECTROCARDI OLOGY	0	3, 727		3, 727	0	69.00
71. 00		EDICAL SUPPLIES CHARGED TO PATIENT	0	0	Ö	Ö	0	71. 00
72.00	07200 I M	MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73.00		RUGS CHARGED TO PATIENTS	0	12, 323	1	20, 093	0	73. 00
76.00	03950 NE		0	0		0	0	76. 00 77. 00
77. 00		LOGENEIC HSCT ACQUISITION ENT SERVICE COST CENTERS	U _I	0	<u> </u>	<u> </u>	0	77.00
88. 00		JRAL HEALTH CLINIC	0	459, 662	135, 639	595, 301	0	88. 00
88. 01		JRAL HEALTH CLINIC (RHC) ERIE	0	0	1	0	0	88. 01
91.00	09100 EM		0	149, 997	53, 534	203, 531	0	91.00
92. 00 93. 00	1 1	BSERVATION BEDS (NON-DISTINCT PART DUND CARE	0	5, 541	0	0 5, 541	0	92. 00 93. 00
73.00		ELMBURSABLE COST CENTERS	U _I	5, 541	<u> </u>	5, 541	0	73.00
95.00		MBULANCE SERVICES	0	76, 728	47, 276	124, 004	0	95. 00
	10200 OP	PIOID TREATMENT PROGRAM	0			O	0	102. 00
440.00		PURPOSE COST CENTERS			T T			140.00
113.00		ITEREST EXPENSE JBTOTALS (SUM OF LINES 1 through 117)	0	2, 378, 562	1, 099, 994	3, 478, 556	0	113. 00 118. 00
110.00		BURSABLE COST CENTERS	O _I	2, 376, 302	1, 077, 774	3, 476, 550	0	1110.00
190.00		FT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
		XON CLINIC	O	0	0	O		194. 00
		ENTAL SPACE	0	0	0	o		194. 01
		THER NON-REIMBURSABLE COST CENTERS ORRISON ORTHOPEDIC CLINIC	0	0		0		194. 02 194. 03
		INTON CLINIC	0	0		0		194. 03
200.00		ross Foot Adjustments				Ö		200. 00
201.00		egative Cost Centers		0	0	0		201. 00
202.00) T0	OTAL (sum lines 118 through 201)	0	2, 378, 562	1, 099, 994	3, 478, 556	0	202. 00

| Peri od: | Worksheet B | From 07/01/2022 | Part II | To 06/30/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1329

				To	06/30/2023	Date/Time Pre 11/29/2023 3:	
	Cost Center Description	PURCHASI NG	PERSONNEL	CASHI ERI NG/ACC	ADMI NI STRATI VE	OPERATION OF	45 piii
	5051 5011tol 505011 pt 1 511	RECEIVING AND	. 2.1.00111122	OUNTS	& GENERAL	PLANT	
		STORES		RECEI VABLE			
		5. 01	5. 02	5. 03	5. 05	7. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00560 PURCHASING RECEIVING AND STORES	48, 689					5. 01
5.02	00591 PERSONNEL	48	12, 103				5. 02
5.03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	1, 061	522	49, 333			5. 03
5.05	00590 ADMINISTRATIVE & GENERAL	1, 796	603	0	215, 004		5. 05
7.00	00700 OPERATION OF PLANT	96	122		7, 232	525, 804	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	12	0		659	14, 215	8. 00
9.00	00900 HOUSEKEEPI NG	24	139		1, 858	5, 933	9. 00
10. 00	01000 DI ETARY	289	188		2, 579	17, 075	10. 00
11. 00	01100 CAFETERI A	0	0		117	6, 328	
13. 00	01300 NURSING ADMINISTRATION	36	168		2, 301	4, 578	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	11, 054	63		2, 214	17, 117	14. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	48	300		4, 839	15, 933	
17. 00	01700 SOCIAL SERVICE	0	42		516	1, 633	17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	539	0	37	0	19. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				45 541	00.400	
30. 00	03000 ADULTS & PEDI ATRI CS	1, 881	1, 165	1, 451	17, 514	98, 638	30. 00
F0 00	ANCILLARY SERVICE COST CENTERS	44 774	07.4	45 334	04.440	45.007	F0 00
50.00	05000 OPERATING ROOM	14, 771	974		24, 112	45, 237	50.00
53. 00	05300 ANESTHESI OLOGY	988	0		1, 183	0	53. 00
54. 00	05400 RADI OLOGY - DI AGNOSTI C	1, 374	497	· ·	11, 944	23, 158	
60.00	06000 LABORATORY	1, 374	347	· ·	14, 042	21, 984	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	43		1, 370	0	64.00
65. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	(75	45		652 3. 195	0 2F 004	65. 00
66. 00 67. 00	l l	675	214	· ·		25, 996	66. 00 67. 00
	06700 OCCUPATIONAL THERAPY	0	108		1, 322	2, 977	
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0	188	46 88	1, 185 0	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	470	0	1	2, 102	0	69. 00 71. 00
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	470	0		19, 925	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	265	143		8, 553	3, 917	73.00
76. 00	03950 NEUROLOGY	12	8		150	3, 417	76.00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0	77.00
77.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>		0	<u> </u>		77.00
88. 00	08800 RURAL HEALTH CLINIC	6, 859	4, 820	4, 735	61, 650	146, 084	88. 00
88. 01	08801 RURAL HEALTH CLINIC (RHC) ERIE	0,037	4, 020	1	10	0	88. 01
91. 00	09100 EMERGENCY	4, 267	513		17, 791	47, 670	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,20,	0.0	1, 555	.,,,,,	.,, ,,,	92. 00
93. 00	04950 WOUND CARE	84	50	95	613	1, 761	93. 00
	OTHER REIMBURSABLE COST CENTERS					.,	
95.00	09500 AMBULANCE SERVICES	1, 205	84	461	2, 174	24, 385	95. 00
	10200 OPI OI D TREATMENT PROGRAM	0	0		, 0		102.00
	SPECIAL PURPOSE COST CENTERS			'	,		
113.00	11300 I NTEREST EXPENSE						113. 00
118.00		48, 689	11, 698	49, 333	210, 788	525, 804	118. 00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	07950 DIXON CLINIC	O	32	0	349	0	194. 00
194. 01	07951 RENTAL SPACE	O	0	0	o		194. 01
194. 02	07952 OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	205		194. 02
194. 03	07953 MORRISON ORTHOPEDIC CLINIC	0	206	0	2, 009	0	194. 03
194. 04	07954 CLINTON CLINIC	O	167	0	1, 653	0	194. 04
200.00	Cross Foot Adjustments						200. 00
201.00		0	0		0		201. 00
202.00	TOTAL (sum lines 118 through 201)	48, 689	12, 103	49, 333	215, 004	525, 804	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1329

Peri od: Worksheet B From 07/01/2022 Part II To 06/30/2023 Date/Time Prepared:

11/29/2023 3:45 pm Cost Center Description LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG ADMI NI STRATI ON LINEN SERVICE 9.00 10.00 11.00 13.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00560 PURCHASING RECEIVING AND STORES 5 01 5 01 5.02 00591 PERSONNEL 5.02 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.03 5.03 5.05 00590 ADMINISTRATIVE & GENERAL 5.05 7.00 00700 OPERATION OF PLANT 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 59, 613 8.00 9.00 00900 HOUSEKEEPI NG 0 26, 624 9 00 01000 DI ETARY 74, 796 10.00 0 939 10 00 11.00 01100 CAFETERI A 0 348 51,829 78, 534 11.00 13.00 01300 NURSING ADMINISTRATION 0 0 1, 299 38, 822 13.00 0 01400 CENTRAL SERVICES & SUPPLY 14.00 942 0 1.263 14.00 0 01600 MEDICAL RECORDS & LIBRARY 0 16.00 485 4.853 0 16.00 17.00 01700 SOCIAL SERVICE 0 90 0 616 664 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 19, 071 5, 329 21, 192 15, 663 30.00 03000 ADULTS & PEDIATRICS 14, 574 30.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 23, 155 2, 489 637 8, 714 9, 368 50.00 05300 ANESTHESI OLOGY 53.00 0 1,576 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1,946 1, 180 0 5, 260 0 54.00 4, 446 60.00 06000 LABORATORY 0 1, 209 0 0 60.00 64.00 06400 I NTRAVENOUS THERAPY 0 188 0 0 64.00 06500 RESPIRATORY THERAPY 0 65.00 0 532 572 65.00 0 66.00 06600 PHYSI CAL THERAPY 1,414 1, 429 2, 139 2, 299 66.00 06700 OCCUPATIONAL THERAPY 0 1, 100 67.00 0 164 1, 023 67.00 0 06800 SPEECH PATHOLOGY 0 68.00 65 0 0 68.00 06900 ELECTROCARDI OLOGY 0 0 69.00 C 10 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73 00 170 0 1, 247 1, 340 73 00 03950 NEUROLOGY 0 0 76.00 0 76.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 77.00 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 3, 395 9,066 0 22, 711 0 88. 01 08801 RURAL HEALTH CLINIC (RHC) ERIE 0 0 88.01 91.00 09100 EMERGENCY 10,507 2, 622 1, 138 6, 752 7, 258 91.00 92 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 04950 WOUND CARE 93.00 97 0 522 558 93.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 809 0 95.00 125 0 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 102, 00 0 0 0 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 59, 613 26, 624 74, 796 78, 534 38, 822 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 0 190. 00 194.00 07950 DIXON CLINIC 0 0 0 0 194. 00 0 0 194. 01 07951 RENTAL SPACE 0 0 0 194. 01 194. 02 07952 OTHER NON-REIMBURSABLE COST CENTERS Ω 0 0 0 194 02 194.03 07953 MORRISON ORTHOPEDIC CLINIC 0 0 0 0 194. 03 194. 04 07954 CLINTON CLINIC 0 0 0 0 194. 04 Cross Foot Adjustments 200.00 200.00 201.00 Negative Cost Centers Γ 0 201.00 202.00 TOTAL (sum lines 118 through 201) 78, 534 38, 822 202. 00 59,613 26, 624 74, 796

| Peri od: | Worksheet B | From 07/01/2022 | Part II | To 06/30/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1329

				T	06/30/2023	Date/Time Pre 11/29/2023 3:	
	Cost Center Description	CENTRAL	MEDI CAL	SOCIAL SERVICE	NONPHYSI CI AN	Subtotal	45 piii
		SERVICES &	RECORDS &		ANESTHETI STS		
		SUPPLY	LI BRARY				
		14. 00	16. 00	17. 00	19. 00	24. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00560 PURCHASING RECEIVING AND STORES						5. 01
5. 02	00591 PERSONNEL						5. 02
5. 03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 03
5. 05 7. 00	00590 ADMINISTRATIVE & GENERAL						5. 05
8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10. 00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11.00
13. 00	01300 NURSING ADMINISTRATION						13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	100, 102					14. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	76, 763				16. 00
17. 00	01700 SOCIAL SERVICE	o	0				17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	o	0		576		19.00
	INPATIENT ROUTINE SERVICE COST CENTERS	,	_	,		!	
30.00	03000 ADULTS & PEDI ATRI CS	0	2, 050	8, 699		559, 252	30.00
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	67, 234	26, 370	0		654, 393	50.00
53.00	05300 ANESTHESI OLOGY	0	4, 787	0		93, 228	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	9, 595	0		404, 832	54.00
60.00	06000 LABORATORY	0	6, 659	0		157, 016	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	1, 756	0		4, 600	
65.00	06500 RESPI RATORY THERAPY	0	156			11, 519	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	1, 550			122, 062	1
67. 00	06700 OCCUPATI ONAL THERAPY	0	461			16, 850	1
68. 00	06800 SPEECH PATHOLOGY	0	6			5, 033	1
69. 00	06900 ELECTROCARDI OLOGY	0	338			625	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	813			3, 960	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	6, 577	1		31, 156	1
73.00	07300 DRUGS CHARGED TO PATIENTS	0	4, 759	1		43, 855	1
76. 00	03950 NEUROLOGY	0	277			597	1
77. 00	07700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS	l d	0	0		0	77. 00
88. 00	08800 RURAL HEALTH CLINIC	31, 856	6, 691	0		893, 168	88. 00
88. 01	08801 RURAL HEALTH CLINIC (RHC) ERIE	31, 630	0, 091			10	1
91. 00	09100 EMERGENCY	1, 012	3, 132			307, 849	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,012	3, 132			307, 047	92.00
93. 00	04950 WOUND CARE	0	134	0		9, 455	1
70.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>	101			7, 100	70.00
95. 00	09500 AMBULANCE SERVICES	0	652	0		153, 899	95. 00
	10200 OPIOID TREATMENT PROGRAM	o	0				102. 00
	SPECIAL PURPOSE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
113.00	11300 I NTEREST EXPENSE						113. 00
118.00		100, 102	76, 763	8, 699	0		
	NONREI MBURSABLE COST CENTERS						1
190.00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0		0	190. 00
	07950 DIXON CLINIC	0	0				194. 00
	07951 RENTAL SPACE	0	0				194. 01
	07952 OTHER NON-REIMBURSABLE COST CENTERS	0	0	_			194. 02
	07953 MORRISON ORTHOPEDIC CLINIC	0	0	0			194. 03
	07954 CLINTON CLINIC	0	0	0			194. 04
200.00					576		200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	100, 102	76, 763	8, 699	576	3, 478, 556	J202. 00

Health Financial Systems MORRISON COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10

ALLOCATION OF CARLTAL PELATED COSTS

Provider CCN: 14-1329 Period: Worksheet R

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1329 Peri od: Worksheet B From 07/01/2022 Part II 06/30/2023 Date/Time Prepared: 11/29/2023 3:45 pm Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00560 PURCHASING RECEIVING AND STORES 5.01 5.01 00591 PERSONNEL 5.02 5.02 5.03 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.03 5.05 00590 ADMINISTRATIVE & GENERAL 5.05 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01300 NURSING ADMINISTRATION 13 00 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17.00 17 00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 0 559, 252 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 654, 393 50.00 05300 ANESTHESI OLOGY 0 93, 228 53.00 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 000000000000 404, 832 54.00 06000 LABORATORY 157, 016 60 00 60 00 06400 I NTRAVENOUS THERAPY 64.00 4,600 64.00 06500 RESPIRATORY THERAPY 11, 519 65.00 65.00 06600 PHYSI CAL THERAPY 122, 062 66.00 66, 00 06700 OCCUPATIONAL THERAPY 67.00 16,850 67.00 68.00 06800 SPEECH PATHOLOGY 5, 033 68.00 06900 ELECTROCARDI OLOGY 69 00 625 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 3, 960 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 31, 156 72 00 43, 855 73.00 07300 DRUGS CHARGED TO PATIENTS 73.00 03950 NEUROLOGY 76.00 597 76.00 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 77.00 0 OUTPATIENT SERVICE COST CENTERS 0 88.00 08800 RURAL HEALTH CLINIC 893, 168 88.00 88. 01 08801 RURAL HEALTH CLINIC (RHC) ERIE 88.01 10 09100 EMERGENCY 0 91.00 307, 849 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 93.00 04950 WOUND CARE 0 9, 455 93.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 153, 899 95.00 102.00 10200 OPIOID TREATMENT PROGRAM 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 0 3, 473, 359 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GLFT FLOWER COFFEE SHOP & CANTEEN 190.00 0 00000 194.00 07950 DIXON CLINIC 381 194.00 194. 01 07951 RENTAL SPACE 0 194. 01 194. 02 07952 OTHER NON-REIMBURSABLE COST CENTERS 194. 02 205 194. 03 07953 MORRI SON ORTHOPEDIC CLINIC 2 215 194. 03 194. 04 07954 CLINTON CLINIC 1,820 194.04 200.00 Cross Foot Adjustments 576 200.00 0 201.00 Negative Cost Centers 201.00 202.00 TOTAL (sum lines 118 through 201) 3, 478, 556 202.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Peri od: Worksheet B-1 From 07/01/2022 To 06/30/2023 Date/Time Prepared: Provider CCN: 14-1329

				'	0 06/30/2023	11/29/2023 3:	
		CAPITAL RE	LATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	 EMPLOYEE	PURCHASI NG	PERSONNEL	
	Sect Conten Boost Ptron		(DOLLAR VALUE)	BENEFITS	RECEIVING AND	(GROSS	
				DEPARTMENT	STORES	SALARI ES)	
				(GROSS SALARI ES)	(PURCHASE ORDERS)		
		1.00	2.00	4. 00	5. 01	5. 02	
	GENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FIXT	70, 835					1. 00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP		1, 081, 834				2.00
4. 00 5. 01	00400 EMPLOYEE BENEFITS DEPARTMENT 00560 PURCHASING RECEIVING AND STORES	1, 450	0	l '' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '			4. 00 5. 01
5. 02	00591 PERSONNEL	359	l .	83, 767	4	17, 340, 080	1
5.03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	1, 147	l .		88	747, 372	1
	00590 ADMINISTRATIVE & GENERAL	3, 192	1			863, 950	1
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE	15, 416 1, 332	l .		8	175, 344 0	1
9. 00	00900 HOUSEKEEPI NG	556		·	2	199, 359	
10.00	01000 DI ETARY	1, 600	l .			269, 042	1
11. 00	01100 CAFETERI A	593		0	o	0	
13.00	01300 NURSI NG ADMINI STRATI ON	429			3	241, 345	
14. 00 16. 00	01400 CENTRAL SERVICES & SUPPLY 01600 MEDICAL RECORDS & LIBRARY	1, 604 1, 493	l ·		917	90, 267 430, 366	1
17. 00	01700 SOCIAL SERVICE	153	l .		0	60, 636	1
	01900 NONPHYSICIAN ANESTHETISTS	0	l .			772, 884	1
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	9, 243	40, 967	1, 669, 707	156	1, 669, 707	30. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	4, 239	268, 705	1, 394, 899	1, 225	1, 394, 899	50.00
53. 00	05300 ANESTHESI OLOGY	4, 237	81, 308		82	1, 374, 677	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 170				711, 344	1
60.00	06000 LABORATORY	2, 060	32, 524	496, 911	114	496, 911	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	_			61, 276	•
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	,,2,0			64, 718	1
67. 00	06700 OCCUPATIONAL THERAPY	2, 436 279	l .			306, 108 155, 398	
68. 00	06800 SPEECH PATHOLOGY	111	Ö	0	Ö	0	1
69. 00	06900 ELECTROCARDI OLOGY	0	0	1, 106		1, 106	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	39	0	
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	367	7 442	0	0 22	205 082	
76. 00	03950 NEUROLOGY	307	7, 642			205, 082 11, 410	1
	07700 ALLOGENEIC HSCT ACQUISITION		_		l	0	1
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	13, 689	133, 400			6, 904, 574	1
88. 01 91. 00	08801 RURAL HEALTH CLINIC (RHC) ERIE 09100 EMERGENCY	4, 467	52, 650	462 735, 520	0 354	462 735, 520	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	4, 407	32,030	733, 320	334	733, 320	92.00
	04950 WOUND CARE	165	0	71, 051	7	71, 051	1
	OTHER REIMBURSABLE COST CENTERS		1				
	09500 AMBULANCE SERVICES	2, 285		1		120, 832	95. 00 102. 00
102.00	10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS		0	0	U	U	1102.00
113.00	11300 NTEREST EXPENSE						113. 00
118.00	` ;	70, 835	1, 081, 834	10, 266, 182	4, 039	16, 760, 963	118. 00
	NONREI MBURSABLE COST CENTERS		1		ما		1100.00
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN 07950 DIXON CLINIC	0	0				190. 00 194. 00
	07951 RENTAL SPACE		0	0			194. 00
	07952 OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	o		194. 02
	07953 MORRISON ORTHOPEDIC CLINIC	0	0	0	0	294, 434	
	07954 CLINTON CLINIC	0	0	0	0	239, 042	1
200. 00 201. 00	l	-					200. 00 201. 00
202.00	1 1 9	2, 378, 562	1, 099, 994	3, 393, 973	149, 355	141, 309	
	Part I)				·		
203.00		33. 578909	1. 016786	0. 330597		0. 008149	
204. 00				0	48, 689	12, 103	204. 00
205. 00	Part II) Unit cost multiplier (Wkst. B, Part			0. 000000	12. 054717	0. 000698	205 00
200.00	II)			0.000000	12.007/1/	3. 000070	
206.00	NAHE adjustment amount to be allocated						206. 00
207.00	(per Wkst. B-2)						207.00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00
	1. 3. 25 3	1	1	1	ı		1

Heal th	Fi nan	cial Systems	MORRISON COMMUNIT	ΓΥ HOSPI TAL		In Lie	u of Form CMS-	2552-10
		TION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
						From 07/01/2022 Fo 06/30/2023		
		Cost Center Description	CASHI ERI NG/ACC Re	_ conciliation	ADMI NI STRATI VI	OPERATION OF	11/29/2023 3: LAUNDRY &	45 pm
		Sect Control Boost (pt. o.)	OUNTS		& GENERAL	PLANT	LINEN SERVICE	
			RECEI VABLE (NON-NH		(ACCUM. COST)	(SQUARE FEET)	(POUNDS OF LAUNDRY)	
			CHARGES)				LAUNDICT)	
	CENED	AL CEDIUSE COCT CENTEDO	5. 03	5A. 05	5. 05	7. 00	8. 00	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT						1.00
2.00		CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00 5. 01		EMPLOYEE BENEFITS DEPARTMENT PURCHASING RECEIVING AND STORES						4. 00 5. 01
5. 02		PERSONNEL						5. 02
5. 03	1	CASHI ERI NG/ACCOUNTS RECEI VABLE	75, 798, 232					5. 03
5. 05	1	ADMINISTRATIVE & GENERAL OPERATION OF PLANT	0	-2, 182, 791	36, 719, 062 1, 235, 265			5. 05 7. 00
7. 00 8. 00		LAUNDRY & LINEN SERVICE		0	1, 235, 20		16, 698	
9.00	00900	HOUSEKEEPI NG	O	0	317, 34	556	0	9. 00
10.00	1	DIETARY	0	0	440, 45		0	
11. 00 13. 00		CAFETERIA NURSI NG ADMINI STRATI ON		0	19, 912 393, 056		0	
14. 00	01400	CENTRAL SERVICES & SUPPLY	O	0	378, 213		0	14. 00
		MEDICAL RECORDS & LIBRARY	0	0	,		0	
		SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS	0	0	88, 083 6, 298		0	
	I NPAT	ENT ROUTINE SERVICE COST CENTERS						1
30. 00		ADULTS & PEDIATRICS LARY SERVICE COST CENTERS	2, 228, 534	0	2, 991, 268	9, 243	5, 342	30.00
50. 00		OPERATING ROOM	24, 249, 814	0	4, 118, 25!	4, 239	6, 486	50.00
53. 00	1	ANESTHESI OLOGY	3, 104, 696	0			0	
54. 00 60. 00	1	RADI OLOGY-DI AGNOSTI C LABORATORY	10, 310, 882 7, 237, 923	0	_, -, ,		545 0	
64. 00		INTRAVENOUS THERAPY	1, 908, 983	0	234, 032		0	
65.00		RESPI RATORY THERAPY	169, 905	0	111, 278		0	
66. 00 67. 00	1	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	1, 684, 909 501, 232	0	545, 653 225, 764		396 0	
68. 00		SPEECH PATHOLOGY	6, 422	0	7, 82!		0	
	1	ELECTROCARDI OLOGY	288, 154	0	14, 966		0	
		MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS	883, 257 7, 148, 867	0	359, 015 3, 403, 129		0	
		DRUGS CHARGED TO PATIENTS	5, 173, 064	0			0	
76. 00		NEUROLOGY	231, 090	0	25, 64		0	
77. 00		ALLOGENEIC HSCT ACQUISITION TIENT SERVICE COST CENTERS	0	0		0	0	77. 00
88. 00		RURAL HEALTH CLINIC	7, 272, 883	0	10, 526, 97	1 13, 689	951	88. 00
88. 01		RURAL HEALTH CLINIC (RHC) ERIE	0	0			0	
	1	EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	2, 543, 093	0	3, 038, 578	4, 467	2, 943	91. 00 92. 00
	04950	WOUND CARE	145, 788	0	104, 63	7 165	0	1
95 00		REI MBURSABLE COST CENTERS AMBULANCE SERVI CES	708, 736	0	371, 249	2, 285	25	95. 00
	1	OPLOID TREATMENT PROGRAM	708, 730	0		0 0		102. 00
112 00		AL PURPOSE COST CENTERS INTEREST EXPENSE			ı	1		112 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	75, 798, 232	-2, 182, 791	35, 998, 878	49, 271	16, 698	113. 00 118. 00
	NONRE	MBURSABLE COST CENTERS					•	
		GIFT FLOWER COFFEE SHOP & CANTEEN DIXON CLINIC	0	0				190. 00 194. 00
		RENTAL SPACE		0	37, 032			194. 01
		OTHER NON-REIMBURSABLE COST CENTERS	0	0	35, 063			194. 02
		MORRISON ORTHOPEDIC CLINIC CLINTON CLINIC	0	0	343, 176 282, 293			194. 03 194. 04
200.00		Cross Foot Adjustments		0	202, 27.		0	200.00
201.00	1	Negative Cost Centers						201.00
202. 00		Cost to be allocated (per Wkst. B, Part I)	1, 160, 862		2, 182, 79°	1, 308, 697	154, 693	202. 00
203.00		Unit cost multiplier (Wkst. B, Part I)	0. 015315		0. 059446	26. 561202	9. 264163	203. 00
204.00		Cost to be allocated (per Wkst. B, Part II)	49, 333		215, 004	525, 804	59, 613	204. 00
205. 00		Unit cost multiplier (Wkst. B, Part	0. 000651		0. 00585!	10. 671673	3. 570068	205. 00
206. 00		NAHE adjustment amount to be allocated						206. 00
		(per Wkst. B-2)						
207. 00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

		TION - STATISTICAL BASIS		Provi der CO	CN: 14-1329 F	Peri od:	Worksheet B-1	
						From 07/01/2022 o 06/30/2023		
		Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	11/29/2023 3: CENTRAL	45 pm
		cost center bescription		(MEALS SERVED)	(FTES)	ADMI NI STRATI ON	SERVICES &	
						(HOURS OF	SUPPLY	
						(HOURS OF SERVICE)	(LOADS)	
			9. 00	10.00	11. 00	13. 00	14. 00	
1 00		AL SERVICE COST CENTERS		I				1 00
1. 00 2. 00		CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	1	PURCHASING RECEIVING AND STORES						5. 01
5. 02 5. 03		PERSONNEL CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 02 5. 03
5. 05	1	ADMINISTRATIVE & GENERAL						5. 05
7.00		OPERATION OF PLANT						7. 00
8.00		LAUNDRY & LINEN SERVICE	45 272					8.00
9. 00 10. 00		HOUSEKEEPI NG DI ETARY	45, 373 1, 600					9. 00 10. 00
		CAFETERI A	593		15, 050			11. 00
	1	NURSING ADMINISTRATION	0		249			13. 00
	1	CENTRAL SERVICES & SUPPLY	1, 605	l .	930 930	I	14, 744 0	
16. 00 17. 00		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	826 153		118		0	
		NONPHYSICIAN ANESTHETISTS	0	l .	(0	
		I ENT ROUTINE SERVICE COST CENTERS				50.004		
30. 00		ADULTS & PEDIATRICS LARY SERVICE COST CENTERS	9, 082	6, 255	2, 793	58, 094	0	30.00
50. 00		OPERATING ROOM	4, 241	188	1, 670	34, 744	9, 903	50.00
53.00	05300	ANESTHESI OLOGY	0		302	0	0	1
54.00	1	RADI OLOGY-DI AGNOSTI C	2, 011	l .	1, 008		0	
60. 00 64. 00		LABORATORY INTRAVENOUS THERAPY	2, 060	l .	852 3 <i>6</i>	I	0	
65. 00		RESPI RATORY THERAPY		-	102	I	0	
66.00	06600	PHYSI CAL THERAPY	2, 436		410		0	66. 00
67.00		OCCUPATIONAL THERAPY	279	0	196		0	
68. 00 69. 00	1	SPEECH PATHOLOGY ELECTROCARDI OLOGY	111	0			0	
	1	MEDICAL SUPPLIES CHARGED TO PATIENT	0		Ċ		0	1
		IMPL. DEV. CHARGED TO PATIENTS	0		C		0	
		DRUGS CHARGED TO PATIENTS NEUROLOGY	289		239		0	
		ALLOGENEIC HSCT ACQUISITION					0	
	OUTPA	TIENT SERVICE COST CENTERS	-					
	1	RURAL HEALTH CLINIC	15, 453	0			4, 692	
88. 01 91. 00		RURAL HEALTH CLINIC (RHC) ERIE EMERGENCY	4, 469	336	1, 294	-1	0 149	
92.00	1	OBSERVATION BEDS (NON-DISTINCT PART	1, 10,		1,27	20, 710	117	92.00
93. 00		WOUND CARE	165	0	100	2, 071	0	93. 00
95. 00		REIMBURSABLE COST CENTERS AMBULANCE SERVICES	0	0	155	ol ol	0	95.00
		OPIOID TREATMENT PROGRAM						102.00
		AL PURPOSE COST CENTERS	-	_		1	_	
		I NTEREST EXPENSE	45 070	00.077	45.056	140,000	44 744	113.00
118. 00	-	SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	45, 373	22, 077	15, 050	143, 990	14, /44	118. 00
	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	C	0	0	190. 00
		DIXON CLINIC	0	-				194. 00
		RENTAL SPACE OTHER NON-REIMBURSABLE COST CENTERS	0	0	(I I	0	194. 01 194. 02
		MORRISON ORTHOPEDIC CLINIC		0		-1		194. 02
194.04	07954	CLINTON CLINIC	0	0	C	o o		194. 04
200.00	1	Cross Foot Adjustments						200. 00
201. 00 202. 00		Negative Cost Centers Cost to be allocated (per Wkst. B,	350, 977	521, 509	402, 808	434, 481	462, 192	201.00
202.00		Part I)	330, 711	321, 307	402, 000	434, 401	402, 172	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7. 735371	l .	26. 764651	I I	31. 347802	
204. 00	1	Cost to be allocated (per Wkst. B,	26, 624	74, 796	78, 534	38, 822	100, 102	204. 00
205. 00		Part II) Unit cost multiplier (Wkst. B, Part	0. 586781	3. 387960	5. 21820 <i>6</i>	0. 269616	6. 789338	205. 00
		[11]	3. 555761]	3.2.3200	2.23,010	2.,0,000	
206.00	1	NAHE adjustment amount to be allocated						206. 00
207. 00		(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207. 00
50		Parts III and IV)						

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 Provider CCN: 14-1329

					To	06/30/2023 Date/Time Pro 11/29/2023 3	
		Cost Center Description	MEDI CAL	SOCI AL SERVI CE	NONPHYSI CI AN	1172772023 3	. 43 piii
			RECORDS &	(TIME CDENT)	ANESTHETI STS		
			LI BRARY (NON-NH	(TIME SPENT)	(ASSIGNED TIME)		
			CHARGES)		,		
	CENED	AL CEDVICE COCT CENTERS	16. 00	17. 00	19. 00		
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT					1.00
2.00	1	CAP REL COSTS-MVBLE EQUIP					2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 01 5. 02	1	PURCHASING RECEIVING AND STORES PERSONNEL					5. 01 5. 02
5. 02	1	CASHI ERI NG/ACCOUNTS RECEI VABLE					5. 02
5. 05	1	ADMINISTRATIVE & GENERAL					5. 05
7.00	1	OPERATION OF PLANT					7. 00
8. 00 9. 00	1	LAUNDRY & LINEN SERVICE HOUSEKEEPING					8. 00 9. 00
10. 00		DI ETARY					10.00
11. 00		CAFETERI A					11. 00
13.00	1	NURSI NG ADMI NI STRATI ON					13.00
14. 00 16. 00	1	CENTRAL SERVICES & SUPPLY MEDICAL RECORDS & LIBRARY	83, 444, 096				14. 00 16. 00
17. 00	1	SOCIAL SERVICE	03, 444, 070	100			17. 00
19. 00	01900	NONPHYSICIAN ANESTHETISTS	0	0	100		19. 00
20.00		I ENT ROUTI NE SERVI CE COST CENTERS	2, 228, 534	100	O		20.00
30. 00		ADULTS & PEDIATRICS LARY SERVICE COST CENTERS	2, 228, 534	100	<u> </u>		30.00
50.00		OPERATI NG ROOM	28, 668, 264	0	0		50.00
53.00	1	ANESTHESI OLOGY	5, 203, 446	0			53. 00
54. 00 60. 00		RADI OLOGY-DI AGNOSTI C LABORATORY	10, 429, 737 7, 238, 112	0	-		54. 00 60. 00
64. 00	1	INTRAVENOUS THERAPY	1, 908, 983	0	-		64. 00
65. 00	1	RESPI RATORY THERAPY	169, 905	0	0		65. 00
66.00	1	PHYSI CAL THERAPY	1, 684, 909	0	-		66. 00
67. 00 68. 00	1	OCCUPATIONAL THERAPY SPEECH PATHOLOGY	501, 232 6, 422	0			67. 00 68. 00
69. 00		ELECTROCARDI OLOGY	367, 166	0			69. 00
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENT	883, 257	0	0		71. 00
72. 00	1	IMPL. DEV. CHARGED TO PATIENTS	7, 148, 867	0	0		72. 00
73. 00 76. 00		DRUGS CHARGED TO PATIENTS NEUROLOGY	5, 173, 064 300, 725	0			73. 00 76. 00
77. 00	1	ALLOGENEIC HSCT ACQUISITION	0	0			77. 00
		TIENT SERVICE COST CENTERS					
88. 00 88. 01		RURAL HEALTH CLINIC RURAL HEALTH CLINIC (RHC) ERIE	7, 272, 883	0			88. 00 88. 01
91. 00		EMERGENCY	3, 404, 066	0			91.00
92.00	1	OBSERVATION BEDS (NON-DISTINCT PART					92. 00
93. 00		WOUND CARE REIMBURSABLE COST CENTERS	145, 788	0	0		93. 00
95. 00		AMBULANCE SERVICES	708, 736	0	0		95. 00
	10200	OPIOID TREATMENT PROGRAM	0				102. 00
112 00		AL PURPOSE COST CENTERS					112 00
118.00	1	INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	83, 444, 096	100	100		113. 00 118. 00
		IMBURSABLE COST CENTERS	227 7 2 . 2				
		GIFT FLOWER COFFEE SHOP & CANTEEN	0	0			190.00
		DIXON CLINIC RENTAL SPACE	0	0	-		194. 00 194. 01
		OTHER NON-REIMBURSABLE COST CENTERS	0	0	-		194. 02
		MORRISON ORTHOPEDIC CLINIC	0	0	0		194. 03
194. 04 200. 00		CLINTON CLINIC	0	0	0		194. 04 200. 00
200.00	1	Cross Foot Adjustments Negative Cost Centers					200.00
202.00	1	Cost to be allocated (per Wkst. B,	946, 594	109, 154	6, 672		202. 00
202.00		Part I)	0.011244	1 001 540000	44 720000		202 00
203. 00 204. 00	1	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	0. 011344 76, 763	1, 091. 540000 8, 699			203. 00 204. 00
		Part II)					
205.00		Unit cost multiplier (Wkst. B, Part	0. 000920	86. 990000	5. 760000		205. 00
206. 00		NAHE adjustment amount to be allocated					206. 00
		(per Wkst. B-2)					
207. 00	'	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207. 00
	1	,	ı I		. '		1

Health Financial Systems
POST STEPDOWN ADJUSTMENTS MORRISON COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 14-1329

				_	11/29/2023 3.4	+5 PIII
			Work	sheet		
	Descripti	on	CODE	Li ne No.	Amount	
	1.00		2.00	3. 00	4. 00	
1.00	ADJ FOR EPO COSTS	IN RENAL		1 74.00	0	1. 00
	DI ALYSI S					l
2.00	ADJ FOR EPO COSTS	IN HOME		1 94.00	0	2. 00
	PROGRAM					l
3.00	ADJ FOR ARANESP CO	STS IN		1 74.00	0	3. 00
	RENAL DIALYSIS					l
4. 00	ADJ FOR ARANESP CO	STS IN		1 94.00	0	4. 00
	HOME PROGRAM					l
5. 00	ADJ FOR ESA COSTS	IN RENAL		1 74.00	0	5. 00
	DI ALYSI S					l
6. 00	ADJ FOR ESA COSTS	IN HOME		1 94.00	0	6. 00
	PROGRAM					l
7. 00	IV THERAPY			1 30.00	-180, 856	
8. 00	IV THERAPY			1 64.00	180, 856	8. 00

	ncial Systems OF RATIO OF COSTS TO CHARGES	MORRI SON COMMUI	Provi der Co	^N: 14_1320	Peri od:	u of Form CMS-: Worksheet C	
COMITOTATION	of MATTO OF GOSTS TO GHANGES		Trovider of	014. 14 1327	From 07/01/2022	Part I	
					To 06/30/2023	Date/Time Pre 11/29/2023 3:	pared:
			Ti +Lo	xVIII	Hospi tal	11/29/2023 3: Cost	45 pm
			l litte	XVIII	Costs	COST	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
	oost denter bescription	(from Wkst. B,	Adj.	10141 00313	Di sal I owance	10141 00313	
		Part I, col.	,				
		26)					
		1. 00	2. 00	3.00	4. 00	5. 00	
	TIENT ROUTINE SERVICE COST CENTERS						
	ADULTS & PEDIATRICS	3, 885, 718		3, 885, 7	18 0	0	30.00
	LARY SERVICE COST CENTERS						
	OPERATING ROOM	5, 358, 185		5, 358, 1		0	
	ANESTHESI OLOGY	287, 794		287, 7		0	
	RADI OLOGY-DI AGNOSTI C	2, 384, 851		2, 384, 8		0	
	LABORATORY	2, 716, 470		2, 716, 4		0	
	I NTRAVENOUS THERAPY	451, 420		451, 4		0	
	RESPI RATORY THERAPY	128, 956	l e			0	
	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	721, 123 271, 997	0	721, 1 271, 9		0	
	SPEECH PATHOLOGY	12, 170	0	12, 1		0	
	ELECTROCARDI OLOGY	20, 075		20, 0		0	
	MEDICAL SUPPLIES CHARGED TO PATIENT	390, 377		390, 3		0	
	IMPL. DEV. CHARGED TO PATIENTS	3, 686, 528		3, 686, 5		0	1
	D DRUGS CHARGED TO PATIENTS	1, 639, 671		1, 639, 6		0	
	NEUROLOGY	30, 583		30, 5		0	
	ALLOGENEIC HSCT ACQUISITION	0	l e	00,0	0 0	0	
	ATIENT SERVICE COST CENTERS				٥,		1
	RURAL HEALTH CLINIC	11, 990, 754		11, 990, 7	54 0	0	88. 00
	RURAL HEALTH CLINIC (RHC) ERIE	1, 797	l .	1, 7		0	
	EMERGENCY	3, 566, 771		3, 566, 7		0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	739, 819		739, 8		0	92.00
93.00 04950	WOUND CARE	127, 095		127, 0		0	93.00
OTHER	R REIMBURSABLE COST CENTERS						
	AMBULANCE SERVICES	466, 523		466, 5	23 0	0	95. 00
	OPIOID TREATMENT PROGRAM	0			0	0	102. 00
	AL PURPOSE COST CENTERS						
	INTEREST EXPENSE						113. 00
200.00	Subtotal (see instructions)	38, 878, 677	0				200. 00
201.00	Less Observation Beds	739, 819	l e	739, 8			201.00
202.00	Total (see instructions)	38, 138, 858	0	38, 138, 8	58 0	0	202.00

Heal th	Financial Systems	MORRI SON COMMUN	II TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	TATION OF RATIO OF COSTS TO CHARGES		Provi der C	CN: 14-1329	Peri od: From 07/01/2022 To 06/30/2023	Worksheet C Part I Date/Time Pre 11/29/2023 3:	pared:
			Title	XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	966, 369		966, 36	59		30.00
	ANCILLARY SERVICE COST CENTERS			1			
50. 00	05000 OPERATING ROOM	28, 553	23, 605, 361			0. 000000	
53.00	05300 ANESTHESI OLOGY	4, 673	3, 026, 847			0. 000000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	85, 297	9, 956, 727			0. 000000	
60. 00	06000 LABORATORY	255, 981	6, 838, 534			0. 000000	
64.00	06400 I NTRAVENOUS THERAPY	163, 964	1, 723, 579			0. 000000	
65. 00	06500 RESPI RATORY THERAPY	40, 197	55, 846			0. 000000	
66. 00	06600 PHYSI CAL THERAPY	442, 839	1, 250, 777			0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	299, 030	198, 599			0. 000000	
68. 00	06800 SPEECH PATHOLOGY	2, 453	3, 969			0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	2, 955	279, 165			0. 000000	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	81, 742	783, 219			0. 000000	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	97, 284	7, 014, 762			0. 000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	687, 772	4, 418, 757			0. 000000	
76. 00	03950 NEUROLOGY	0	226, 961			0. 000000	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	1	0.000000	0. 000000	77. 00
00.00	OUTPATIENT SERVICE COST CENTERS	100.00/	/ 0/0 077	7 000 0	· al		00.00
88. 00	08800 RURAL HEALTH CLINIC	129, 386	6, 968, 977		0		88. 00 88. 01
88. 01	08801 RURAL HEALTH CLINIC (RHC) ERIE 09100 EMERGENCY	0	2 524 442	1	0	0.000000	
91. 00 92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	116	2, 524, 662			0. 000000 0. 000000	
92.00	04950 WOUND CARE	0	1, 244, 967			0. 000000	
93.00	OTHER REIMBURSABLE COST CENTERS	4, 040	141, 748	145, 78	0.871780	0.000000	93.00
05 00	09500 AMBULANCE SERVICES	O	708, 736	708, 73	0. 658247	0. 000000	95. 00
	10200 OPI OI D TREATMENT PROGRAM		706, 730		0. 030247	0.000000	102. 00
102.00	SPECIAL PURPOSE COST CENTERS	l d		1	U		102.00
112 00	11300 INTEREST EXPENSE						113. 00
200.00		3, 292, 651	70, 972, 193	74, 264, 84	14		200. 00
200.00		3, 272, 031	10, 712, 193	74, 204, 04	17		200.00
201.00		3, 292, 651	70, 972, 193	74, 264, 84	14		201.00
202.00	Total (See Histiactions)	3, 272, 031	10, 112, 173	1 14, 204, 04	17		1202.00

	Financial Systems	MORRI SON COMMUNI			u of Form CMS-:	2552-10
COMPUT	TATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-1329	Peri od: From 07/01/2022	Worksheet C Part I	
					Date/Time Pre	pared:
					11/29/2023 3:	45 pm
			Title XVIII	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00	03000 ADULTS & PEDIATRICS					30.00
	ANCILLARY SERVICE COST CENTERS					
	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
60.00	06000 LABORATORY	0. 000000				60.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000				64. 00
65.00	06500 RESPI RATORY THERAPY	0. 000000				65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000				66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000				67.00

0.000000

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0.000000

0. 000000

68.00

69.00

71.00

72.00

73.00

76.00

77.00

88.00

88. 01 91. 00

92.00

93.00

95.00

102.00

113.00

200. 00

201.00

202. 00

68.00 06800 SPEECH PATHOLOGY

03950 NEUROLOGY

09100 EMERGENCY

04950 WOUND CARE

95. 00 09500 AMBULANCE SERVICES

113. 00 11300 INTEREST EXPENSE

102.00 10200 OPI OI D TREATMENT PROGRAM

SPECIAL PURPOSE COST CENTERS

71.00

73.00

76.00

77.00

88.00

88. 01

91.00

92.00

93.00

200.00

201.00

202.00

06900 ELECTROCARDI OLOGY

08800 RURAL HEALTH CLINIC

72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS

07300 DRUGS CHARGED TO PATIENTS

07700 ALLOGENEIC HSCT ACQUISITION
OUTPATIENT SERVICE COST CENTERS

OTHER REIMBURSABLE COST CENTERS

08801 RURAL HEALTH CLINIC (RHC) ERIE

09200 OBSERVATION BEDS (NON-DISTINCT PART

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

07100 MEDICAL SUPPLIES CHARGED TO PATIENT

Heal th	Financial Systems	MORRISON COMMU	NITY HOSPITAL		In Lie	u of Form CMS-	2552-10
	ATION OF RATIO OF COSTS TO CHARGES		Provi der C		Peri od: From 07/01/2022 To 06/30/2023	Worksheet C Part I Date/Time Pre 11/29/2023 3:	pared:
			Ti tl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)		Total Costs	Di sal I owance	Total Costs	
		1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	3, 885, 718	B	3, 885, 7	18 0	3, 885, 718	30.00
	ANCILLARY SERVICE COST CENTERS	5 050 405			a=		
50.00	05000 OPERATI NG ROOM	5, 358, 185		5, 358, 18		5, 358, 185	
53.00	05300 ANESTHESI OLOGY	287, 794	l control of the cont	287, 79		287, 794	
54. 00 60. 00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	2, 384, 851	l control of the cont	2, 384, 85		2, 384, 851	1
64. 00	06400 I NTRAVENOUS THERAPY	2, 716, 470 451, 420		2, 716, 47 451, 42		2, 716, 470 451, 420	1
65. 00	06500 RESPIRATORY THERAPY	128, 956				128, 956	
66. 00	06600 PHYSI CAL THERAPY	721, 123		721, 12		721, 123	
67. 00	06700 OCCUPATI ONAL THERAPY	271, 123		271, 12		271, 123	
68. 00	06800 SPEECH PATHOLOGY	12, 170				12, 170	
69. 00	06900 ELECTROCARDI OLOGY	20, 075		20, 0		20, 075	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	390, 377		390, 3		390, 377	
	07200 I MPL. DEV. CHARGED TO PATIENTS	3, 686, 528		3, 686, 52		3, 686, 528	
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 639, 671		1, 639, 6		1, 639, 671	
76. 00	03950 NEUROLOGY	30, 583		30, 58		30, 583	1
	07700 ALLOGENEIC HSCT ACQUISITION	30, 303	1	30, 30	0 0	0	1
77.00	OUTPATIENT SERVICE COST CENTERS		1		<u> </u>		177.00
88. 00	08800 RURAL HEALTH CLINIC	11, 990, 754		11, 990, 7	54 0	11, 990, 754	88. 00
88. 01	08801 RURAL HEALTH CLINIC (RHC) ERIE	1, 797	l .	1, 79		1, 797	1
91. 00	09100 EMERGENCY	3, 566, 771	1	3, 566, 7		3, 566, 771	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	739, 819	1	739, 8		739, 819	
	04950 WOUND CARE	127, 095		127, 09		127, 095	
	OTHER REIMBURSABLE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,	'			,	
95.00	09500 AMBULANCE SERVICES	466, 523	3	466, 52	23 0	466, 523	95. 00
102.00	10200 OPI OI D TREATMENT PROGRAM	0			0		102.00
	SPECIAL PURPOSE COST CENTERS	•			<u> </u>]
113.00	11300 I NTEREST EXPENSE						113. 00
200.00		38, 878, 677	' O	38, 878, 67	77 0	38, 878, 677	
201.00	Less Observation Beds	739, 819		739, 81	19	739, 819	
202.00	Total (see instructions)	38, 138, 858	s o	38, 138, 8	58 0	38, 138, 858	202. 00

Heal th	Financial Systems	MORRI SON COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
	FATION OF RATIO OF COSTS TO CHARGES		Provi der C	CN: 14-1329	Period: From 07/01/2022 To 06/30/2023	Worksheet C Part I Date/Time Pre 11/29/2023 3:	pared:
			Ti tl	e XIX	Hospi tal	Cost	
	·		Charges		·		
	Cost Center Description	I npati ent	Outpati ent	Total (col. + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00		966, 369		966, 36	9		30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	28, 553	23, 605, 361				
53.00	05300 ANESTHESI OLOGY	4, 673	3, 026, 847				
54.00	05400 RADI OLOGY-DI AGNOSTI C	85, 297	9, 956, 727			0.000000	
60.00	06000 LABORATORY	255, 981	6, 838, 534			0.000000	
64. 00	06400 I NTRAVENOUS THERAPY	163, 964	1, 723, 579			0.000000	
65. 00	06500 RESPI RATORY THERAPY	40, 197	55, 846			0.000000	65. 00
66. 00	06600 PHYSI CAL THERAPY	442, 839	1, 250, 777			0.000000	
67. 00	06700 OCCUPATI ONAL THERAPY	299, 030	198, 599			0. 000000	
68. 00	06800 SPEECH PATHOLOGY	2, 453	3, 969			0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	2, 955	279, 165			0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	81, 742	783, 219			0. 000000	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	97, 284	7, 014, 762			0. 000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	687, 772	4, 418, 757			0.000000	
76. 00	03950 NEUROLOGY	0	226, 961	1		0. 000000	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0.000000	0.000000	77. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	129, 386	6, 968, 977			0. 000000	
88. 01	08801 RURAL HEALTH CLINIC (RHC) ERIE	0	0		0. 000000	0. 000000	
91. 00	09100 EMERGENCY	116	2, 524, 662			0. 000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 244, 967			0. 000000	
93. 00	04950 WOUND CARE	4, 040	141, 748	145, 78	0. 871780	0. 000000	93. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	0	708, 736			0. 000000	
102.00	10200 OPIOID TREATMENT PROGRAM	0	0		0		102. 00
	SPECIAL PURPOSE COST CENTERS			1			
	11300 INTEREST EXPENSE						113. 00
200.00		3, 292, 651	70, 972, 193	74, 264, 84	4		200. 00
201.00			70 070 :				201. 00
202.00	Total (see instructions)	3, 292, 651	70, 972, 193	74, 264, 84	4		202. 00

Health Financial Systems	MORRI SON COMMUNI	TY HOSPI TAL	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-1329	Peri od: From 07/01/2022 To 06/30/2023	Worksheet C Part I Date/Time Pre 11/29/2023 3:	epared: 45 pm
		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
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
60. 00 06000 LABORATORY	0. 000000				60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000				64. 00
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65. 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
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN					71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
76. 00 03950 NEUROLOGY	0. 000000				76.00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000				77. 00
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC	0. 000000				88. 00
88. 01 08801 RURAL HEALTH CLINIC (RHC) ERIE	0. 000000				88. 01
91. 00 09100 EMERGENCY	0. 000000				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PAR					92.00
93. 00 04950 WOUND CARE	0. 000000				93.00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES	0. 000000				95.00
102. 00 10200 OPI OI D TREATMENT PROGRAM					102. 00
SPECIAL PURPOSE COST CENTERS					
113. 00 11300 INTEREST EXPENSE					113. 00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00

113. 00 200. 00 201. 00 202. 00

202.00

Total (see instructions)

Heal th	Financial Systems	MORRI SON COMMUI	NITY HOSPITAL		In lie	eu of Form CMS-2	2552-10
	TONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provider Co	CN: 14-1329	Period: From 07/01/2022 To 06/30/2023	Worksheet D Part II	pared:
				XVIII	Hospi tal	Cost	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,	·		. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	T	T	1			
50. 00	05000 OPERATING ROOM	654, 393		1			
53.00	05300 ANESTHESI OLOGY	93, 228		1			
54.00	05400 RADI OLOGY-DI AGNOSTI C	404, 832		1		895	
60.00	06000 LABORATORY	157, 016		1			60.00
64. 00	06400 I NTRAVENOUS THERAPY	4, 600		1	·		64. 00
65. 00	06500 RESPI RATORY THERAPY	11, 519		1	·	493	
66. 00	06600 PHYSI CAL THERAPY	122, 062	1, 693, 616	0. 07207	72 4, 774	344	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	16, 850	497, 629			122	67. 00
68.00	06800 SPEECH PATHOLOGY	5, 033	6, 422	0. 78371	12 0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	625	282, 120	0. 00221	1, 293	3	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 960	864, 961	0.00457	78 12, 020	55	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	31, 156	7, 112, 046	0. 00438	31 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	43, 855	5, 106, 529	0. 00858	53, 416	459	73.00
76.00	03950 NEUROLOGY	597	226, 961	0.00263	0 0	0	76. 00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.00000	00	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						1
88. 00	08800 RURAL HEALTH CLINIC	893, 168	7, 098, 363	0. 12582	27 0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC (RHC) ERIE	10		1	00	0	88. 01
91.00	09100 EMERGENCY	307, 849	2, 524, 778	0. 12193	31 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	106, 478	1, 244, 967			0	92. 00
93.00	04950 WOUND CARE	9, 455		1		3	93. 00
	OTHER RELMBURSABLE COST CENTERS			•	•		1

2, 866, 686

72, 589, 739

184, 857

95. 00

3, 786 200. 00

OTHER REIMBURSABLE COST CENTERS

95. 00 09500 AMBULANCE SERVICES

200. 00 Total (Lines 50 through 199)

Heal th	Financial Systems	MORRI SON COMMUI	NITY HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF SH COSTS	RVICE OTHER PASS	S Provider Co	CN: 14-1329	Peri od: From 07/01/2022 To 06/30/2023		pared: 45 pm
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician Anesthetist Cost	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0		0	0	
53. 00	05300 ANESTHESI OLOGY	0	0		0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
60.00	06000 LABORATORY	0	0		0	0	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0	0		0 0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0		0 0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		0 0	0	68. 00
	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73. 00
	03950 NEUROLOGY	0	0		0	0	76. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0		0	0	
00 01	00001 DUDAL HEALTH CLINIC (DUC) EDIE	1	1 0	I			00 01

0

0

0

0 88. 01

0 91.00

0 92.00

93.00 0

95.00

0 200. 00

08801 RURAL HEALTH CLINIC (RHC) ERIE

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

91. 00 09100 EMERGENCY

93. 00 04950 WOUND CARE

	Financial Systems	MORRI SON COMMUN	NITY HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS	VICE OTHER PASS			Period: From 07/01/2022 To 06/30/2023		pared: 45 pm
				XVIII	Hospi tal	Cost	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost			· ·	(col. 5 + col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
	ANOLILIADY OFFICE COOT OFFITTED	4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	1		T	00 (00 01)		
50.00	05000 OPERATING ROOM	0	0		0 23, 633, 914		1
53.00	05300 ANESTHESI OLOGY	0	0		0 3, 031, 520		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 10, 042, 024		
60.00	06000 LABORATORY	0	0		0 7, 094, 515		
64. 00	06400 I NTRAVENOUS THERAPY	0	0		0 1, 887, 543		
65. 00	06500 RESPI RATORY THERAPY	0	0		96, 043		l
	06600 PHYSI CAL THERAPY	0	0		0 1, 693, 616		
	06700 OCCUPATI ONAL THERAPY	0	0		0 497, 629		
	06800 SPEECH PATHOLOGY	0	0		0 6, 422		
	06900 ELECTROCARDI OLOGY	0	0		0 282, 120		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 864, 961	0. 000000	1
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 7, 112, 046		
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 5, 106, 529		1
76.00	03950 NEUROLOGY	0	0		0 226, 961	0. 000000	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0.000000	77. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0		0 7, 098, 363		
88. 01	08801 RURAL HEALTH CLINIC (RHC) ERIE	0	0		0	0. 000000	88. 01
	09100 EMERGENCY	0	0		0 2, 524, 778		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	i .	0 1, 244, 967		1
93.00	04950 WOUND CARE	0	0		0 145, 788	0.000000	93. 00

0

72, 589, 739

93.00 95.00

200.00

	<i>J</i>	MORRI SON COMMUNI	_			eu of Form CMS-2	2552-10
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS	VICE OTHER PASS	Provi der CC		Period: From 07/01/2022 To 06/30/2023		
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col.	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col.		Outpatient Program Pass-Through Costs (col. 9	
		7)		x col . 10)	5	x col . 12)	
		9, 00	10. 00	11.00	12.00	13.00	
_	ANCILLARY SERVICE COST CENTERS	7.00	10.00	11.00	12.00	13.00	
50.00	05000 OPERATING ROOM	0. 000000	16, 789		0 0	0	50.00
53. 00	05300 ANESTHESI OLOGY	0. 000000	1, 094		0 0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	22, 211		0 0	0	54.00
60.00	06000 LABORATORY	0. 000000	38, 278		0 0	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	27, 215		0 0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0. 000000	4, 111		0 0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	4, 774		0 0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	3, 612		0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	1, 293		0 0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	12, 020		0 0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	53, 416		0 0	0	73. 00
76.00	03950 NEUROLOGY	0. 000000	0		0 0	0	76. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0		0	0	
88. 01	08801 RURAL HEALTH CLINIC (RHC) ERIE	0. 000000	0		0	0	88. 01
91. 00	09100 EMERGENCY	0. 000000	0		0	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0	0	92. 00
93. 00	04950 WOUND CARE	0. 000000	44		0 0	0	93. 00

184, 857

0

0

95. 00 0 200. 00

OTHER REIMBURSABLE COST CENTERS

95. 00 09500 AMBULANCE SERVICES

200. 00 Total (Lines 50 through 199)

Heal th	n Financial Systems	MORRI SON COMMUI	NITY HOSPITAL		In lie	eu of Form CMS-2	2552-10
	TIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN		Provider CO		Peri od: From 07/01/2022 To 06/30/2023	Worksheet D Part V	pared:
			Title	XVIII	Hospi tal	Cost	
				Charges		Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
			Services (see		Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
		4.00	0.00	(see inst.)	(see inst.)	F 00	
	ANGLILIADY CEDVICE COCT CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
50. 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	0. 226716		4 250 00	20 0	0	F0 00
53. 00	05300 OPERATING ROOM 05300 ANESTHESI OLOGY	0. 226716	-	4, 358, 00) 0	00.00
53.00	05400 RADI OLOGY - DI AGNOSTI C	0. 094934	0	580, 91) 0	54.00
60.00	06000 LABORATORY		0	2, 243, 47		0	
64. 00	06400 NTRAVENOUS THERAPY	0. 382897 0. 239157	0	1, 329, 14 479, 05) 	64. 00
65. 00	06500 RESPIRATORY THERAPY					0	65. 00
66. 00	06600 PHYSI CAL THERAPY	1. 342690 0. 425789		12, 92		0	66.00
	06700 OCCUPATIONAL THERAPY	0. 425789		264, 87		0	
67. 00 68. 00	06800 SPEECH PATHOLOGY			52, 56		0	
69. 00	06900 ELECTROCARDI OLOGY	1. 895048 0. 071158		1, 09 94, 67		0	68. 00 69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 071158		218, 19		0	
		0. 451323		1, 498, 78		0	
		0. 321093				0	73. 00
	03950 NEUROLOGY	0. 321093		1, 328, 93 49, 08		0	
76.00	03950 NEUROLOGY	0. 134750	0	49, 08	0	0	76.00

0. 000000

1. 412707

0. 594248

0. 871780

0.658247

0

944, 435

69, 130

13, 525, 281

13, 525, 281

0 77.00

0 91.00

0 92.00

0

0

0

0

88.00

88. 01

93. 00

95.00

0 200. 00

0 202.00

201. 00

09100 EMERGENCY

04950 WOUND CARE

07700 ALLOGENEIC HSCT ACQUISITION

08801 RURAL HEALTH CLINIC (RHC) ERIE

09200 OBSERVATION BEDS (NON-DISTINCT PART

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC

OTHER REIMBURSABLE COST CENTERS

09500 AMBULANCE SERVICES

Only Charges

77.00

88.00

88. 01

91.00

92.00

93.00

95.00

200.00

201.00

202.00

Health Financial Systems	MORRISON COMM	UNITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der (CCN: 14-1329	Peri od: From 07/01/2022 To 06/30/2023	Worksheet D Part V Date/Time Pre 11/29/2023 3:	
		Ti tl	e XVIII	Hospi tal	Cost	
	C	osts				
Cost Center Description	Cost Reimbursed	Cost Reimbursed				
	C!	C N-+				

			Title	XVIII	Hospi tal	Cost	
		Cos	sts				
	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						
	05000 OPERATING ROOM	988, 029					50.00
53.00	05300 ANESTHESI OLOGY	55, 149	0				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	532, 796	0				54.00
60.00	06000 LABORATORY	508, 924	0				60.00
64.00	06400 I NTRAVENOUS THERAPY	114, 568	0				64.00
65.00	06500 RESPI RATORY THERAPY	17, 356	0				65.00
66.00	06600 PHYSI CAL THERAPY	112, 780	0				66.00
67. 00	06700 OCCUPATI ONAL THERAPY	28, 731	0				67.00
68. 00	06800 SPEECH PATHOLOGY	2, 083	0				68.00
69. 00	06900 ELECTROCARDI OLOGY	6, 737	0				69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	98, 477	0				71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	776, 893	0				72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	426, 712	l o				73.00
76. 00	03950 NEUROLOGY	6, 615	l o				76.00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0					77. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC						88.00
88. 01	08801 RURAL HEALTH CLINIC (RHC) ERIE						88. 01
91. 00	09100 EMERGENCY	1, 334, 210	0				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.00
93.00	04950 WOUND CARE	60, 266	0				93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0					95.00
200.00	Subtotal (see instructions)	5, 070, 326	0				200. 00
201.00	Less PBP Clinic Lab. Services-Program	0				[:	201. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	5, 070, 326	0			:	202. 00
				•			

Health Financial Cyctems MADDI CAN COMMINITY HOCDITAL	In Liquide Form CMC	2552 10
Health Financial Systems MORRISON COMMUNITY HOSPITAL COMPUTATION OF INPATIENT OPERATING COST Provider CCN: 14-1329 Period:	In Lieu of Form CMS- Worksheet D-	
From 07/0	1/2022	
To 06/30	0/2023 Date/Time Pro 11/29/2023 3	
Title XVIII Hospit		10 piii
Cost Center Description		
PART I - ALL PROVIDER COMPONENTS	1.00	
INPATIENT DAYS		+
1.00 Inpatient days (including private room days and swing-bed days, excluding newborn)	2, 15!	1.00
2.00 Inpatient days (including private room days, excluding swing-bed and newborn days)	591	
3.00 Private room days (excluding swing-bed and observation bed days). If you have only private room	days, (3. 00
do not complete this line. 4.00 Semi-private room days (excluding swing-bed and observation bed days)	212	4.00
5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the		1
reporting period		
6.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the c	cost 690	6. 00
reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the	cost 92	7. 00
reporting period	72	7.00
8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the co	ost 9°	8. 00
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 newborn days) (see instructions)	and 7	9. 00
10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	548	10.00
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) a	after 373	11. 00
December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days	5)	12.00
through December 31 of the cost reporting period	`	12.00
13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days	s) (13. 00
after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		14.00
14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only)		
16.00 Nursery days (title V or XIX only)		
SWING BED ADJUSTMENT		
17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17. 00
reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		18. 00
reporting period		10.00
19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	188. 44	19. 00
reporting period	200 7/	20.00
20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	208. 70	20.00
21.00 Total general inpatient routine service cost (see instructions)	3, 885, 718	21.00
22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period	(line (22. 00
5 x line 17)		22.00
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (I x line 18)	line 6	23. 00
24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period ((line 17, 336	24. 00
7 x line 19)		
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (li	ne 8 18, 992	25. 00
x line 20) 26.00 Total swing-bed cost (see instructions)	2, 732, 068	26. 00
27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1, 153, 650	
PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)		
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)	0.00000	

19.00	medical difface for swifig-bed in services applicable to services through becember 51 of the cost	100.44	19.00
	reporting period		
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	208. 70	20.00
	reporting period		
21.00	Total general inpatient routine service cost (see instructions)	3, 885, 718	21.00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22.00
	5 x line 17)		
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23.00
	x line 18)		
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	17, 336	24.00
	7 x line 19)		
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	18, 992	25.00
	x line 20)		
26. 00	Total swing-bed cost (see instructions)	2, 732, 068	
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1, 153, 650	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29. 00	Private room charges (excluding swing-bed charges)	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	1, 153, 650	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)	1, 952. 02	38.00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	150, 306	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	150, 306	41.00

Intensive Core Type Impatient Research (Research Section 1) 1.00 1		Financial Systems ATION OF INPATIENT OPERATING COST	MORRISON COMMU	NITY HOSPITAL Provider CO	CN: 14-1329 F	In Lie Period:	eu of Form CMS-2 Worksheet D-1	2552-10
Cost Center Description								
Impact on Cost Inpact on Days Direct (201 1 + Cost 3 x col 4 c			T					
		Cost Center Description			Diem (col. 1 ·		(col. 3 x col.	
Interestive Care Lype Inpattient Respirate Units			1.00	2.00		4. 00		
	42. 00							42. 00
44.00 CORNARY CARE UNIT	40.00			I			Г	40.00
45.00 SIRRE (LINTENSIVE CARE URIT								
46.00 SURCICAL INTERINE CARE UNIT 7.00 (JOHRS PECCIAL CARE (SECIETY) Cost Center Description Cost Cent								
1,00								46. 00
100	47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
48.00 Program inpatient ancil lary service cost (Mist. D-3, col. 3, line 200) Col. 40.00 Col. 40.00 Program inpatient collular therapy acquisition cost (Kin/Kishot D-6, Part III, line 10, column 1) 2, 84.00 R0.00		Cost Center Description					1.00	
Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	48 00	Program inpatient ancillary service cost (Wks	st D_3 col 3	R line 200)				48 00
17.00 17.01 Program inpatient costs (sum of lines 41 through 48.01)(see instructions) 212,891 49.00 20.00					III. line 10.	column 1)		
50.00 Pass through costs applicable to Program inpatient ancillary services (from West. 0, sum of Parts I and III Description Pass through costs applicable to Program inpatient ancillary services (from West. 0, sum of Parts II Description Des							-	
1110 1110								
51.00 Personant adjustment amount per discharge 6.00 Program anount per discharge 6.01 Program amount per discharge 7.02 Program amount per discharge 7.03 Program amount per discharge 7.04 Program amount per discharge 7.05 Program amount per discharge 7.06 Program amount per discharge 7.07 Program amount per discharge 7.08 Program amount per discharge 7.09 Program amount per discharge 7.00 Program amount per discharge 7.00 Program amount per discharge (contractor use only) 7.00 Program (see Instructions) 7.00 Program (contractor use (instructions) 7.00 Program	50. 00		atient routine	services (from	Wkst. D, sum	of Parts I and	0	50.00
52.00 Total Program excludable cost (sum of lines 50 and 51) 0 52.00 10 10 10 10 10 10 10	51. 00	Pass through costs applicable to Program inpa	atient ancillar	y services (fr	om Wkst. D, sı	um of Parts II	0	51.00
3.3 00 Total Program Inpatient operating cost excluding capital related, non-physician anesthetist, and model coduction costs (line 49 minus line 52) Minus line 52)	52 00		50 and 51)				0	52.00
medical education costs (line 49 minus line 52)				elated, non-phy	sician anesthe	etist, and	-	53.00
54.00 Program discharges 0 54.00								
55.00 Target amount per discharge 0.00 55.00 55.01 Permenent adjustment amounts per discharge 0.00 55.01 55.02 Adjustment amount per discharge (contractor use only) 0.00 55.01 55.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02) 0.00 55.00 56.00 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0.57.00 56.00 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0.57.00 58.00 58.00 59.00 Trended costs (lesser of line 53 + line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket) 0.58.00 0.0								
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1.00 Target amount (line 54 x sum of lines 55, 55, 01, and 55, 02) 0.50 0.00			use only)					
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updated and compounded by the market basket) 0. 00 Expected costs (lesser of line 54, or line 54, or line 55 from prior year cost report, updated by the market basket) 6. 00 Relice to costs (lesser of line 53 + line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53, are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero. (see instructions) 6. 00 Relicef payment (site instructions) 6. 00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (see instructions) (site instructions) 6. 00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions 6. 00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 6. 00 Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 6. 00 Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 6. 00 Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 6. 00 Total title V or XIX swing-bed NF inpatient routine service cost (line 70 + line 68) 6. 00 Total title V or XIX swing-bed NF inpatient routine service cost (line 70 + line 68) 6. 00 Payment (line 13 x line 20) 7. 00 Total Program general inpatient routine service costs (line 72 + line 73) 7. 00 Program routine se			on line EE from	. + ho ooo+ rono	mting ported a	anding 100/	1	
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61.00 Continuous improvement bonus payment (if line 53 * line 54 is less than the lowest of lines 55 plus 5.01 or line 99 or line 60. enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions) 62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Regression of the first structions (line 15 km) or 10 km which is line 11 km with line 12 km with line	60.00		or line 55 fro	om prior year c	ost report, up	odated by the	0.00	60.00
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Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) Program inpatient ancillary services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,952.03 88.00				n (line 14 x li	ne 35)			1
26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Program inpatient routine cost general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Agjusted general inpatient routine cost per diem (line 27 ÷ line 2)		, , , , , , , , , , , , , , , , , , , ,						74. 00
76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Paggram capital-related costs (line 9 x line 8) 76.00 70.	75. 00	Capital-related cost allocated to inpatient	routine service	costs (from W	orksheet B, Pa	art II, column		75. 00
77. 00 Program capital-related costs (line 9 x line 76) 78. 00 Inpatient routine service cost (line 74 minus line 77) 79. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81. 00 Inpatient routine service cost per diem limitation 81. 00 Inpatient routine service cost limitation (line 9 x line 81) 82. 00 Reasonable inpatient routine service costs (see instructions) 84. 00 Program inpatient ancillary services (see instructions) 85. 00 Utilization review - physician compensation (see instructions) 86. 00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 77. 00 78. 00 77. 00 78. 00 77. 00 78. 00 79. 00 80. 00 80. 00 81. 00 81. 00 82. 00 83. 00 84. 00 85. 00 86. 00 87. 00 87. 00 88. 00 88. 00	7/ 00		20					74 00
78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost per diem limitation 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 778.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 787.00 Algusted general inpatient routine cost per diem (line 27 ÷ line 2) 788.00 Inpatient routine service costs (see instructions) 79.00 Security (see instructions) 79.00 Inpatient routine service costs (from provider records) 79.00 Security (see instructions) 79.00 Security (see instru		· · · · · · · · · · · · · · · · · · ·						
79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine service costs (from provider records) 80.00 Total Program routine service costs (see instructions) 80.00 Section (line 78 minus line 79) 81.00 Section (line 78 minus line 79) 81.00 Section (line 78 minus line 79) 82.00 Section (line 78 minus line 79) 83.00 Section (line 78 minus line 79) 84.00 Section (line 78 minus line 79) 85.00 Section (line 78 minus line 79) 86.00 Section (line 78 minus line 79) 87.00 Section (line 78 minus line 79) 88.00 Adjusted general inpatient routine service costs (from provider records) 89.00 Section (line 78 minus line 79) 80.00 Section (line 78 minus line 79) 80.00 Section (line 78 minus line 79) 81.00 Section (line 78 minus line 79) 82.00 Section (line 78 minus line 79) 83.00 Section (line 78 minus line 79) 84.00 Section (line 78 minus line 79) 85.00 Section (line 78 minus line 79) 86.00 Section (line 78 minus line 79) 87.00 Section (line 78 minus line 79) 88.00 Adjusted general inpatient routine service cost limitation (line 81) 89.00 Section (line 78 minus line 79) 80.00 Section (line 78 minus line 79) 80.00 Section (line 78 minus line 79) 81.00 Section (line 78 minus line 79) 82.00 Section (line 78 minus line 79) 83.00 Section (line 78 minus line 79)								78. 00
81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 81.00 Seasonable inpatient routine service costs (see instructions) 81.00 Seasonable inpatient routine service costs (see instructions) 82.00 Seasonable inpatient routine service costs (see instructions) 84.00 Seasonable inpatient routine service costs (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine service costs (see instructions) 89.00 Adjusted general inpatient routine service costs (see instructions) 89.00 Adjusted general inpatient routine service costs (see instructions) 89.00 Adjusted general inpatient routine service costs (see instructions) 89.00 Adjusted general inpatient routine service costs (see instructions) 89.00 Adjusted general inpatient routine service costs (see instructions) 89.00 Adjusted general inpatient routine service costs (see instructions) 89.00 Adjusted general inpatient routine service costs (see instructions) 89.00 Adjusted general inpatient routine service costs (see instructions) 89.00 Adjusted general inpatient routine service costs (see instructions) 89.00 Adjusted general inpatient routine service costs (see instructions) 89.00 Adjusted general inpatient routine service costs (see instructions) 89.00 Adjusted general inpatient routine service costs (see instructions	79. 00	Aggregate charges to beneficiaries for excess	s costs (from p		· *.			79. 00
82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Reasonable inpatient routine service costs (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reasonable inpatient routine service costs (see instructions) 88.00 Reasonable inpatient routine service costs (see instructions) 88.00 Reasonable inpatient routine service costs (see instructions) 89.00 Reasonable inpatient routine services (se				cost limitation	(line 78 minu	us line 79)		80.00
83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 83.00 83.00 84.00		·		1)				
84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 7 Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		·		· * .				83.00
85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 7 Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,952.03 88.00		·		-/				84. 00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87. 00 Total observation bed days (see instructions) 88. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,952.03 88.00	85. 00	Utilization review - physician compensation	(see instructio					85. 00
87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,952.03 88.00	86. 00			rough 85)				86. 00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,952.03 88.00	87 NO						370	87 00
		,		- line 2)				
		,	•	,				1

Health Financial Systems	MORRI SON COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 07/01/2022 To 06/30/2023		pared: 45 pm_
		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 THROUG	H COST					
90.00 Capital -related cost	559, 252	3, 885, 718	0. 14392	5 739, 819	106, 478	90.00
91.00 Nursing Program cost	O	3, 885, 718	0.00000	739, 819	0	91.00
92.00 Allied health cost	O	3, 885, 718	0.00000	739, 819	0	92.00
93.00 All other Medical Education	o	3, 885, 718	0.00000	739, 819	0	93.00

INPATIENT AN	ICILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 14-1329	Peri od: From 07/01/2022 To 06/30/2023	Worksheet D-3 Date/Time Pre 11/29/2023 3:	pared:
		Title	XVIII	Hospi tal	Cost	•
	Cost Center Description		Ratio of Cos To Charges	Program	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	ENT ROUTINE SERVICE COST CENTERS					
	ADULTS & PEDI ATRI CS			80, 150		30.0
	_ARY_SERVICE_COST_CENTERS				0.007	
	OPERATING ROOM		0. 2267		-	
	ANESTHESI OLOGY		0.0949		104	
	RADI OLOGY-DI AGNOSTI C LABORATORY		0. 2374 0. 3828		5, 275 14, 657	
	INTRAVENOUS THERAPY		0. 3828		-	
	RESPIRATORY THERAPY		1. 3426		5, 520	
	PHYSI CAL THERAPY		0. 4257		2, 033	
	OCCUPATI ONAL THERAPY		0. 5465		1, 974	
	SPEECH PATHOLOGY		1. 8950		0	1
	ELECTROCARDI OLOGY		0. 0711		92	69. 0
	MEDICAL SUPPLIES CHARGED TO PATIENT		0. 4513		5, 425	
	IMPL. DEV. CHARGED TO PATIENTS		0. 5183		0, .20	1
	DRUGS CHARGED TO PATIENTS		0. 3210		17, 152	73. 0
76. 00 03950			0. 1347		0	1
77. 00 07700	ALLOGENEIC HSCT ACQUISITION		0.0000	00 0	0	77.0
	TIENT SERVICE COST CENTERS					
	RURAL HEALTH CLINIC		0.0000	00	0	
88. 01 08801	RURAL HEALTH CLINIC (RHC) ERIE		0.0000	00	0	88. 0
91.00 09100			1. 4127	07 0	0	91.0
	OBSERVATION BEDS (NON-DISTINCT PART		0. 5942		0	
	WOUND CARE		0. 8717	80 44	38	93.0
	REI MBURSABLE COST CENTERS		1			
	AMBULANCE SERVICES					95.0
200. 00	Total (sum of lines 50 through 94 and 96 through 98)	(1)		184, 857	62, 585	
	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201. 0
202. 00	Net charges (line 200 minus line 201)			184, 857		202.0

I NPATIENT	ANCILLARY SERVICE COST APPORTIONMENT PI	rovider C		Peri od:	Worksheet D-3	
	Co	omponent	CCN: 14-Z329	From 07/01/2022 To 06/30/2023	Date/Time Prep 11/29/2023 3:4	pared: 45 pm
		Ti tl e	: XVIII	Swing Beds - SNF		
	Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1. 00	2. 00	3. 00	
	ITIENT ROUTINE SERVICE COST CENTERS					1
	DO ADULTS & PEDIATRICS					30.00
	LLARY SERVICE COST CENTERS					
	OO OPERATING ROOM		0. 22671			
	00 ANESTHESI OLOGY		0. 09493			
	DO RADI OLOGY-DI AGNOSTI C		0. 23748			
	DO LABORATORY		0. 38289			
	00 I NTRAVENOUS THERAPY		0. 23915	· ·		
	OO RESPI RATORY THERAPY		1. 34269	· ·		
	OO PHYSI CAL THERAPY		0. 42578			
	00 OCCUPATIONAL THERAPY		0. 54658			
	OO SPEECH PATHOLOGY		1. 89504			
	DO ELECTROCARDI OLOGY		0. 07115			69.00
	DO MEDICAL SUPPLIES CHARGED TO PATIENT		0. 45132	· ·	31, 467	
	DO IMPL. DEV. CHARGED TO PATIENTS		0. 51835		0	
	DO DRUGS CHARGED TO PATIENTS		0. 32109			
	50 NEUROLOGY		0. 13475			
	DO ALLOGENEI C HSCT ACQUI SI TI ON		0.00000	00 0	0	77. 00
	PATIENT SERVICE COST CENTERS ON RURAL HEALTH CLINIC		0.00000	20	0	00 00
			0.00000		0	
	DI RURAL HEALTH CLINIC (RHC) ERIE		0.00000		0	
	OO EMERGENCY		1. 41270		0	
	OO OBSERVATION BEDS (NON-DISTINCT PART		0. 59424		0	
	50 WOUND CARE		0. 87178	3, 428	2, 988	93. 00
	R REIMBURSABLE COST CENTERS ON AMBULANCE SERVICES		1			95.00
200.00				1 055 040	440 703	
200.00	Total (sum of lines 50 through 94 and 96 through 98) Less PBP Clinic Laboratory Services-Program only charges (I	ino (1)		1, 055, 868		200.00
ZUI UUI	THESS POP CITTLE LADOLATORY SELVICES-PROGRAM ONLY CHARGES (1	THE OI)	I .	()	i	レロコ. ロロ

Health Financial Systems	MORRISON COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-1329	Peri od: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 11/29/2023 3:45 pm

		Title XVIII	Hospi tal	11/29/2023 3: 4 Cost	45 pm
				1. 00	
F	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
	Medical and other services (see instructions)			5, 070, 326	1. 00
1	Medical and other services reimbursed under OPPS (see instruct	tions)		0	2. 00
1	OPPS or REH payments			0	3. 00
	Outlier payment (see instructions)			0	4. 00 4. 01
1	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instruc	rtions)		0.000	5. 00
	Line 2 times line 5	211 0113)		0.000	6. 00
1	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00
8.00	Transitional corridor payment (see instructions)			0	8. 00
1	Ancillary service other pass through costs from Wkst. D, Pt. I	V, col. 13, line 200		0	9. 00
4	Organ acquisitions			0	10.00
	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			5, 070, 326	11. 00
-	Reasonable charges				
	Ancillary service charges			0	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		0	13. 00
-	Total reasonable charges (sum of lines 12 and 13)			0	14. 00
	Customary charges				15 00
	Aggregate amount actually collected from patients liable for p Amounts that would have been realized from patients liable fou			0	15. 00 16. 00
I .	had such payment been made in accordance with 42 CFR §413.13(a	. 3	i a cilai gebasi s		10.00
	Ratio of line 15 to line 16 (not to exceed 1.000000)	-,		0. 000000	17. 00
18. 00	Total customary charges (see instructions)			0	18. 00
	Excess of customary charges over reasonable cost (complete on	y if line 18 exceeds lin	ne 11) (see	0	19. 00
4	instructions)	! € ! == 11	10) (20.00
	Excess of reasonable cost over customary charges (complete onlinstructions)	y IT Tine II exceeds III	ne 18) (See	0	20. 00
1	Lesser of cost or charges (see instructions)			5, 121, 029	21. 00
	Interns and residents (see instructions)			0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	23. 00
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	24. 00
_	COMPUTATION OF REIMBURSEMENT SETTLEMENT	- \		10.007	25.00
	Deductibles and coinsurance amounts (for CAH, see instructions Deductibles and Coinsurance amounts relating to amount on line		ictions)	19, 027 2, 428, 858	25. 00 26. 00
1	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p			2, 428, 638	
	instructions)	5. 45 the 54m 5. 111165 EE	aa 20] (000	2,0,0,111	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	28. 00
	REH facility payment amount				28. 50
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
	Subtotal (sum of lines 27, 28, 28.50 and 29) Primary payer payments			2, 673, 144 297	30. 00 31. 00
	Subtotal (line 30 minus line 31)			2, 672, 847	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	CES)		2,072,017	02.00
	Composite rate ESRD (from Wkst. I-5, line 11)			0	33. 00
	Allowable bad debts (see instructions)			103, 899	
	Adjusted reimbursable bad debts (see instructions)			67, 534	
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		36, 583	
	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			2, 740, 381 0	38.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)				39. 00
1	Pioneer ACO demonstration payment adjustment (see instructions	5)			39. 50
1	N95 respirator payment adjustment amount (see instructions)			0	39. 75
39. 97	Demonstration payment adjustment amount before sequestration			0	39. 97
1	Partial or full credits received from manufacturers for replac	ced devices (see instruc	tions)	0	39. 98
1	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
1	Subtotal (see instructions) Sequestration adjustment (see instructions)			2, 740, 381	40.00
1	Demonstration payment adjustment amount after sequestration			54, 808	40. 01 40. 02
1	Sequestration adjustment-PARHM pass-throughs				40. 03
1	Interim payments			2, 335, 128	
1	Interim payments-PARHM				41. 01
1	Tentative settlement (for contractors use only)			0	42.00
1	Tentative settlement-PARHM (for contractor use only)			050 475	42. 01
1	Balance due provider/program (see instructions)			350, 445	43. 00 43. 01
1	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15-2	chanter 1	0	44. 00
	§115. 2	.55 WELL OND LUD. 10-2, (0ap (0) 1,		1 1. 00
-	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions)			0	91.00
1	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	93. 00 94. 00
					, , , , , , ,

Health Financial Systems	MORRI SON COMMUNI TY	HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1329	Peri od:	Worksheet E	
			From 07/01/2022	Part B	
			To 06/30/2023	Date/Time Pre	pared:
				11/29/2023 3:	45 pm_
		Title XVIII	Hospi tal	Cost	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200. 00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 14-1329 Peri od: Worksheet E-1 From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 11/29/2023 3:45 pm Title XVIII Hospi tal Cost Part B Inpatient Part A mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 248, 784 2, 502, 206 1. 00 2.00 Interim payments payable on individual bills, either 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 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 0 02/27/2023 180, 354 3.01 3.02 0 3.02 3.03 0 0 3.04 0 Ω 3.04 3.05 0 0 3.05 Provider to Program 02/27/2023 3.50 ADJUSTMENTS TO PROGRAM 19, 181 06/15/2023 347, 432 3.50 3.51 06/15/2023 40, 359 Ω 3.51 3.52 0 0 3.52 3.53 0 0 3.53 3.54 Ω Λ 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines -59, 540 -167, 078 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 189, 244 2, 335, 128 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) 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) Program to Provider 5.01 TENTATIVE TO PROVIDER 0 0 5.01 5.02 0 0 5.02 0 5.03 0 5.03

Heal th Financial Systems MORRI ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

		Component	CCN. 14-Z329	10 00/30/2023	11/29/2023 3:	
		Title	XVIII S	Swing Beds - SNF		•
		I npati en	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		2, 305, 30	4	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)					ļ
	Program to Provider					ļ
3. 01	ADJUSTMENTS TO PROVIDER	06/15/2023	211, 71		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
0 50	Provi der to Program	00 (07 (0000	70.05	-		
3.50	ADJUSTMENTS TO PROGRAM	02/27/2023	79, 35		0	3. 50
3. 51				0	0	3.51
3. 52			•	0		3. 52
3. 53 3. 54			•	0		3. 53 3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		132, 35	~	0	3. 99
3. 99	3. 50-3. 98)		132, 33	3	0	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 437, 65	o	0	4.00
1. 00	(transfer to Wkst. E or Wkst. E-3, line and column as		2, 107, 00		ľ	1. 00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR		I.			İ
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5.01	TENTATI VE TO PROVI DER			0	0	5. 01
5.02				0	0	5. 02
5.03				0	0	5. 03
	Provider to Program			_		ļ
5. 50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
6. 01	the cost report. (1) SETTLEMENT TO PROVIDER			O	0	6. 01
6. 02	SETTLEMENT TO PROVIDER		246, 91	-	0	6.02
7.00	Total Medicare program liability (see instructions)		2, 190, 74		0	
7.00	Trotal medicale program francisty (see instructions)		2, 190, 74	Contractor	NPR Date	7. 00
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	The state of the s	1			1	

Health Financial Systems	MORRISON COMMUNIT	Y HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 14-1329		Worksheet E-2
			From 07/01/2022	
		Component CCN: 14-Z329	To 06/30/2023	Date/Time Prepared:
				11/29/2023 3:45 pm

		Component CCN: 14-Z329	To 06/30/2023	Date/Time Pre 11/29/2023 3:	
		Title XVIII	Swing Beds - SNF		то р
			Part A	Part B	
	COMPUTATION OF MET COOT OF COMPTED CERTIFICATION		1. 00	2. 00	
1. 00	COMPUTATION OF NET COST OF COVERED SERVICES Inpatient routine services - swing bed-SNF (see instructions)		1 015 700	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)		1, 815, 788	l	2.00
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part	· A and sum of Wkst D	445, 110	0	3.00
0.00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swin		· ·	l	0.00
	instructions)	3 3 ,			
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
F 00	instructions)		004		F 00
5.00	Program days	estructions)	921	0	5.00
6. 00 7. 00	Interns and residents not in approved teaching program (see in Utilization review - physician compensation - SNF optional met	hod only	0	l	6. 00 7. 00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	riod offi y	2, 260, 898	0	1
9. 00	Primary payer payments (see instructions)		2, 200, 070	ĺ	
10. 00	Subtotal (line 8 minus line 9)		2, 260, 898		
11. 00	Deductibles billed to program patients (exclude amounts applic	able to physician	0	0	
	professional services)	. 3			
12. 00	Subtotal (line 10 minus line 11)		2, 260, 898		12. 00
13. 00	Coinsurance billed to program patients (from provider records)	(excl ude coi nsurance	33, 146	0	13. 00
	for physician professional services)			_	
14.00	80% of Part B costs (line 12 x 80%)		0 007 750	0	
15. 00	Subtotal (see instructions)		2, 227, 752	0	1
16. 00 16. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions	.)	0	1	16. 00 16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstr	•	0		16. 55
10. 55	adjustment (see instructions)	ation) payment	J		10.55
16. 99	Demonstration payment adjustment amount before sequestration		0	0	16. 99
17. 00	Allowable bad debts (see instructions)		11, 850	0	17. 00
17. 01	Adjusted reimbursable bad debts (see instructions)		7, 703	0	17. 01
18.00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)	9, 775	0	18. 00
19. 00	Total (see instructions)		2, 235, 455		
19. 01	Sequestration adjustment (see instructions)		44, 709		19. 01
19. 02	Demonstration payment adjustment amount after sequestration)		0	0	
19. 03	Sequestration adjustment-PARHM pass-throughs				19. 03
19. 25	Sequestration for non-claims based amounts (see instructions)		0	0	19. 25
20.00	Interim payments		2, 437, 659	0	
20. 01	Interim payments-PARHM		0	0	20. 01
21. 00 21. 01	Tentative settlement (for contractor use only) Tentative settlement-PARHM (for contractor use only)		0	l	21.00
22. 00	Balance due provider/program (line 19 minus lines 19.01, 19.02	19 25 20 and 21)	-246, 913	0	
22. 01	Balance due provider/program-PARHM (see instructions)	., 17. 23, 20, and 21)	240, 713	l	22. 01
23. 00	Protested amounts (nonallowable cost report items) in accordan	ice with CMS Pub. 15-2.	0	0	1
	chapter 1, §115.2				
	Rural Community Hospital Demonstration Project (§410A Demonstr				
200.00	Is this the first year of the current 5-year demonstration per	iod under the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.				
201 00	Cost Reimbursement	Uset D.1 Dt II line			201 00
201.00	Medicare swing-bed SNF inpatient routine service costs (from W 66 (title XVIII hospital))	rkst. D-1, Pt. 11, Tine			201. 00
202 00	Medicare swing-bed SNF inpatient ancillary service costs (from	wkst D-3 col 3 lin	Δ .		202. 00
202.00	200 (title XVIII swing-bed SNF))	. mat. b o, cor. o, rri	Ŭ		202.00
203.00	Total (sum of lines 201 and 202)				203. 00
204.00	Medicare swing-bed SNF discharges (see instructions)				204. 00
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-year demonst	ration	
	peri od)				
	Medicare swing-bed SNF target amount				205. 00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti				206. 00
207.00	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				207.00
	Program reimbursement under the §410A Demonstration (see instr	-	1	l e	207. 00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2 and 3)	t, cor. I, sum of fines	!		208. 00
209 00	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	etions)			209. 00
	Reserved for future use	,			210. 00
	Comparision of PPS versus Cost Reimbursement		1		1
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 2	09 plus line 210) (see			215. 00
	instructions)			l	

Health Financial Systems	MORRISON COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-1329	Peri od: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part V Date/Time Prepared: 11/29/2023 3:45 pm
	Title XVIII	Hospi tal	Cost

	Title XVIII Hospital	11/29/2023 3: 2 Cost	45 pm
		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT	1.00	
1. 00	Inpatient services	212, 891	1. 00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2. 00
3.00	Organ acqui si ti on		3. 00
3. 01	Cellular therapy acquisition cost (see instructions)	0	3. 01
4. 00	Subtotal (sum of lines 1 through 3.01)	212, 891	4. 00
5. 00	Primary payer payments	0	5. 00
6. 00	Total cost (line 4 less line 5). For CAH (see instructions)	212, 891	6. 00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	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
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis	0	12.00
	had such payment been made in accordance with 42 CFR 413.13(e)		
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15. 00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see	0	15.00
	instructions)		
16. 00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see	0	16. 00
47.00	instructions)		47.00
17. 00	Cost of physicians' services in a teaching hospital (see instructions)	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	18.00
19. 00	Cost of covered services (sum of lines 6, 17 and 18)	212, 891	19.00
20.00	Deductibles (exclude professional component)	39, 096	20.00
21. 00	Excess reasonable cost (from line 16)	172 705	21. 00
22. 00 23. 00	Subtotal (line 19 minus line 20 and 21) Coinsurance	173, 795	22. 00 23. 00
24. 00	Subtotal (line 22 minus line 23)	173, 795	
25. 00		4, 040	25. 00
26. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions) Adjusted reimbursable bad debts (see instructions)	2, 626	
27. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1, 600	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)	176, 421	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29. 00
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)		29. 50
29. 98	Recovery of accelerated depreciation.		29. 98
29. 99	Demonstration payment adjustment amount before sequestration		29. 99
30. 00	Subtotal (see instructions)	176, 421	30. 00
30. 01	Sequestration adjustment (see instructions)	3, 528	
30. 01	Demonstration payment adjustment amount after sequestration	0, 320	30. 02
30. 03	Sequestration adjustment-PARHM		30. 03
31. 00	Interim payments	189, 244	
31. 01	Interim payments-PARHM	1077211	31. 01
32. 00	Tentative settlement (for contractor use only)	0	32. 00
32. 01	Tentative settlement-PARHM (for contractor use only)		32. 01
33. 00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-16, 351	
33. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33. 01
34. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	34. 00
	§115. 2		
		·	

Health Financial Systems MORRISON COMBALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 14-1329 | Period: From 07/01/ To 06/30/

Peri od: Worksheet G From 07/01/2022 To 06/30/2023 Date/Time Prepared: 11/29/2023 3:45 pm

Seminary Company Com	onl y)			'	0 00/30/2023	11/29/2023 3:	
1.00			General Fund		Endowment Fund		·
Cash on hand in banks		I	1.00		3. 00	4. 00	
Temporary Investments	1 00		22 250 404	1		0	1 00
Notes receivable			23, 230, 604	1	1 1		
4.00 Accounts receivable 0,037,479 0 0 0 4.00 6.00 All Jovanes for uncell actible notes and accounts receivable 1,227,860 0 0 0 0 6.00 All Jovanes for uncell actible notes and accounts receivable 1,227,860 0 0 0 0 6.00 All Jovanes for uncell actible notes and accounts receivable 1,227,860 0 0 0 0 6.00 All Jovanes for uncell actible notes and accounts receivable 1,227,860 0 0 0 0 6.00 All Jovanes for uncell actible notes and accounts receivable 1,227,860 0 0 0 0 6.00 All Jovanes for uncell actible notes and accounts receivable 1,227,860 0 0 0 0 6.00 Account active for uncell actible notes and accounts receivable 1,227,860 0 0 0 0 6.00 Account active depreciation 4,230,861 0 0 0 1,000 6.00 Account active depreciation 4,230,362 0 0 0 0 6.00 Account active depreciation 4,230,362 0 0 0 0 6.00 Account active depreciation 4,230,362 0 0 0 0 6.00 Account active depreciation 4,230,362 0 0 0 0 6.00 Account active depreciation 4,230,362 0 0 0 0 6.00 Account active depreciation 4,230,362 0 0 0 0 6.00 Account active depreciation 4,230,362 0 0 0 6.00 Account active depreciation 4,230,362 0 0 0 0 6.00 Account active depreciation 4,230,362 0 0 0 0 6.00 Account active depreciation 4,230,362 0 0 0 0 6.00 Account active depreciation 4,230,362 0 0 0 0 6.00 Account active depreciation 6,230,362 0 0 0 6.00 Account active depreciation 6,230,362 0 0 0 6.00 Account active depreciation 6,230,362 0 0 6.00 Account active depreciation 6,230,362 0 6.00 Account active depreci			0	1	-		3.00
1, 27, 850 0 0 0 5 50			9, 037, 479	1	o		4. 00
Toward T	5.00	Other recei vable		l .	0	0	5. 00
Proposite Systems 332, 184 0 0 8 0 0 0 0 0 0 0	6.00	Allowances for uncollectible notes and accounts receivable	0) c	0	0	6.00
Oncompany Onco	7.00	Inventory	728, 111	(0		7. 00
10.00 Due from other funds				l .	0		
11.00			-20, 620	1	0		
FIXED ASSETS			04 555 (44				
12.00 Land approvements	11.00	· · · · · · · · · · · · · · · · · · ·	34, 555, 614	· C) 0	0	111.00
13.00 Land improvements	12 00		/1/ 019			0	12 00
14.00 Accumulated depreciation -0.23, 0.32 0 0 14.00				1	-		
15.00		1		1			
10.00 Accumulated depreciation -8,802,582 0 0 16.00					o		15. 00
18.00 Accumul ated depreciation 0 0 0 0 18.00	16.00			d c	0	0	16. 00
19.00 Fixed equipment	17.00	Leasehold improvements	0	ol c	0	0	17. 00
20.00 Accumulated depreciation -6,174,719 0 0 0 20.00	18. 00		0) c	0		18. 00
21.00 Automobil es and trucks 0 0 0 0 21.00		· '		1	-		19. 00
22.00 Accumulated depreciation 0 0 0 22.00		•	-6, 174, 719	i	-		20.00
23.00 Maj or movable equipment 10,516,074 0 0 0 23.00			0		0		
24.00 Accumul ated depreciation			0		0		
25.00 Minor equipment depreciable 0 0 0 0 25.00		1 3					
26.00 Accumul ated depreciation 0 0 0 0 26.00 27.00 NT designated Assets 0 0 0 0 0 27.00 28.00 Accumul ated depreciation 0 0 0 0 0 27.00 On the designated Assets 0 0 0 0 28.00 Total Fixed assets (sum of lines 12-29) 32,912,880 0 0 0 29.00 Total Fixed assets (sum of lines 12-29) 32,912,880 0 0 0 29.00 Total Fixed assets (sum of lines 12-29) 32,912,880 0 0 0 29.00 Deposits on leases 0 0 0 0 20.00 Other assets 0 0 0 0 20.00 Other assets 0 0 0 0 20.00 Other assets 0 0 0 0 20.00 Other assets (sum of lines 31-34) 0 0 0 20.00 CURRENT LIABILITIES		·	-1, 200, 795	1			
27.00 HIT designated Assets 0 0 0 0 27.00			0	1	1		
28. 00 Accumula a ded depreciation 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		•	0	1	-		
29.00 Minor equipment-nondepreciable 0 0 0 0 0 0 0 0 0			Ö	i c	o		28. 00
OTHER ASSETS Investments 0 0 0 0 0 31,00 32,00 0 0 0 0 0 0 32,00 0 0 0 0 0 0 0 32,00 0 0 0 0 0 0 0 0 32,00 0 0 0 0 0 0 0 0 0		·	0	d	Ö		29. 00
31.00 Investments	30.00		32, 912, 880	ol c	0	0	30.00
32.00 Deposits on leases 0 0 0 0 32.00 33.00 Due from owners/officers 0 0 0 0 0 33.00 34.00 Other assets (sum of lines 31-34) 0 0 0 0 0 33.00 35.00 Total dother assets (sum of lines 31-34) 0 0 0 0 0 35.00 36.00 Total assets (sum of lines 11, 30, and 35) 67, 468, 494 0 0 0 0 36.00 36.00 Total assets (sum of lines 11, 30, and 35) 67, 468, 494 0 0 0 0 36.00 36.00 Total assets (sum of lines 11, 30, and 35) 67, 468, 494 0 0 0 0 36.00 37.00 Accounts payable 0 0 0 0 0 37.00 38.00 Salaries, wages, and fees payable 1, 459, 266 0 0 0 0 38.00 40.01 Payroll taxes payable (short term) 0 0 0 0 0 0 0 40.00 Notes and loans payable (short term) 0 0 0 0 0 0 0 40.00 Accelerated payments 0 0 0 0 0 0 0 40.00 Accelerated payments 0 0 0 0 0 0 40.00 Other current liabilities 0 0 0 0 0 0 0 40.00 Other current liabilities (sum of lines 37 thru 44) 4,756,509 0 0 0 0 0 40.00 Accelerated loans 0 0 0 0 0 40.00 Other long term liabilities (sum of lines 46 thru 49) 22,952,086 0 0 0 0 0 40.00 Other long term liabilities (sum of lines 46 thru 49) 22,952,086 0 0 0 0 0 40.00 Other long term liabilities (sum of lines 46 thru 49) 22,952,086 0 0 0 0 0 40.00 Total liabilities (sum of lines 46 thru 49) 22,952,086 0 0 0 0 0 40.00 Total liabilities (sum of lines 46 thru 49) 22,952,086 0 0 0 0 0 40.00 Total liabilities (sum of lines 46 thru 49) 22,952,086 0 0 0 0 0 40.00 Total liabilities (sum of lines 46 thru 49) 22,952,086 0 0 0 0 0 40.00 Total liabilities (sum of lines 46 thru 49) 22,952,086 0 0 0 0 40.00 Total liabilities (sum of lines 46 thru 49) 27,708,595 0 0 0 0 40.00 Total liabilities (sum of lines 4		OTHER ASSETS					
33 00 Due from owners/officers 0 0 0 0 0 33 .00			0	C	0		31.00
34. 00 Other assets 0 0 0 0 0 0 34. 00 35. 00 Total assets (sum of lines 31-34) 0 0 0 0 0 35. 00 36. 00 CURRENT LIABILITIES		1 .	0	1	-		32. 00
35.00			0				1
Total assets (sum of lines 11, 30, and 35) 67, 468, 494 0 0 0 36. 00			0		-		
CURRENT LIABILITIES		1	U 47 440 404				
37, 00 Accounts payable	36.00		07, 408, 494	1)l Ol	0	36.00
38.00 Salaries, wages, and fees payable 1,459,266 0 0 0 0 38.00 39.00 Payroll taxes payable 0 0 0 0 0 0 39.00 40.00 Notes and loans payable (short term) 0 0 0 0 0 40.00 41.00 Deferred income 0 0 0 0 0 0 41.00 42.00 Accelerated payments 0 0 0 0 0 43.00 43.00 Due to other funds 0 0 0 0 0 43.00 44.00 Other current liabilities 604,659 0 0 0 0 44.00 45.00 Total current liabilities 0 604,659 0 0 0 0 44.00 47.00 Notes payable 0 0 0 0 0 0 45.00 LONG TERM LIABILITIES 46.00 Mortgage payable 0 0 0 0 0 0 47.00 48.00 Unsecured loans 0 0 0 0 0 47.00 48.00 Unsecured loans 0 0 0 0 0 47.00 50.00 Total long term liabilities (sum of lines 46 thru 49) 22,952,086 0 0 0 0 0 48.00 51.00 Total liabilities (sum of lines 46 thru 49) 22,952,086 0 0 0 0 550.00 51.00 Total liabilities (sum of lines 46 thru 49) 22,952,086 0 0 0 0 550.00 55.00 Donor created - endowment fund balance - restricted 0 55.00 55.00 Donor created - endowment fund balance - unrestricted 0 57.00 Find balance - invested in plant 0 57.00 Find Ind balance - invested in plant 0 58.00 Find Inda balance - reserve for plant improvement, replacement, and expansion 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	37 00		2 692 584	1		0	37 00
39.00 Payroll taxes payable 0 0 0 0 39.00				1			
40.00 Notes and loans payable (short term)			0	1	o		39. 00
42. 00		, ,	0		o		40.00
43.00 Due to other funds 0 0 0 0 0 43.00 44.00 Other current liabilities (sum of lines 37 thru 44) 4,756,509 0 0 0 44.00 LONG TERM LIABILITIES 46.00 Mortgage payable 0 0 0 0 0 0 45.00 48.00 Unsecured loans 0 0 0 0 0 0 48.00 49.00 Other long term liabilities (sum of lines 46 thru 49) 22,952,086 0 0 0 0 0 48.00 50.00 Total liabilities (sum of lines 46 thru 49) 22,952,086 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	41.00	Deferred income	0	ol c	o	0	41.00
44.00 Other current liabilities 604,659 0 0 0 44.00 45.00 Total current liabilities (sum of lines 37 thru 44) 4,756,509 0 0 0 45.00 46.00 Mortgage payable 0 0 0 0 0 0 47.00 48.00 Unsecured loans 0 0 0 0 0 48.00 49.00 Other long term liabilities 0 0 0 0 0 48.00 49.00 Other long term liabilities (sum of lines 46 thru 49) 22,952,086 0 0 0 49.00 51.00 Total liabilities (sum of lines 45 and 50) 27,708,595 0 0 0 51.00 52.00 General fund balance 39,759,899 0 0 53.00 52.00 54.00 Donor created - endowment fund balance - restricted 0 54.00 55.00 55.00 Doror created - endowment fund balance 0 55.00 55.00 56.00 Overning body created - endowment fund balance 0 55.00 57.00 Plant fund ba	42.00	Accel erated payments	0)			42.00
45.00	43.00		0) c	0		
LONG TERM LIABILITIES					1		
46.00 Mortgage payable	45. 00		4, 756, 509	<u> </u> C	0	0	45.00
47. 00 Notes payable				1	J		
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) 10 22,952,086 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 1 3	0 050 00/		-		
49.00 Other long term liabilities 0 0 0 49.00 50.00 Total long term liabilities (sum of lines 46 thru 49) 22,952,086 0 0 0 50.00 51.00 Total liabilities (sum of lines 45 and 50) 27,708,595 0 0 0 51.00 CAPITAL ACCOUNTS 52.00 General fund balance 39,759,899 52.00 53.00 Specific purpose fund 0 53.00 54.00 Donor created - endowment fund balance - restricted 0 54.00 55.00 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 59.00 Total fund balances (sum of lines 52 thru 58) 39,759,899 0 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and 67,468,494 0 0 0 60.00			22, 952, 086				
50. 00 Total long term liabilities (sum of lines 46 thru 49) 22, 952, 086 0 0 0 50. 00 51. 00 Total liabilities (sum of lines 45 and 50) 27, 708, 595 0 0 0 51. 00 CAPITAL ACCOUNTS 52. 00 General fund balance 39, 759, 899 52. 00 53. 00 Specific purpose fund 0 53. 00 54. 00 Donor created - endowment fund balance - restricted 0 54. 00 55. 00 Governing body created - endowment fund balance 0 55. 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) 39, 759, 899 0 0 0 59. 00 60. 00 Total liabilities and fund balances (sum of lines 51 and 67, 468, 494 0 0 0 60. 00			0	1	-		
51.00 Total liabilities (sum of lines 45 and 50) 27,708,595 0 0 0 51.00 CAPITAL ACCOUNTS 39,759,899 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 66.00 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 57.00 59.00 Total fund balances (sum of lines 52 thru 58) 39,759,899 0 0 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and 67,468,494 0 0 60.00			22 952 086	-			1
CAPITAL ACCOUNTS Second General fund bal b		,			1		
52. 00 General fund balance 39,759,899 53. 00 Specific purpose fund 0 54. 00 Donor created - endowment fund balance - restricted 0 55. 00 Donor created - endowment fund balance - unrestricted 0 56. 00 Governing body created - endowment fund balance 0 57. 00 Plant fund balance - invested in plant 0 58. 00 Plant fund balance - reserve for plant improvement, replacement, and expansion 0 59. 00 Total fund balances (sum of lines 52 thru 58) 39,759,899 0 0 0 59.00 60. 00 Total liabilities and fund balances (sum of lines 51 and 67,468,494 0 0 0 60.00	01.00		27,700,070	1	,	<u> </u>	01.00
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 67,468,494 0 54.00 55.00 56.00 57.00 58.00 59.00 59.00 59.00 60.00 59.00 60.00	52.00		39, 759, 899				52.00
55.00 Donor created - endowment fund balance - unrestricted 66.00 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 67, 468, 494 0 55.00 56.00 57.00 58.00 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and				1)		53.00
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 67,468,494 0 56.00 56.00 57.00 58.00 58.00 59.00 0 0 59.00 0 0 60.00	54.00				0		54. 00
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 67,468,494 0 0 57.00 58.00 0 59.00 0 0 59.00 0 0 60.00	55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
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 67, 468, 494 0 0 0 60.00					0		56. 00
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 67, 468, 494 0 0 0 60.00							
59.00 Total fund balances (sum of lines 52 thru 58) 39,759,899 0 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and 67,468,494 67,468,494 0 0 60.00	58. 00					0	58. 00
60.00 Total liabilities and fund balances (sum of lines 51 and 67, 468, 494 0 0 0 60.00	E0.00		20 750 000		,	_	F0 00
				1			
	υυ. UU		07, 408, 494		ή		00.00
		1/	I	1	1		1

Provider CCN: 14-1329

| Peri od: | Worksheet G-1 | From 07/01/2022 | To 06/30/2023 | Date/Ti me Prepared:

					To 06/30/2023	Date/Time Prep 11/29/2023 3:4	oared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	+5 piii
		1.00	2.00	3. 00	4.00	5. 00	
1.00	Fund balances at beginning of period		26, 695, 462		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		13, 064, 450				2.00
3.00	Total (sum of line 1 and line 2)		39, 759, 912		0		3. 00
4.00	Additions (credit adjustments) (specify)	0			0	0	4. 00
5.00		0			0	0	5. 00
6.00		0			0	0	6. 00
7. 00		0			0	0	7. 00
8.00		0			0	0	8. 00
9.00		0			0	0	9. 00
10. 00	Total additions (sum of line 4-9)		0		0		10.00
11. 00	Subtotal (line 3 plus line 10)		39, 759, 912		0		11. 00
12. 00	PLUG IN	13			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	T	0	4.0		0	0	17. 00
18.00	Total deductions (sum of lines 12-17)		13		0		18.00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)		39, 759, 899		0		19. 00
	Silver (Title II illinus IIIIe 10)	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			0				7. 00
8.00			0				8. 00
9.00			0				9. 00
10. 00	Total additions (sum of line 4-9)	0			0		10.00
11. 00	Subtotal (line 3 plus line 10)	0			0		11. 00
12. 00	PLUG IN		0				12.00
13. 00			0				13.00
14. 00			0				14.00
15. 00			0				15. 00
16. 00			0				16.00
17. 00	T	_	0				17. 00
18. 00	Total deductions (sum of lines 12-17)	0			0		18.00
19. 00	Fund balance at end of period per balance	0			0		19. 00
	sheet (line 11 minus line 18)	ı I			I		

Health Financial Systems MC STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 14-1329

Cost Center Description Inpatient Outpatient Total	5. 15 p
1.00 2.00 3.00	
PART I - PATIENT REVENUES	
General Inpatient Routine Services	
1.00 Hospital 1,481,489 1,481,4	89 1.00
2. 00 SUBPROVI DER - I PF	2. 00
3. 00 SUBPROVI DER - I RF	3. 00
4. 00 SUBPROVI DER	4. 00
5.00 Swing bed - SNF 730, 672 730, 6	72 5.00
6.00 Swing bed - NF 21,077 21,07	77 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) 2, 233, 238 2, 233, 238	38 10. 00
Intensive Care Type Inpatient Hospital Services	
11.00 INTENSIVE CARE UNIT	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	0 16.00
11-15)	
17.00 Total inpatient routine care services (sum of lines 10 and 16) 2,233,238 2,233,238	38 17. 00
18.00 Ancillary services 2, 128, 452 67, 514, 226 69, 642, 6	78 18. 00
19.00 Outpatient services 4,361 3,546,799 3,551,	60 19.00
20. 00 RURAL HEALTH CLINI C 129, 386 7, 804, 106 7, 933, 4	92 20.00
20.01 RURAL HEALTH CLINIC (RHC) ERIE 0 0	0 20. 01
21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 0	0 21.00
22.00 HOME HEALTH AGENCY	22. 00
23. 00 AMBULANCE SERVICES 0 708, 736 708, 7	36 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 0	0 27.00
28.00 Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. 4,495,437 79,573,867 84,069,3	04 28.00
G-3, line 1)	
PART II - OPERATING EXPENSES	
29.00 Operating expenses (per Wkst. A, column 3, line 200) 42,010,120	29. 00
30.00 ADD (SPECIFY) 0	30. 00
31.00	31. 00
32.00	32. 00
33.00	33. 00
34.00	34. 00
35.00	35. 00
36.00 Total additions (sum of lines 30-35)	36. 00
37. 00 OTHER EXPENSES INTEREST EXPENSE 604, 081	37. 00
38.00 OTHER EXPENSES LEASE INT 34,536	38. 00
39.00	39. 00
40.00	40. 00
41.00	41. 00
42.00 Total deductions (sum of lines 37-41) 638,617	42. 00
43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 41,371,503	43. 00
to Wkst. G-3, line 4)	I

STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 14-1329	Peri od:	Worksheet G-3	
			From 07/01/2022		
			To 06/30/2023	Date/Time Prep	
				11/29/2023 3:2	45 pm
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin	28)		84, 069, 304	1. 00
2. 00	Less contractual allowances and discounts on patients' accoun			30, 883, 239	
3. 00	Net patient revenues (line 1 minus line 2)			53, 186, 065	
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		41, 371, 503	
5. 00	Net income from service to patients (line 3 minus line 4)	.5)		11, 814, 562	
	OTHER I NCOME		<u> </u>	,,	
6.00	Contributions, donations, bequests, etc			152, 262	6. 00
7.00	Income from investments			7, 891	7. 00
8.00	Revenues from telephone and other miscellaneous communication	servi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking Lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	
14.00	Revenue from meals sold to employees and guests			67, 148	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 t	han patients		0	16. 00
17. 00	Revenue from sale of drugs to other than patients			152, 429	
18. 00	Revenue from sale of medical records and abstracts			3, 701	18. 00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	
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			1, 327, 977	23. 00
24.00	MI SCELLANEOUS REVENUE			91, 376	24. 00
24. 01	GAI N/LOSS			-43, 523	24. 01
24. 50	COVI D-19 PHE Fundi ng			129, 244	24. 50
25. 00	Total other income (sum of lines 6-24)			1, 888, 505	
	Total (line 5 plus line 25)			13, 703, 067	
	INTEREST EXPENSE AND LEASE INTEREST			638, 617	
	Total other expenses (sum of line 27 and subscripts)			638, 617	
29 00	Net income (or loss) for the period (line 26 minus line 28)			13, 064, 450	29.00

		MORRISON COMMUN		N 14 1220	In Li∈ Period:	eu of Form CMS-1	2552-10
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der CO		Period: From 07/01/2022	Worksheet M-1	
			Component (To 06/30/2023		
					RHC I	Cost	
		Compensation	Other Costs		1 Reclassi ficati		
				+ col. 2)	ons	Trial Balance	
						(col. 3 + col.	
		1.00	2. 00	3. 00	4. 00	4) 5. 00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3.00	4.00	3.00	
1. 00	Physician	5, 181, 009	0	5, 181, 00	9 -247, 693	4, 933, 316	1.00
2. 00	Physician Assistant	757, 999	0	757, 99			2.00
3. 00	Nurse Practitioner	221, 110	0	221, 11			3.00
4. 00	Visiting Nurse	0	0	22.7	0 0	0	
5. 00	Other Nurse	-63, 714	0	-63, 71	4 0	-63, 714	5. 00
6.00	Clinical Psychologist	o	0		0 0	0	6.00
7.00	Clinical Social Worker	o	0		0 0	0	7. 00
8.00	Laboratory Techni ci an	o	0		0 0	0	8. 00
9.00	Other Facility Health Care Staff Costs	998, 495	0	998, 49	5 -304, 149	694, 346	9. 00
10.00	Subtotal (sum of lines 1 through 9)	7, 094, 899	0	7, 094, 89	9 -579, 578	6, 515, 321	10.00
11.00	Physician Services Under Agreement	0	1, 082, 662	1, 082, 66	2 0	1, 082, 662	11. 00
12.00	Physician Supervision Under Agreement	0	0		0	0	
13.00	Other Costs Under Agreement	0	0		0	0	
14.00	Subtotal (sum of lines 11 through 13)	0	1, 082, 662	1, 082, 66		1, 082, 662	
15. 00	Medical Supplies	0	61, 823	61, 82		61, 823	•
16. 00	Transportation (Health Care Staff)	0	0		0	0	
17. 00	Depreciation-Medical Equipment	0	0	400.00	0 0	0	
18.00	Professional Liability Insurance	0	139, 281	139, 28	-139, 281	0	18.00
19.00	Other Health Care Costs	U	Ü		0	0	19. 00 20. 00
20.00	Allowable GME Costs Subtotal (sum of lines 15 through 20)		201 104	201 10	120 201	(1.022	
21. 00 22. 00	Total Cost of Health Care Services (sum of	7, 094, 899	201, 104 1, 283, 766	201, 10 8, 378, 66			•
22.00	lines 10, 14, and 21)	7,094,099	1, 203, 700	0, 370, 00	5 -710,009	7, 039, 000	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	Pharmacy	ol	0		0 0	0	23. 00
24. 00	Dental	o	0		0 0	0	24. 00
25.00	Optometry	o	0		0 0	0	25. 00
25. 01	Tel eheal th	2, 012	0	2, 01	2 0	2, 012	25. 01
25. 02	Chronic Care Management	o	0		0 0	0	25. 02
26.00	All other nonreimbursable costs	387, 241	20, 317	407, 55	8 0	407, 558	26. 00
27. 00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	389, 253	20, 317	409, 57	0	409, 570	28. 00
	through 27)						
00.05	FACILITY OVERHEAD		ane a1	405 :-	al -	105 455	00.00
29. 00	Facility Costs	0	105, 108	105, 10			•
30.00	Administrative Costs	0	107, 263	107, 26			1
31. 00	Total Facility Overhead (sum of lines 29 and		212, 371	212, 37	1, 106, 041	1, 318, 412	31. 00

7, 484, 152

1, 516, 454

9, 000, 606

387, 182

9, 387, 788

32.00

and 31)

32.00 Total facility costs (sum of lines 22, 28

Health Financial Systems	MORRISON COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 14-1329	Peri od: From 07/01/2022	Worksheet M-1
	Component CCN: 14-3981	To 06/30/2023	Date/Time Prepared: 11/29/2023 3:45 pm
		RHC I	Cost

						11/29/2023 3:	45 pm_
					RHC I	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	4, 933, 316				1. 00
2.00	Physician Assistant	0	738, 962				2. 00
3.00	Nurse Practitioner	0	212, 411				3. 00
4.00	Visiting Nurse	0	0	1			4. 00
5.00	Other Nurse	0	-63, 714				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	694, 346				9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	6, 515, 321				10.00
11. 00	Physician Services Under Agreement	0	1, 082, 662				11. 00
12.00	Physician Supervision Under Agreement	0	0				12. 00
13.00	Other Costs Under Agreement	0	0				13.00
14.00	Subtotal (sum of lines 11 through 13)	0	1, 082, 662				14.00
15.00	Medical Supplies	0	61, 823				15.00
16.00	Transportation (Health Care Staff)	0	0				16. 00
17.00	Depreciation-Medical Equipment	0	0				17. 00
18.00	Professional Liability Insurance	0	0				18. 00
19.00	Other Health Care Costs	0	0				19. 00
20.00	Allowable GME Costs						20. 00
21.00	Subtotal (sum of lines 15 through 20)	0	61, 823				21. 00
22.00	Total Cost of Health Care Services (sum of	0	7, 659, 806				22. 00
	lines 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	1			25. 00
25. 01	Tel eheal th	0	2, 012				25. 01
25. 02	Chronic Care Management	0	0				25. 02
26.00	All other nonreimbursable costs	0	407, 558				26. 00
27. 00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	409, 570				28. 00
	through 27)						
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	105, 108				29. 00
30.00	Administrative Costs	0	1, 213, 304				30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	1, 318, 412				31. 00
	30)						
32.00	Total facility costs (sum of lines 22, 28	0	9, 387, 788				32. 00
	and 31)						

							6.5	
	Financial Systems SIS OF HOSPITAL-BASED RHC/FOHC COSTS	MORRISON COMMUN	Provider C	CN: 14 1220	Do	In Lie eriod:	eu of Form CMS-2 Worksheet M-1	2552-10
ANALTS	SIS OF HOSPITAL-BASED RHC/FUNC COSTS		Provider C	UN. 14-1329		om 07/01/2022	WOLKSHEET M-1	
			Component	CCN: 14-8657	То	06/30/2023	Date/Time Pre 11/29/2023 3:	
					Ц,	RHC II	Cost	
		Compensation	Other Costs		1 F	Recl assi fi cati		
				+ 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	2.00	3.00	_	4.00	5.00	
1. 00	Physi ci an	0	0		0	0	0	1.00
2. 00	Physician Assistant	o	0		0	0	o o	2.00
3. 00	Nurse Practitioner	0	0		0	462	462	3. 00
4.00	Visiting Nurse	0	0		0	0	0	4. 00
5.00	Other Nurse	0	0		0	0	0	5. 00
6.00	Clinical Psychologist	0	0		0	0	0	6. 00
7.00	Clinical Social Worker	0	0		0	0	0	7. 00
8.00	Laboratory Techni ci an	0	0		0	0	0	8. 00
9.00	Other Facility Health Care Staff Costs	0	0		0	0	0	9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	0		0	462	462	
11. 00	Physician Services Under Agreement	0	0		0	0	0	11. 00
12. 00	Physician Supervision Under Agreement	0	0		0	0	0	12.00
13.00	Other Costs Under Agreement	0	0		0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0	0	0	14. 00
15. 00 16. 00	Medical Supplies	0	0		0	0	0	15. 00 16. 00
17. 00	Transportation (Health Care Staff) Depreciation-Medical Equipment	0	0		0	0		17. 00
18. 00	Professional Liability Insurance	0	0		0	0		18.00
	Other Health Care Costs	0	0		0	0	Ö	19. 00
20. 00	Allowable GME Costs	J	O		Ŭ	J		20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	0		0	0	o	21. 00
22. 00	Total Cost of Health Care Services (sum of	0	0		0	462	462	22. 00
	lines 10, 14, and 21)							
	COSTS OTHER THAN RHC/FQHC SERVICES							
23. 00	Pharmacy	0	0	l .	0	0	0	23. 00
24. 00	Dental	0	0		0	0	0	24. 00
25. 00	Optometry	0	0		0	0	0	25. 00
25. 01	Tel eheal th	0	0		0	0	0	25. 01
25. 02	Chronic Care Management	0	0		0	0	0	25. 02
26. 00 27. 00	All other nonreimbursable costs	U	Ü		0	U	0	26. 00 27. 00
28. 00	Nonallowable GME costs Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	0	
26.00	through 27)	U	U		U	U		20.00
	FACILITY OVERHEAD							
29. 00		0	100	1	00	0	100	29. 00
30.00	Administrative Costs	o	977	l .	77	0	977	30.00
31. 00	Total Facility Overhead (sum of lines 29 and	o o	1, 077			0	1, 077	31. 00
	30)			1		-	·	

1, 077

1, 077

462

32.00

1, 539

32.00 Total facility costs (sum of lines 22, 28 and 31)

Health Financial Systems	MORRISON COMMU	NITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CCN: 14-1329	Peri od: From 07/01/2022	Worksheet M-1	
		Component	CCN: 14-8657	To 06/30/2023	Date/Time Prep 11/29/2023 3:4	
				RHC II	Cost	
	Adjustments	Net Expenses				

						11/29/2023 3:	45 pm_
					RHC II	Cost	
		Adjustments	Net	Expenses			
		,	for A	Allocation			
				. 5 + col.			
			(001.	6)			
		6. 00		7. 00			
	FACILITY HEALTH CARE STAFF COSTS						4
1. 00	Physi ci an	0	기	0			1. 00
2.00	Physician Assistant	0		0			2. 00
3.00	Nurse Practitioner	0	ol	462			3.00
4.00	Visiting Nurse	0		0			4. 00
5. 00	Other Nurse	0	3	0			5.00
	i i	0	1	-			
6.00	Clinical Psychologist	0	기	0			6. 00
7.00	Clinical Social Worker	0	기	0			7. 00
8.00	Laboratory Techni ci an	0		0			8. 00
9.00	Other Facility Health Care Staff Costs	0	ol	0			9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	ol l	462			10.00
11. 00	Physician Services Under Agreement	0	5	0			11. 00
	9	0	1	-			1
12.00	Physician Supervision Under Agreement	0	2	0			12.00
13. 00	Other Costs Under Agreement	0	기	0			13. 00
14.00	Subtotal (sum of lines 11 through 13)	0		0			14. 00
15.00	Medical Supplies	0		0			15. 00
16.00	Transportation (Health Care Staff)	0	ol	0			16. 00
17. 00	Depreciation-Medical Equipment	0		0			17. 00
18. 00	Professional Liability Insurance	0	3	Ö			18. 00
		0	1	-			1
19. 00	Other Health Care Costs	Ü	7	0			19. 00
20. 00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0		0			21. 00
22.00	Total Cost of Health Care Services (sum of	0	ol	462			22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						1
23. 00	Pharmacy	0		0			23. 00
24. 00	Dental	0	3	0			24. 00
		0	1	-			
25. 00	Optometry	Ü	2	0			25. 00
25. 01	Tel eheal th	0	기	0			25. 01
25. 02	Chronic Care Management	0		0			25. 02
26.00	All other nonreimbursable costs	0		0			26. 00
27.00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0		0			28. 00
20.00	through 27)	O	1	O			20.00
							-
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	-	100			29. 00
30.00	Administrative Costs	0)	977			30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	ol	1, 077			31.00
	30)			•			1
32.00	Total facility costs (sum of lines 22, 28	0	ol .	1, 539			32. 00
52. 50	and 31)		1	1, 337			32.00
	and or,		1	1			1

Heal th	Financial Systems	MORRI SON COMMUI	NITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FOHC S	SERVI CES	Provi der Co		Period: From 07/01/2022	Worksheet M-2	
			Component	CCN: 14-3981	To 06/30/2023	Date/Time Prep 11/29/2023 3:4	
					RHC I	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col.		
		1.00	0.00	2.00	3)	4	
	VICLEC AND DEODUCTIVIEW	1.00	2. 00	3.00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY Positions						
1.00	Physi ci an	6. 92	18, 846	4, 20	0 29, 064		1.00
2.00	Physician Assistant	1. 12					2.00
3.00	Nurse Practitioner	3. 92					3.00
4.00	Subtotal (sum of lines 1 through 3)	11. 96			39, 648		4.00
5.00	Visiting Nurse	0.00			37, 040	39, 048	5.00
6.00	Clinical Psychologist	0.00				0	6.00
7. 00	Clinical Social Worker	1. 70				5	7.00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	7. 01
7. 02	Diabetes Self Management Training (FQHC	0.00				0	7. 02
7.02	only)	0.00				o l	7.02
8.00	Total FTEs and Visits (sum of lines 4	13. 66	32, 367			39, 653	8. 00
	through 7)		,				
9.00	Physician Services Under Agreements		0			0	9. 00
	•						
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T			VI CES			
	Total costs of health care services (from Wk					7, 659, 806	
11. 00	Total nonreimbursable costs (from Wkst. M-1,					409, 570	
12.00	Cost of all services (excluding overhead) (s					8, 069, 376	
13.00	Ratio of hospital-based RHC/FQHC services (I					0. 949244	
14.00	Total hospital-based RHC/FQHC overhead - (fr			ne 31)		1, 318, 412	1
15. 00	Parent provider overhead allocated to facili	ty (see instruc	ctions)			2, 602, 966	
16.00	Total overhead (sum of lines 14 and 15)					3, 921, 378	
17. 00	Allowable GME overhead (see instructions)					0	
	Enter the amount from line 16		40 11 4	0)		3, 921, 378	
	Overhead applicable to hospital-based RHC/FQ					3, 722, 345	
20.00	Total allowable cost of hospital-based RHC/F	UHC SERVICES (S	sum or lines 10	and 19)		11, 382, 151	J 20. 00

Heal th	Financial Systems	MORRI SON COMMUN	NITY HOSPITAL		In Lie	u of Form CMS-2	2552-10	
	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Period: From 07/01/2022	Worksheet M-2		
			Component	CCN: 14-8657	To 06/30/2023	Date/Time Pre 11/29/2023 3:		
					RHC II	Cost		
		Number of FTE	Total Visits		Minimum Visits			
		Personnel		Standard (1)	(col. 1 x col. 3)	col. 2 or col. 4		
		1.00	2.00	3.00	4. 00	5. 00		
	VISITS AND PRODUCTIVITY				•			
	Posi ti ons							
1.00	Physi ci an	0.00	C	4, 20	0 0		1. 00	
2.00	Physi ci an Assi stant	0.00	C	2, 10	0		2. 00	
3.00	Nurse Practitioner	0. 01	1	2, 10			3. 00	
4.00	Subtotal (sum of lines 1 through 3)	0. 01	1		21	21	4. 00	
5.00	Visiting Nurse	0. 00		1		0		
6.00	Clinical Psychologist	0.00)		0	6. 00	
7.00	Clinical Social Worker	0.00)		0		
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0		
7.02	Diabetes Self Management Training (FQHC	0.00	C	1		0	7. 02	
	onl y)							
8.00	Total FTEs and Visits (sum of lines 4	0. 01	1			21	8. 00	
0.00	through 7)					0	0.00	
9. 00	Physician Services Under Agreements			1		0	9. 00	
						1. 00		
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPITAL-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)			462	10.00	
11. 00						0	11. 00	
12.00	Cost of all services (excluding overhead) (s	sum of lines 10	and 11)			462	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			ne 31)		1, 077	14. 00 15. 00	
15. 00	15.00 Parent provider overhead allocated to facility (see instructions)							
16.00	16.00 Total overhead (sum of lines 14 and 15)							
17. 00	Allowable GME overhead (see instructions)					0		
	Enter the amount from line 16					1, 335	l	
	Overhead applicable to hospital-based RHC/FC					1, 335		
20. 00	Total allowable cost of hospital-based RHC/F	·QHC services (s	sum of lines 10	and 19)		1, 797	20. 00	

Heal th	Financial Systems MORRISON COMMUNIT	Y HOSPITAI	In lie	u of Form CMS-2	2552-10	
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provi der CCN: 14-1329	Peri od:	Worksheet M-3		
SERVI C	ES		From 07/01/2022			
		Component CCN: 14-3981	To 06/30/2023	Date/Time Prep 11/29/2023 3:4		
		Title XVIII	RHC I	Cost	45 рііі	
				1. 00		
1. 00	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES Total Allowable Cost of hospital-based RHC/FQHC Services (from	m Wkst M 2 line 20)		11, 382, 151	1.00	
2.00	Cost of injections/infusions and their administration (from W			20, 705	1	
3.00	Total allowable cost excluding injections/infusions (line 1 m			11, 361, 446	1	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	,		39, 653	1	
5.00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5. 00	
6.00	Total adjusted visits (line 4 plus line 5)			39, 653	1	
7. 00	Adjusted cost per visit (line 3 divided by line 6)		Cal cul ati on	286.52	7. 00	
			Carcuration	OI LIMIT (I)		
			Rate Period 1			
			(07/01/2022	(01/01/2023		
			through 12/31/2022)	through 06/30/2023)		
			1. 00	2. 00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	242. 78	252. 00	8. 00	
9.00	Rate for Program covered visits (see instructions)		242. 78	252. 00	9. 00	
40.00	CALCULATION OF SETTLEMENT		0.000	0.070	1 40 00	
10. 00 11. 00	Program covered visits excluding mental health services (from Program cost excluding costs for mental health services (line	,	2, 930 711, 345	2, 872 723, 744		
12. 00	Program covered visits for mental health services (from contra		711, 343	723, 744	12.00	
13. 00	Program covered cost from mental health services (line 9 x li		728	Ö	13. 00	
14.00	Limit adjustment for mental health services (see instructions)	728	0	14. 00	
15. 00	Graduate Medical Education Pass Through Cost (see instruction	•			15. 00	
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	,	0	1, 435, 817	1	
16. 01	Total program charges (see instructions) (from contractor's re	•		1, 279, 588	1	
16. 02 16. 03	Total program preventive charges (see instructions)(from prov Total program preventive costs ((line 16.02/line 16.01) times			27, 534 30, 896	1	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0			1, 067, 940	1	
	(Titles V and XIX see instructions.)			.,,		
16. 05	Total program cost (see instructions)		0	1, 098, 836	•	
17. 00	Primary payer amounts	(6		297	•	
18. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(Trom contractor		69, 996	18. 00	
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		236, 212	19. 00	
	records)					
20. 00	Net Medicare cost excluding vaccines (see instructions)			1, 098, 539		
21. 00	Program cost of vaccines and their administration (from Wkst. Total reimbursable Program cost (line 20 plus line 21)	M-4, line 16)		8, 939	1	
22. 00 23. 00	Allowable bad debts (see instructions)			1, 107, 478 47, 408	1	
23. 01	Adjusted reimbursable bad debts (see instructions)			30, 815	1	
	1 7	Allowable bad debts for dual eligible beneficiaries (see instructions)				
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ŕ		0		
	Pioneer ACO demonstration payment adjustment (see instructions)				25. 50	
25. 99	Demonstration payment adjustment amount before sequestration				25. 99	
26. 00 26. 01	Net reimbursable amount (see instructions) Sequestration adjustment (see instructions)	1, 138, 293 22, 766				
26. 01	Demonstration payment adjustment amount after sequestration	22, 766	1			
	Interim payments	1, 008, 246				
28. 00	. 3					
29. 00	.00 Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)					
30. 00	,	nce with CMS Pub. 15-II,		0	30. 00	
	chapter I		1		I	

Heal th	Financial Systems MORRISON COMMU	NITY HOSPITAL		In Li∈	eu of Form CMS-2	2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST		Provi der CC	Provider CCN: 14-1329		Worksheet M-4	
		Component (To 06/30/2023	Date/Time Pre 11/29/2023 3:	
	Title XVIII				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	Health care staff cost (from Wkst. M-1, col. 7, line 10)	6, 515, 321	6, 515, 3	21 6, 515, 321	6, 515, 321	1. 00
2.00	Ratio of injection/infusion staff time to total health care staff time	0. 000046	0. 0000	0. 000023	0. 000000	2. 00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	300	3	19 150	0	3. 00
4. 00	Injections/infusions and related medical supplies costs (from your records)	10, 726	2, 4	40 0	0	4. 00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	11. 026	2.7	59 150	0	5. 00
6.00	Total direct cost of the hospital-based RHC/FQHC (from	7, 659, 806				
	Worksheet M-1, col. 7, line 22)	1,001,000	.,, .	.,,	.,,	
7.00	Total overhead (from Wkst. M-2, line 19)	3, 722, 345	3, 722, 3	45 3, 722, 345	3, 722, 345	7. 00
8.00	Ratio of injection/infusion direct cost to total direct	0. 001439	0. 0003	0. 000020		8. 00
	cost (line 5 divided by line 6)					
9.00	Overhead cost - injection/infusion (line 7 x line 8)	5, 356	1, 3	40 74	0	9. 00
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	16, 382	4, 0	99 224	0	10. 00
11.00	Total number of injections/infusions (from your records)	61		51 24	0	11. 00
12.00	Cost per injection/infusion (line 10/line 11)	268. 56	80.	9. 33	0.00	12.00
13. 00	Number of injection/infusion administered to Program beneficiaries	27		21 0	0	13. 00
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 01
14. 00	Program cost of injections/infusions and their	7, 251	1.6	38 0	0	14. 00
	administration costs (line 12 times the sum of lines 13	,	, -			
	and 13.01, as applicable)					
					COST OF	
					INJECTIONS /	
					INFUSIONS AND	
					ADMI NI STRATI ON	
45.00	T-11 1 C: 1 1 1 1 C: 1 1 1 1 1 1 1 1 1 1 1			1. 00	2. 00	45.00
15. 00	Total cost of injections/infusions and their administratio 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		columns 1,		20, 705	15. 00
16. 00	Total Program cost of injections/infusions and their admin		•		8, 939	16. 00
	columns 1, 2, 2.01, and 2.02, line 14) (transfer this amou	nt to Wkst. M-3	, line 21)			

Health Financial Systems	MORRISON COMMUNITY	MORRISON COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10		
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIA		Provider CCN: 14-1329 Component CCN: 14-3981	From 07/01/2022			
			DUC I	C+		

				11/29/2023 3: 4	45 pm
			RHC I	Cost	•
	<u> </u>		Par	rt B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			1, 016, 368	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			06/15/2023	6, 087	3. 01
3. 02				0	3. 02
3.03				0	3. 03
3.04				0	3. 04
3.05				0	3. 05
	Provider to Program				
3.50			02/27/2023	14, 209	3. 50
3.51				0	3. 5
3.52				0	3. 52
3.53				0	3. 53
3.54				0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		-8, 122	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	fer to Worksheet M-3, line		1, 008, 246	4.00
	27)				
	TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after des	k review. Also show date of	-		5.00
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
5. 01				0	5. 0
5.02				0	5. 02
5.03				0	5. 03
	Provider to Program				
5.50				0	5. 50
5. 51				0	5. 51
5. 52				0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.			0	5. 9
6.00	Determined net settlement amount (balance due) based on the	cost report. (1)			6. 00
6. 01	SETTLEMENT TO PROVIDER			107, 281	6. 0
6. 02	SETTLEMENT TO PROGRAM			0	6. 02
7. 00	Total Medicare program liability (see instructions)			1, 115, 527	7. 00
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2. 00	8. 00
8.00	Name of Contractor				