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: 14-1310 Worksheet S Peri od: From 10/01/2022 Parts I-III AND SETTLEMENT SUMMARY 09/30/2023 Date/Time Prepared: 2/25/2024 7:10 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 2/25/2024 7:10 pm Manually prepared cost report use only If 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 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. 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 MENDOTA COMMUNITY HOSPITAL (14-1310) for the cost reporting period beginning 10/01/2022 and ending 09/30/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	R CHECKBOX					
	1	2	SI GNATURE STATEMENT				
1			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			2			
3	Signatory Title			3			
4	Date			4			

		Title	XVIII			
	Title V	Part A	Part B	HI T	Title XIX	
	1. 00	2. 00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY						
1. 00 HOSPI TAL	0	-49, 435	-1, 263, 376	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	-30, 018	0		0	5.00
6.00 SWING BED - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC I	0		169, 381		0	10.00
200. 00 TOTAL	0	-79, 453	-1, 093, 995	0	0	200.00
The above amounts represent "due to" or "due from"	the applicable	program for t	he element of	the above comp	lov indicated	

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

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

Health Financial Systems MENDOTA COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-1310 Peri od: Worksheet S-2 From 10/01/2022 Part I 09/30/2023 Date/Time Prepared: 2/25/2024 7:10 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1401 EAST 12TH ST 1.00 PO Box: 1.00 Zip Code: 61342-9216 County: LA SALLE 2.00 City: MENDOTA State: IL 2.00 Provi der Component Name CCN CBSA Date Payment System (P, T, 0, or N)
/ XVIII XIX Туре Certi fi ed Number Number 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 MENDOTA COMMUNITY 141310 99914 01/15/2001 Ν 0 N 3.00 HOSPI TAL Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF MENDOTA COMMUNITY SWING 99914 N 147310 01/25/2001 N 0 7.00 7 00 BED- SNF 8.00 Swing Beds - NF 8.00 9.00 Hospital -Based SNF 9.00 Hospital -Based NF 10.00 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospital -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14 00 14 00 15.00 Hospital-Based Health Clinic - RHC MENDOTA COMMUNITY 148535 99914 02/11/2015 N 0 N 15.00 HOSPITAL - RHC 16.00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 2 00 1 00 20.00 Cost Reporting Period (mm/dd/yyyy) 10/01/2022 09/30/2023 20.00 21.00 Type of Control (see instructions) 21.00 1. 00 2. 00 3. 00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for N N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no Ν Ν 22.01 for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 22.02 Ν Ν 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to N Ν Ν 22.03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for

yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 23 00 3 N below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

Health Financial Systems MENDOTA COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-1310 Peri od: Worksheet S-2 From 10/01/2022 Part I 09/30/2023 Date/Time Prepared: 2/25/2024 7:10 pm In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days unpai d pai d days el i gi bl e days unpai d 1.00 2. 00 3.00 4. 00 5. 00 6. 00 24.00 If this provider is an IPPS hospital, enter the 0 24.00 \cap Λ in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 0 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. Urban/Rural S Date of Geogr 1.00 2.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 enter the effective date of the geographic reclassification in column 2. 35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in 0 35.00 effect in the cost reporting period. Begi nni ng: Endi ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates. 36 00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 0 37.00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in 37.01 accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 38.00 | If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39.00 Ν hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or Ν N 40.00 "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions) XVIII XIX V 1. 00 2.00 3.00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance N N N 45.00 with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstances 46.00 Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. N N N 47.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. 48.00 Ν N Ν 48.00 Teachi ng Hospi tal s Is this a hospital involved in training residents in approved GME programs? For cost reporting Ν 56.00 periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter Y" for yes; otherwise, enter "N" for no in column 2. 57.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, Ν 57.00 is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of

which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.

Health Financial Systems MENDOTA COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-1310 Peri od: Worksheet S-2 From 10/01/2022 Part I 09/30/2023 Date/Time Prepared: 2/25/2024 7: 10 pm | XVIII | XIX 1. 00 2.00 3.00 58.00 | If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. Ν 58.00 Pt. I Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qualification Cri teri on Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see 60 00 N instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. IME Direct GME IME Direct GME 1. 00 2.00 3. 00 4. 00 5.00 61.00 Did your hospital receive FTE slots under ACA 0.00 0.00 61.00 Ν section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61 02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unwei ghted Unwei ghted IME FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 0.00 61.10 61.10 Of the FTEs in line 61.05, specify each new program 0. 00 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 63.00 Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

Health Financial Systems	MENDOTA	COMMUNITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP				eriod: rom 10/01/2022	Worksheet S-2 Part I Date/Time Pre 2/25/2024 7:10	pared:
			Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
Cootion FEOA of the ACA Doos Vos	un ETE Docidonto in N	annavi dan Catti nga	1. 00	2.00	3.00	
Section 5504 of the ACA Base Year period that begins on or after a			- mis base year	is your cost	reporting	
64.00 Enter in column 1, if line 63 is in the base year period, the numeresident FTEs attributable to resettings. Enter in column 2 the resident FTEs that trained in your of (column 1 divided by (column)		0.00		64.00		
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
			FTES	FTEs in	3/ (col . 3 +	
			Nonprovi der Si te	Hospi tal	col. 4))	
	1. 00	2. 00	3.00	4. 00	5. 00	
65.00 Enter in column 1, if line 63	1.00	2.00	0.00			65.00
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						03.00
			Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 +	
			Nonprovi der	Hospi tal	col . 2))	
			Si te	i i	· · ·	
			1.00	2. 00	3. 00	
Section 5504 of the ACA Current		n Nonprovider Settin	gsEffective 1	for cost report	ing periods	
beginning on or after July 1, 20 66.00 Enter in column 1 the number of		cy caro rosidont	0.00	0.00	0. 000000	66 00
FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	ccurring in all nonpount unweighted non-priman al. Enter in column 3	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0. 000000	00.00
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
			FTES Nonprovi don	FTEs in	3/ (col . 3 +	
			Nonprovi der Si te	Hospi tal	col. 4))	
	1. 00	2. 00	3.00	4. 00	5. 00	
67.00 Enter in column 1, the program	1. 00	2.00	0.00			67.00
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						

Health Financial Systems MENDOTA COMMUNI	TY HOSPITAL		In	Lieu	of Form CMS	-2552-10				
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CC	CN: 14-1310	Peri od: From 10/01/ To 09/30/	2022	Worksheet S- Part I Date/Time Pr 2/25/2024 7:	2 epared:				
					1. 00					
Direct GME in Accordance with the FY 2023 IPPS Final Rule, 68.00 For a cost reporting period beginning prior to October 1, 20 MAC to apply the new DGME formula in accordance with the FY (August 10, 2022)?	022, did you o	btain permis	sion from yo			68. 00				
				1. 00	2.00 3.00					
70.00 Is this facility an Inpatient Psychiatric Facility (IPF), o	r does it cont	ain an IPF s	ubprovi der?	N		70.00				
Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS										
75.00 Is this facility an Inpatient Rehabilitation Facility (IRF) subprovider? Enter "Y" for yes and "N" for no.	, or does it c	ontain an IR	F	N		75. 00				
76.00 If line 75 is yes: Column 1: Did the facility have an approrecent cost reporting period ending on or before November 1: no. Column 2: Did this facility train residents in a new teacher (CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no indicate which program year began during this cost reporting	5, 2004? Enter aching program . Column 3: If	"Y" for yes in accordar column 2 is	or "N" for ce with 42 Y,		0	76. 00				
					1. 00					
Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.										
TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.										
87.00 Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	al classified	under sectio	n		N	87.00				
			Approved Permane Adjustme (Y/N) 1.00	nt ent	Number of Approved Permanent Adjustments 2.00					
88.00 Column 1: Is this hospital approved for a permanent adjustm amount per discharge? Enter "Y" for yes or "N" for no. If ye 89. (see instructions)	es, complete c	RA target ol. 2 and li	N			0 88.00				
Column 2: Enter the number of approved permanent adjustment	S	Wkst. A Lir	ne Effecti	ve	Approved					
		No.	Date		Permanent Adjustment Amount Per Discharge					
89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A	line number	1.00	2. 00		3. 00	0 89.00				
on which the per discharge permanent adjustment approval was Column 2: Enter the effective date (i.e., the cost reporting beginning date) for the permanent adjustment to the TEFRA to per discharge.	s based. g period arget amount	-								
Column 3: Enter the amount of the approved permanent adjusting TEFRA target amount per discharge.	ment to the									
			1. 00		XI X 2. 00					
Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital	al services? E	nter "Y" for	N		Υ	90.00				
yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through		N	91.00							
full or in part? Enter "Y" for yes or "N" for no in the app 92.00 Are title XIX NF patients occupying title XVIII SNF beds (d					N	92.00				
instructions) Enter "Y" for yes or "N" for no in the applic. 93.00 Does this facility operate an ICF/IID facility for purposes	able column.		N		N	93.00				
"Y" for yes or "N" for no in the applicable column. 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes,			N		N	94.00				
applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the app	plicable colum	n.	0. 00		0. 00	95.00				
 96.00 Does title V or XIX reduce operating cost? Enter "Y" for year applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 			0. 00		N O. OO	96.00				
	F 5451 6 601 alli		1 0.00	ı	0.00	1 00				

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der Co	CN: 14-1310	In Lie Period:	Worksheet S	5-2			
SOFT THE AND HOST THE HEALTH SAINE SOME EEX TRENTTH ON DATA	Trovider of		From 10/01/2022 To 09/30/2023	Part I				
			V	2/25/2024 7 XI X	7: 10 pm			
			1.00	2.00	\dashv			
8.00 Does title V or XIX follow Medicare (title XVIII) for the i stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" column 1 for title V, and in column 2 for title XIX.			N	N	98. 0			
Boes title V or XIX follow Medicare (title XVIII) for the r C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for t title XIX.				Y	98. 0			
3.02 Does title V or XIX follow Medicare (title XVIII) for the composition bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes for title V, and in column 2 for title XIX.			N	Y	98. 0			
3.03 Does title V or XIX follow Medicare (title XVIII) for a cri reimbursed 101% of inpatient services cost? Enter "Y" for y for title V, and in column 2 for title XIX.				N	98.0			
B. O4 Does title V or XIX follow Medicare (title XVIII) for a CAF outpatient services cost? Enter "Y" for yes or "N" for no i in column 2 for title XIX.			N	N	98.0			
8.05 Does title V or XIX follow Medicare (title XVIII) and add b Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in	5 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, an column 2 for title XIX. 6 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D							
8.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in colum column 2 for title XIX.			N	N	98.0			
Rural Providers				1				
O5.00 Does this hospital qualify as a CAH? O6.00 If this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)	-inclusive met	chod of paymen	t Y Y		105. 0 106. 0			
07.00 Column 1: If line 105 is Y, is this facility eligible for contraining programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded I	N		107. C					
Enter "Y" for yes or "N" for no in column 2. (see instruct 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.		edul e? See 42	N		108. 0			
	Physi cal	Occupati onal	Speech 3.00	Respirator 4.00	У			
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therapy services provided by outside supplier? Enter "Y"	. N	N	N N	N	109. 0			
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128.00 This is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 129.00 This is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 130.00 This is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 130.00 This is a Medicare-certified instinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 130.00 This is a Medicare-certified instinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 131.00 This is a hospital-based organ procurement organization (OPO), enter the certification date in column 1 and termination date, if applicable, in column 2. 131.00 This is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2. 131.00 This is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2. 132.00 This is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2. 132.00 This is a hospital-based organization or home office costs as defined in CMS Pub. 15-1, and termination date, if applicable, in column 2. 133.00 This is a hospital date in column 2. 140.00 This is a hospital date in column 2. 140.00 This is a hospital date in column 2. 141.00 This is a hospital date in column 2. 142.00 This is a hospital date in column 2. 143.00 This is a hospital date in column 2. 144.00 This is a hospital date in column 3. 145.00 This is a hospital date in column 3. 146.00 This is a hospital date in column 3. 146.00 This is a hospital date in column 4. 147.00	127.00 f this is a Medicare-certified heart t	ransplant program, ent	er the certif	ication date	9		127. 00
129.00 f this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 130.00 f this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 131.00 this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 132.00 this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 133.00 Removed and reserved	128.00 If this is a Medicare-certified liver t	ransplant program, ent	er the certif	ication date	e		128. 00
in column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare-certified approcase transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 132.00 If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 133.00 Removed and reserved 134.00 If this is a hospital-based organ procurement organization (0PO), enter the 0PO number in column 1 and termination date, if applicable, in column 2. 141.00 In this is a hospital-based organ procurement organization (0PO), enter the 0PO number in column 1 and termination date, if applicable, in column 2. 141.00 In this is a hospital-based organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see Instructions) 140.00 Are provider based physicians' costs included in Worksheet A? 141.00 Name: 0SF HEALTHCARE SYSTEM Contractor's Name: WPS Contractor's Number: 05901 141.00 144.00 1			r the certifi	cation date			129. 00
date in column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 132.00 If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 133.00 Removed and reserved 134.00 If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2. All Providers 140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions) 100			enter the cer	tification			130.00
date in column 1 and termination date, if applicable, in column 2. 132.00 If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 133.00 Removed and reserved 134.00 If this is a hospital-based organ procurement organization (0PO), enter the 0PO number in column 1 and termination date, if applicable, in column 2. All Providers 140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions) 1.00	date in column 1 and termination date,	if applicable, in colu	mn 2.				
132.00 If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 133.00 Removed and reserved 133.00 134.00 1				erti fi cati or	ו		131. 00
133. 00 Removed and reserved 133. 00 134. 115 135. 00 134. 115 135. 00 134. 00 1	132.00 If this is a Medicare-certified islet t	ransplant program, ent		ication date	9		132.00
in column 1 and termination date, if applicable, in column 2. All Providers 140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, V HB1728 140.00 chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions) 1.00 2.00 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number. 141.00 Name: OSF HEALTHCARE SYSTEM Contractor's Name: WPS Contractor's Number: 05901 141.00 142.00 Street: 124 SW ADAMS PO Box: 142.00 Street: 124 SW ADAMS PO Box: 143.00 State: IL Zip Code: 61602 143.00 144.00 Are provider based physicians' costs included in Worksheet A? Y 144.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodol ogy changed from the previously filed cost report? N 146.00 Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If	133.00 Removed and reserved						133. 00
All Providers 140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions) 1.00 2.00 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number. 141.00 Name: 0SF HEALTHCARE SYSTEM Contractor's Name: WPS Contractor's Number: 05901 141.00 142.00 Street: 124 SW ADAMS PO Box: 143.00 City: PEORIA State: IL Zip Code: 61602 1.00 1.00 1.00 1.00 1.00 1.44.00 Are provider based physicians' costs included in Worksheet A? 1.00			PO), enter th	ie OPO number	-		134. 00
chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions) 1.00 2.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number. 141.00 Name: OSF HEALTHCARE SYSTEM Contractor's Name: WPS Contractor's Number: 05901 141.00 142.00 Street: 124 SW ADAMS PO Box: IL Zip Code: 61602 143.00 143.00 City: PEORIA State: IL Zip Code: 61602 143.00 144.00 Are provider based physicians' costs included in Worksheet A? Y 144.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? N 146.00 146.00 Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If	All Providers		fined in CMS	Dub 1E 1	V	UD1720	140.00
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number. 141.00 Name: OSF HEALTHCARE SYSTEM Contractor's Name: WPS Contractor's Number: 05901 141.00 142.00 142.00 143.00 142.00 143.00 144.00 143.00 144.	chapter 10? Enter "Y" for yes or "N" for are claimed, enter in column 2 the home	r no in column 1. If y office chain number.	es, and home	office costs	5	пвт/20	140.00
office and enter the home office contractor name and contractor number. 141.00 Name: OSF HEALTHCARE SYSTEM Contractor's Name: WPS Contractor's Number: 05901 141.00 142.00 Street: 124 SW ADAMS PO Box: 142.00 143.00 City: PEORIA State: IL Zip Code: 61602 143.00 144.00 Are provider based physicians' costs included in Worksheet A? Y 144.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? N 146.00 141.00 Inpatient services only? Enter "Y" for yes or "N" for no in column 2.			nes 141 throu	 ugh 143 the i		of the home	
142.00 Street: 124 SW ADAMS PO Box: IL Zip Code: 61602 143.00 143.00 City: PEORIA State: IL Zip Code: 61602 143.00 1.00 1.00 1.00 2.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? N 146.00 Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If	office and enter the home office contra	ictor name and contract					141 00
1.00 144.00 Are provider based physicians' costs included in Worksheet A? 1.00 1.00 1.00 2.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? N 1.00 1.00 1.00 1.45.00				Contracti	JI S Nulliber . 0370	1	
144.00 Are provider based physicians' costs included in Worksheet A? 1.00 1.00 2.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? N 146.00 Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If	143. 00 Ci ty: PEORIA	State: IL		Zi p Code:	6160	2	143.00
145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? N 146.00 Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If	144.00 Are provider based physicians' costs in	cluded in Worksheet A?					144. 00
inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If					1. 00	2. 00	
146.00 Has the cost allocation methodology changed from the previously filed cost report? N 146.00 Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If	inpatient services only? Enter "Y" for no, does the dialysis facility include	yes or "N" for no in c Medicare utilization f	olumn 1. If o	olumn 1 is			145. 00
	146.00 Has the cost allocation methodology cha Enter "Y" for yes or "N" for no in colu	nged from the previous mn 1. (See CMS Pub. 15					146. 00

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE			TY HOSPITAL	N. 14 104			In Lie	u of Form CMS-	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	EX IDENIIFICATION DATA	4	Provider CC	N: 14-1310	F		/01/2022 /30/2023		epared:
								1. 00	-
47.00Was there a change in the statist	ical basis? Enter "Y"	for v	es or "N" for	no.				N N	147.0
148.00Was there a change in the order o								N	148.0
149.00 Was there a change to the simplif	ied cost finding metho	od? En	iter "Y" for y	es or "N"	for	no.		N	149. 0
			Part A	Part			tle V	Title XIX	
			1. 00	2. 00			3. 00	4. 00	
Does this facility contain a prov or charges? Enter "Y" for yes or									
55. 00 Hospi tal			N	N			N	N	155.0
56.00 Subprovi der - IPF			N	N			N	N	156.0
57.00 Subprovi der - IRF			N	N			N	N	157. C
58. 00 SUBPROVI DER									158.0
59. 00 SNF			N	N			N	N	159.0
60. 00 HOME HEALTH AGENCY			N	N			N	N	160.0
61. 00 CMHC				N			N	N	161.0
								1.00	-
Mul ti campus									
65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that ha	as one	or more camp	uses in d	i ffer	ent CE	BSAs?	N	165.0
Effect 1 For year of 10 For He.	Name		County	State	Zip	Code	CBSA	FTE/Campus	
	0		1. 00	2.00		.00	4. 00	5. 00	
66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.0	0166.0
								1.00	-
Health Information Technology (HI	T) incentive in the A	meri ca	n Recovery an	d Rei nves	tmen	t Act			
67.00 s this provider a meaningful use	r under §1886(n)? En	ter "Y	" for yes or	"N" for n	0.			Υ	ີ່ 167. C
68.00 If this provider is a CAH (line 1				e 167 is	"Y"),	enter	the		168.0
reasonable cost incurred for the									
68.01 If this provider is a CAH and is						a hard	ishi p		168.0
exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful	user (line 167 is "Y")					'N"), e	enter the	0.0	0169.0
transition factor. (see instructi	ons)					Pog	ji nni ng	Endi ng	
							1. 00	2. 00	-
70.00 Enter in columns 1 and 2 the EHR	beginning date and end	dina d	ate for the r	eporti na			1. 00	2.00	170. C
period respectively (mm/dd/yyyy)									1.70.0
							1. 00	2.00	
71.00 If line 167 is "Y", does this pro	vider have any days fo	or ind	li vi dual s enro	lled in			N		0 171. C
section 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	, Pt.	I, line 2, co	I. 6? Ent		ו			

Heal th	Financial Systems MENDOTA COMMUN	ITV HOSPITAL		In lie	u of Form CMS-	2552_10
	THIRD THE SYSTEMS STATE OF THE	Provi der C	CN: 14-1310	Period: From 10/01/2022	Worksheet S-2 Part II	2
				To 09/30/2023	Date/Time Pre 2/25/2024 7:	
				Y/N 1. 00	Date	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE	EMENT QUESTION	NAI RE	1.00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter Mmm/dd/yyyy format. COMPLETED BY ALL HOSPITALS			er all dates in	the	
	Provider Organization and Operation					
1. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in a			N		1.00
	preporting perrous in yes, enter the date of the change in t	corumir z. (See	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
2. 00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.00
3.00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home 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	N			3.00	
	relationships? (see instructions)		Y/N	Type	Date	
			1.00	2. 00	3. 00	
	Financial Data and Reports					
4. 005. 00	Column 1: Were the financial statements prepared by a Certacountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avacolumn 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues difference.	for Compiled, ailable in	Y	A		4. 00 5. 00
5.00	those on the filed financial statements? If yes, submit received		14			3.00
	•			Y/N	Legal Oper.	
	Approved Educational Activities			1. 00	2. 00	
6. 00	Column 1: Are costs claimed for a nursing program? Column the legal operator of the program?	2: If yes, i	s the provide	er N		6.00
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.		wed during th	ne N		7. 00 8. 00
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	ns.				9.00
10. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.			N		10.00
11. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	I & R in an Ap	proved 	N	Y/N	11.00
					1.00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection paried of the provider's bad debt collection in the provider is the provider of			ost reporting	Y	12. 00 13. 00
14. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsuralinstructions.	ance amounts w	aived? If yes	s, see	N	14. 00
15 00	Bed Complement Did total beds available change from the prior cost reporti	na neriod2 lf	ves see inc	tructions	N	15. 00
13.00	The total beds available change from the pirol cost reporti		t A		t B	13.00
		Y/N	Date	Y/N	Date	
	PS&R Data	1. 00	2.00	3. 00	4. 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	N		N		16. 00
17. 00	date of the PS&R Report used in columns 2 and 4 (see instructions) 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	12/13/2023	Y	12/13/2023	17.00
18. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18.00
19. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00
	·					

Heal th	Financial Systems MENDOTA COMMUN	IITY HOSPITAL		In Lie	u of Form CM	S-2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 14-1310	Peri od: From 10/01/2022 To 09/30/2023	Worksheet S Part II	S-2 Prepared:
			iption	Y/N	Y/N	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R		0	1. 00 N	3. 00 N	20.00
20.00	Report data for Other? Describe the other adjustments:			IN	IN	20.00
		Y/N	Date	Y/N	Date	
04.00	lw	1.00	2. 00	3.00	4. 00	01.00
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCI					
22.00	Capital Related Cost	- ! + + !				
22. 00 23. 00	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense			ring the cost	Y N	22. 00 23. 00
20.00	reporting period? If yes, see instructions.	ado to appi ai	Sar S made ad	Trig the cost	.,	20.00
24. 00	Were new leases and/or amendments to existing leases enterollifyes, see instructions	ed into during	this cost r	eporting period?	N	24. 00
25. 00	Have there been new capitalized leases entered into during	the cost repo	rting period	? If yes, see	N	25. 00
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during the	he cost report	ing period?	If yes, see	N	26. 00
27. 00	instructions. Has the provider's capitalization policy changed during the	o cost roporti	ng poriod? L	fivos submit	N	27. 00
27.00	сору.	e cost reporti		i yes, subiii t	IV	27.00
28. 00	Interest Expense Were new Loans, mortgage agreements or letters of credit e	ntered into du	ring the cos	t reporting	N	28. 00
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	bond funds (D	ebt Service I	Reserve Fund)	N	29. 00
30. 00	treated as a funded depreciation account? If yes, see install Has existing debt been replaced prior to its scheduled mate		debt? If ve	s. see	N	30.00
31. 00	instructions. Has debt been recalled before scheduled maturity without is		N	31.00		
01.00	instructions. Purchased Services		dobt. 11 ye.	3, 300	.,	
32. 00	Have changes or new agreements occurred in patient care se		ed through c	ontractual	Y	32.00
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app		ng to compet	itive bidding? If	N	33. 00
	no, see instructions. Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an	arrangement wi	th provider-	pased physicians?	' Y	34.00
35 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex	isting agreeme	nts with the	provi der-based	N	35. 00
	physicians during the cost reporting period? If yes, see in					00.00
				Y/N 1. 00	2. 00	
	Home Office Costs			1.00	2.00	
	Were home office costs claimed on the cost report?			Y		36.00
37. 00	If line 36 is yes, has a home office cost statement been pulf yes, see instructions.	repared by the	home office	? Y		37. 00
38. 00	If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en			f N		38. 00
39. 00	If line 36 is yes, did the provider render services to other			s, N		39. 00
40. 00	see instructions. If line 36 is yes, did the provider render services to the	home office?	If yes, see	N		40. 00
	instructions.					
		1.	00	2.	00	
	Cost Report Preparer Contact Information	l · · ·				
41. 00	held by the cost report preparer in columns 1, 2, and 3,	PATRI CI A		RACHELL		41.00
42. 00	respectively. Enter the employer/company name of the cost report	FORVI S				42. 00
43. 00	preparer. Enter the telephone number and email address of the cost	(314) 231-5544	1	PATTY. RACHELL@	FORVIS. COM	43.00
	report preparer in columns 1 and 2, respectively.					

Heal th Fina	ncial Systems	MENDOTA COMMUN	ITY HOSPITAL	=	In Lieu of Form CMS-2552-			
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provi der	CCN: 14-1310	Fro				
					То	09/30/2023	Date/Time Pre 2/25/2024 7:1	o pm
				3. 00				
Cost	Report Preparer Contact Information							
41.00 Ente	r the first name, last name and the f	title/position	MANAGING DIF	RECTOR				41.00
hel d	by the cost report preparer in colur	nns 1, 2, and 3,						
resp	ecti vel y.							
42.00 Ente	r the employer/company name of the co	ost report						42.00
prep	arer.							
43.00 Ente	r the telephone number and email addu	ress of the cost						43.00
repo	rt preparer in columns 1 and 2, respe	ecti vel y.						

 Health Financial
 Systems
 MENDOTA

 HOSPITAL
 AND
 HOSPITAL
 HEALTH CARE COMPLEX
 STATISTICAL
 DATA
 Provider CCN: 14-1310

						To 09/30/2023	Date/Time Pre 2/25/2024 7:1	
							I/P Days /	O PIII
							0/P Visits /	
							Tri ps	
	Component	Worksheet A	No	. of Beds	Bed Days	CAH/REH Hours	Title V	
		Li ne No.		0.00	Avai I abl e	4.00	F 00	
	PART I - STATISTICAL DATA	1. 00		2.00	3. 00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		21	7, 665	35, 151. 12	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 I RF Subprovi der						_	4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF			0.4	7.//	05 454 40	0	6.00
7. 00	Total Adults and Peds. (exclude observation			21	7, 665	35, 151. 12	0	7. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT	31.00		4	1, 460	742. 17	0	8. 00
9. 00	CORONARY CARE UNIT	31.00		4	1, 400	742.17	U	9.00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12.00
13. 00	NURSERY							13.00
14. 00	Total (see instructions)			25	9, 125	35, 893. 29	0	14.00
15.00	CAH visits						0	15.00
15. 10	REH hours and visits							15. 10
16.00	SUBPROVIDER - IPF							16.00
17.00	SUBPROVIDER - IRF							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 24. 10	HOSPICE	30. 00						24. 00 24. 10
25. 00	HOSPICE (non-distinct part) CMHC - CMHC	30.00						25. 00
26. 00	RHC (CONSOLI DATED)	88. 00					0	26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00					Ö	26. 25
27. 00	Total (sum of lines 14-26)	07.00		25				27. 00
28. 00	Observation Bed Days			20			0	28.00
29. 00	Ambulance Trips							29. 00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF							31.00
32.00	Labor & delivery days (see instructions)			0	(32.00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33. 00	,							33.00
33. 01	LTCH site neutral days and discharges	22		_1			_	33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30. 00		0	(ון	0	34.00

 Health Financial
 Systems
 MENDOTA

 HOSPITAL
 AND
 HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provider CCN: 14-1310

				''	0 09/30/2023	2/25/2024 7: 1	
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	J
		.,. baya	, ,, ,, ,, ,,	,ps		equi vai onto	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8.00	9. 00	10.00	
	PART I - STATISTICAL DATA	0.00	71.00	0.00	7. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	753	28	1, 465			1.00
	8 exclude Swing Bed, Observation Bed and	, , ,	20	1, 100			
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)	362	80				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4. 00	HMO IRF Subprovider		0				4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF	602	0				5.00
6. 00	Hospital Adults & Peds. Swing Bed NF	002	0				6.00
7. 00	Total Adults and Peds. (exclude observation	1, 355	28				7.00
7.00	beds) (see instructions)	1, 333	20	2, 327			7.00
8. 00	INTENSIVE CARE UNIT	25	13	62			8.00
9. 00	1	25	13	02			9.00
	CORONARY CARE UNIT						
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	1 200	4.1	2 500	0.00	140.75	13.00
14.00	Total (see instructions)	1, 380	41	2, 589	0. 00	148. 75	
15.00	CAH visits	U	0	0			15.00
15. 10	REH hours and visits						15. 10
16.00	SUBPROVI DER - I PF						16.00
17. 00	SUBPROVI DER - I RF						17.00
18.00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGI CAL 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	RHC (CONSOLI DATED)	6, 173	5, 483	24, 443	0. 00		
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0. 00	l	
27. 00	Total (sum of lines 14-26)				0. 00	182. 97	27. 00
28. 00	Observation Bed Days		85	579			28. 00
29. 00	Ambul ance Trips	0					29. 00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0				32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	0					33.00
33. 01	LTCH site neutral days and discharges	0					33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

Heal th Financial SystemsMENDOTAHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 14-1310 Peri od: Worksheet S-3 From 10/01/2022 Part I

				To	09/30/2023	Date/Time Pre 2/25/2024 7:1	
		Full Time		Di sch	arges	272072021 7. 1	o piii
	Component	Equi val ents Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	Component	Workers	11 110 1	I II II O XVIII	TI CI O XI X	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	193	9	509	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)			79	37		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6. 00	Hospi tal Adul ts & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGI CAL INTENSI VE CARE UNI T						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	193	9	509	14.00
15. 00	CAH visits						15.00
15. 10							15. 10
16. 00	SUBPROVI DER - I PF						16. 00
17.00	SUBPROVI DER - I RF						17.00
18.00	SUBPROVI DER						18.00
19. 00 20. 00	SKILLED NURSING FACILITY NURSING FACILITY						19. 00 20. 00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	1						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	RHC (CONSOLI DATED)	0. 00					26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
	Total (sum of lines 14-26)	0. 00					27.00
28. 00 29. 00	Observation Bed Days						28. 00 29. 00
30.00	Ambulance Trips Employee discount days (see instruction)						30. 00
31. 00	Employee discount days (see Fristruction)						31. 00
32. 00	Labor & delivery days (see instructions)						32.00
32. 00	Total ancillary labor & delivery room						32. 00
	outpatient days (see instructions)						
33.00	LTCH non-covered days			0			33.00
33. 01	LTCH site neutral days and discharges			0			33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

	AL-BASED RHC/FQHC STATISTICAL DATA	MENDOTA COMMUNIT	_	CN: 14-1310	Peri od:	eu of Form CN Worksheet		
	7.E 5.025 (M6) 1 410 0 0 M 1 5 T 5 E 5 M 1			CCN: 14-8535	From 10/01/2022 To 09/30/2023	?	Prep	
					RHC I	Cos		э рііі
					1	00		
	Clinic Address and Identification				1.	. 00		
. 00	Street			_	1405 E. 12TH S			1. 0
				ty	State	ZIP Code		
2. 00	City, State, ZIP Code, County	ME	I. ENDOTA	00	2.00	3.00		2. 0
	10.03, 20.000, 20.000				· ·			
2 00	HOCDITAL BACED FOLICE ONLY. Designation. Fort	"D"	"!!"			1.00		2.6
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rural	or "U" Tor		nt Award	Date	0	3.0
					1. 00	2.00		
	Source of Federal Funds							
4. 00	Community Health Center (Section 330(d), PHS							4.0
5. 00 5. 00	Migrant Health Center (Section 329(d), PHS A Health Services for the Homeless (Section 34							5. C
7. 00	Appal achi an Regional Commission	o(d), 1110 /101)						7.0
3. 00	Look-Alikes							8. 0
9. 00	OTHER (SPECIFY)							9. 0
					1. 00	2.00		
0. 00	Does this facility operate as other than a h	ospi tal -based RH	C or FQHC? E	nter "Y" for	N		0	10.0
	yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o							
	hours.)	Sunda	NV	I N	londay	Tuesday		
		from	to	from	to	from		
		1. 00	2. 00	3. 00	4. 00	5. 00		
	Facility hours of operations (1)							
11 00				00.00	17.00	00.00		11 0
11. 00	CLINIC			08: 00	17: 00	08: 00		11.0
11. 00				08: 00	17: 00	08: 00		11. C
12. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report.	d in CMS Pub. 10 umn 1. If yes, e	0-04, chapte nter in colu	ard? r 9, section mn 2 the	1.00 N		2	12.0
12. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col	d in CMS Pub. 10 umn 1. If yes, e	0-04, chapte nter in colu	ard? r 9, section mn 2 the ders and	1.00 N	2. 00 CCN	2	12. 0
12. 00 13. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	d in CMS Pub. 10 umn 1. If yes, e	0-04, chapte nter in colu	ard? r 9, section mn 2 the ders and	1.00 N Y	2. 00 CCN 2. 00	2	12. C 13. C
12. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	d in CMS Pub. 10 umn 1. If yes, e	0-04, chapte nter in colu	ard? r 9, section mn 2 the ders and Prov MENDOTA COMM	1.00 N Y	2. 00 CCN 2. 00	2	12. C 13. C
12.00 13.00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	d in CMS Pub. 10 umn 1. If yes, e	0-04, chapte nter in colu	ard? r 9, section mn 2 the ders and Prov MENDOTA COMM	1.00 N Y	2. 00 CCN 2. 00 148535	2	12. C 13. C
12. 00 13. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	d in CMS Pub. 10 umn 1. If yes, e List the names	0-04, chapte nter in colu of all provi	ard? r 9, section mn 2 the ders and Prov MENDOTA COMM RHC OSF MEDICAL STREET XVIII	1.00 N Y ider name 1.00 IUNITY HOSPITAL - GROUP WASHINGTON	2.00 CCN 2.00 148535 148567 Total Visi		12. 0 13. 0 14. 0
12. 00 3. 00 14. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FQHC name, CCN	d in CMS Pub. 10 umn 1. If yes, e List the names	0-04, chapte nter in colu of all provi	ard? r 9, section mn 2 the ders and Prov MENDOTA COMM RHC OSF MEDICAL STREET	1.00 N Y ider name 1.00 IUNITY HOSPITAL - GROUP WASHINGTON	2. 00 CCN 2. 00 148535 148567		12. C 13. C
12. 00 13. 00 14. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	d in CMS Pub. 10 umn 1. If yes, e List the names Y/N 1.00	0-04, chapte nter in colu of all provi V 2.00	ard? r 9, section mn 2 the ders and Prov MENDOTA COMN RHC OSF MEDICAL STREET XVIII 3.00	1.00 N Y ider name 1.00 IUNITY HOSPITAL - GROUP WASHINGTON	2.00 CCN 2.00 148535 148567 Total Visi		12. C 13. C
12. 00 13. 00 14. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in col umn 1. If yes, enter in col umns 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.	d in CMS Pub. 10 umn 1. If yes, e List the names Y/N 1.00	0-04, chapte nter in colu of all provi V 2.00	ard? r 9, section mn 2 the ders and Prov MENDOTA COMM RHC OSF MEDICAL STREET XVIII	1.00 N Y ider name 1.00 IUNITY HOSPITAL - GROUP WASHINGTON	2.00 CCN 2.00 148535 148567 Total Visi		12. C 13. C

Health Financial Systems	MENDOTA COMMUN	II TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C		Peri od:	Worksheet S-8	
		Component	CCN: 14-8535	From 10/01/2022 To 09/30/2023		
				RHC I	Cost	
	Tuesday	Wedn	esday	Thur	sday	
	to	from	to	from	to	
	6. 00	7. 00	8. 00	9. 00	10.00	
Facility hours of operations (1)						
11. 00 CLINIC	17: 00	08: 00	17: 00	08: 00	17: 00	11.00
	Fri	day	Sat	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

Heal th	Financial Systems MENDOTA COMMUNITY	HOSPI TAI		In lie	u of Form CMS-2	2552-10				
		Provi der CC	CN: 14-1310	Peri od: From 10/01/2022 To 09/30/2023	Worksheet S-1 Parts I & II	0 pared:				
					1. 00					
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA				1.00					
	Uncompensated and Indigent Care Cost-to-Charge Ratio									
1. 00	Cost to charge ratio (see instructions)				0. 291169	1.00				
	Medicaid (see instructions for each line)									
2.00	Net revenue from Medicaid				2, 473, 319	2.00				
3.00	Did you receive DSH or supplemental payments from Medicaid?				Υ	3. 00				
4. 00	If line 3 is yes, does line 2 include all DSH and/or supplemen	, ,		ai d?	Υ	4. 00				
5.00	If line 4 is no, then enter DSH and/or supplemental payments f	rom Medicai	d		0	5.00				
6.00	Medicaid charges		15, 834, 524	6.00						
7. 00 8. 00	Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program		4, 610, 523	7. 00 8. 00						
6.00			2, 137, 204	0.00						
9. 00	Children's Health Insurance Program (CHIP) (see instructions for each line) Net revenue from stand-alone CHIP									
10.00	Stand-allone CHIP charges				0	9. 00 10. 00				
11. 00	Stand-alone CHIP cost (line 1 times line 10)				Ö					
12.00	Difference between net revenue and costs for stand-alone CHIP	(see instru	ıcti ons)		0	12.00				
	Other state or local government indigent care program (see ins									
13.00	Net revenue from state or local indigent care program (Not inc				0					
14. 00	Charges for patients covered under state or local indigent card	e program (Not included	in lines 6 or	0	14.00				
15. 00	10) State or local indigent care program cost (line 1 times line 1	4)			0	15. 00				
	Difference between net revenue and costs for state or local in		nrogram (se	a instructions)	0					
10.00	Grants, donations and total unreimbursed cost for Medicaid, CHI					10.00				
	instructions for each line)			3						
17. 00	Private grants, donations, or endowment income restricted to for	undi ng char	ity care		0	17. 00				
18. 00	Government grants, appropriations or transfers for support of				0	18. 00				
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and local	l indigent	care program	s (sum of lines	2, 137, 204	19. 00				
	8, 12 and 16)		Uni nsured	Insured	Total (col. 1					
			patients	patients	+ col . 2)					
			1.00	2. 00	3. 00					
	Uncompensated care cost (see instructions for each line)									
20.00	Charity care charges and uninsured discounts (see instructions)	′ '	1, 406, 5	·	1, 630, 875	20.00				
21. 00	Cost of patients approved for charity care and uninsured disconinstructions)	unts (see	409, 53	32 224, 364	633, 896	21. 00				
22. 00	Payments received from patients for amounts previously written	off as		0 0	0	22. 00				
22.00	charity care	011 43				22.00				
23. 00			409, 53	32 224, 364	633, 896	23.00				
24. 00	Door the amount on line 20 cal. 2 include charges for noticest	daya bayan	ud a Langth a	f atou limit	1. 00 N	24.00				
24.00	Does the amount on line 20 col. 2, include charges for patient imposed on patients covered by Medicaid or other indigent care	IN	24. 00							
25. 00	If line 24 is yes, enter the charges for patient days beyond the	0	25. 00							
	stay limit									
25. 01										
	00 Bad debt amount (see instructions) 1,571,875									
27. 00	00 Medicare reimbursable bad debts (see instructions) 218,269									
27. 01	Medicare allowable bad debts (see instructions)				335, 798					
28. 00	Non-Medicare bad debt amount (see instructions)	ounto (o	i noterioti	`	1, 236, 077					
29. 00 30. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt am Cost of uncompensated care (line 23, col. 3, plus line 29)	ounts (see	THSTIUCTIONS)	477, 436 1, 111, 332					
	Total unreimbursed and uncompensated care cost (line 19 plus I)	ine 30)			3, 248, 536					
500	1.212. 2 31a. 33a and anomportured out o cost (11110-17 plus i				5, 210, 000					

HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CCN: 14-1310	Peri od: From 10/01/2022 To 09/30/2023	Worksheet S-1 Parts I & II Date/Time Pre 2/25/2024 7:1	epared
				1. 00	
	PART II - HOSPITAL DATA				
	Uncompensated and Indigent Care Cost-to-Charge Ratio				1
00	Cost to charge ratio (see instructions)				1.
	Medicaid (see instructions for each line)				
00	Net revenue from Medicaid				2.
. 00	Did you receive DSH or supplemental payments from Medicaid?				3.
. 00	If line 3 is yes, does line 2 include all DSH and/or supplement	1 3	cai d?		4.
. 00	If line 4 is no, then enter DSH and/or supplemental payments fr	om Medicaid			5.
. 00	Medi cai d charges				6.
00	Medicaid cost (line 1 times line 6)				7.
00	Difference between net revenue and costs for Medicaid program (8.
	Children's Health Insurance Program (CHIP) (see instructions fo	or each line)			4 .
00	Net revenue from stand-alone CHIP				9.
0.00	Stand-allone CHIP charges				10.
1.00	Stand-alone CHIP cost (line 1 times line 10)	(!++!)			11.
2. 00	Difference between net revenue and costs for stand-alone CHIP (2)		12.
8. 00	Other state or local government indigent care program (see inst Net revenue from state or local indigent care program (Not incl				13.
1.00	Charges for patients covered under state or local indigent care				14.
1. 00	10)	e program (Not include	d III IIIles o oi		14.
5. 00	State or local indigent care program cost (line 1 times line 14	1)			15.
5. 00	Difference between net revenue and costs for state or local ind		ee instructions)		16.
3. 00	Grants, donations and total unreimbursed cost for Medicaid, CHI			ms (see	1 10.
	instructions for each line)		. go oa. o p. og. a		
7. 00	Private grants, donations, or endowment income restricted to fu	unding charity care			1 17.
3. 00	Government grants, appropriations or transfers for support of h				18.
9. 00	Total unreimbursed cost for Medicaid, CHIP and state and local	indigent care progra	ms (sum of lines		19.
	8, 12 and 16)				
		Uni nsured		Total (col. 1	
		patients		+ col . 2)	
		1.00	2. 00	3. 00	-
	Uncompensated care cost (see instructions for each line)				1
0.00	Charity care charges and uninsured discounts (see instructions)				20.
1.00	Cost of patients approved for charity care and uninsured discouinstructions)	ints (see			21.
2. 00	Payments received from patients for amounts previously written	off as			22.
2.00	charity care	orr as			22.
3. 00	Cost of charity care (see instructions)				23.
7. 00	dost of charty care (see thistractions)				25.
				1. 00	
. 00	Does the amount on line 20 col. 2, include charges for patient	days beyond a Length	of stay limit		24.
	imposed on patients covered by Medicaid or other indigent care				
. 00	If line 24 is yes, enter the charges for patient days beyond th		am's Length of		25.
	stay limit	. 3	<u> </u>		
. 01	Charges for insured patients' liability (see instructions)				25.
. 00	Bad debt amount (see instructions)				26.
. 00	Medicare reimbursable bad debts (see instructions)				27.
7. 01	Medicare allowable bad debts (see instructions)				27.
0 00	Non-Medicare had debt amount (see instructions)				28

28.00 Non-Medicare bad debt amount (see instructions)
29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)
30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)

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

28.00 29. 00 30. 00

31.00

	Financial Systems	MENDOTA COMMUNIT				u of Form CMS-	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der Co	CN: 14-1310	Period: From 10/01/2022	Worksheet A	
					To 09/30/2023		
	Coot Contar Decement on	Colorias	O+hon	Total (agl 1	Dool oooi fi oot	2/25/2024 7: 1	O pm
	Cost Center Description	Sal ari es	0ther	+ col . 2)	Reclassificat ions (See	Reclassified Trial Balance	
				1 001. 2)	A-6)	(col. 3 +-	
					,	col . 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FLXT		168, 730	168, 73	35, 518	204, 248	1.00
1. 00	00101 CAP REL COSTS-DEDG & TTXT		100, 730		0 33, 318	204, 248	1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP		473, 408	1	-	513, 230	2.00
3.00	00300 OTHER CAP REL COSTS		0		0	0	3.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	119, 782	686, 789			4, 194, 359	4. 00
5. 01 5. 02	O1140 BUSI NESS OFFI CE O0550 DATA PROCESSI NG	0	3, 538 6, 847			3, 538	5. 01 5. 02
5. 02	00570 ADMITTING		0, 847		7 1, 036, 946 0 0	1, 043, 793 0	5. 02
5. 04	00560 PURCHASING RECEIVING AND STORES	124, 282	225, 602	349, 88	26, 796	376, 680	1
5.05	00590 OTHER A&G	629, 524	6, 167, 301	6, 796, 82	-1, 470, 873	5, 325, 952	5. 05
7. 00	00700 OPERATION OF PLANT	259, 821	1, 517, 327				
8. 00	00800 LAUNDRY & LINEN SERVICE	16, 005	86, 421			97, 744	8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	447, 013 339, 274	282, 188 236, 827		· ·	618, 754 161, 555	
11. 00	01100 CAFETERI A	0	230, 027		333, 454	333, 454	
13.00	01300 NURSING ADMINISTRATION	186, 485	58, 541	245, 02		262, 063	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	384				
17. 00	01700 SOCIAL SERVICE	0	0		269, 062	269, 062	17.00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	1 054 455	407 720	2 554 10	-450, 381	2, 103, 812	30.00
31.00	03100 INTENSIVE CARE UNIT	1, 856, 455 190, 200	697, 738 70, 838				1
011.00	ANCILLARY SERVICE COST CENTERS	1707200	70,000	20.700	5, 31,777	220,20,	0 00
50.00	05000 OPERATING ROOM	444, 234	757, 067		-364, 634	836, 667	50.00
51.00	05100 RECOVERY ROOM	105, 896	50, 839			124, 971	
53.00	05300 ANESTHESI OLOGY	223, 124	-63, 868				
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRASOUND	392, 706 8, 881	130, 766 330, 397			819, 834 337, 545	1
54. 01	05402 MAMMOGRAPHY	122, 263	40, 270			130, 180	1
56.00	05600 RADI OI SOTOPE	3, 636	204, 331				1
57.00	05700 CT SCAN	182, 774	104, 959			243, 397	
58.00	05800 MRI	104, 878	46, 347			122, 934	
60. 00 63. 00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING, & TRANS.	751, 540 0	991, 926 51, 262			1, 565, 210 51, 262	
64. 00	06400 I NTRAVENOUS THERAPY	312, 040	128, 126				
65.00	06500 RESPI RATORY THERAPY	476, 376	181, 881				
65. 01	06501 SLEEP LAB	69, 094	26, 648	95, 74	-16, 219	79, 523	
66.00	06600 PHYSI CAL THERAPY	651, 400	176, 270			694, 924	
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	129, 610 40, 972	49, 196 11, 028			143, 103 44, 415	1
69. 00	06900 ELECTROCARDI OLOGY	40, 7/2	11,028	1	0 -7, 363	0	1
69. 01	06901 ECHOCARDI OGRAPHY	4, 959	1, 440		-		69. 01
	06902 CARDI OLOGY	0	3, 042	3, 04	2 0	3, 042	69. 02
	06903 PULMONARY REHAB	0	0	0, 70	0	0	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPLANTABLE DEVICES CHARGED TO	0	-36, 739	-36, 73	79, 410 189, 267		1
72.00	PATIENTS		U	'	109, 207	189, 267	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	239, 368	1, 266, 795	1, 506, 16	13, 350	1, 519, 513	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	12	•		0	
76.00	03020 CANCER CARE CENTER	72, 763	8, 840		· ·	73, 529	1
76. 97 77. 00	07697 CARDIAC REHABILITATION 07700 ALLOGENEIC HSCT ACQUISITION	63, 681	26, 225	89, 90	-24, 299	65, 607 0	1
78.00	07800 CAR T-CELL IMMUNOTHERAPY		0			0	1
	OUTPATIENT SERVICE COST CENTERS				-, -,		
	08800 RURAL HEALTH CLINIC	3, 379, 857	1, 806, 959	5, 186, 81	-793, 077	4, 393, 739	
90.00	09000 CLINIC	0	0	1	0	0	
91.00	09100 EMERGENCY	1, 497, 041	2, 041, 295	3, 538, 33	-311, 142	3, 227, 194	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0		0	0	102.00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE	10 115 001	0	00 440 70	0 0		113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	13, 445, 934	19, 017, 793	32, 463, 72	627, 571	33, 091, 298]118.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	56, 549	56, 54	9	56 549	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	3, 145	3, 861				192.00
192. 01	19201 PHYSICIAN OFFICE PRIOR TO RHC CERT	3, 588, 101	1, 065, 674	4, 653, 77	-588, 118	4, 065, 657	192. 01
	07950 OTHER NRCC	4, 469	-10, 648				194.00
	07951 MARKETI NG	0	22				194. 01
	2 07952 FOUNDATI ON 3 07953 RESEARCH		81, 242 0	81, 24	2 -38, 372 0 0		194. 02 194. 03
200.00		17, 041, 649	20, 214, 493	37, 256, 14			
		<u>, </u>					

Provi der CCN: 14-1310

				2/25/2024 7: 10	
	Cost Center Description	Adjustments	Net Expenses	2, 20, 202 1 , 1 .	<u>р</u>
		(See A-8)	For Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS			.1	
1.00	00100 CAP REL COSTS-BLDG & FLXT	136, 922	1		1.00
1. 01 2. 00	00101 CAP REL COSTS-OFFSITE MOBS 00200 CAP REL COSTS-MVBLE EQUIP	0 241, 082	0 754, 312		1. 01 2. 00
3. 00	00300 OTHER CAP REL COSTS	0	0		3.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	-30, 217	4, 164, 142		4.00
5. 01	01140 BUSINESS OFFICE	0	3, 538	1	5. 01
5. 02	00550 DATA PROCESSI NG	0	,		5. 02
5. 03 5. 04	00570 ADMITTING 00560 PURCHASING RECEIVING AND STORES	0	0 376, 680		5. 03 5. 04
5. 05	00590 OTHER A&G	-607, 390	1	1	5. 05
7. 00	00700 OPERATION OF PLANT	-12, 778	1	1	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	97, 744	1	8.00
9. 00	00900 HOUSEKEEPI NG	0	618, 754		9. 00
10.00	01000 DI ETARY	0	161, 555		10.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	-76, 745 358, 263	256, 709 620, 326		11. 00 13. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	330, 203	56, 652		16.00
17. 00	01700 SOCIAL SERVICE	-32, 136			17.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDI ATRI CS	-24, 711	1	1	30.00
31. 00	03100 I NTENSI VE CARE UNI T	-2, 889	223, 350)	31.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	836, 667	7	50.00
51. 00	05100 RECOVERY ROOM	4, 000	1		51.00
53. 00	05300 ANESTHESI OLOGY	-116, 728		1	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-18, 373	801, 461		54.00
54. 01	05401 ULTRASOUND	0	337, 545		54. 01
54. 02	05402 MAMMOGRAPHY	0	130, 180	l .	54.02
56. 00 57. 00	05600 RADI OI SOTOPE 05700 CT SCAN	0	183, 097 243, 397	1	56. 00 57. 00
58. 00	05800 MRI	0	122, 934		58.00
60.00	06000 LABORATORY	-3, 527	1, 561, 683	1	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	51, 262		63.00
64.00	06400 I NTRAVENOUS THERAPY	0	361, 976	1	64.00
65.00	06500 RESPIRATORY THERAPY	0	538, 327	1	65.00
65. 01 66. 00	06501 SLEEP LAB 06600 PHYSI CAL THERAPY	0 4, 603	79, 523 699, 527	1	65. 01 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 285		1	67.00
68. 00	06800 SPEECH PATHOLOGY	288			68.00
69. 00	06900 ELECTROCARDI OLOGY	0	0		69.00
69. 01	06901 ECHOCARDI OGRAPHY	0	1		69. 01
69. 02	06902 CARDI OLOGY	0	3, 042		69. 02
69. 03 71. 00	O6903 PULMONARY REHAB O7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0 42, 671		69. 03 71. 00
71.00	07200 I MPLANTABLE DEVICES CHARGED TO	0	l	l .	72.00
	PATI ENTS		107,207		/ 2.00
	07300 DRUGS CHARGED TO PATIENTS	-230, 771	1, 288, 742		73.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	1	75.00
76.00	03020 CANCER CARE CENTER	0	73, 529		76.00
76. 97	07697 CARDI AC REHABILITATION 07700 ALLOGENEIC HSCT ACQUISITION	-2, 431	63, 176 0		76. 97 77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		78.00
. 5. 55	OUTPATIENT SERVICE COST CENTERS			1	
88. 00	08800 RURAL HEALTH CLINIC	-268, 457	4, 125, 282	2	88. 00
90.00	09000 CLI NI C	0	1		90.00
91.00	09100 EMERGENCY	-1, 196, 711	2, 030, 483	3	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS				92.00
102 00	10200 OPI OI D TREATMENT PROGRAM	0	О		102.00
.02.00	SPECIAL PURPOSE COST CENTERS			1	1.02.00
113.00	11300 INTEREST EXPENSE	0	0		113.00
118.00		-1, 877, 421	31, 213, 877	7	118. 00
400.00	NONREI MBURSABLE COST CENTERS		F. 54		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	7 004		1	190.00
	19200 PHYSICIANS' PRIVATE OFFICES 19201 PHYSICIAN OFFICE PRIOR TO RHC CERT	-7, 006 0	15 4, 065, 657	1	192. 00 192. 01
	07950 OTHER NRCC		-7, 275		194. 00
	07951 MARKETI NG	Ö	22		194. 01
194. 02	07952 FOUNDATI ON	0	42, 870		194. 02
	07953 RESEARCH	0	0.5.5.5	1	194. 03
200.00	TOTAL (SUM OF LINES 118 through 199)	-1, 884, 427	35, 371, 715		200. 00

Heal th	Financial Systems		MENDOTA COMMUN	ITY HOSPITAL		In Lieu	u of Form CMS-2552-10
	SI FI CATI ONS				CN: 14-1310	Peri od:	Worksheet A-6
						From 10/01/2022 To 09/30/2023	Date/Time Prepared:
	1					10 077 007 2020	2/25/2024 7: 10 pm
	Cook Cooker	Increases	Callarin	0+1			
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00			
	B - TO RECLASS COPIER LEASE I		4.00	3.00			
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	38, 042			1.00
2.00		0.00	0_	0			2.00
	0		0	38, 042			
1. 00	C - TO RECLASS BENEFITS EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	3, 878, 187			1.00
2. 00	LWFLOTEL BENEFITS DEPARTMENT	0.00	o	3, 676, 167			2.00
3.00		0.00	o	0			3.00
4.00		0.00	О	0			4.00
5.00		0.00	0	0			5. 00
6.00		0.00	0	0			6.00
7. 00 8. 00		0. 00 0. 00	0	0			7. 00 8. 00
9. 00		0.00	0	0			9.00
10.00		0.00	ő	Ö			10.00
11.00		0.00	O	0			11.00
12.00		0.00	0	0			12.00
13. 00		0.00	0	0			13.00
14.00		0.00	0	0			14.00
15. 00 16. 00	•	0. 00 0. 00	0	0			15. 00 16. 00
17. 00		0.00	o	0			17.00
18. 00		0.00	Ö	Ö			18. 00
19.00		0.00	O	0			19.00
20.00		0.00	0	0			20.00
21. 00		0.00	0	0			21. 00
22. 00		0.00	0	0			22.00
23. 00 24. 00	+	0. 00 0. 00	0	0			23. 00 24. 00
25. 00		0.00	o	0			25. 00
26. 00		0.00	Ö	0			26.00
27.00		0.00	О	0			27.00
28. 00		0.00	0	0			28. 00
29. 00		0.00	0	0			29.00
30.00		0. 00 0. 00	0	0			30.00
31. 00 32. 00		0.00	0	0			31. 00 32. 00
33. 00		0.00	0	0			33.00
			— — -	3, 878, 187			
	D - TO RECLASS CAFETERIA COST						
1. 00	CAFETERI A		229, 488	103, 966			1.00
	F - TO RECLASS VACATION, PTO,	REWARDS	229, 488	103, 966			
1. 00	PURCHASING RECEIVING AND	5. 04	49	0			1.00
1.00	STORES	0.01	17				1.00
2.00	OTHER A&G	5. 05	645	0			2.00
3. 00	OPERATION OF PLANT	7. 00	102	0			3.00
4.00	LAUNDRY & LINEN SERVICE	8. 00	6	0			4.00
5. 00 6. 00	HOUSEKEEPI NG DI ETARY	9. 00 10. 00	469 134	0			5. 00 6. 00
7. 00	NURSING ADMINISTRATION	13. 00	73	0			7.00
8. 00	ADULTS & PEDIATRICS	30.00	795	O			8.00
9. 00	INTENSIVE CARE UNIT	31. 00	75	0			9. 00
10.00	OPERATING ROOM	50.00	175	0			10.00
11. 00	RECOVERY ROOM	51. 00	42	0			11.00
12.00	ANESTHESI OLOGY	53.00	88	0			12.00
13. 00 14. 00	RADI OLOGY-DI AGNOSTI C ULTRASOUND	54. 00 54. 01	155 3	0			13.00
15. 00	MAMMOGRAPHY	54. 02	48	0			15. 00
16. 00	RADI OI SOTOPE	56. 00	1	0			16.00
17.00	CT SCAN	57. 00	72	0			17. 00
18. 00	MRI	58. 00	41	0			18.00
19.00	LABORATORY	60.00	296	0			19.00
20. 00 21. 00	I NTRAVENOUS THERAPY RESPI RATORY THERAPY	64. 00 65. 00	123 188	0			20.00
21.00	SLEEP LAB	65. 00	27	0			21.00
23. 00	PHYSI CAL THERAPY	66. 00	257	0			23. 00
24. 00	OCCUPATI ONAL THERAPY	67. 00	51	0			24. 00
25.00	SPEECH PATHOLOGY	68. 00	16	0			25. 00
26. 00	ECHOCARDI OGRAPHY	69. 01	2	0			26.00
27. 00	DRUGS CHARGED TO PATIENTS	73.00	94	0			27.00
28. 00 29. 00	CANCER CARE CENTER CARDIAC REHABILITATION	76. 00 76. 97	29 25	0			28. 00 29. 00
30.00	RURAL HEALTH CLINIC	88. 00	1, 332	0			30.00
		, 33. 30	., 552	9			1 22.00

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 10/01/2022 To 09/30/2023 Date/Ti me Prepared: 2/25/2024 7:10 pm Provi der CCN: 14-1310

						10 09/30	2/25/2024	
1.00 MERGENCY 91.00 5.00 0 0 0 0 0 0 0 0 0			Increases			•		
131.00 PARTRICHICY 10.00 500 0 0 332.00 PARTSICIANO FERIVATE OFFICES 192.00 1 1.414 0 0 0 0 0 0 0 0 0								
12.00 HYSICIANS FRIVATE OFFICES 192.00 1 0 1,414 0 1 1,414	04.00							24.00
33. 00 PHYSICIAN OFFICE PRIOR TO				590	-			31. 00 32. 00
RHC CERT				1 414	0			33.00
1.00	33.00		172.01	1, 414	o o			33.00
O	34.00		194. 00	2	0			34.00
ADULTS & PEDIATRICS		0		7, 420	- — <u> </u>			
2. 00 INTENSIVE CARE UNIT 31. 00 0 2, 769 4. 00 PHYSI CAL THERAPY 0 0 0 3, 240 1. 00 CAPATIN CROWN 50. 00 0 2, 155 1. 01 CAPATIN CROWN 50. 00 0 14, 159 1. 02 CAPATIN CROWN 50. 00 0 1, 780 2. 00 CAPATIN CROWN 50. 00 0 3, 510 2. 00 CAPATIN CROWN 50. 00 0 3, 510 2. 00 CAPATIN CROWN 50. 00 0 3, 510 2. 00 CAPATIN CROWN 50. 00 0 3, 510 2. 00 CAPATIN CROWN 50. 00 0 50, 726 2. 00 CAPATIN CROWN 50. 00 50, 726 2. 00 CAPATIN CROWN 50.								
3. 00 OPERATI NO ROOM		l l						1.00
4.00 PHYSI CAL THERAPY		l l	l l	- 1				2.00
TOTALS		l l	i i					3.00
1. TO RECLASS AUTO & OTHER PROP I NSUR	4.00			+_				4. 00
1.00			PROP INSUR	<u> </u>	14, 137			
2. 00 CAP REL COSTS-BLIDG & FIXT 1. 00 0 35, 518 3. 00 OTRE AGG 5. 05 0 480, 449 1. 00 MEDICAL SUPPLIES CHARGED TO 71. 00 0 50, 726 PATIENT TOTALS 0 50, 726	1. 00			0	1, 780			1.00
1.00 MEDICAL SUPPLIES CHARGED TO 71.00 0 50.726	2.00	CAP REL COSTS-BLDG & FIXT	1. 00	О				2.00
1.00 MEDICAL SUPPLIES	3.00	OTHER A&G	5. 05	0	480, 449			3. 00
1.00 MEDICAL SUPPLIES CHARGED TO		0		0	517, 747			
PATI ENT	4 00		74 00	ما	50 70 <i>t</i>			4
TOTALS	1.00		/1.00	O	50, 726			1.00
To reclass Implants To reclass Implants To reclass Implants To reclass Deugs To patients			+		50 726			
1.00				O _I	30, 720			
TO_PATIENTS	1. 00		72. 00	0	189, 267			1.00
L - TO RECLASS DRUGS		TO PATIENTS			·			
1. 00 DRUGS CHARGED TO PATIENTS 73. 00 0 30, 183 2. 00 3. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0		0	189, 267			
2.00 3.00 0.00 0.00 0.00 0.00 0.00 0.00								
3.00		DRUGS CHARGED TO PATIENTS		1				1.00
O			l l	0	-			2.00
M - MINISTRY MEDICAL RECORDS MEDICAL RECORDS & LIBRARY 16.00 0 56, 268 N - FOUNDATION EXPENSE RECLASS O DIFER ANG 0 0 37, 150 2.00 DI ETARY 10.00 0 413 3.00 CANCER CARE CENTER 76.00 0 809 O - TO RECLASS NURSING ADMIN SALARIES 1.00 NURSING ADMINISTRATION 13.00 72, 260 0 D - TO RECLASS NURSING EXPENSE 1.00 DITHER ANG 5.05 0 37, 0	3.00							3. 00
1.00 MEDICAL RECORDS & LIBRARY 16.00 0 56.268 0 0 56.268 0 0 56.268 0 0 56.268 0 0 56.268 0 0 56.268 0 0 56.268 0 0 56.268 0 0 56.268 0 0 56.268 0 0 56.268 0 0 56.268 0 0 0 0 0 0 0 0 0		M - MINISTRY MEDICAL RECORDS		<u> </u>	30, 103			
O	1. 00		16. 00	0	56, 268			1.00
1.00		0						
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3.00 CANCER CARE CENTER 76.00 0 809 0 38,372 0 - TO RECLASS NURSING ADMIN SALARIES 1.00 NURSING ADMINISTRATION 13.00 72,260 0 P - TO RECLASS ADVERTISING EXPENSE 1.00 OTHER A&G 5.05 0 37 0 37 0 0 - TO RECLASS OTHER THERAPEUTIC SVCS 1.00 INTRAVENOUS THERAPY 64,00 9,203 0 P - TO RECLASS RETENTION BONUS 1.00 PURCHASING RECEIVING AND 5.04 544 STORES 2.00 OTHER A&G 5.05 2,755 0 STORES 2.00 OTHER A&G 5.05 2,755 0 STORES 2.00 OTHER A&G 5.05 2,755 0 STORES 3.00 OPERATION OF PLANT 7.00 1,137 0 STORES 1.00 DETARY 1.00 1,957 0 STORES 3.00 OPERATION SERVICE 8.00 70 0 STORES 1.00				- 1				1.00
1.00				0				2.00
1. 00 NURSI NG ADMI NI STRATI ON 13. 00 72, 260 0 0 72, 260 0 0 0 72, 260 0 0 0 0 0 0 0 0 0	3.00	CANCER CARE CENTER		0				3. 00
1. 00 NURSING ADMINISTRATION 13. 00 72, 260 0 0 72, 260 0 0 72, 260 0 0 72, 260 0 0 72, 260 0 0 72, 260 0 0 72, 260 0 0 72, 260 0 0 37 0 0 37 0 0 37 0 0 0 37 0 0 0 0 0 0 0 0 0		O _ TO PECLASS NUIDSLING ADMIN	SALADIES	UU	38, 372			
1.00	1 00			72 260	0			1.00
P - TO RECLASS ADVERTISING EXPENSE		0						1 55
O		P - TO RECLASS ADVERTISING EX	(PENSE					
1.00	1.00	OTHER A&G	5. 05					1.00
1.00		0		0	37			
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O R - TO RECLASS RETENTION BONUS		INTRAVENOUS THERAPY	i i	9, 203				1.00
R - TO RECLASS RETENTION BONUS 1. 00 PURCHASI NG RECEI VI NG AND STORES 2. 00 OTHER A&G 5. 05 2, 755 0 3. 00 OPERATION OF PLANT 7. 00 1, 137 0 4. 00 LAUNDRY & LI NEN SERVI CE 8. 00 70 0 5. 00 HOUSEKEEPI NG 9. 00 1, 957 0 6. 00 DI ETARY 10. 00 1, 485 0 7. 00 NURSI NG ADMINISTRATION 13. 00 1, 111 0 8. 00 ADULTS & PEDI ATRI CS 30. 00 23, 698 0 9. 00 INTENSI VE CARE UNIT 31. 00 833 0 10. 00 OPERATI NG ROOM 50. 00 9, 768 0 11. 00 RECOVERY ROOM 51. 00 1, 718 0 12. 00 ANESTHESI OLOGY 53. 00 977 0 13. 00 RADI OLOGY-DI AGNOSTI C 54. 00 1, 719 0	2.00			$ \frac{0}{9.203}$				2.00
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13. 00 RADI OLOGY-DI AGNOSTI C 54. 00 1, 719 0		l l						11. 00
					-			12. 00
14 UO III IRANUIND 54 OTI 30 OT			l l					13.00
	14.00	ULTRASOUND	54. 01	39				14.00
15. 00 MAMMOGRAPHY 54. 02 535 0 16. 00 RADI 0I SOTOPE 56. 00 16 0			l l	1				15. 00 16. 00
17. 00 CT SCAN 57. 00 800 0								17. 00
18. 00 MRI 58. 00 459 0								18.00
19. 00 LABORATORY 60. 00 3, 290 0		l l						19. 00
20. 00 I NTRAVENOUS THERAPY 64. 00 4, 790 0					0			20.00
21. 00 RESPI RATORY THERAPY 65. 00 9, 465 0		1	l l					21. 00
22. 00 SLEEP LAB 65. 01 302 0			l l	l l				22.00
23. 00 PHYSI CAL THERAPY 66. 00 2, 851 0			l l					23.00
24. 00 OCCUPATI ONAL THERAPY 67. 00 567 0	∠4. UU	OCCUPATIONAL THERAPY	67.00	56/	U			24.00

Peri od: Worksheet A-6 From 10/01/2022 To 09/30/2023 Date/Time Prepared:

						 2/25/2024 7:	10 pm
		Increases					
	Cost Center	Li ne #	Sal ary	0ther			
	2. 00	3. 00	4. 00	5. 00			
25.00	SPEECH PATHOLOGY	68. 00	179	0			25.00
26.00	ECHOCARDI OGRAPHY	69. 01	22	0			26.00
27.00	DRUGS CHARGED TO PATIENTS	73.00	1, 048	0			27. 00
28.00	CANCER CARE CENTER	76.00	318	0			28.00
29.00	CARDIAC REHABILITATION	76. 97	279	0			29.00
30.00	RURAL HEALTH CLINIC	88. 00	14, 794	0			30.00
31.00	EMERGENCY	91.00	16, 516	0			31.00
32.00	PHYSICIANS' PRIVATE OFFICES	192. 00	14	0			32.00
33.00	PHYSICIAN OFFICE PRIOR TO	192. 01	15, 705	0			33.00
	RHC CERT						
34.00	OTHER NRCC	194. 00	20	0			34.00
	TOTALS		119, 781	0			
	S - RECLASS PREMIER CONTRACT	ADMIN FEE	,				
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	28, 684			1.00
	PATI ENT			,			
	TOTALS			28, 684			i
	V - RHC PHYSICIAN HOSP COSTS	L	-1				
1.00	ADULTS & PEDIATRICS	30.00	7, 815	0			1.00
	0		7, 815	0			
	X - UTILITY EXPENSE	L	.,	-1			
1.00	OPERATION OF PLANT	7. 00	0	51, 538			1.00
2. 00		0.00	0	0			2.00
2.00		— — - : - : 	— — "	51, 538			2.00
	Y - CLINICAL ENGINEERING DEP	Т	<u> </u>	0.7000			
1. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	396, 895			1.00
2. 00	LABORATORY	60.00	0	76, 454			2.00
2.00	0		— — "	473, 349			2.00
	Z - MINISTRY RECLASS		<u> </u>	1707017			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	153, 796			1.00
2. 00	DATA PROCESSING	5. 02	0	1, 036, 946			2.00
3. 00	PURCHASING RECEIVING AND	5. 04	0	102, 709			3.00
5. 00	STORES	3.04		102, 707			3.00
4.00	OPERATION OF PLANT	7. 00	0	81, 577			4.00
5. 00	SOCIAL SERVICE	17. 00	0	269, 062			5.00
6. 00	PHYSI CAL THERAPY	66. 00	ő	16, 751			6.00
7. 00	OCCUPATIONAL THERAPY	67. 00	ő	4, 675			7. 00
8. 00	SPEECH PATHOLOGY	68. 00	0	1, 048			8.00
9. 00	DRUGS CHARGED TO PATIENTS	73. 00	o	36, 235			9.00
7. 00	0	— , , , , , , , , , , , , , , , , , , ,	— — —	1, 702, 799			7.00
	AA - TO RECLASS EXPENSES FROM	M ASC	٥	1, 102, 177			1
1. 00	INTRAVENOUS THERAPY	64. 00	n	12			1.00
1. 50	0	— — 54. 50	— — "	1 <u>2</u> 12			1.00
	AB - TO RECLASS REGIONAL ADMI	IN FXPFNSF	<u> </u>	12			1
1. 00	RURAL HEALTH CLINIC	88.00	nl	5, 605			1.00
00	TOTALS	— - 55. 00	— — "	5, 605			1.00
500 00	Grand Total: Increases		445, 967	7, 178, 941			500.00
555.00	10. aa 10 tar. 11101 0a303	ı	175, 767	7, 170, 741	I		1 555. 55

Provider CCN: 14-1310

Peri od: Worksheet A-6 From 10/01/2022 To 09/30/2023 Date/Time Prepared:

COST CONTROL Line S							2/25/2024 7:	
1.00 ADMINISTRATION 1.00								
B. TO RECLASS DEFIRE LEAST EXPENSE! 54.00 0 705 10 1.00								
1.00				8. 00	9. 00	10.00		
ADDRATTION ADD	1 00				405	10		1 00
1.00 PIRCHASS BEREFITS		l .	· ·					1
1.00 REGISTER SERVETTS 1.100 1	2.00	0						2.00
DIRECTION OF STATE		C - TO RECLASS BENEFITS	II_	<u> </u>	00, 012			
2.00 OTHER AGG 5.05 0 154,680 0 2.00 3.00 OTHER AGG 5.05 0 7.7,786 0 3.2,00 3.00 OTHER AGG 5.05 0 4.7,786 0 3.2,00 3.00 0 4.7,786 0 4.00	1.00		5. 04	0	47, 822	0		1.00
0.00 PREMAT NO OF PLANT		STORES						
ADDITION ALTERNATION STRYLET B. D. D. D. C.		l .	l I			1		1
DOUBLE D		l .	1	-				1
0.00 O ETARY 10.00 0 83,124 0 0.00 7.00		l .	l I					1
2.00 MURSING ADMINISTRATION 13.00 0 56,407 0 7.00 8.00 0 7.00 0		l control of the cont	1					1
BOOD MOULTS & PEDIATRICS 30.00 0 473,735 0 9.00			1	-		1		1
9.00 NTTINSINE CARF UNIT 31.00 35.397 0 9.00 11.00 RECOVERY ROOM 51.00 0 33.524 0 11.00 11.00 RECOVERY ROOM 51.00 0 33.524 0 11.00 11.00 ADMINISTRIS OLIGIY 23.00 12.00 11.00 ADMINISTRIS OLIGIY 24.00 23.2, 736 0 11.00 ADMINISTRIS OLIGIY 24.00 23.2, 736 0 11.00 ADMINISTRIS OLIGIY 24.00 23.2, 736 0 11.00 ADMINISTRIS OLIGIY 24.00 23.00 12.00 18.00 ADMINISTRIS OLIGIY 24.00 23.00 23.00 12.00 18.00 ADMINISTRIS OLIGIY 24.00 23.00 23.00 23.00 18.00 ADMINISTRIS OLIGIY 24.00 23.00 23.00 23.00 18.00 ADMINISTRIS OLIGIY 24.00 24.00 24.00 24.00 24.00 24.00 21.00 ADMINISTRIS OLIGIY 24.00 24.		l control of the cont	1	-				1
10. 00 OPERATING ROOM		l control of the cont	1					1
11.00 RECOVERY ROOM 51.00 0 33.524 0 11.00 12.00 13.		l control of the cont	1					1
13. 00 ADDI LOCY - DI ACMOSTIC		l control of the cont	1	-				1
14. 00 ILTERSOLIND		l .	1	0				1
15.00 MAMMORGAPHY	13.00	RADI OLOGY-DI AGNOSTI C	54.00	0	101, 816	0		13.00
10. 00 RADIO ISOTOPE	14.00	ULTRASOUND	54. 01	0	1, 775	0		14.00
17. 00 CT SCAN 57. 00 0 39, 283 0 17. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 19. 00		l control of the cont	l I	-				1
18. 00		l .	1	- I				
19, 00 LABORATORY			1					
20.00 INTRAVENOUS THERAPY 64.00 0 22.318 0 22.00		l .	l I					
21. 00 RESPIRATORY THERAPY			l I					
22.00 SLEP LAB			1					1
23.00 PHYSICAL THERAPY								1
24.00			l I					4
25.00 SPEECH PATHOLOGY			1	-				4
27.00 DRUGS CHARGED TO PATIENTS 73.00 0 54,210 0 27.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 29.00 28.00 29.00 28.00 29.00 28.00 29.00 28.00 29.00 28.00 29.00			· ·	0				4
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29. 00 CARDI AC REHABILLITATI ON 76. 97 0 24, 603 0 30. 00 29. 00 30. 00 20. 00	27.00	DRUGS CHARGED TO PATIENTS	73. 00	O	54, 210	0		27.00
30.00 RURAL HEALTH CLINIC	28.00	CANCER CARE CENTER	l I	0	9, 230	0		28. 00
33.00 EMERGENCY 91.00 0 328, 211 0 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 33.00 32.00 33.00		l .						1
32.00 PHYSICIAN OFFICE PRIOR TO 192.01 0 589,094 0 0 33.00			1	-		1		1
STATE STAT		l control of the cont	1	-				1
33.00 OTHER NRCC	32.00		192.01	٩	589, 094	0		32.00
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1.00	00.00							00.00
To The color		D - TO RECLASS CAFETERIA COST	TS	-				
F - TO RECLASS VACATION, PTO. REWARDS EMPLOYEE BENEFITS DEPARTMENT 4.00 0 6,667 0 1.00	1.00	DI ETARY	10.00	229, 488	103, 966	0		1.00
1. 00 EMPLOYEE BENEFITS DEPARTMENT		0		229, 488	103, 966			
2 . 00 OTHER A&G 5 . 05 0 397 0 2 . 00 3 . 00 4 . 00 5 . 00 6 . 3 . 00 5 . 00 6 . 00 5 . 00 6 . 00 0 0 0 0 0 0 0 0								
3. 00 HOUSEKEEPING		l control of the cont	l I					•
4. 00 ADULTS & PEDIATRICS 30. 00 0 63 0 0 5. 00 5. 00 6. 00 0 0 0 0 0 7. 00 8. 00 0 0 0 0 0 8. 00 9. 00 0 0 0 0 9. 00 0 0 0 0 0 10. 00 11. 00 0 0 0 11. 00 12. 00 0 0 0 13. 00 14. 00 0 0 0 15. 00 0 0 0 16. 00 0 0 0 17. 00 0 0 0 18. 00 0 0 0 19. 00 0 0 11. 00 0 0 11. 00 0 0 12. 00 0 0 13. 00 14. 00 0 15. 00 0 0 16. 00 17. 00 18. 00 0 0 0 19. 00 0 0 19. 00 0 0 20. 00 0 0 21. 00 0 0 22. 00 0 0 23. 00 0 0 24. 00 25. 00 26. 00 27. 00 28. 00 0 0 0 28. 00 0 0 28. 00 0 0 28. 00 0 0 28. 00 0 0 28. 00 0 0 20. 00 0 0 20. 00 0 0 20. 00 0 0 21. 00 0 22. 00 0 0 23. 00 0 24. 00 0 25. 00 0 26. 00 0 27. 00 28. 00 28. 00 0 29. 00 0 20. 00 0 20. 00 0 20. 00 0 20. 00 0 20. 00 20.								
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13.00 0.00 0 0 0 0 13.00 14.00 0.00 0 0 0 0 14.00 15.00 0.00 0 0 0 0 15.00 16.00 0.00 0 0 0 0 16.00 17.00 17.00 0.00 0 0 0 0 17.00 18.00 19.00 <td>11.00</td> <td></td> <td>0.00</td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td>11.00</td>	11.00		0.00	0	0	0		11.00
14.00 0.00 0.00 0.00 0.00 0.00 0.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 16.00 15.00 16.00 16.00 16.00 16.00 17.00 16.00 17.00 17.00 17.00 17.00 17.00 17.00 18.00 19.00 0.00 0.00 19.00 </td <td></td> <td></td> <td></td> <td>•</td> <td>0</td> <td>0</td> <td></td> <td></td>				•	0	0		
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16.00 0.00 0.00 0.00 0.00 0.00 0.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 19.00								1
17. 00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 19. 0								
18.00 0.00 0.00 0.00 0.00 0.00 0.00 19.00								
19.00 0.00				•				
20.00 0.00								
21.00 0.00 0 0 0 0 21.00 22.00 0.00 0 0 0 0 22.00 23.00 0.00 0 0 0 0 23.00 24.00 0.00 0 0 0 0 24.00 25.00 0.00 0 0 0 0 25.00 26.00 0.00 0 0 0 0 26.00 27.00 0.00 0 0 0 0 27.00 28.00 0.00 0 0 0 0 28.00								
22.00 0.00								1
23.00 0.00				•				1
24.00 0.00 0 0 0 0 24.00 25.00 0.00 0 0 0 0 25.00 26.00 0.00 0 0 0 0 26.00 27.00 0.00 0 0 0 0 27.00 28.00 0.00 0 0 0 0 28.00								1
25. 00 0.00 0 0 0 25. 00 26. 00 0.00 0 0 0 0 26. 00 27. 00 0.00 0 0 0 0 27. 00 28. 00 0.00 0 0 0 0 28. 00								
26. 00 0.00 0 0 0 26. 00 27. 00 0.00 0 0 0 0 27. 00 28. 00 0.00 0 0 0 0 28. 00				•	0			
28.00 0.00 0 0 0 28.00								
29.00 0.00 0 0 0 29.00	29. 00	1	0.00	0	0	0		29. 00

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 10/01/2022 To 09/30/2023 Date/Ti me Prepared: 2/25/2024 7:10 pm Provi der CCN: 14-1310

						2/25/2024 7:	
		Decreases					
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.		
30. 00	6. 00	7. 00	8. 00	9. 00	10.00		30.00
31. 00		0.00	o	0	o		31.00
32.00		0. 00	0	0	0		32.00
33.00		0.00	0	0	0		33.00
34.00			0	0	0		34.00
	H - TO RECLASS SHORT TERM DIS	ARILITY	0	7, 420			-
1. 00	ADULTS & PEDIATRICS	30.00	5, 995	0	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	2, 769	0	0		2.00
3.00	OPERATING ROOM	50. 00	2, 155	0	0		3.00
4. 00	PHYSI CAL THERAPY	6600	3, 240	0	0		4. 00
	TOTALS I - TO RECLASS AUTO & OTHER F	DOOD INCLID	14, 159	0			-
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	517, 747	12		1.00
2. 00	Established Services	0.00	Ö	0			2.00
3.00		000	o	0	0		3.00
	0		0	517, 747			
1. 00	J - TO RECLASS SUPPLIES OPERATING ROOM	50.00	O	50, 726	O		1.00
1.00	TOTALS			5 <u>0, 726</u> 50, 726			1.00
	K - TO RECLASS IMPLANTS		<u> </u>	30, 720			
1.00	OPERATING ROOM	50.00	0	189, 267	0		1.00
	0		0	189, 267			
1 00	L - TO RECLASS DRUGS	F4 00	ol	0/	0		1 00
1. 00 2. 00	RADI OLOGY-DI AGNOSTI C RADI OI SOTOPE	54. 00 56. 00	O O	96 24, 162			1.00 2.00
3. 00	CT_SCAN	57. 00	0	5, 925			3.00
	0			30, 183			1
	M - MINISTRY MEDICAL RECORDS						
1. 00	OTHER A&G	505	0	5 <u>6, 2</u> 68			1.00
	N - FOUNDATION EXPENSE RECLAS	ec	0	56, 268			-
1. 00	FOUNDATION	194. 02	0	38, 372	O		1.00
2. 00		0.00	O	0	o		2.00
3.00		0.00	0	0	0		3.00
	O TO DECLACE NUIDELNIC ADMIN	CALADIEC	0	38, 372			_
1. 00	O - TO RECLASS NURSING ADMIN	5. 05	72, 260	0	0		1.00
1.00	0		72, 260	ŏ			1.00
	P - TO RECLASS ADVERTISING EX	PENSE					
1.00	EMERGENCY	<u>91.</u> 00		37	0		1.00
	O Q - TO RECLASS OTHER THERAPEL	ITI C SVCS	0	37			-
1. 00	ADULTS & PEDIATRICS	30.00	8, 893	0	0		1.00
2. 00	INTENSIVE CARE UNIT	31. 00	310	0	o		2.00
	0		9, 203				
	R - TO RECLASS RETENTION BONL			_			
1.00	EMPLOYEE BENEFITS DEPARTMENT		119, 781	0			1.00
2. 00 3. 00		0. 00 0. 00	0	0			2. 00 3. 00
4. 00		0.00	Ö	Ö	1		4.00
5.00		0. 00	0	0	0		5.00
6. 00		0.00	0	0	0		6. 00
7.00		0.00	0	0	1		7.00
8. 00 9. 00	1	0. 00 0. 00	0	0	0		8. 00 9. 00
10. 00		0.00	o	0	1		10.00
11. 00		0.00	o	0	1		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14. 00 15. 00		0. 00 0. 00	0	0	0		14. 00 15. 00
16. 00		0.00	0	0			16.00
17. 00		0. 00	o	0	1		17. 00
18.00		0. 00	О	0	1		18.00
19. 00		0. 00	0	0	1		19.00
20.00		0.00	0	0	0		20.00
21. 00 22. 00		0. 00 0. 00	0	0	0		21. 00 22. 00
23. 00		0.00	0	0	0		23.00
24. 00		0. 00	o	0	o		24.00
25.00		0. 00	О	0			25. 00
26. 00		0. 00	0	0	I I		26.00
27. 00		0. 00	0	0	0		27. 00

| Peri od: | Worksheet A-6 | From 10/01/2022 | To 09/30/2023 | Date/Time Prepared:

Decreases Cost Center Li ne # Sal ary Other Wkst. A-7 Ref.	2/25/2024 7: 10 pm 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00
	29. 00 30. 00 31. 00 32. 00 33. 00 34. 00
28. 00 29. 00 30. 00 30. 00 31. 00 32. 00 33. 00 34. 00 TOTALS S - RECLASS PREMIER CONTRACT ADMIN FEE PURCHASING RECEIVING AND STORES TOTALS TOTALS	29. 00 30. 00 31. 00 32. 00 33. 00 34. 00
29. 00 30. 00 30. 00 31. 00 31. 00 32. 00 33. 00 34. 00 TOTALS S - RECLASS PREMIER CONTRACT ADMIN FEE 1. 00 PURCHASI NG RECEI VI NG AND STORES TOTALS TOTALS 0 28, 684 0 28, 684	29. 00 30. 00 31. 00 32. 00 33. 00 34. 00
30. 00 31. 00 31. 00 32. 00 33. 00 34. 00 TOTALS S - RECLASS PREMI ER CONTRACT ADMIN FEE 1. 00 PURCHASI NG RECEI VI NG AND STORES TOTALS TOTALS 0 28, 684 0 28, 684	30. 00 31. 00 32. 00 33. 00 34. 00
31. 00 32. 00 33. 00 34. 00 TOTALS S - RECLASS PREMIER CONTRACT ADMIN FEE 1. 00 PURCHASI NG RECEI VI NG AND STORES TOTALS TOTALS 0 28, 684 0 28, 684	31. 00 32. 00 33. 00 34. 00
32. 00 33. 00 34. 00 TOTALS S - RECLASS PREMIER CONTRACT ADMIN FEE 1. 00 PURCHASI NG RECEI VI NG AND STORES TOTALS TOTALS TOTALS 0 28, 684 0 28, 684	32. 00 33. 00 34. 00
33. 00 34. 00 TOTALS S - RECLASS PREMIER CONTRACT ADMIN FEE 1. 00 PURCHASI NG RECEI VI NG AND STORES TOTALS TOTALS TOTALS TOTALS 0 28, 684 0 28, 684	33. 00 34. 00
34. 00	34.00
TOTALS	
TOTALS	
S - RECLASS PREMIER CONTRACT ADMIN FEE 1. 00 PURCHASI NG RECEI VI NG AND	1.00
1. 00 PURCHASI NG RECEI VI NG AND 5. 04 0 28, 684 0 TOTALS 0 28, 684	1.00
STORES	
TOTALS 0 28, 684	
V - RHC PHYSICIAN HOSP COSTS	
	1.00
1.00 RURAL HEALTH CLINIC	1.00
X - UTILITY EXPENSE	
1. 00 RURAL HEALTH CLINIC 88. 00 0 35, 395 0	1.00
2.00 PHYSI CI AN OFFI CE PRI OR TO 192.01 0 16, 143	2.00
RHC CERT	2.00
0 51,538	
Y - CLINICAL ENGINEERING DEPT	
1. 00 OPERATION OF PLANT 7. 00 0 473, 349 0	1.00
2.00 0 0 0	2.00
$\begin{bmatrix} 0 & -1 & -1 & -1 & -1 & -1 & -1 & -1 & $	2.00
Z - MINISTRY RECLASS	
1. 00 OTHER A&G 5. 05 0 1, 702, 799 0	1.00
2. 00 011LK A&G 0 1, 702, 777 0 0 0 0 0	2.00
3.00	3.00
4.00	4.00
5.00 0 0 0	5.00
6.00 0 0 0	6.00
7. 00 0. 00 0 0	7.00
8.00 0.00 0 0	8.00
9.00	9. 00
0 1,702,799	
AA - TO RECLASS EXPENSES FROM ASC	
1.00 ASC (NON-DISTINCT PART)	1.00
AB - TO RECLASS REGIONAL ADMIN EXPENSE	
1.00 OTHER A&G 5.05 0 5,605 0	1.00
TOTALS 0 5, 605	
500.00 Grand Total: Decreases 452,706 7,172,202	500.00

					o 09/30/2023	Date/Time Pre	
				Acqui si ti ons		2/25/2024 7:1	U pm
		Begi nni ng	Purchases	Donation	Total	Di sposal s and	
		Bal ances	rui Cliases	Donation	Total	Retirements	
		1, 00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE		2.00	0.00	1. 00	0.00	
1. 00	Land	1, 927, 000	500, 000	O	500, 000	0	1.00
2.00	Land Improvements	2, 056, 749	61, 186		61, 186	0	2.00
3.00	Buildings and Fixtures	16, 340, 581	3, 072, 371	C	3, 072, 371	0	3.00
4.00	Building Improvements	0	0	O	0	0	4.00
5.00	Fi xed Equipment	o	0	O	0	0	5.00
6.00	Movable Equipment	14, 636, 255	338, 835	0	338, 835	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	34, 960, 585	3, 972, 392	C	3, 972, 392	0	8.00
9.00	Reconciling Items	90, 658	137, 371	C	137, 371	0	9. 00
10.00	Total (line 8 minus line 9)	34, 869, 927	3, 835, 021	0	3, 835, 021	0	10.00
		Endi ng	Ful I y				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE		_				
1.00	Land	2, 427, 000	0				1.00
2.00	Land Improvements	2, 117, 935	0				2.00
3.00	Buildings and Fixtures	19, 412, 952	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	14 075 000	0				5.00
6. 00 7. 00	Movable Equipment HIT designated Assets	14, 975, 090	0				6. 00 7. 00
8. 00	Subtotal (sum of lines 1-7)	38, 932, 977	0				8.00
9. 00	Reconciling Items	228, 029	0				9.00
10.00	Total (line 8 minus line 9)	38, 704, 948	0				10.00
10.00	Tiotal (Title o milius Title 9)	30, 704, 940	V	I			10.00

Heal th	Financial Systems	MENDOTA COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONC	RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 14-1310	Peri od: From 10/01/2022 To 09/30/2023		pared:
			Sl	JMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9. 00	10. 00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR			and 2			
1.00	CAP REL COSTS-BLDG & FLXT	168, 730	0		0	0	
1. 01	CAP REL COSTS-OFFSITE MOBS	0	0		0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	473, 408	0		0	0	2.00
3.00	Total (sum of lines 1-2)	642, 138			0 0	0	3.00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	Other	Total (1)				
		Capi tal -Rel at	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN					
1. 00	CAP REL COSTS-BLDG & FIXT	0	168, 730				1.00
1. 01	CAP REL COSTS-OFFSITE MOBS	0	0				1. 01
2.00	CAP REL COSTS-MVBLE EQUIP	0	473, 408	1			2.00
3. 00	Total (sum of lines 1-2)	0	642, 138				3.00

Health Financial Systems	MENDOTA COMMUN	IITY HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 10/01/2022 To 09/30/2023		pared:
	СОМІ	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
		Leases	for Ratio (col. 1 -	instructions)		
			col . 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS						
1.00 CAP REL COSTS-BLDG & FIXT	23, 957, 887	0	23, 957, 88			1.00
1. 01 CAP REL COSTS-OFFSITE MOBS	0	0		0. 000000		1. 01
2. 00 CAP REL COSTS-MVBLE EQUIP	14, 975, 090		14, 975, 09		1	2. 00
3.00 Total (sum of lines 1-2)	38, 932, 977		38, 932, 97			3. 00
	ALLOCA	TION OF OTHER (CAPITAL	SUMMARY (OF CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel at	cols. 5	· ·		
		ed Costs	through 7)			
	6. 00	7. 00	8. 00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS	CENTERS				,	
1.00 CAP REL COSTS-BLDG & FIXT	0	0		0 305, 652	1	1.00
1. 01 CAP REL COSTS-OFFSITE MOBS	0	0	1	0	1 0	1. 01
2. 00 CAP REL COSTS-MVBLE EQUIP	0	0		0 714, 490		2. 00
3.00 Total (sum of lines 1-2)	0	0		0 1, 020, 142	38, 042	3. 00
		St	JMMARY OF CAPI	IAL		
Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
		(see	instructions)	Capi tal -Rel at	(sum of cols.	
		instructions)		ed Costs (see	9 through 14)	
				instructions)		
	11. 00	12. 00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS	CENTERS		T			
1. 00 CAP REL COSTS-BLDG & FIXT	0	35, 518	1	0	341, 170	1.00
1. 01 CAP REL COSTS-OFFSITE MOBS	0	0	l .	0	0	1. 01
2. 00 CAP REL COSTS-MVBLE EQUIP		1, 780		0	754, 312	2.00
3.00 Total (sum of lines 1-2)	1 0	37, 298	1	0 0	1, 095, 482	3. 00

ADJUST	WENTS TO EXPENSES			Provider Con: 14-1310	From 10/01/2022 To 09/30/2023	Date/Time Pre 2/25/2024 7:1	
			Т	Expense Classification oo/From Which the Amount is			
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	cost conten bescription	(2) 1.00	2. 00	3.00	4.00	Ref. 5. 00	
1. 00	Investment income - CAP REL	1.00		AP REL COSTS-BLDG & FLXT	1.00	5.00	1.00
1. 01	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		o c	AP REL COSTS-OFFSITE MOBS	1. 01	0	1. 01
2. 00	COSTS-OFFSITE MOBS (chapter 2) Investment income - CAP REL		oc	AP REL COSTS-MVBLE EQUIP	2.00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time		0		0.00	0	4. 00
5. 00	discounts (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)						
7. 00	Tel ephone servi ces (pay stati ons excluded) (chapter		0		0.00	0	7. 00
8. 00	21) Tel evi si on and radio servi ce		0		0.00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0. 00	0	9. 00
10. 00	Provi der-based physician adjustment	A-8-2	-1, 440, 442			0	10.00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11. 00
12. 00	Related organization transactions (chapter 10)	A-8-1	798, 671			0	
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	В	0 -76, 121 C	AFETERI A	0. 00 11. 00	0	13. 00 14. 00
15. 00	Rental of quarters to employee and others		0		0.00	0	15. 00
16. 00	Sale of medical and surgical supplies to other than		0		0. 00	0	16. 00
17. 00	patients Sale of drugs to other than		0		0. 00	0	17. 00
18. 00	patients Sale of medical records and	В	ОМ	EDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	abstracts Nursing and allied health		0		0.00	0	19. 00
	education (tuition, fees, books, etc.)						
20. 00 21. 00	Vending machines Income from imposition of	В	-624 C 0	AFETERI A	11. 00 0. 00	0	20. 00 21. 00
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	OR	ESPIRATORY THERAPY	65. 00		23. 00
20.00	therapy costs in excess of limitation (chapter 14)	0 0			35. 55		20.00
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0 P	HYSI CAL THERAPY	66. 00		24. 00
05 00	limitation (chapter 14)			** 0 . 0 . 5			05 00
25. 00	Utilization review - physicians' compensation		0 *	** Cost Center Deleted ***	114.00		25. 00
26. 00	(chapter 21) Depreciation - CAP REL		ос	AP REL COSTS-BLDG & FIXT	1.00	0	26. 00
26. 01	COSTS-BLDG & FIXT Depreciation - CAP REL		oc	AP REL COSTS-OFFSITE MOBS	1. 01	0	26. 01
27. 00	COSTS-OFFSITE MOBS Depreciation - CAP REL		o c	AP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0 *	** Cost Center Deleted ***	19.00		28. 00
29. 00	Physicians' assistant	A C C	О		0. 00	0	29. 00
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0 0	CCUPATI ONAL THERAPY	67. 00		30. 00
	limitation (chapter 14)						

ADJUSTMENTS TO EXPENSES				Peri od: From 10/01/2022	Worksheet A-8	i
				To 09/30/2023	Date/Time Pre 2/25/2024 7:1	
			Expense Classification o			
			To/From Which the Amount is	to be Adjusted		
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	1. 00	2. 00	3. 00	4. 00	5. 00	
30.99 Hospice (non-distinct) (see		0.	ADULTS & PEDIATRICS	30.00		30. 99
instructions) 31.00 Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
pathology costs in excess of	N 0 3		or Econ TATHOLOGI	00.00		31.00
limitation (chapter 14)						
32.00 CAH HIT Adjustment for		0		0. 00	0	32.00
Depreciation and Interest 33.00 MISCELLANEOUS INCOME	В	-190	OTHER A&G	5. 05	0	33.00
33. 01 MI SCELLANEOUS I NCOME	В		NURSING ADMINISTRATION	13. 00	0	1
33. 02 MISCELLANEOUS INCOME	В		CARDIAC REHABILITATION	76. 97	0	
33. 03 340B EXPENSE	В	-232, 294	DRUGS CHARGED TO PATIENTS	73.00	0	33. 03
33. 04 MISCELLANEOUS INCOME	В		RURAL HEALTH CLINIC	88. 00	0	33.04
33. 05 DONATI ONS	Α		OTHER A&G	5. 05	0	33. 05
33.06 MOB PROPERTY TAXES	A	-34, 165	OTHER A&G	5. 05	0	33.06
33. 07 MOB PROPERTY TAXES	A	-3, 802	RURAL HEALTH CLINIC	88. 00	0	33. 07
33. 08 COMMUNITY HEALTH EXPENSE - OTHER	A	-346	OTHER A&G	5. 05	0	33. 08
33. 09 LOBBYING EXPENSE	Α	-11, 928	OTHER A&G	5. 05	0	33. 09
33. 10 CRNA BENEFIT EXPENSE	A		EMPLOYEE BENEFITS DEPARTMEN	T 4.00	0	33. 10
33. 11 PROVIDER TAX IDPA EXPENSE	Α	-1, 088, 403	OTHER A&G	5. 05	0	33. 11
33. 12 NON RHC PHYSICIAN BENEFITS	A		EMPLOYEE BENEFITS DEPARTMEN		0	33. 12
33. 13 ASSET RE-LIFING	A		CAP REL COSTS-BLDG & FIXT	1.00	9	33. 13
33. 14 ASSET RE-LIFING	Α		CAP REL COSTS-MVBLE EQUIP	2. 00	9	33. 14
33. 15 ADVERTI SI NG	Α		OTHER A&G	5. 05	0	
33. 16 PROMPTCARE - SALARY	A		PHYSICIANS' PRIVATE OFFICES		0	
33. 17 PROMPTCARE - OTHER	A		PHYSICIANS' PRIVATE OFFICES		0	33. 17
33. 18 PHYSICIAN PT B BENEFITS	A		EMPLOYEE BENEFITS DEPARTMEN		0	
33. 19 OSFMG CRNA EXPENSE	A		ANESTHESI OLOGY	53.00	0	
33. 20 OSFMG HOSPITALIST EXPENSE	A		ADULTS & PEDIATRICS	30.00	0	
33. 21 PHYSI CLAN RECRUITMENT EXPENSE	A		OTHER A&G	5. 05	0	
33. 22 GUILD ADJUSTMENT 33. 23 MALPRACTICE EXPENSE	A A		RECOVERY ROOM OTHER A&G	51. 00 5. 05	0	
50.00 TOTAL (sum of lines 1 thru 40)		_1 884 427		3.03	U	50.23

-1, 884, 427

50.00

50.00 TOTAL (sum of lines 1 thru 49)

(Transfer to Worksheet A, column 6, line 200.)

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

⁽³⁾ Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

OFFICE COSTS

OFFICE	: C0S1S			To 09/30/2023		
	Li ne No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount	<u>о</u> рііі
					5	
	1.00	2.00	3.00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTI	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OF	CLAIMED HOME	
	OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL BLDG HO BLDG CAPITA	155, 147	277, 419	1.00
2.00	2. 00	CAP REL COSTS-MVBLE EQUIP	CAPITAL MME HO MME CAPITAL	384, 740	0	2.00
3.00	5. 05	OTHER A&G	HO POOLED - ADMIN & GENERAL	1, 485, 989	1, 770, 650	3.00
3. 01	4.00	EMPLOYEE BENEFITS DEPARTMENT	MINISTRY ALLOCATION	153, 796	153, 796	3. 01
3.02	5. 02	DATA PROCESSING	MINISTRY ALLOCATION	1, 036, 946	1, 036, 946	3.02
3.03	5. 04	PURCHASING RECEIVING AND STO	MINISTRY ALLOCATION	102, 709	102, 709	3.03
3.04	7. 00	OPERATION OF PLANT	MINISTRY ALLOCATION	81, 698	81, 698	3.04
3.05	30.00	ADULTS & PEDIATRICS	MINISTRY ALLOCATION	26, 712	0	3.05
3.06	66.00	PHYSI CAL THERAPY	MINISTRY ALLOCATION	21, 354	16, 751	3.06
3.07	67. 00	OCCUPATI ONAL THERAPY	MINISTRY ALLOCATION	5, 960	4, 675	3.07
3.08	68.00	SPEECH PATHOLOGY	MINISTRY ALLOCATION	1, 336	1, 048	3.08
3.09	73.00	DRUGS CHARGED TO PATIENTS	MINISTRY ALLOCATION	36, 235	36, 235	3.09
3. 10			MINISTRY ALLOCATION	173	173	3. 10
3. 11	60.00	LABORATORY	MINISTRY ALLOCATION	33	33	3. 11
3. 12	13.00	NURSING ADMINISTRATION	HO FUNCTIONAL - NURSING ADMI	359, 103	0	3. 12
3. 13	73.00	DRUGS CHARGED TO PATIENTS	HO FUNCTIONAL - NURSING ADMI	90, 020	90, 020	3. 13
3.14			HO FUNCTIONAL - SOCIAL SERVI	236, 926	269, 062	3. 14
4.00	5. 05	OTHER A&G	HO FUNCTIONAL - ADMIN & GEN	1, 970, 970	1, 171, 423	4.00
4. 01			HO FUNCTIONAL - PHARMACY	1, 523	0	4.01
4. 02	5. 05		RELATED PARTY SFI CVO	25, 199	25, 144	4.02
4.03	54.00	RADI OLOGY-DI AGNOSTI C	RELATED PARTY SFI EETS EQUIP	3, 505	3, 564	4.03
4.04	5. 05	OTHER A&G	RELATED PARTY SFI HTM CONTRA	334	495	4.04
4.05	7. 00	OPERATION OF PLANT	SFI HEALTHCARE TECHNOLOGY SV	264, 143	276, 921	4.05
4.06			SFI HEALTHCARE TECHNOLOGY SV	378, 574	396, 888	4.06
4.07			SFI HEALTHCARE TECHNOLOGY SV	72, 924	76, 451	4.07
4. 08			EI CU	5, 198	8, 087	4.08
4.09	5. 05	OTHER A&G	PURCH SVCS-ST GABRIEL	207, 571	208, 060	4.09
4. 10	1.00	CAP REL COSTS-BLDG & FIXT	OSFMG MINISTRY ALLOCATION	709	14, 150	4. 10
4. 11	30.00	ADULTS & PEDIATRICS	OSFMG MINISTRY ALLOCATION	388	6, 088	4. 11
4. 12	53.00	ANESTHESI OLOGY	OSFMG MINISTRY ALLOCATION	212	3, 332	4. 12
4. 13	88.00	RURAL HEALTH CLINIC	OSFMG MINISTRY ALLOCATION	322, 699	577, 754	4. 13
4. 14		EMERGENCY	OSFMG MINISTRY ALLOCATION	1, 671	26, 254	4.14
5.00	TOTALS (sum of lines 1-4).			7, 434, 497	6, 635, 826	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

			Related Organization(s) and/or Home Office		
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6.00	В	0.00 OSF HEALTHCARE 100.00	6.00
7.00		0.00	7.00
8.00		0.00	8.00
9.00		0.00	9.00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

Heal th	Financial Systems	MENDOTA COMMU	NITY HOSPITAL		In Lie	eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider (CCN: 14-1310	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS				From 10/01/2022 To 09/30/2023	Date/Time Pre 2/25/2024 7:	
				Related Orga	nization(s) and/	or Home Office	·
	Symbol (1)	Name	Percentage of	1	Name	Percentage of	
			Ownershi p			Ownershi p	
	1. 00	2. 00	3. 00	4	4. 00	5. 00	

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.B. Corporation, partnership, or other organization has financial interest in provider.C. Provider has financial interest in corporation, partnership, or other organization.

- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related
- E. Individual is director, officer, administrator, or key person of provider and related organization.

 F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der.

OTTTOL	00313				To 09/30/2023	Date/Time Pro 2/25/2024 7:	epared: 10 pm
	Net	Wkst. A-7 Ref.					
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6. 00	7. 00					
		RED AND ADJUSTME	ENTS REQUIRED AS A RESULT OF TR	RANSACTIONS WITH RELATED O	RGANI ZATI ONS OR	CLAIMED HOME	
	OFFICE COSTS:	,					
1.00	-122, 272						1.00
2.00	384, 740						2.00
3.00	-284, 661	0					3.00
3. 01	0						3. 01
3. 02	0						3. 02
3. 03	0	1					3. 03
3.04	0						3. 04
3. 05	26, 712						3. 05
3.06	4, 603						3. 06
3. 07	1, 285						3. 07
3.08	288						3. 08
3.09	0						3. 09
3. 10	0	1					3. 10
3. 11	0						3. 11
3. 12	359, 103						3. 12
3. 13	0	1					3. 13
3. 14	-32, 136						3.14
4. 00	799, 547						4.00
4. 01	1, 523						4. 01
4. 02	55						4. 02
4. 03	-59						4. 03
4.04	-161						4. 04
4. 05	-12, 778						4. 05
4. 06	-18, 314						4. 06
4. 07	-3, 527						4. 07
4. 08	-2, 889						4. 08
4. 09	-489						4. 09
4. 10	-13, 441	9					4. 10
4. 11	-5, 700						4. 11
4. 12	-3, 120						4. 12
4. 13	-255, 055						4. 13
4. 14	-24, 583						4. 14
5. 00	798, 671						5. 00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6. 00		
'	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

	HOME OFFICE		6.00
7.00			7.00
8. 00 9. 00 10. 00			8.00
9.00			9.00
10.00			10.00
100.00		1	100.00

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Peri od: Worksheet A-8-2 From 10/01/2022 To 09/30/2023 Date/Time Prepared: Provider CCN: 14-1310

					-	To 09/30/2023	B Date/Time Pre 2/25/2024 7:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	у р
		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	5. 05 (OTHER A&G	80, 592	0	80, 592	0	0	1.00
2.00	30.00 ADULTS & PEDIATRICS		45, 190	45, 190	0	0	0	2.00
3.00	53. 00 ANESTHESI OLOGY		223, 124	223, 124	0	0	0	3. 00
4.00	60. 00 LABORATORY		16, 620	0	16, 620	0	0	4.00
5.00	91. 00 EMERGENCY		1, 448, 502	1, 172, 128	276, 374	0	0	5.00
6.00	0. 00		0	0	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	0	0	10.00
200.00			1, 814, 028		373, 586		0	200.00
	Wkst. A Line #		Unadjusted RCE		Cost of		Physician Cost	
		ldenti fi er	Limit		Memberships &		of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
4.00	1.00	2.00	8. 00	9. 00	12. 00	13. 00	14.00	1.00
1.00		OTHER A&G	0	· -	-	_		
2.00	30. 00 ADULTS & PEDI ATRI CS		0	0		0		
3.00	53. 00 ANESTHESI OLOGY		0		9		0	3.00
4. 00	60. 00 LABORATORY		0	0	0		0	
5.00	91. 00 EMERGENCY		0	0	0		0	5.00
6. 00	0.00		0	0	0		0	
7. 00	0.00		0	0	0		0	7.00
8.00	0.00		0	0	0		0	
9.00	0.00		0	0	0		0	9.00
10.00	0. 00		0	0	0		0	
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	0	200.00
	WKSt. A LITTE #	I denti fi er	Component	Limit	Di sal I owance	Aujustillerit		
		rdentrirei	Share of col.	Limit	Di Sai i Owance			
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00	5. 05 (OTHER A&G	0	0	0	0		1. 00
2.00	30.00 ADULTS & PEDIATRICS		0	0	0	45, 190		2.00
3.00	53. 00 ANESTHESI OLOGY		0	0	0	223, 124		3.00
4.00	60. 00 LABORATORY		0	0	0	0		4.00
5.00	91. OO EMERGENCY		0	0	0	1, 172, 128		5. 00
6.00	0. 00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7. 00
8.00	0.00		0	0	0	0		8. 00
9.00	0.00		0	0	0	0		9. 00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1, 440, 442		200.00
	•		•	-	*	•		

| Peri od: | Worksheet B | From 10/01/2022 | Part | | To | 09/30/2023 | Date/Time Prepared: Provider CCN: 14-1310

					T	09/30/2023	Date/Time Pre 2/25/2024 7:1	
				CAP	TAL RELATED CO	STS	1 27 207 202 1 71 1	<u>Б</u>
		Cost Center Description	Net Expenses	BLDG & FIXT	OFFSITE MOBS	MVBLE EQUIP	EMPLOYEE	
		·	for Cost				BENEFITS	
			Allocation (from Wkst A				DEPARTMENT	
			col. 7)					
	GENER	AL SERVICE COST CENTERS	0	1.00	1. 01	2. 00	4. 00	
1.00	00100	CAP REL COSTS-BLDG & FIXT	341, 170	341, 170				1.00
1. 01 2. 00		CAP REL COSTS-OFFSITE MOBS CAP REL COSTS-MVBLE EQUIP	754 212	0	0	754 212		1. 01 2. 00
4. 00		EMPLOYEE BENEFITS DEPARTMENT	754, 312 4, 164, 142	459	0	754, 312 0	4, 164, 601	4.00
5. 01		BUSI NESS OFFI CE	3, 538			248	0	5. 01
5. 02 5. 03	1	DATA PROCESSING ADMITTING	1, 043, 793 0	5, 057 2, 670		18, 481 232	0	5. 02 5. 03
5.04	00560	PURCHASING RECEIVING AND STORES	376, 680	1, 185	0	257	31, 023	5. 04
5. 05 7. 00		OTHER A&G OPERATION OF PLANT	4, 718, 562 1, 353, 590	63, 384 14, 597		20, 461 37, 159	139, 288 64, 856	5. 05 7. 00
8. 00		LAUNDRY & LINEN SERVICE	97, 744	1, 543		37, 139	3, 995	8.00
9.00	1	HOUSEKEEPI NG	618, 754	3, 562		2, 153	111, 655	9.00
10. 00 11. 00		DI ETARY CAFETERI A	161, 555 256, 709			20, 634 0	27, 677 57, 012	10. 00 11. 00
13.00	01300	NURSING ADMINISTRATION	620, 326	1, 156	0	0	64, 575	13.00
16. 00 17. 00		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	56, 652 236, 926			147 0	0	16. 00 17. 00
17.00		TENT ROUTINE SERVICE COST CENTERS	230, 920	7/4		0	0	17.00
30.00	03000	ADULTS & PEDIATRICS	2, 079, 101	49, 741			454, 306	
31. 00		INTENSIVE CARE UNIT LARY SERVICE COST CENTERS	223, 350	7, 534	0	2, 104	46, 713	31.00
50.00	05000	OPERATING ROOM	836, 667	14, 232		178, 922	112, 297	50.00
51. 00 53. 00	1	RECOVERY ROOM ANESTHESI OLOGY	128, 971 19, 862	15, 967 420		0 27, 818	26, 745 265	51.00 53.00
54.00		RADI OLOGY-DI AGNOSTI C	801, 461	10, 911		54, 542	98, 027	
54. 01	1	ULTRASOUND	337, 545	684		0	2, 217	54.01
54. 02 56. 00		MAMMOGRAPHY RADI OI SOTOPE	130, 180 183, 097	475 2, 237		17, 134 0	30, 519 908	
57.00	05700	CT SCAN	243, 397	1, 508	0	46, 211	45, 624	57.00
58. 00 60. 00	05800	MRI LABORATORY	122, 934 1, 561, 683			0 64, 520	26, 179 187, 598	58. 00 60. 00
63.00		BLOOD STORING, PROCESSING, & TRANS.	51, 262	345		4, 388	0	63.00
64.00	1	I NTRAVENOUS THERAPY	361, 976			1, 199	81, 028	
65. 00 65. 01		RESPIRATORY THERAPY SLEEP LAB	538, 327 79, 523	4, 542 778		25, 127 6, 132	120, 746 17, 247	65. 00 65. 01
66.00		PHYSI CAL THERAPY	699, 527	6, 818	0	4, 138	161, 796	
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	144, 388 44, 703	889 329		0	32, 353 10, 227	67. 00 68. 00
69. 00	06900	ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
69. 01 69. 02		ECHOCARDI OGRAPHY CARDI OLOGY	5, 278 3, 042	381 332		0 17, 994	1, 238 0	69. 01 69. 02
		PULMONARY REHAB	3, 042	0	0	17, 994		69. 03
		MEDICAL SUPPLIES CHARGED TO PATIENT	42, 671	9, 107		0	0	
72. 00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	189, 267	0	0	U	0	72.00
73. 00		DRUGS CHARGED TO PATIENTS	1, 288, 742	2, 575	0	42, 032	59, 751	
75. 00 76. 00		ASC (NON-DISTINCT PART) CANCER CARE CENTER	73, 529	710	0	0	0 18, 163	75. 00 76. 00
76. 97	07697	CARDIAC REHABILITATION	63, 176			4, 894	15, 896	76. 97
77.00		ALLOGENEIC HSCT ACQUISITION CAR T-CELL IMMUNOTHERAPY	0	0		0	0	
78. 00		TIENT SERVICE COST CENTERS	U	0	0	U]	0	/8.00
88. 00	08800	RURAL HEALTH CLINIC	4, 125, 282	27, 321		11, 892	841, 733	
90. 00 91. 00		CLINIC EMERGENCY	0 2, 030, 483	0 16, 111	0	0 35, 762	0 376, 164	90. 00 91. 00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,000,100	10, 111		00,702	0,0,101	92.00
102.00		REIMBURSABLE COST CENTERS OPIOID TREATMENT PROGRAM	0	0	0	O	0	102. 00
102.00		AL PURPOSE COST CENTERS	0	0	0	U ₁		102.00
		INTEREST EXPENSE	04 040 077	040 (74		750 051	0.047.004	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	31, 213, 877	313, 674	0	753, 251	3, 267, 821	118.00
	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	56, 549			0		190. 00
		PHYSICIANS' PRIVATE OFFICES PHYSICIAN OFFICE PRIOR TO RHC CERT	15 4 065 657	10, 614 15, 710		0	4 895, 660	192.00
194.00	07950	OTHER NRCC	4, 065, 657 -7, 275	15, 710		1, 061	1, 116	194.00
		MARKETI NG	22			0	0	194. 01
194. 02	4 ₀ 0/952	FOUNDATI ON	42, 870	192	0	0	0	194. 02

Health Financial Systems	MENDOTA COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co		Period: From 10/01/2022	Worksheet B	
				o 09/30/2023		pared:
					2/25/2024 7:1	O pm
		CAPI	TAL RELATED C	0STS		
October Description	No. 1. E	DI DO A FLYT	OFFICIATE MODE	MANDLE FOLLID	EMBL OVEE	
Cost Center Description	Net Expenses	BLDG & FIXT	OFFSITE MOBS	MVBLE EQUIP	EMPLOYEE	
	for Cost				BENEFITS	
	Allocation				DEPARTMENT	
	(from Wkst A					
	col. 7)					
	0	1. 00	1. 01	2. 00	4. 00	
194. 03 07953 RESEARCH	0	0	C	0	0	194. 03
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0		o	0	201.00
202.00 TOTAL (sum lines 118 through 201) 35, 371, 715	341, 170	[c	754, 312	4, 164, 601	202. 00

Peri od: Worksheet B From 10/01/2022 Part I To 09/30/2023 Date/Ti me Prepared:

				09/30/2023	2/25/2024 7:1	
Cost Center Description	Subtotal	BUSINESS	DATA	Subtotal	ADMITTI NG	
	4A	0FFI CE 5. 01	PROCESSI NG 5. 02	5A. 02	5. 03	
GENERAL SERVICE COST CENTERS	4A	5.01	5.02	5A. U2	5.05	
1. 00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
1.01 00101 CAP REL COSTS-OFFSITE MOBS						1.01
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	0.444	0.447				4.00
5. 01 01140 BUSI NESS OFFI CE 5. 02 00550 DATA PROCESSI NG	8, 116 1, 067, 331	8, 116 245	1			5. 01 5. 02
5. 03 00570 ADMITTING	2, 902	243	1,067,576	2, 903	2, 903	5.02
5. 04 00560 PURCHASING RECEIVING AND STORES	409, 145	94	_	411, 688	40	5. 04
5. 05 00590 OTHER A&G	4, 941, 695	1, 137	156, 708	5, 099, 540	485	5. 05
7.00 00700 OPERATION OF PLANT	1, 470, 202	338		1, 470, 540	143	7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	103, 282	24		103, 306	10	8.00
9. 00 00900 HOUSEKEEPI NG	736, 124	169		739, 966	72	9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	218, 725 317, 218	50 73		218, 775 317, 291	21 31	10. 00 11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	686, 057	158		698, 458	68	13.00
16.00 01600 MEDICAL RECORDS & LIBRARY	59, 687	14		59, 701	6	16.00
17.00 01700 SOCIAL SERVICE	237, 900	55	0	237, 955	23	17.00
INPATIENT ROUTINE SERVICE COST CENTERS	0 (04 040	/10	040 577	0 000 044		
30. 00 03000 ADULTS & PEDI ATRI CS	2, 691, 818	619		2, 903, 014	282	30. 00 31. 00
31. 00 03100 INTENSIVE CARE UNIT ANCILLARY SERVICE COST CENTERS	279, 701	64	0	279, 765	27	31.00
50. 00 05000 OPERATING ROOM	1, 142, 118	263	O	1, 142, 381	111	50.00
51. 00 05100 RECOVERY ROOM	171, 683	39		174, 171	17	51.00
53. 00 05300 ANESTHESI OLOGY	48, 365	11	30, 607	78, 983	8	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	964, 941	222		1, 047, 190	102	54.00
54. 01 05401 ULTRASOUND	340, 446	78	1	340, 524	33	54. 01
54. 02 05402 MAMMOGRAPHY	178, 308	41	1	178, 349	17	54.02
56. 00 05600 RADI 01 SOTOPE 57. 00 05700 CT SCAN	186, 242 336, 740	43 77		186, 285 336, 817	18 33	56. 00 57. 00
58. 00 05800 MRI	152, 489	35	1	152, 524	15	58.00
60. 00 06000 LABORATORY	1, 819, 636	419	1	1, 958, 399	190	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	55, 995	13	0	56, 008	5	63.00
64. 00 06400 I NTRAVENOUS THERAPY	458, 829	106		611, 971	59	64.00
65. 00 06500 RESPIRATORY THERAPY	688, 742	158	1	688, 900	67	65.00
65. 01 06501 SLEEP LAB 66. 00 06600 PHYSI CAL THERAPY	103, 680 872, 279	24 201	0 13, 467	103, 704 885, 947	10 86	65. 01 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	177, 630	41	1	177, 671	17	67.00
68. 00 06800 SPEECH PATHOLOGY	55, 259	13	1	55, 272	5	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	1	0	0	69.00
69. 01 06901 ECHOCARDI OGRAPHY	6, 897	2	0	6, 899	1	69. 01
69. 02 06902 CARDI OLOGY	21, 368	5	1	21, 373	2	69. 02
69. 03 06903 PULMONARY REHAB	0 51 770	0	1	0 51 700	0	69.03
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72. 00 07200 MPLANTABLE DEVICES CHARGED TO	51, 778 189, 267	12 44	1	51, 790 189, 311	5 18	71. 00 72. 00
PATIENTS	107, 207	44		107, 311	10	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 393, 100	320	0	1, 393, 420	135	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	o	0	75.00
76. 00 03020 CANCER CARE CENTER	92, 402	21	1	92, 423	9	76.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	85, 695	20	I	85, 715	8	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION 78.00 07800 CAR T-CELL MMUNOTHERAPY	0	0	_	0	0	77. 00 78. 00
OUTPATIENT SERVICE COST CENTERS	O _I	0	<u> </u>	υ _l	0	78.00
88. 00 08800 RURAL HEALTH CLINIC	5, 006, 228	1, 155	233, 837	5, 241, 220	0	88. 00
90. 00 09000 CLI NI C	0	0	0	О	0	90.00
91. 00 09100 EMERGENCY	2, 458, 520	565	28, 159	2, 487, 244	241	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0		92.00
OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI 0I D TREATMENT PROGRAM	0	0	ol	ol	0	102. 00
SPECIAL PURPOSE COST CENTERS	U	0	ıj U	U	U	102.00
113. 00 11300 INTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	30, 288, 540	6, 969	1, 067, 576	30, 287, 393	2, 420	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	57, 337	0	0	57, 337		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	10, 633	2	0	10, 635		192.00
192. 01 19201 PHYSICIAN OFFICE PRIOR TO RHC CERT	4, 977, 027	1, 145	0	4, 978, 172		192.01
194. 00 07950 OTHER NRCC 194. 01 07951 MARKETI NG	-5, 098 214	0		-5, 098 214		194. 00 194. 01
194. 02 07952 FOUNDATI ON	43, 062	0		43, 062		194. 01
194. 03 07953 RESEARCH	0	0	o	0		194. 03
200.00 Cross Foot Adjustments	О			o		200. 00
201.00 Negative Cost Centers	0	0	0	0		201.00
202.00 TOTAL (sum lines 118 through 201)	35, 371, 715	8, 116	1, 067, 576	35, 371, 715	2, 903	202. 00

Peri od: Worksheet B From 10/01/2022 Part I To 09/30/2023 Date/Time Prepared:

				'	0 09/30/2023	2/25/2024 7: 1	
	Cost Center Description	PURCHASI NG	Subtotal	OTHER A&G	OPERATION OF	LAUNDRY &	
		RECEIVING AND STORES			PLANT	LINEN SERVICE	
		5. 04	5A. 04	5. 05	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01	00101 CAP REL COSTS-OFFSITE MOBS					ļ	1. 01
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	01140 BUSI NESS OFFI CE					ļ	5. 01
5. 02	00550 DATA PROCESSI NG						5. 02
5. 03	00570 ADMITTING	411 700					5.03
5. 04 5. 05	00560 PURCHASING RECEIVING AND STORES 00590 OTHER A&G	411, 728	E 102 440	F 102 440		ļ	5. 04 5. 05
5. 05 7. 00	00700 OPERATION OF PLANT	3, 423 1, 402	5, 103, 448 1, 472, 085	5, 103, 448 248, 163			7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	1, 402	1, 472, 065	17, 417		131, 374	8.00
9. 00	00900 HOUSEKEEPI NG	29, 801	769, 839	129, 779		131, 374	9.00
10. 00	01000 DI ETARY	2, 407	221, 203	37, 290			
11. 00	01100 CAFETERI A	5, 032	322, 354	54, 342			11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	60	698, 586	117, 767			13.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	168	59, 875	10, 094	,	Ö	16.00
17. 00	01700 SOCI AL SERVI CE	0	237, 978			o o	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS	91	207,770	107110	0,7.0	J	
30.00	03000 ADULTS & PEDIATRICS	35, 619	2, 938, 915	495, 439	342, 969	33, 687	30.00
31.00	03100 INTENSIVE CARE UNIT	6, 595	286, 387	48, 279	51, 950	1, 142	31.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	73, 297	1, 215, 789	204, 956	98, 130	5, 446	50.00
51.00	05100 RECOVERY ROOM	6, 599	180, 787	30, 477	110, 096	665	51.00
53.00	05300 ANESTHESI OLOGY	6, 784	85, 775	14, 460	2, 896	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 705	1, 051, 997	177, 345		3, 577	54.00
54. 01	05401 ULTRASOUND	7, 646	348, 203	58, 700	·	2, 141	1
54. 02	05402 MAMMOGRAPHY	476	178, 842	30, 149			
56. 00	05600 RADI OI SOTOPE	688	186, 991	31, 523		1, 187	56.00
57. 00	05700 CT SCAN	20, 536	357, 386	60, 248			
58. 00	05800 MRI	5, 391	157, 930	26, 624		4, 236	
60.00	06000 LABORATORY	39, 028	1, 997, 617	336, 756		0	60.00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	12 404	56, 013	9, 443			63. 00 64. 00
65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	12, 694	624, 724	105, 315			
65. 00	06501 SLEEP LAB	22, 313 3, 744	711, 280 107, 458	119, 907 18, 115	31, 318 5, 366		65.00
66. 00	06600 PHYSI CAL THERAPY	3, 426	889, 459	149, 944		7, 712	1
67. 00	06700 OCCUPATI ONAL THERAPY	396	178, 084	30, 021	6, 129		
68. 00	06800 SPEECH PATHOLOGY	388	55, 665	9, 384		1, 3,4	68.00
69. 00	06900 ELECTROCARDI OLOGY	0	33, 003	7, 304	2, 207		69.00
69. 01	06901 ECHOCARDI OGRAPHY	133	7, 033	1, 186	2, 627	0	69. 01
69. 02	06902 CARDI OLOGY	1, 140	22, 515	3, 796			69.02
69. 03	06903 PULMONARY REHAB	', ' '	0	0,770	0	o o	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	51, 795	8, 732	62, 793	Ö	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO	O	189, 329	31, 917	0	0	72.00
	PATI ENTS						ĺ
	07300 DRUGS CHARGED TO PATIENTS	6, 327	1, 399, 882	235, 991	17, 758	0	73.00
	07500 ASC (NON-DISTINCT PART)	0	0	C	0	0	75. 00
76.00	03020 CANCER CARE CENTER	41	92, 473			0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	399	86, 122	14, 518	11, 921	0	76. 97
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	15, 787	5, 257, 007	886, 212	188, 380		88.00
90.00	09000 CLINIC	(5.000	0 550 700	400 000	0	0	90.00
91.00	09100 EMERGENCY	65, 223	2, 552, 708	430, 333	111, 084	48, 638	
92. 00	O9200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS		U				92.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	C	0		102.00
102.00	SPECIAL PURPOSE COST CENTERS	U _I	U		0	Ü	102.00
113 00	11300 I NTEREST EXPENSE						113.00
118.00		381, 668	30, 256, 850	4, 240, 329	1, 530, 655	131, 374	1
	NONREI MBURSABLE COST CENTERS	00.7000	00, 200, 000	1/210/02/	17 0007 000	1017071	
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	24, 426	81, 763	13, 784	5, 433	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	10, 635	1, 793			192.00
	19201 PHYSICIAN OFFICE PRIOR TO RHC CERT	5, 624	4, 984, 279				192. 01
	07950 OTHER NRCC	0	-5, 098				194.00
	07951 MARKETI NG	10	224	38	1, 325	0	194. 01
194. 02	07952 FOUNDATI ON	0	43, 062	7, 259			194. 02
	07953 RESEARCH	0	0	0	0		194. 03
200.00			0				200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	411, 728	35, 371, 715	5, 103, 448	1, 720, 248	131, 374	202. 00

Peri od: Worksheet B From 10/01/2022 Part I To 09/30/2023 Date/Time Prepared:

NUMBER COST CENTER DESCRIPTION HOUSEKEEPING DIFTARY CAFETRIA AND INSTRATIO RECORDS & LIERARY					'	0 09/30/2023	Date/lime Pre 2/25/2024 7:1	
		Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A		MEDI CAL	, p
FORTIGN SPRINTEN 9.00 10.00 11.00 13.00 16.00								
CHERNEL SERVICE COST CENTERS 1.00 00100 CAP BEL COSTS-ADD A FIXTS 1.00 00100 CAP BEL COSTS CAP B			9. 00	10. 00	11.00			
1.01 0.01 0.07 REL COSTS-OFFS IT LINGS 2.00 0.000 0.001		GENERAL SERVICE COST CENTERS						
2.00 DOUGO CAP REL COSTS-WINE EXAMPLE FOUR 4.00 0.00								1
4 00 00000 DEPLOYEE BERKETTS DEPARTMENT 5 00 5 00 00000 DEPLOYEE BERKETS OF COSTO 5 00 5 00 00000 DEPLOYEE STATE 5 00 5 00 00000 DEPLOYEE STATE 5 00 5 00 00000 DEPLOYEE STATE 5 00 00000 DEPLOYEE STATE 5 00 00000 DEPLOYEE STATE 5 00 DEPLOYEE		1 1						ł
0.01 0.00		1 1						
5.02 0.00500 DATA PROCESSING								ł
5.03 0.0570 JAMIN TILING 5.05 0.0500								ł
5.04 0.0560 PURCHASTING RECEIVING AND STORES								ı
5.05 0.05990 OTHER AGO		1						ı
2.00 0.0000 QUERATION OF PLANT								
8.00 00000 DETARY 0 0 0000 DETARY 0 0 0000 DETARY 0 0 0000 DETARY 0 0 0 0 0 0 0 170 110 00 100 DETARY 0 0 0 0 0 0 0 170 110 00 0								ı
0.000 0.0000 0.00ENERPING 0 0.110, 0.00 0.000 0.00 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000		1 1						ı
10.00 1000Q DETARY		1 1	024 170					l
11.00 01100 CAFETERIA 10.1 10.0 0 410, 968 30, 310 13.00 1300 01000 MUSTING ADMINISTRATION 0 0 0 0 0 101, 313 16.00 10		l	1	310 580				l
13.00 01300 NURSI INC ADMINISTRATION 0 0 5,987 830,310 1 13.00 17.00 0 0 0 0 0 0 0 17.313 16.00 16.00 16.00 17.00 0 0 0 0 0 0 0 0 17.00		l l	1 -1		/10 060			•
16.00 01600 NEDICAL, RECORDS & LIBRARY 11, 431		1	1 1	ĭ				
17.00		1 1	-1				101 313	•
IMPATT ENT ROUT IN SERVICE COST CENTERS 227,764 290,953 64,485 388,972 20,263 30 30 00 3000 (ADUTS & PEDIATRIC S 22,786 290,953 34,497 3,977 22,624 0 31,00 31,00 31,00 31,00 31,00 31,00 31,00 31,00 31,00 32,00 31,00 32,00 31,00 31,00 31,00 31,00 32,00 31,00 32,00 31,00 32,00 31,00 32,00 31,00 32,00			1 1	ŭ		0		•
30.00	17.00		<u> </u>	<u> </u>		<u> </u>		17.00
ANCIL LARY SERVICE COST CENTERS	30.00		227, 764	290, 953	64, 485	388, 972	20, 263	30.00
50.00	31.00	03100 INTENSIVE CARE UNIT	26, 248	3, 439	3, 917	23, 624	0	31.00
15.1 0.0 05.100 RECOVERY ROOM 6.5, 196 3, 203 3, 721 22, 399 16, 886 51.00 0 0 0, 966 0 0 53.00 05.30 0 05.00 ARSTHESI OLOY 0 0 0, 1966 0 0 0, 53.00 05.00 ARSTHESI OLOY 0 0, 1, 689 54.00 0 224 0 1, 689 54.00 0 24.00 0.05 54.01 0.05		ANCILLARY SERVICE COST CENTERS						
53.00	50.00	05000 OPERATING ROOM	57, 999	0	13, 988	84, 378	0	50.00
54. 00 05400 RADIO LOGY-DI ACNOSTIC 39, 372 1, 484 15, 247 0 1, 689 54. 00 54. 01 05401 UTRASOLUND 1. CRASOLUND 2, 540 0 224 0 0, 555 54. 01 54. 02 05402 MAMMORRAPHY 1, 693 0 4, 392 0 844 54. 02 65. 00 05600 RADIO ISTOPE 8, 044 0 84 0 6.33 55. 00 05700 CT SCAN 5. 504 0 6, 826 0 8, 021 57. 00 67. 00 05700 CT SCAN 1, 277 0 3, 245 0 1, 900 58. 00 05800 MRI ORDOR PRINTED 1, 277 0 3, 245 0 1, 900 58. 00 05800 MRI ORDOR PRINTED 1, 277 0 3, 245 0 1, 900 58. 00 05800 MRI ORDOR PRINTED 1, 277 0 3, 245 0 1, 900 58. 00 05800 MRI ORDOR PRINTED 1, 900 1, 900 0 0 0 0 0 0 0 0 0	51.00		65, 196	3, 203	3, 721	22, 399	16, 886	51.00
54.01 05401 UTRASOUND 1.055 54.01 05600 224 0 1.055 54.01 05600 05600 RADIO ISOTOPE 8.044 0.84 0.83 56.00 05600 RADIO ISOTOPE 0.5500 05600 RADIO ISOTOPE 0.5000 0.500	53.00	05300 ANESTHESI OLOGY	0	0	1, 986	0	0	53.00
54 OC 05402 MAMDGRAPHY	54.00	1 1	39, 372	1, 484		0	1, 689	54.00
56. 00	54.01	05401 ULTRASOUND	2, 540	0		0	1, 055	54. 01
57.00 OSTOO CT SCAN	54.02	05402 MAMMOGRAPHY	1, 693	0	4, 392	0	844	54.02
18. 00 0.6800 MRI 12. 277		1 1	1 1	0		0	633	ł
60.00 06.000 LABORATORY 40,219			1 1	-				
0		1 1	1 1	-		0		ł
64.00 O6400 INTRAVENOUS THERAPY 38,525 0 12,030 0 0 64.00 06.50 06.50 06.50 RESPIRATORY THERAPY 16,934 0 16,618 0 0 65.00 06.50 RESPIRATORY THERAPY 74,087 0 18,912 0 10,765 66.00 06.		1 1	1 1			0		ł
65. 00 0.0500 RESPIRATORY THERAPY 16, 934 0 16, 618 0 0 65. 00 65. 01 0.0501 SLEEP LAB 0 0 0 0 0 0 65. 01 0.0501 SLEEP LAB 0 0 0 0 0 0 66. 00 0.0600 0.0501 SLEEP LAB 0 0 0 0 0 67. 00 0.0700 0.0CUDATI ONAL THERAPY 74, 087 0 18, 912 0 10,765 66. 00 68. 00 0.0600 0.0CUDATI ONAL THERAPY 9, 737 0 41, 112 0 0 67. 00 69. 00 0.0600 0.0CUDATI ONAL THERAPY 9, 737 0 41, 112 0 0 67. 00 69. 00 0.0600 0.0CUDATI ONAL THERAPY 0 0 0 0 0 0 0 69. 00 0.0600 0.0CUDATI ONAL THERAPY 0 0 0 0 0 0 0 69. 00 0.0600 0.0CUDATI ONAL THERAPY 0 0 0 0 0 0 0 69. 00 0.0600 0.0CUDATI ONAL THERAPY 0 0 0 0 0 0 0 69. 00 0.0000 0.0CUDATI ONAL THERAPY 0 0 0 0 0 0 0 0 69. 00 0.0000 0.0CUDATI ONAL THERAPY 0 0 0 0 0 0 0 0 69. 00 0.0000 0.0CUDATI ONAL THERAPY 0 0 0 0 0 0 0 0 69. 00 0.0000 0.0CUDATI ONAL THERAPY 0 0 0 0 0 0 0 69. 00 0.0000 0.0CUDATI ONAL THERAPY 0 0 0 0 0 0 0 69. 00 0.0000 0.0000 0 0 0 0		1 1	1		-	0		ı
65.01 0.6501 0.6501 0.6501 0.6501 0.6500 0.		l l	1 1	-				ı
66.00 06600 PHYSI CAL THERAPY 74, 087 0 18, 912 0 10, 765 66. 00 67.00 06700 0CCUPATIONAL THERAPY 9, 737 0 1, 112 0 0 0 67. 00 68.00 06800 SPECH PATHOLOGY 0 0 0 0 0 0 0 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 69.01 06901 ECHOCARDI OLOGY 0 0 0 112 738 0 69. 01 69.02 06902 CARDI OLOGY 0 0 0 0 0 0 0 0 69.03 06903 PULMONARY REHAB 0 0 0 0 0 0 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 2, 963 0 0 0 0 0 0 0 72.00 07200 IMPLANTRABLE DEVICES CHARGED TO PATIENT 2, 963 0 0 0 0 0 0 0 75.00 07200 IMPLANTRABLE DEVICES CHARGED TO PATIENTS 5, 927 0 6, 882 41, 431 0 73. 00 75.00 07500 ASC (NON-DISTINOT PART) 0 0 0 0 0 0 0 0 76.00 03020 CANCER CARE CENTER 0 0 0 2, 014 0 0 0 75. 00 76.00 03020 CANCER CARE CENTER 0 0 0 2, 014 0 0 0 0 76.00 07607 CARDI AC REHABILI TATION 0 0 2, 788 0 0 75. 00 76.00 07000 0700 0700 0700 0 0			1		· ·			ı
67: 00 06700 06700 06700 06700 06700 067: 00 068: 00 068: 00 068: 00 068: 00 068: 00 068: 00 068: 00 068: 00 068: 00 068: 00 069: 00 071: 00 071: 00 072: 00 072: 00 072: 00 072: 00 073: 00		1 1	-1					ı
68.00 06800 SPECCH PATHOLOGY 0 0 1,511 0 0 68.00		1 1	1 1			-		1
69.00 06900 ECHOCARDI OLOGY 0 0 0 0 0 69.00		1 1	1	-		0		l
69. 01 06901 CCHOCARDI OCRAPHY 0 0 0 112 738 0 69. 01			1	-		0		•
69. 02 06902 CARDIOLOGY			0	-	-	720		1
69.03 06903 PULMONARY REHAB			0	0		/38		•
171.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 2,963 0 0 0 0 0 0 0 0 0			0	0		0		•
72. 00 07200 IMPLANTABLE DEVICES CHARGED TO 0 0 0 0 0 0 72. 00 PATIENTS 5, 927 0 6, 882 41, 431 0 73. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 76. 00 03020 CANCER CARE CENTER 0 0 0 0 0 0 0 76. 00 03020 CANCER CARE CENTER 0 0 0 0 0 0 0 76. 97 07697 CARDI AC REHABILITATION 0 0 0 0 0 0 0 77. 00 07700 ALLOGENEI CHSCT ACQUISITION 0 0 0 0 0 0 0 78. 00 07800 CART CELL I IMMUNTHERAPY 0 0 0 0 0 0 0 78. 00 07800 CART CELL I IMMUNTHERAPY 0 0 0 0 0 0 0 79. 00 07900 CARDI HEALTH CLINIC 99,065 0 75,226 0 0 88. 00 79. 00 09000 CINIL C 0 0 0 0 0 0 0 791. 00 09100 EMERGENCY 129,969 20,501 44,566 268,768 27,437 91.00 792. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 0 792. 00 09200 0910 DID TREATMENT PROGRAM 0 0 0 0 0 0 792. 00 01200 0910 DI TREATMENT PROGRAM 0 0 0 0 0 793. 00 01300 INTEREST EXPENSE 113. 00 11300 INTEREST EXPENSE 113. 00 11300 INTEREST EXPENSE 113. 00 1120 09100			2 042	0	0	0		•
PATIENTS			1 1	0	0	0		•
73.00 07300 DRUGS CHARGED TO PATIENTS 5,927 0 6,882 41,431 0 73.00	72.00		٥	U	0	U U	U	/2.00
75. 00 07500 ASC (NON-DI STI NCT PART)	73 00		5 927	0	6 882	41 431	0	73 00
76. 00 03020 CANCER CARE CENTER 0 0 2,014 0 0 76. 07 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 77. 00 76. 97 77. 00 78. 00 78.			-,	n			-	
76. 97 07697 CARDI AC REHABILITATION 0 0 2,798 0 0 76. 97 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 78. 00 00TPATI ENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 99,065 0 75,226 0 0 88. 00 90. 00 09000 CLINIC 0 0 0 0 0 0 0 91. 00 09100 EMERGENCY 129,969 20,501 44,566 268,768 27,437 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 129,969 20,501 44,566 268,768 27,437 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 92. 00 92. 01 10200 OPI 0I D TREATMENT PROGRAM 0 0 0 0 0 0 92. 02 00 00 0 0 0 0 0 0 92. 03 00 00 0 0 0 0 0 94. 00 00 0 0 0 0 0 0 95. 01 102. 00 000 0 0 0 0 0 0 95. 02 000 000 000 0 0 0 0				0				•
77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 77. 00 78. 00 78. 00 07800 CAR T-CELL I MMUNOTHERAPY 0 0 0 0 0 0 0 78. 00 78. 00 78. 00 0 0 0 0 0 0 0 0 78. 00 78. 00 78. 00 08800 RURAL HEALTH CLINIC 99, 065 0 75, 226 0 0 0 0 0 0 0 0 0				0			-	
78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 78. 00			o	0	_, 0	o		
88. 00 08800 RURAL HEALTH CLINIC 99,065 0 75,226 0 0 0 0 0 0 0 0 0			O	0	0	o	0	
90. 00		OUTPATIENT SERVICE COST CENTERS	<u> </u>			<u> </u>		ĺ
91. 00	88.00		99, 065	0	75, 226	0	0	88. 00
92. 00	90.00		0	o		0	0	
OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI 0I D TREATMENT PROGRAM O O O O O O 0 102.00	91.00	09100 EMERGENCY	129, 969	20, 501	44, 566	268, 768	27, 437	91.00
102.00 10200 OPI OI D TREATMENT PROGRAM O O O O O O O O O	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS 113.00 1NTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) 885,654 319,580 343,630 830,310 101,313 118.00								
113.00	102.00		0	0	0	0	0	102.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 885,654 319,580 343,630 830,310 101,313 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190.00 192.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 38,525 0 0 0 0 192.00 192.01 1920 PHYSI CI AN OFFICE PRI OR TO RHC CERT 0 0 67,198 0 0 192.01 194.00 194.0								
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 38,525 0 0 0 0 192. 00 192. 01 19201 PHYSI CI AN OFFI CE PRI OR TO RHC CERT 0 0 67, 198 0 0 192. 01 194. 00 07950 OTHER NRCC 0 0 140 0 0 194. 00 194. 01 07951 MARKETI NG 0 0 0 0 0 0 194. 02 07952 FOUNDATI ON 0 0 0 0 0 194. 03 07953 RESEARCH 0 0 0 0 0 200. 00 Cross Foot Adjustments 200. 00 201. 00 Negati ve Cost Centers 0 0 0 0 0 201. 00 O 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 202. 00 0 0 0 0 203. 00 0 0 0 0 204. 00 0 0 0 0 205. 00 0 0 0 0 206. 00 0 0 0 207. 00 0 0 0 208. 00 0 0 0 208. 00 0 0 0 208. 00 0 0 0 209. 00 0 0 0 209. 00 0 0 0 209. 00 0 0 0 209. 00 0 0 0 209. 00 0 0 209. 00 0 0 209. 00 0 0 209. 00 0 0 209. 00 0 0 209. 00 0 209								
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00 192. 00 192. 00 192.00 192.00 192.00 192.01	118.00		885, 654	319, 580	343, 630	830, 310	101, 313	118. 00
192.00 19200	400.55			_1	_		_	100.00
192.01 19201 PHYSICIAN OFFICE PRIOR TO RHC CERT 0 0 67, 198 0 0 192.01 194.00 07950 OTHER NRCC 0 0 0 140 0 0 194.00 194.01 07951 MARKETING 0 0 0 0 0 0 0 194.01 194.02 07952 FOUNDATION 0 0 0 0 0 0 0 194.02 194.03 07953 RESEARCH 0 0 0 0 0 0 194.02 200.00 Cross Foot Adjustments 0 Negative Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1	0		_		
194. 00 07950 OTHER NRCC 0 0 140 0 0 194. 00 194. 01 07951 MARKETING 0 0 0 0 0 0 194. 01 194. 02 07952 FOUNDATION 0 0 0 0 0 0 194. 02 194. 03 07953 RESEARCH 0 0 0 0 0 0 0 194. 03 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			38, 525	0	-	-		
194. 01 07951 MARKETING 0 0 0 0 0 194. 01 194. 02 07952 FOUNDATION 0 0 0 0 0 194. 02 194. 03 07953 RESEARCH 0 0 0 0 0 0 0 194. 03 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 0 0 0 0 201. 00			0	0		0		
194. 02 07952 FOUNDATION 0 0 0 0 194. 02 194. 03 07953 RESEARCH 0 0 0 0 0 194. 03 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 0 0 0 0 0 0 0 0 0 0 201. 00			0	0	140	0		
194.03 07953 RESEARCH 0 0 0 0 194.03 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 0 0 0 0 0 0 201.00			0	0	0	0		
200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00			0	0	0	0		
201.00 Negative Cost Centers 0 0 0 0 0 201.00			0	O	0		0	
					^		0	
202. 00 101/12 (30iii 111ies 110 tiii 0ugii 201) 724, 1/7 317, 300 410, 400 030, 310 101, 313 202. 00			024 170	310 500	/10 040	020 210		
	202.00	TIVIAL (Sum TITIES TO UNIOUGH 201)	724, 179	317, 360	410, 708	030, 310	101, 313	<u> </u> 202.00

					To	09/30/2023	Date/Time Pre 2/25/2024 7:1	
		Cost Center Description	SOCI AL	Subtotal	Intern &	Total	7 27 207 202 1 7. 1) piii
			SERVI CE		Residents			
					Cost & Post Stepdown			
					Adjustments			
			17. 00	24. 00	25. 00	26. 00		
1 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FLXT			I I			1 00
1. 00 1. 01		CAP REL COSTS-BLDG & FIXT						1.00 1.01
2. 00		CAP REL COSTS-MVBLE EQUIP						2.00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01		BUSINESS OFFICE						5. 01
5. 02 5. 03	1	DATA PROCESSING ADMITTING						5. 02 5. 03
5. 03		PURCHASING RECEIVING AND STORES						5. 04
5. 05	1	OTHER A&G						5. 05
7. 00		OPERATION OF PLANT						7. 00
8.00		LAUNDRY & LINEN SERVICE						8.00
9. 00 10. 00		HOUSEKEEPI NG DI ETARY						9. 00 10. 00
11. 00		CAFETERI A						11.00
13.00	1	NURSING ADMINISTRATION						13.00
16.00	1	MEDICAL RECORDS & LIBRARY						16.00
17. 00		SOCIAL SERVICE	284, 809					17. 00
30. 00		ADULTS & PEDIATRICS	284, 809	5, 088, 256	0	5, 088, 256		30.00
31.00		INTENSIVE CARE UNIT	0	444, 986		444, 986		31.00
		LARY SERVICE COST CENTERS			. 1			
50.00		OPERATING ROOM	0	1, 680, 686		1, 680, 686	i e	50.00
51. 00 53. 00		RECOVERY ROOM ANESTHESI OLOGY	0	433, 430 105, 117	1	433, 430 105, 117		51.00 53.00
54. 00		RADI OLOGY-DI AGNOSTI C	0	1, 365, 942		1, 365, 942		54.00
54. 01		ULTRASOUND	0	417, 578		417, 578		54. 01
54. 02		MAMMOGRAPHY	0	220, 921	0	220, 921		54.02
56. 00 57. 00	1	RADI OI SOTOPE	0	243, 885		243, 885		56.00
58.00	05800	CT SCAN	0	465, 589 229, 493		465, 589 229, 493		57. 00 58. 00
60.00	1	LABORATORY	Ö	2, 458, 480		2, 458, 480		60.00
63.00		BLOOD STORING, PROCESSING, & TRANS.	0	67, 836		67, 836		63.00
64.00		I NTRAVENOUS THERAPY	0	881, 440		881, 440		64.00
65. 00 65. 01		RESPI RATORY THERAPY SLEEP LAB	0	897, 482 133, 849		897, 482 133, 849		65. 00 65. 01
66. 00		PHYSI CAL THERAPY	0	1, 197, 890		1, 197, 890		66.00
67.00		OCCUPATI ONAL THERAPY	0	229, 657	0	229, 657		67.00
68.00		SPEECH PATHOLOGY	0	68, 827	0	68, 827		68.00
69.00	1	ELECTROCARDI OLOGY	0	11 404	· ·	11 404		69.00
69. 01 69. 02		ECHOCARDI OGRAPHY CARDI OLOGY	0	11, 696 28, 601	0	11, 696 28, 601		69. 01 69. 02
69. 03	1	PULMONARY REHAB	Ö	0	1	0		69. 03
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	0	126, 283	0	126, 283		71.00
72. 00	07200	IMPLANTABLE DEVICES CHARGED TO	0	221, 246	0	221, 246		72. 00
73. 00	07300	PATIENTS DRUGS CHARGED TO PATIENTS	0	1, 707, 871	0	1, 707, 871		73. 00
75. 00		ASC (NON-DISTINCT PART)	ő	0	Ö	0		75. 00
76. 00		CANCER CARE CENTER	0	114, 970		114, 970	•	76. 00
		CARDI AC REHABI LI TATI ON	0	115, 359		115, 359		76. 97
77. 00 78. 00		ALLOGENEIC HSCT ACQUISITION CAR T-CELL IMMUNOTHERAPY	0	0		0		77. 00 78. 00
, 0. 00	OUTPA	TIENT SERVICE COST CENTERS	<u> </u>	0				, 3. 00
88. 00	08800	RURAL HEALTH CLINIC	0	6, 506, 901		6, 506, 901		88. 00
90.00		CLINIC	0	0	0	0		90.00
91.00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	O	3, 634, 004	0	3, 634, 004		91. 00 92. 00
92.00		REIMBURSABLE COST CENTERS			<u> </u>			92.00
102.00		OPIOID TREATMENT PROGRAM	0	0	0	0		102.00
		AL PURPOSE COST CENTERS						
		INTEREST EXPENSE	204 000	20 000 275		20 000 275		113.00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	284, 809	29, 098, 275	0	29, 098, 275		118. 00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	100, 980	0	100, 980		190. 00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	o	124, 141		124, 141		192. 00
		PHYSICIAN OFFICE PRIOR TO RHC CERT	0	6, 000, 044		6, 000, 044		192. 01
		OTHER NRCC	0	-4, 958 1 587		-4, 958 1 597		194. 00 194. 01
		MARKETI NG FOUNDATI ON	0	1, 587 51, 646		1, 587 51, 646		194. 01
		RESEARCH	o	0		0		194. 03
200.00		Cross Foot Adjustments	1	0		o		200.00

Heal th Finan	cial Systems	MENDOTA COMMUN	TY HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCAT	TION - GENERAL SERVICE COSTS		Provi der CO		Peri od:	Worksheet B	
					From 10/01/2022	Part Date/Time Pre	narodi
					10 09/30/2023	2/25/2024 7: 1	
	Cost Center Description	SOCI AL	Subtotal	Intern &	Total		
		SERVI CE		Resi dents			
				Cost & Post			
				Stepdown			
				Adjustments			
		17. 00	24. 00	25.00	26.00		
201. 00	Negative Cost Centers	0	0		0 0		201.00
202.00	TOTAL (sum lines 118 through 201)	284, 809	35, 371, 715		0 35, 371, 715		202.00

| Peri od: | Worksheet B | From 10/01/2022 | Part | I | To | 09/30/2023 | Date/Time | Prepared: | Provider CCN: 14-1310

				T	09/30/2023	Date/Time Pre 2/25/2024 7:1	
			CAP	TAL RELATED CO	STS	2, 20, 202 ; ,;	<u> </u>
	Cost Center Description	Di rectly	BLDG & FIXT	OFFSITE MOBS	MVBLE EQUIP	Subtotal	
		Assigned New Capital					
		Related Costs					
	GENERAL SERVICE COST CENTERS	0	1.00	1. 01	2. 00	2A	
1. 00	00100 CAP REL COSTS-BLDG & FLXT						1.00
1. 01	00101 CAP REL COSTS-OFFSITE MOBS						1.01
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	0	459	0	0	459	2. 00 4. 00
5. 01	01140 BUSINESS OFFICE	0	4, 330	0	248	4, 578	5. 01
5. 02 5. 03	00550 DATA PROCESSI NG 00570 ADMI TTI NG	0	5, 057 2, 670		- ,	23, 538 2, 902	1
5.04	00560 PURCHASING RECEIVING AND STORES	0	1, 185	1		1, 442	1
5. 05 7. 00	00590 OTHER A&G 00700 OPERATION OF PLANT	0	63, 384 14, 597			83, 845 51, 756	1
8. 00	00800 LAUNDRY & LINEN SERVICE	0	1, 543	1			1
9.00	00900 HOUSEKEEPI NG	0	3, 562	1	,		1
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	0	8, 859 3, 497	1		29, 493 3, 497	1
13.00	01300 NURSING ADMINISTRATION	0	1, 156	0		1, 156	13.00
16. 00 17. 00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	0	2, 888 974			3, 035 974	1
17.00	INPATIENT ROUTINE SERVICE COST CENTERS						17.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0				158, 411 9, 638	30. 00 31. 00
31.00	ANCILLARY SERVICE COST CENTERS	0	7,334	0	2, 104	7, 030	31.00
50.00	05000 OPERATING ROOM	0	,			193, 154	50. 00 51. 00
51. 00 53. 00	05100 RECOVERY ROOM 05300 ANESTHESI OLOGY	0	15, 967 420		_	15, 967 28, 238	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	10, 911	0	54, 542	65, 453	54.00
54. 01 54. 02	05401 ULTRASOUND 05402 MAMMOGRAPHY	0	684 475			684 17, 609	1
56.00	05600 RADI OI SOTOPE	0	2, 237			2, 237	56.00
57. 00 58. 00	05700 CT SCAN 05800 MRI	0	1, 508 3, 376			47, 719 3, 376	1
60.00	06000 LABORATORY	0	5, 835		_		
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	345		.,		1
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	14, 626 4, 542	1	,		1
65. 01	06501 SLEEP LAB	0	778		- ,		1
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	6, 818 889	1		10, 956 889	1
68. 00	06800 SPEECH PATHOLOGY	0	329	0		329	68.00
69. 00 69. 01	06900 ELECTROCARDI OLOGY 06901 ECHOCARDI OGRAPHY	0	0 381		_	0 381	69. 00 69. 01
69. 02	06902 CARDI OLOGY	0	332	1	_	18, 326	1
69. 03	06903 PULMONARY REHAB	0	0 107		0	0 9, 107	
	07100 MEDICAL SUPPLIES CHARGED TO PATTENT 07200 IMPLANTABLE DEVICES CHARGED TO	0	9, 107 0		0		
72.00	PATIENTS		2 575		42,022	44 (07	72.00
73. 00 75. 00	07300 DRUGS CHARGED TO PATIENTS 07500 ASC (NON-DISTINCT PART)	0	2, 575 0	0	42, 032 0	44, 607 0	1
76. 00		0	710	1	0	710	1
76. 97 77. 00		0	1, 729 0		4, 894 0	6, 623 0	1
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0				1
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	1 0	27, 321	Ιο	11, 892	39, 213	88. 00
90.00		0	27, 321			39, 213	1
91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	16, 111	0	35, 762		
92.00	OTHER REIMBURSABLE COST CENTERS					0	92.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
113 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	313, 674	0	753, 251	1, 066, 925	1
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		788	0	0	700	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	10, 614			10, 614	192. 00
	19201 PHYSICIAN OFFICE PRIOR TO RHC CERT	0	15, 710	1	0		192. 01
	0 07950 0THER_NRCC 07951 MARKETING	0	0 192	_	1, 061 0		194. 00 194. 01
194. 02	07952 FOUNDATI ON	0	192	0		192	194. 02
194. 03	8 07953 RESEARCH	1 0	0	0	0	0	194. 03

Health Financial Systems	MENDOTA COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C		Peri od:	Worksheet B	
				From 10/01/2022 To 09/30/2023		nared·
					2/25/2024 7: 1	
		CAP	ITAL RELATED C	OSTS		
Cook Cooker Books at low	D:+1	DIDC & FLVT	OFFCLIF MODE	MVDLE FOLLID	C	
Cost Center Description	Directly	BLDG & FIXT	OFFSITE MOBS	MVBLE EQUIP	Subtotal	
	Assigned New					
	Capi tal					
	Related Costs					
	0	1. 00	1. 01	2.00	2A	
200.00 Cross Foot Adjustments					0	200.00
201.00 Negative Cost Centers		0		0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	341, 170	(754, 312	1, 095, 482	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 14-1310

SPINEMENT SPRAYED FOOT CONTERNS		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	BUSI NESS OFFI CE	DATA PROCESSI NG	ADMI TTI NG	2/25/2024 7: 1 PURCHASI NG RECEI VI NG AND STORES	
0.000 CAP REL COSTS-BLUE & FIXT 1.00 1				5. 01	5. 02	5. 03		
1.01 0.01 0.02 P ET 0.0755. OFFSI TF 1005 2.00 0.000 0.00							I	
11.00 0 1000 (MES) NEA MAIN ISTRATION 7 89 227 68 0 13.00 10.00 10.00 MES) NEA MAIN ISTRATION 7 89 227 68 0 13.00 10.00 10.00 MES) NEA MESON SEL MERKEY 8 0 31 0 2 0 1 10.00 10.00 10.00 MES) NEA MESON SEL ME	1. 01 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 7. 00 8. 00 9. 00	00101 CAP REL COSTS-OFFSITE MOBS 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 01140 BUSINESS OFFICE 00550 DATA PROCESSING 00570 ADMITTING 00560 PURCHASING RECEIVING AND STORES 00590 OTHER A&G 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0 0 0 3 15 7 0	139 0 53 642 191 13	23, 677 0 54 3, 476 0 0 81	40 484 143 10 72	1, 592 13 5 0 115	1. 01 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 7. 00 8. 00 9. 00
10 00 01600 MEDICAL RECORDS & LIBRARY 0 8 0 0 1 10 00			6		1			
30.00	16. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	1	8	0	6	1	16. 00
MINI LIARY SERVICE COST CENTERS		03000 ADULTS & PEDIATRICS						1
50.00	31. 00		5	36	0	27	25	31.00
53.00	50. 00		12	148	0	111	286	50.00
SBR 00 OSBOO MRI SBR 00 DESTOR ING PROCESSING, & TRANS. O 7 O 5 O 63 O 64 O O 64 O O 64 O O O O O O O O O	53. 00 54. 00 54. 01 54. 02 56. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRASOUND 05402 MAMMOGRAPHY 05600 RADI OI SOTOPE	0 11 0 3 0	6 125 44 23 24	679	8 102 33 17 18	26 18 30 2 3	53.00 54.00 54.01 54.02 56.00
00.00 0,000 0,000 0,000 0,000 0,000 0,000 0,00		l i	1		0			1
63.0 0 0.0300 BLOOD STORING, PROCESSING, & TRANS. 0 7 0 5 0 63.0 0 64.0 0 0.400 INTEAMENDUS THERAPY 9 9 60 3,394 59 49 64.0 0 65.0 0 0.500 INTEAMENDUS THERAPY 133 90 0 6 67 86 65.0 0 65.0 0 0.501 INTEAMENDUS THERAPY 18 13 90 0 0 67 86 65.0 0 65.0 0 0.501 INTEAMENDUS THERAPY 18 13 0 10 14 65.0 1 66.0 0 0.500 INTEAMENDUS THERAPY 18 18 113 299 86 13 66.0 0 66.0 0 0.500 INTEAMENDUS THERAPY 18 18 113 299 86 13 66.0 0 0.0 0 17 2 67.0 0 0.0 0 0 17 2 67.0 0 0.0 0 0 0 17 2 67.0 0 0.0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		· · · · · · · · · · · · · · · · · · ·	1		I			1
65. 0 06500 RESPI PATORY THERAPY 13 90 0 67 86 65 50 65. 01 06501 SLEP LAB 2 13 0 10 14 65 01 66. 01 06501 SLEP LAB 2 13 0 10 14 65 01 66. 00 06600 PHYSI CAL THERAPY 18 113 299 86 13 66 00 67. 00 06700 06700 0CCUPATI ONAL THERAPY 4 23 0 17 2 67 00 68. 00 06800 SPECH PATHOLOGY 1 7 0 5 1 68 00 69. 00 06900 SPECH PATHOLOGY 0 0 0 0 0 0 0 0 69. 00 06900 ELECTROCARD IOLOGY 0 0 0 0 0 0 0 69. 01 06901 ECHOCARD IOCOGRAPHY 0 1 0 1 1 69 01 69. 02 06902 CARDI IOCOGRAPHY 0 0 3 0 2 4 69 02 69. 03 06903 PULMOMARY REHAB 0 0 0 0 0 0 0 0 0 69. 03 06903 PULMOMARY REHAB 0 0 0 0 0 0 0 0 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 7 0 5 0 71 00 72. 00 07200 IMPLANTABLE DEVICES CHARGED TO 0 25 0 18 0 72 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 6 181 0 135 24 73 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 75 00 76. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 76. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 77. 00 07700 ALIOGENEIC HISCT ACQUISITION 2 11 0 8 2 76 97 77. 00 07700 ALIOGENEIC HISCT ACQUISITION 2 11 0 8 2 76 97 78. 00 07800 CART -CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 0 0 79. 00 07900 06000 0 0 0 0 0 0 0	63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	0		0	5	0	63.00
65.01 06501 SLEEP LAB 2		l l	1					1
66.00 06600 PHYSICAL THERAPY 18 113 299 86 13 66.00 67.00 06700 0CCUPATIONAL THERAPY 4 23 0 17 2 67.00 68.00 06800 SPECH PATHOLOGY 1 7 0 5 1 68.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 69.00 69.01 06900 ELCHOCARDIOLOGY 0 0 0 0 0 0 0 0 69.00 69.02 06900 ELCHOCARDIOLOGY 0 0 0 0 0 0 0 0 0 69.01 06900 ELCHOCARDIOLOGY 0 0 0 0 0 0 0 0 0 69.02 06902 CARDIOLOGY 0 0 3 0 2 4 69.02 69.03 06903 PULMONARY REHAB 0 0 0 0 0 0 0 0 0		1	1					1
68.00 06800 SPEECH PATHOLOGY 1 7 0 5 1 68.00 69.00 06900 ELCENCCARDI OLOGY 0 0 0 0 0 69.00 69.01 06900 ELCHOCARDI OLOGY 0 0 1 0 1 1 69.01 69.02 06902 CARDI OLOGY 0 3 0 2 4 69.02 69.03 06903 PULMONARY REHAB 0 0 0 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 7 0 5 0 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO 0 25 0 18 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 6 181 0 135 24 73.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 76.00 07500 CARC CARE CENTER 2 12 0 9 0 76.00 76.00 07500 CARC CARE CENTER 2 12 0 9 0 76.00 76.00 07500 CARC CALL IMMUNTHERAPY 0 0 0 0 0 0 0 77.00 07500 CAR T-CELL IMMUNTHERAPY 0 0 0 0 0 0 78.00 07500 CAR T-CELL IMMUNTHERAPY 0 0 0 0 0 0 78.00 07500 CART T-CELL IMMUNTHERAPY 0 0 0 0 0 0 78.00 07500 CART T-CELL IMMUNTHERAPY 0 0 0 0 0 79.00 07000 CMR-T-CELL IMMUNTHERAPY 0 0 0 0 0 79.00 07000 CMR-T-CELL IMMUNTHERAPY 0 0 0 0 0 79.00 07000 0 0 0 0 0 79.00 07000 0 0 0 0 0 79.00 0 0 0 0 0 79.00 0 0 0 0 0 79.00 0 0 0 0 0 79.00 0 0 0 0 79.00 0 0 0 0 79.00 0 0 0 0 0 79.00 0 0 0 0 79.00 0 0 0 0 0 79.00 0 0 0 0 79.00 0 0 0 0 79.00 0 0 0 0 0 79.00 0 0 0 0 79.00 0 0 0 0 0 79.00 0 0 0 0 79.00 0 0 0 0 79.00 0 0 0 0 0 79.00 0 0 0 0 79.00 0 0 0 0 79.00 0 0 0 0 79.00 0 0 0 0 79.00 0 0 0 0 79.00 0 0 0 0 79.00 0 0 0 79.00 0 0 0 0 0 79.00 0 0 0 0 79.00 0 0 0 0 79.00 0 0 0 0 79.00 0 0 0 0 79.00 0 0 0 79.00 0 0 0 0 79.00 0 0 0 0		1						1
69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 0 0 69, 90 69.01 06901 ECHOCARDIOGRAPHY 0 1 0 1 1 1 69, 91 69.02 06902 CARDIOLOGY 0 3 0 2 4 69, 92 69.03 06903 PULMONARY REHAB 0 0 0 0 0 0 0 0 72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENT 0 7 0 5 0 71. 00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO 0 25 0 18 0 72. 00 73.00 07300 DRUGS CHARGED TO PATIENTS 6 181 0 135 24 73. 00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 76.00 03020 CANCER CARE CENTER 2 11 0 8 2 76. 97 77.00 07607 CARDIAC REHABLLITATION 2 11 0 8 2 76. 97 77.00 07607 CARDIAC REHABLLITATION 2 11 0 8 2 76. 97 77.00 07500 ACCEPTION 0 0 0 0 0 0 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 79.00 07900 CARDIAC REHABLLITATION 0 0 0 0 0 79.00 07900 CARDIAC REHABLLITATION 0 0 0 0 0 79.00 07900 07900 07900 07900 79.00 07900 07900 07900 07900 79.00 07900 07900 07900 07900 79.00 07900 07900 07900 07900 79.00 07900 07900 07900 07900 79.00 07900 07900 07900 07900 79.00 07900 07900 07900 79.00 07900 07900 07900 07900 79.00 07900 07900 07900 07900 79.00 07900 07900 07900 79.00 07900 07900 0		1	4		0	17		1
69.01 06901 ECHOCARDI OGRAPHY 0 1 0 1 1 69, 01			1	7	0	5		1
69, 02 06902 CARDI OLOGY		1		0	Ĭ	0		1
69.03 06903 PULMONARY REHAB 0 0 0 0 0 0 69.03		1		3	Ĭ	2		1
72. 00 07200 MPLANTABLE DEVICES CHARGED TO 0 25 0 18 0 72. 00 PATIENTS PATIENTS 0 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0		1 I	O	0	Ö	0		1
PATLENTS			0	7	0	5	0	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 6 181 0 135 24 73. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 75. 00 76. 00 03020 CANCER CARE CENTER 2 12 0 0 9 0 76. 00 76. 97 07697 CARDI AC REHABILITATION 2 111 0 8 8 2 76. 97 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 77. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 77. 00 00 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	72. 00		0	25	0	18	0	72.00
75. 00 07500 ASC (NON-DISTINCT PART)	73 00		6	181	0	135	24	73.00
76. 07 07697		07500 ASC (NON-DISTINCT PART)	1		1			
77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 78. 00		03020 CANCER CARE CENTER	2			9		
78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 78.00			2		1	8		
88. 00 08800 RURAL HEALTH CLINIC 91 647 5, 186 0 61 88. 00			1			0		
90. 00	70.00		<u> </u>	0	<u> </u>			70.00
91. 00			1	647	5, 186	0	61	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART OTHER REI MBURSABLE COST CENTERS ODE ODE				-	-	· ·	l .	
OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI 0I D TREATMENT PROGRAM O O O O O 102.00			41	320	625	241	252	
102. 00 10200 OPI 0I D TREATMENT PROGRAM O O O O O 102. 00	72.00							72.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 353 3,930 23,677 2,419 1,476 118.00		10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00 192. 00 192. 00 192. 00 192. 00 192. 01 192. 01 192. 01 192. 01 192. 01 192. 01 192. 01 192. 01 192. 01 192. 01 192. 01 192. 01 193. 01 193. 01 193. 01 194. 01 194. 01 194. 01 194. 01 194. 02 194. 01 194. 02 194. 03 194.			353	3, 930	23, 677	2, 419	1, 476	
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	46	NONREI MBURSABLE COST CENTERS						
192. 01 1920			1	0		-		
194. 00 07950 OTHER NRCC 0 0 0 194. 00 194. 01 194. 02 194. 02 194. 03 194			- 1	1 647		ŭ		
194. 02 07952 FOUNDATION 0 0 0 194. 02 194. 03 07953 RESEARCH 0 0 0 0 0 194. 03 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 0 0 0 0 0 0 0 201. 00	194.0	0 07950 OTHER NRCC	0	0	o o	0		
194. 03 07953 RESEARCH 0 0 0 194. 03 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 0 0 201. 00			0	0	0	0		
200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 0 0 201.00			0	0	0	0		
201.00 Negative Cost Centers 0 0 0 0 201.00		1	0	0	0	0	0	
		1 1	0	0	0	0		201.00
			459	4, 578	23, 677	2, 902		

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 10/01/2022 | Part II |
| To 09/30/2023 | Date/Time Prepared: 2/25/2024 7:10 pm

			, ,	0 09/30/2023	2/25/2024 7:1	
Cost Center Description	OTHER A&G	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
	5. 05	7. 00	8.00	9. 00	10.00	
GENERAL SERVICE COST CENTERS						
1. 00 00100 CAP REL COSTS-BLDG & FLXT						1.00
1. 01 00101 CAP REL COSTS-OFFSITE MOBS 2. 00 00200 CAP REL COSTS-MVBLE EQUIP						1. 01 2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 01140 BUSINESS OFFICE						5. 01
5. 02 00550 DATA PROCESSING						5. 02
5. 03 00570 ADMI TTI NG						5. 03
5. 04 00560 PURCHASING RECEIVING AND STORES						5. 04
5. 05 00590 0THER A&G	88, 475					5. 05
7. 00 00700 OPERATION OF PLANT	4, 303	56, 405	0.047			7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	302 2, 250	349 805	2, 217	9, 146		8. 00 9. 00
10. 00 01000 DI ETARY	2, 250	2, 003	0	9, 140	32, 204	10.00
11. 00 01100 CAFETERI A	942	791	0	101	0	11.00
13. 00 01300 NURSING ADMINISTRATION	2, 042	261	Ö	0	0	13.00
16.00 01600 MEDICAL RECORDS & LIBRARY	175	653	0	113	0	16.00
17. 00 01700 SOCIAL SERVICE	696	220	0	0	0	17. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	8, 590	11, 247	568	· · ·	29, 318	30.00
31. 00 03100 INTENSIVE CARE UNIT	837	1, 703	19	260	347	31.00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	3, 554	3, 218	92	574	0	50.00
51. 00 05100 RECOVERY ROOM	528	3, 610	11	645	323	51.00
53. 00 05300 ANESTHESI OLOGY	251	95	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 075	2, 467	60	390	150	54.00
54. 01 05401 ULTRASOUND	1, 018	155	36	25	0	54. 01
54. 02 05402 MAMMOGRAPHY	523	107	29	17	0	54. 02
56. 00 05600 RADI 01 SOTOPE	547	506	20	80	0	56.00
57. 00 05700 CT SCAN	1, 045	341	290	54	0	57.00
58. 00 05800 MRI	462	763	71	121	0	58.00
60. 00 06000 LABORATORY 63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	5, 839 164	1, 319 78	0	398	0	60. 00 63. 00
64. 00 06400 NTRAVENOUS THERAPY	1, 826	3, 307	0	381	0	64.00
65. 00 06500 RESPIRATORY THERAPY	2, 079	1, 027	24	l :	0	65.00
65. 01 06501 SLEEP LAB	314	176	0	0	0	65. 01
66. 00 06600 PHYSI CAL THERAPY	2, 600	1, 541	130	733	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	521	201	27	96	0	67.00
68. 00 06800 SPEECH PATHOLOGY	163	74	0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
69. 01 06901 ECHOCARDI OGRAPHY 69. 02 06902 CARDI OLOGY	21 66	86 75	0		0	69. 01 69. 02
69. 03 06903 PULMONARY REHAB	0	75	0		0	69.03
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	151	2, 059	0	29	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	553	0	Ō	0	0	72.00
PATI ENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 092	582	0		0	73.00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0		0	0	
76. 00 03020 CANCER CARE CENTER 76. 97 07697 CARDI AC REHABI LI TATI ON	270	160		0	0	76.00
76.97 07697 CARDIAC REHABILITATION 77.00 07700 ALLOGENEIC HSCT ACQUISITION	252 0	391 0	0	0	0	76. 97 77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0		0	78.00
OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>		٥,		70.00
88. 00 08800 RURAL HEALTH CLINIC	15, 349	6, 177	17	980	0	88. 00
90. 00 09000 CLI NI C	0	0	0	O	0	90.00
91. 00 09100 EMERGENCY	7, 462	3, 642	823	1, 286	2, 066	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS		0				100 00
102. 00 10200 OPI OI D TREATMENT PROGRAM SPECI AL PURPOSE COST CENTERS	0	0	0	0	0	102.00
113. 00 11300 I NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	73, 509	50, 189	2, 217	8, 765	32 204	118.00
NONREI MBURSABLE COST CENTERS	,0,00,	307.07		5, , 55	02/201	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	239	178	0	0	0	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	31	2, 400		381		192. 00
192. 01 19201 PHYSICIAN OFFICE PRIOR TO RHC CERT	14, 569	3, 552	0	0		192. 01
194. 00 07950 OTHER NRCC	0	0	0	0		194.00
194. 01 07951 MARKETI NG	1	43		0		194. 01
194. 02 07952 FOUNDATI ON 194. 03 07953 RESEARCH	126	43	0	0		194. 02 194. 03
200.00 Cross Foot Adjustments		0	١	١	U	200.00
201.00 Negative Cost Centers	0	0	n	n	0	201.00
202.00 TOTAL (sum lines 118 through 201)	88, 475	56, 405	2, 217	9, 146		202.00
				· '		

| Peri od: | Worksheet B | From 10/01/2022 | Part | I | To | 09/30/2023 | Date/Time | Prepared: | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1310

				T	09/30/2023	Date/Time Pre 2/25/2024 7:1	
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI O N	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	Subtotal	J
		11. 00	13. 00	16. 00	17. 00	24. 00	
1. 00 1. 01 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 16. 00 17. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MYBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 01140 BUSINESS OFFICE 00550 DATA PROCESSING 00570 ADMITTING 00560 PURCHASING RECEIVING AND STORES 00590 OTHER A&G 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	5, 428 79 0 0	3, 974 0	3, 991 0	1, 944		1. 00 1. 01 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 16. 00 17. 00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	852 52		798 0	1, 944 0	221, 334 13, 062	
75. 00 76. 00 76. 97 77. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05100 RECOVERY ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRASOUND 05402 MAMMOGRAPHY 05600 RADI OI SOTOPE 05700 CT SCAN 05800 MRI 06000 LABORATORY 06300 BLOOD STORING, PROCESSING, & TRANS. 06400 INTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY 06501 SLEEP LAB 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06700 OCCUPATI ONAL THERAPY 06900 ELECTROCARDI OLOGY 06901 ECHOCARDI OGRAPHY 06902 CARDI OLOGY 06903 PULMONARY REHAB 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 07200 IMPLANTABLE DEVI CES CHARGED TO PATI ENT'S 07300 DRUGS CHARGED TO PATI ENTS 07500 ASC (NON-DISTINCT PART) 03020 CANCER CARE CENTER 07697 CARDI AC REHABI LI TATI ON 07700 ALLOGENEI C HSCT ACQUI SI TI ON 07800 CAR T-CELL I IMMUNOTHERAPY	185 49 26 201 3 58 1 90 43 420 0 159 219 38 250 54 20 0 0 1 0 0 27 37 0	107 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 665 0 67 42 33 25 316 75 466 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	201, 738 22, 027 29, 329 73, 938 2, 070 18, 421 3, 461 50, 016 4, 970 82, 463 4, 987 25, 069 33, 442 7, 477 17, 163 1, 834 600 0 496 18, 476 0 11, 358 596 49, 975 0 1, 190 7, 326 0 0	51. 00 53. 00 54. 00 54. 01 54. 02 56. 00 57. 00 58. 00 60. 00 63. 00 65. 00 66. 00 67. 00 68. 00 69. 00 69. 01 69. 02 69. 03 71. 00 72. 00 73. 00 75. 00 76. 00 76. 97 77. 00
91.00	08800 RURAL HEALTH CLINIC 09000 CLINIC 09100 EMERGENCY	994 0 589	0	0 0 1, 080	0 0 0	68, 715 0 71, 586	90. 00 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	92.00
	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE				<u> </u>	0	113.00
118. 00 190. 00 192. 00 192. 01 194. 00 194. 01	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 19201 PHYSICIAN OFFICE PRIOR TO RHC CERT 07950 OTHER NRCC 07951 MARKETING 07952 FOUNDATION 07952 FOUNDATION 07958 RESEARCH Cross Foot Adjustments Negative Cost Centers	4, 538 0 0 888 2 0 0 0 0 5, 428	0 0 0 0 0 0	0 0 0 0 0	1, 944 0 0 0 0 0 0 0 0	13, 427 35, 977 1, 063 236 361 0	118. 00 190. 00 192. 00 192. 01 194. 00 194. 01 194. 02 194. 03 200. 00 201. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 10/01/2022 | Part II | To 09/30/2023 | Date/Time Prepared: | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2024 | 21/2 Provider CCN: 14-1310

Cost Center Description					10 09/30/2023 Date/1	1 me Prepared: 2024 7:10 pm
COST & PROST STREET		Cost Center Description	Intern &	Total	1 2,20,2	102 i 7 i 10 piii
STEPADOS ACQ A						
CEREBRAL SERVICE DOCT CONTERS 25.00 26.00						
PREPAY SERVICE OST CENTERS 100			•			
COLOR STATE STATE COST CENTERS 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				26, 00		
1.01 0.010 CAP REL COSTS-OFFSITE MOSS		GENERAL SERVICE COST CENTERS				
2.00	1.00					1.00
0.0000 DIMPLOYEE BEWEFTS DEPARTMENT		1				
0.11 0.11		1				
5.02 0.0500 DATA PROCESSING 5.03 0.0500 DATA PROCESSING 5.04 5.		1				
5.03 OSPO ADMITTING 5.04 5.05 5.04 OSPO DELICIOSIN OR RECEIVING AND STORES 5.06 5.06 5.06 5.00						
		1				
2.00 00700 DORDON OF PAINT						l l
B.00 OBCOL LAURDEY & LINEN SERVICE B.00 O.00 ODCOLO DETARY TO 0.00 ODCOLO DETARY SERVICE COST CENTERS TO 0.00 ODCOLO DETARY SERVICE CO	5.05	00590 OTHER A&G				5. 05
9, 00 00900 MUSISTER FED NAT 10.00 10.00 DE TARRY 1.10 01.00 01.00 DESTINATION 1.10 DES						
10.00 10000 DIETARY						
11.00						
13.00						
16.00 01600 MEDICAL RECORDS & LIBRARY						
INPATI ENT ROUTINE SERVICE COST CENTERS 33.00 33.00 30						
30.00 30000 ADULTS & PEDIATRICS 0 221, 334 33.00 33.00 ADULTS & PEDIATRICS 31.00 33.00 AMCILLARY SERVICE COST CENTERS	17.00	01700 SOCIAL SERVICE				17. 00
31.00 33100 INTENSIVE CARE UNIT 0 13,062 31.00						
MICHILIARY SERVICE COST CENTERS 50.00		1	l l			
50.00	31.00		<u> </u>	13, 062		31.00
15.1 00 OSTOO RECOVERY ROOM 0 22,027 51,00 35.0 0 OSGOO ARSTHESI OLOGY 0 29,329 53,00 35.0 0 OSGOO ARSTHESI OLOGY 0 29,329 54,00 34.0 10 ISAGO ULTRASOUND 0 2,070 54,01 35.0 0 OSGOO ARSTHESI OLOGY 0 18,421 54,02 35.0 0 OSGOO RADIO INSTORE 0 3,461 56,02 35.0 0 OSGOO RADIO INSTORE 0 3,461 56,02 35.0 0 OSGOO RADIO INSTORE 0 3,461 56,00 35.0 0 OSGOO RADIO INSTORE 0 4,970 58,00 35.0 0 OSGOO RADIO INSTORE 0 4,970 58,00 35.0 0 OSGOO RADIORATORY 0 82,463 60,00 36.0 0 OSGOO REDRIANCE REDRIANCE 0 3,421 63,00 36.0 0 OSGOO REDRIANCE REDRIANCE 0 3,422 66,50 36.0 0 OSGOO RESPIRATORY 1 1834 67,00 36.0 0 OSGOO PINSI CALL THERAPY 0 25,669 64,00 36.0 0 OSGOO PINSI CALL THERAPY 0 7,477 65,01 36.0 0 OSGOO PINSI CALL THERAPY 0 1,834 67,00 36.0 0 OSGOO PINSI CALL THERAPY 0 1,834 67,00 36.0 0 OSGOO DECENTRICATED OLOGY 0 0 69,00 36.0 0 OSGOO SEECH PATHOLICRY 0 1,834 67,00 36.0 0 OSGOO ELECTROCARDIO LOGY 0 0 69,00 36.0 0 OSGOO ELECTROCARDIO LOGY 0 0 69,00 36.0 0 OSGOO ELECTROCARDIO LOGY 0 0 0 69,00 36.0 0 OSGOO ELECTROCARDIO LOGY 0 0 18,476 69,00 36.0 0 OSGOO ELECTROCARDIO LOGY 0 0 18,476 69,00 36.0 0 OSGOO ELECTROCARDIO LOGY 0 0 1,000 1,000 36.0 0 OSGOO DURLA THERAPY 0 1,358 71,00 71,00 37.0 0 OSGOO DURLA THERAPY 0 0 0 0 0 38.0 0 OSGOO ELECTROCARDIO LOGY 0 0 0 0 0 38.0 0 OSGOO ELECTROCARDIO LOGY 0 0 0 0 0 38.0 0 OSGOO ELECTROCARDIO LOGY 0 0 0 0 0 38.0 0 OSGOO DURLA THERAPY 0 0 0 0 0 0 38.0 0 OSGOO DURLA THERAPY 0 0 0 0 0 0 38.0 0 OSGOO URLA THERAPY 0 0 0 0 0 0 0 38.0 0 OSGOO URLA THERAPY 0 0 0 0 0 0	50.00		O	201 738		50.00
154.00 05400 ADD LOGY-DI AGNOSTIC 0 73, 938 54.00 54.01 05401 ULTRASCUIDD 0 2,070 54.01 54.02 05402 MAMROGRAPHY 0 18,421 54.02 56.00 05500 OSTOTOPE 0 3,461 55.00 57.00 05700 CT SCAN 0 50,016 57.00 58.00 05500 MRI 0 4,970 58.00 58.00 05600 MRI 0 74,970 58.00 58.00 05600 MRI 0 74,970 74,970 74,970 58.00 05600 MRI 0 74,970 74,970 74,970 74,970 58.00 05600 MRI 0 74,971 74,9			l l			
54.0 0.5401 ULTRASQUIND	53.00	05300 ANESTHESI OLOGY	o	29, 329		53.00
54. 02 05402 MAMINGRAPHY 0 18. 421 55. 0.0		1	l l			
56.00 OS-600 RADIO I SOTOPE 0 3. 461 55.00 57.00		1	_			
57.00 05700 CT SCAN 0 50.016 57.00 58.00 68.00		1	· ·			
S8. 00 05800 MRI 0 4, 970 58. 00 0.00		1	· ·			
60.0 06000 06000 LABORATORY 0 82, 463 63, 00 63.0 63.0 063.0 064.0 064.0 064.0 064.0 064.0 064.0 064.0 064.0 065		1	l l			
64. 00 0.400 INTRAVENDUS THERAPY 0 25, 0.69 6.4 0.0 65. 00 0.650 0.6		1	o			
65.00 06500 RESPIRATORY THERAPY 0 33, 442 65.00 66.01 06601 SLEEP LAB 0 7,477 65.01 66.00 06600 PHYSICAL THERAPY 0 17, 163 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 1,834 67.00 68.00 06800 SPECH PATHOLOGY 0 600 68.00 69.00 06900 06900 ELECTROCARDI OLOGY 0 496 69.01 69.01 06901 ECHOCARDI OLOGY 0 496 69.01 69.02 06902 CARDIOLOGY 0 18,476 69.01 69.03 06903 PULMOMARY REHAB 0 0 0 69.03 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 11,358 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO 72.00 07300 DRUGS CHARGED TO PATIENT 0 11,358 71.00 73.00 07300 ASC (NON-DISTINCT PART) 0 0 75.00 76.00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 76.00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 77.00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 77.00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 78.00 78.00 07900 07900 07900 07900 07900 78.00 07900 07900 07900 07900 78.00 07900 07900 07900 07900 78.00 07900 07900 07900 07900 78.00 07900 07900 07900 07900 78.00 07900 07900 07900 07900 78.00 07900 07900 07900 07900 78.00 07900 07900 07900 07900 78.00 07900 07900 07900 07900 78.00 07900 07900 07900 07900 78.00 07900 07900 07900 07900 78.00 07900 07900 07900 07900 78.00 07900 07900 07900 07900 78.00 07900 07900 07900 07900 78.00 07900 07900 07900 07900 78.00 07900 07900 07900 07900 07900 78.00 07900 07900 07900 07900 07900 78.00 07900 07900 07900 07900 07900 07900 78.00 079000 07900 079000 079000 079000 07900 07900			· ·			
65.01 06501 SLEEP LAB 65.01			· ·			
66.00 06600 PHYSI CAL THERAPY 0 17, 163 66.00 67.00 06700 CCUPATIONAL THERAPY 0 1,834 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 600 68.00 69.00 06800 SEECH PATHOLOGY 0 0 0 0 69.01 06901 ECHOCARDIO JOGRAPHY 0 496 69.01 69.02 06902 CARDIO LOGY 0 18,476 69.02 69.03 06903 PULMONARY REHAB 0 0 0 69.03 06903 PULMONARY REHAB 0 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 11,358 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO 0 596 72.00 72.00 O7200 IMPLANTABLE DEVICES CHARGED TO 75.00 75.00 07500 ASC (NON-DISTINCT PART) 0 49,975 73.00 76.00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 76.00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 76.07 07697 CARDIA CREHABLILITATION 0 7,326 76.00 77.00 07700 ALLOGENEIC HISCT ACQUISITION 0 0 78.00 78.00 07900 CARLER CELL IMMUNOTHERAPY 0 0 0 80.00 08900 CARLER CELL IL IMMUNOTHERAPY 0 0 0 90.00 09000 CLINIC 0 0 68,715 90.00 09000 09000 CLINIC 0 0 0 91.00 09100 MERGENCY 0 0 0 91.00 09100 MERGENCY 0 0 0 91.00 09100 MERGENCY 0 0 0 92.00 09200 095ERIVATION BEDS (NON-DISTINCT PART 0 91.00 09100 MERGENCY 0 0 0 91.00 09100 EMBURSABLE COST CENTERS 91.00 0000 0000 0000 0000 0000 0000 0000 91.00 09100 MERGENCY 0 0 0 91.00 09100 MERG			· ·			
67.00 06700 06700 06700 0600 068.00 068.00 068.00 068.00 068.00 068.00 068.00 069.00			-			
68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 0 0			1			
69, 01 06901 CHOCARDI OGRAPHY 0 496 69, 01			o			
69. 02 0.6902 CARDI OLOGY 0 18, 476 69. 02 69. 03 06903 PULMONARY REHAB 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 11, 358 71. 00 72. 00 07200 IMPLANTABLE DEVI CES CHARGED TO 0 596 72. 00 PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 49, 975 73. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 75. 00 76. 00 03020 CANCER CARE CENTER 0 1, 190 76. 00 76. 00 03020 CANCER CARE CENTER 0 1, 190 76. 90 76. 00 07000 CARDI AC REHABI LI TATI ON 0 7, 326 76. 90 77. 00 07700 ALLOGENEIC HISCT ACQUISTI ON 0 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 77. 00 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 90. 00 09000 CLI NI C 0 0 68, 715 88. 00 90. 00 09000 CLI NI C 0 0 0 0 91. 00 09100 EMERGENCY 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0 0 10. 00 09200 OND TREATMENT PROGRAM 0 0 0 10. 00 091. 00 OND TREATMENT PROGRAM 0 0 0 10. 00 09200 OND TREATMENT PROGRAM 0 0 1, 299 190. 00 09200 OND CENTERS 113. 00 113.00 11300 INTEREST EXPENSE 113. 00 114. 00 19200 PHYSI CI ANS 'PRI VATE OFFICES 0 13, 427 192. 00 192. 01 19200 PHYSI CI ANS 'PRI VATE OFFICES 0 13, 427 192. 00 194. 00 1950 OTHER NECC 0 0 0 0 0 194. 01 07951 MARKETI NG 0 236 194. 00 194. 01 07951 MARKETI NG 0 0 0 0 194. 02 07952 RESEARCH 0 0 0 0 0 194. 03 07953 RESEARCH 0 0 0 0 0	69. 00	06900 ELECTROCARDI OLOGY	O	O		69. 00
69.03 06903 PULMONARY REHAB 0 0 0 0 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 72			-			
71. 00			-			
72. 00 07200 MPLANTABLE DEVICES CHARGED TO 0 596			· ·	- 1		
PATLENTS			· ·			
75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0	72.00			0,0		72.00
76. 00 03020 CANCER CARE CENTER 0 1,190 76. 00 76. 97 07607 CARDIAC REHABILITATION 0 7,326 76. 97 77. 00 07700 ALTOGENEIC HSCT ACQUISITION 0 0 7,326 77. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 000 000 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 78. 00 000 000 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 78. 00 000 000 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	49, 975		
76. 97			0	-1		
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90. 00 09000 CLINIC 0 0 0 0 0 90. 00 91. 00 91. 00 92. 00 09200 0BERCANTION BEDS (NON-DISTINCT PART 0 92. 00 09200 0			-1			
91. 00 09100 EMERGENCY 0 71, 586 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92. 00 09200 OPI 01 D TREATMENT PROGRAM 0 0 0 0 0 0 0 0 0	88. 00	08800 RURAL HEALTH CLINIC	0	68, 715		88. 00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 0 0			l I	- 1		
OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI 01 D TREATMENT PROGRAM O O O SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) O 1,043,119 118. 00 NONREI MBURSABLE COST CENTERS 1190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN O 1,299 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES O 13,427 192. 00 192. 01 19201 PHYSI CI AN OFFICE PRI OR TO RHC CERT O 35,977 192. 01 194. 00 197950 OTHER NRCC O 1,063 194. 00 194. 01 07951 MARKETI NG O 236 194. 01 194. 02 07952 FOUNDATI ON O 361 194. 02 194. 03 07953 RESEARCH O O 0 194. 03 1			l l	71, 586		•
102. 00 10200 OPI 0I D TREATMENT PROGRAM O O SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) O 1,043,119 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN O 1, 299 192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES O 13, 427 192. 01 19201 PHYSI CI AN OFFICE PRI OR TO RHC CERT O 35, 977 192. 01 194. 00 07950 OTHER NRCC O 1, 063 194. 00 194. 01 07951 MARKETI NG O 236 194. 01 194. 02 07952 FOUNDATI ON O 361 194. 02 194. 03 07953 RESEARCH O O 0 194. 03	92.00		0			92.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) 0 1,043,119 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 1,299 190.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 13,427 192.01 19201 PHYSI CI AN OFFICE PRI OR TO RHC CERT 0 35,977 192.01 194.00 07950 OTHER NRCC 0 1,063 194.00 194.01 07951 MARKETI NG 0 236 194.01 194.02 07952 FOUNDATI ON 0 361 194.02 194.03 07953 RESEARCH 0 0 0 194.03 194	102.00		O	0		102.00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 1, 043, 119 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 13, 427 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 13, 427 192. 00 1920 OTHER NRCC 0 1, 063 194. 00 194. 00 1950 OTHER NRCC 0 1, 063 194. 00 194. 01 194. 02 07952 FOUNDATI ON 0 361 194. 02 194. 03 07953 RESEARCH 0 0 0 0 194. 03 194			-1			
NONRE MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 1, 299 190.00 192.00 192.00 192.00 192.01 192.01 192.01 192.01 192.01 192.01 192.01 192.01 192.01 192.01 192.01 193.01 193.01 193.01 193.01 194.00 193.01 194.00 193.01 193.01 193.01 193.01 193.01 193.01 194.01 193.01 193.01 194.02 193.01 193.01 193.01 193.01 194.02 193.01 193.0						
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 1, 299 190. 00 19200 19200 19200 19201	118. 00	3 /	0	1, 043, 119		118. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 192. 01 19201	100.00			1 200		100.00
192. 01 19201 19201 19201 19201 19201 19201 19201 19400 1940						•
194. 00 07950 OTHER NRCC 0 1, 063 194. 00 194. 01 07951 MARKETI NG 0 236 194. 01 194. 02 07952 FOUNDATI ON 0 361 194. 02 194. 03 07953 RESEARCH 0 0 194. 03			l ől			
194. 02 07952 FOUNDATI ON 0 361 194. 02 194. 03 07953 RESEARCH 0 0 0			o			
194. 03 07953 RESEARCH 0 0 194. 03			0			
200. 00 10 055 F001 Adjustillerits 0 0			· ·			
	∠00.00	TOTOSS FOOT AUJUSTINEITES	ı U	U		J200.00

Heal th Finar	ncial Systems	MENDOTA COMMUNI	TY HOSPITAL		In Lieu	u of Form CMS-	2552-10
ALLOCATI ON	OF CAPITAL RELATED COSTS		Provi der CO	CN: 14-1310	Peri od: From 10/01/2022 To 09/30/2023	Worksheet B Part II Date/Time Pre 2/25/2024 7:1	
	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total				
		25. 00	26. 00				
201.00	Negative Cost Centers	0	0				201.00
202.00	TOTAL (sum lines 118 through 201)	0	1, 095, 482				202.00

					rom 10/01/2022 o 09/30/2023	Date/Time Pre	
		CAPI	TAL RELATED CO	OSTS		2/25/2024 7:1	0 pm
	Cost Center Description	BLDG & FIXT	OFFSITE MOBS	MVBLE EQUIP	EMPLOYEE	Reconciliatio	
	cost deliter beserver on	(SQUARE FEET)	(MOB SQUARE	(DOLLAR	BENEFITS	n	
			FEET)	VALUE)	DEPARTMENT (GROSS		
					SALARI ES)		
	GENERAL SERVICE COST CENTERS	1. 00	1. 01	2. 00	4. 00	5A. 01	
1. 00	00100 CAP REL COSTS-BLDG & FLXT	104, 783					1.00
1. 01 2. 00	00101 CAP REL COSTS-OFFSITE MOBS 00200 CAP REL COSTS-MVBLE EQUIP	0	100	328, 324			1. 01 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	141	0	320, 324			4.00
5. 01	01140 BUSI NESS OFFI CE	1, 330	0	108		-8, 116	5. 01
5. 02 5. 03	00550 DATA PROCESSING 00570 ADMITTING	1, 553 820	0	8, 044 101		0	5. 02 5. 03
5. 04	00560 PURCHASING RECEIVING AND STORES	364	0	112		0	5. 04
5. 05 7. 00	00590 OTHER A&G 00700 OPERATION OF PLANT	19, 467 4, 483	0	8, 906 16, 174		0	5. 05 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	474	0	C	16, 081	0	8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	1, 094 2, 721	0	937 8, 981	·	0	9.00
11. 00	01100 CAFETERI A	1, 074	0	0, 701		1	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	355	0	0		l	13.00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	887 299	0	64			16. 00 17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		_		-		
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	15, 277 2, 314	0			l	1
31.00	ANCILLARY SERVICE COST CENTERS	2, 314	0	710	100, 027		31.00
50.00	05000 OPERATING ROOM	4, 371	0		·	0	
51. 00 53. 00	05100 RECOVERY ROOM 05300 ANESTHESI OLOGY	4, 904 129	0	0 12, 108	,	l	51. 00 53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 351	0	23, 740	394, 580	0	54.00
54. 01 54. 02	05401 ULTRASOUND 05402 MAMMOGRAPHY	210 146	0	0 7, 458	-,	0	54. 01 54. 02
56.00	05600 RADI OI SOTOPE	687	0	,, 100		ő	56.00
57. 00 58. 00	05700 CT SCAN 05800 MRI	463 1, 037	0	20, 114		l e	57. 00 58. 00
60.00	06000 LABORATORY	1, 037	0	28, 083	105, 378 755, 126	l e	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	106	0	1, 910		0	63.00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	4, 492 1, 395	0	522 10, 937	· ·		64. 00 65. 00
65. 01	06501 SLEEP LAB	239	0	2, 669	69, 423	0	65. 01
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	2, 094 273	0	1, 801	651, 268 130, 228	l	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	101	0	Ö	41, 167	ő	68.00
69.00	06900 ELECTROCARDI OLOGY	0 117	0	0	0	0	69. 00 69. 01
69. 01 69. 02	O6901 ECHOCARDI OGRAPHY O6902 CARDI OLOGY	102	0	1	4, 983 0	l	
69. 03	06903 PULMONARY REHAB	0	0	O		0	69. 03
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPLANTABLE DEVICES CHARGED TO	2, 797	0	0	0	0	71. 00 72. 00
	PATI ENTS		9				
73. 00 75. 00	07300 DRUGS CHARGED TO PATIENTS 07500 ASC (NON-DISTINCT PART)	791	0	18, 295	240, 510	0	73. 00 75. 00
	03020 CANCER CARE CENTER	218	0	Ö	73, 110	ľ	76.00
76. 97		531	0	2, 130			76. 97
77. 00 78. 00	07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY	0	0		0	0	
	OUTPATIENT SERVICE COST CENTERS						
88. 00 90. 00	08800 RURAL HEALTH CLINIC 09000 CLINIC	8, 391 0	0	5, 176	3, 388, 168	0	
91.00	09100 EMERGENCY	4, 948	0	15, 566	1, 514, 147		
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
102.00	OTHER REIMBURSABLE COST CENTERS 10200 OPIOID TREATMENT PROGRAM	0	0	С	0	0	102.00
	SPECIAL PURPOSE COST CENTERS			I	I		
113. 00 118. 00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	96, 338	0	327, 862	13, 153, 725	-8 116	113. 00 118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	242 3, 260	0 100	1	0 15	-57, 337	190. 00 192. 00
	19200 PHYSICIANS PRIVATE OFFICES	4, 825	0	O		l	192.00
194.00	07950 OTHER NRCC	0	0	462	4, 491	5, 098	194.00
	07951 MARKETI NG 207952 FOUNDATI ON	59 59	0		0	l	194. 01 194. 02
	t t	, 371				,,	

Health Financial Systems	MENDOTA COMMUN	IITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der Co	F	Period: From 10/01/2022		
			Т	o 09/30/2023	Date/Time Pre 2/25/2024 7:1	
	CAP	TAL RELATED CO	OSTS			
Cost Center Description	BLDG & FIXT (SQUARE FEET)	OFFSITE MOBS (MOB SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	Reconciliatio n	
	1.00		2.22	SALARI ES)	54.04	
	1.00	1. 01	2.00	4. 00	5A. 01	
194. 03 07953 RESEARCH	0	0	(0		194. 03
200.00 Cross Foot Adjustments					l .	200. 00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. Part I)	B, 341, 170	0	754, 312	4, 164, 601		202. 00
203.00 Unit cost multiplier (Wkst. B, F	Part I) 3. 255967	0. 000000	2, 297462	0. 248433		203.00
204.00 Cost to be allocated (per Wkst. Part II)				459		204. 00
205.00 Unit cost multiplier (Wkst. B, F	Part			0. 000027		205. 00
206.00 NAHE adjustment amount to be all (per Wkst. B-2)	ocated					206. 00
207.00 NAHE unit cost multiplier (Wkst. Parts III and IV)	D,					207. 00

	ALLOCATION CTATICTION DACIC		D 1 0/	ON 44 4040 D		West states to D. 4	2552-10
0031 7	ALLOCATION - STATISTICAL BASIS		Provi der Co	F	eriod: rom 10/01/2022 o 09/30/2023	Date/Time Pre	pared:
	Cost Center Description	BUSI NESS OFFI CE (ACCUM. COST)	DATA PROCESSI NG (MACHI NE HO URS)	Reconciliatio n	ADMITTING (ACCUM. COST)	2/25/2024 7: 1 PURCHASI NG RECEI VI NG AND STORES (COSTED REQUI S.)	O pm
		5. 01	5. 02	5A. 03	5. 03	5. 04	
	GENERAL SERVICE COST CENTERS	1		Г	T	Г	
1. 00 1. 01 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 17. 00	00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-OFFSITE MOBS 00200 CAP REL COSTS-MYBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 01140 BUSI NESS OFFICE 00550 DATA PROCESSI NG 00570 ADMITTI NG 00560 PURCHASI NG RECEIVING AND STORES 00590 OTHER A&G 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01100 DIETARY 01100 CAFETERIA 01300 NURSI NG ADMINISTRATION 01600 MEDICAL RECORDS & LIBRARY	35, 268, 084 1, 067, 331 2, 902 409, 145 4, 941, 695 1, 470, 202 103, 282 736, 124 218, 725 317, 218 686, 057 59, 687 237, 900	872 0 2 128 0 0 3 0 0 10 0	-2, 903 0 0 0 0 0 0 0 0	411, 688 5, 099, 540 1, 470, 540 103, 306 739, 966 218, 775 317, 291 698, 458 59, 701	938, 984 7, 806 3, 198 0 67, 963 5, 490 11, 477 136 384	5. 05 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 16. 00
30. 00 31. 00	03000 ADULTS & PEDIATRICS	2, 691, 818 279, 701	172 0				1
50. 00 51. 00 53. 00 54. 00 54. 01 54. 02 56. 00 67. 00 63. 00 65. 01 66. 00 67. 00 68. 00 69. 01 69. 02 69. 03 71. 00 72. 00 73. 00 76. 00 76. 00 76. 00 76. 00 77. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05100 RECOVERY ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRASOUND 05402 MAMMOGRAPHY 05600 RADI OI SOTOPE 05700 CT SCAN 05800 MRI 06000 LABORATORY 06300 BLOOD STORING, PROCESSING, & TRANS. 06400 INTRAVENOUS THERAPY 06501 RESPIRATORY THERAPY 06501 SLEEP LAB 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06900 ELECTROCARDI OLOGY 06901 ECHOCARDI OGRAPHY 06902 CARDI OLOGY 06903 PULMONARY REHAB 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 IMPLANTABLE DEVI CES CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07500 ASC (NON-DI STI NCT PART) 03020 CANCER CARE CENTER	279, 701 1, 142, 118 171, 683 48, 365 964, 941 340, 446 178, 308 186, 242 336, 740 152, 489 1, 819, 636 55, 995 458, 829 688, 742 103, 680 872, 279 177, 630 55, 259 0 6, 897 21, 368 0 51, 778 189, 267 1, 393, 100 92, 402 85, 695 0 0	0 0 2 25 67 0 0 0 0 113 0 0 125 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	000000000000000000000000000000000000000	1, 142, 381 174, 171 78, 983 1, 047, 190 340, 524 178, 349 186, 285 336, 817 152, 524 1, 958, 399 56, 008 611, 971 688, 900 103, 704 885, 947 177, 671 55, 272 0 6, 899 21, 373 0 51, 790 189, 311 1, 393, 420 0 92, 423 85, 715 0	167, 160 15, 049 15, 471 10, 731 17, 437 1, 085 1, 569 46, 834 12, 295 89, 008 0 28, 950 50, 886 8, 538 7, 813 904 884 0 303 2, 601 0 0	50. 00 51. 00 53. 00 54. 01 54. 02 56. 00 57. 00 58. 00 60. 00 63. 00 64. 00 65. 01 66. 00 67. 00 68. 00 69. 01 69. 02 69. 03 71. 00 72. 00 73. 00 76. 97 77. 00
88. 00 90. 00 91. 00 92. 00	09000 CLI NI C 09100 EMERGENCY	5, 006, 228 0 2, 458, 520	191 0 23	-5, 241, 220 0 0	0	0	90.00
102.00	0 10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
113. ດເ	SPECIAL PURPOSE COST CENTERS 0 11300 NTEREST EXPENSE						113. 00
118. 00		30, 280, 424	872	-5, 244, 123	25, 043, 270	870, 430	1
192. 00 192. 01 194. 00 194. 02	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 19200 PHYSICIANS' PRIVATE OFFICES 1 19201 PHYSICIAN OFFICE PRIOR TO RHC CERT 0 07950 OTHER NRCC 1 07951 MARKETING 2 07952 FOUNDATION 3 07953 RESEARCH 0 Cross Foot Adjustments	0 10, 633 4, 977, 027 0 0 0	0 0 0 0 0 0	-57, 337 -10, 635 0 5, 098 -214 -43, 062	0 4, 978, 172 0 0 0	0 12, 825 0 22 1	190. 00 192. 00 192. 01 194. 00 194. 01 194. 02 194. 03 200. 00

Heal th	Financial Systems	MENDOTA COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
					From 10/01/2022		
					Го 09/30/2023	Date/Time Pre 2/25/2024 7:1	
	Cost Center Description	BUSI NESS	DATA	Reconciliatio	ADMITTI NG	PURCHASI NG	J
	·	OFFI CE	PROCESSI NG	n	(ACCUM. COST)	RECEIVING AND	
		(ACCUM. COST)	(MACHINE HO			STORES	
			URS)			(COSTED	
						REQUIS.)	
	, , , , , , , , , , , , , , , , , , , ,	5. 01	5. 02	5A. 03	5. 03	5. 04	
201.00	1 1 3						201.00
202.00	1 1	8, 116	1, 067, 576		2, 903	411, 728	202.00
	Part I)						
203.00		0. 000230		•	0. 000097		
204.00	Cost to be allocated (per Wkst. B, Part II)	4, 578	23, 677		2, 902	1, 592	204. 00
205.00	Unit cost multiplier (Wkst. B, Part	0. 000130	27. 152523		0. 000097	0. 001695	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	/ / /						207. 00

Health Financial Systems MENDOTA COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1310 Period: From 10/01/2022 To 09/30/2023 Date/Time Prepared: 2/25/2024 7: 10 pm

				To	09/30/2023	Date/Time Pre 2/25/2024 7:1	
	Cost Center Description	Reconciliatio n	OTHER A&G (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPI NG (HOURS OF SERVICE)	<u> </u>
		FA 05	5.05		LAUNDRY)		
	GENERAL SERVICE COST CENTERS	5A. 05	5. 05	7.00	8. 00	9. 00	
1. 00	00100 CAP REL COSTS-BLDG & FLXT						1.00
1. 01	00101 CAP REL COSTS-OFFSITE MOBS						1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	01140 BUSI NESS OFFI CE						5. 01
5. 02	00550 DATA PROCESSI NG						5. 02
5. 03	00570 ADMITTING						5.03
5. 04 5. 05	00560 PURCHASING RECEIVING AND STORES 00590 OTHER A&G	-5, 103, 448	30, 273, 365				5. 04 5. 05
7. 00	00700 OPERATION OF PLANT	-5, 103, 448	1, 472, 085	1			7.00
8. 00	00800 LAUNDRY & LI NEN SERVI CE	0	103, 316	1	85, 906		8.00
9. 00	00900 HOUSEKEEPI NG	Ö	769, 839	1	0	2, 183	9. 00
10.00	01000 DI ETARY	0	221, 203		Ö	0	10.00
11.00	01100 CAFETERI A	0	322, 354	1, 074	o	24	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	698, 586		0	0	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	59, 875	1	0	27	16.00
17. 00	01700 SOCI AL SERVI CE	0	237, 978	299	0	0	17. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		2 020 015	15 077	22, 020	F20	20.00
30.00	03000 ADULTS & PEDIATRICS	0			22, 028	538	30.00
31. 00	03100 INTENSIVE CARE UNIT ANCILLARY SERVICE COST CENTERS	0	286, 387	2, 314	747	62	31.00
50. 00	05000 OPERATING ROOM	0	1, 215, 789	4, 371	3, 561	137	50.00
51. 00	05100 RECOVERY ROOM	0	180, 787		435	154	51.00
53. 00	05300 ANESTHESI OLOGY	0	85, 775		0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0		1	2, 339	93	54.00
54.01	05401 ULTRASOUND	0	348, 203	210	1, 400	6	54.01
54. 02	05402 MAMMOGRAPHY	0	178, 842	146	1, 127	4	54.02
56.00	05600 RADI OI SOTOPE	0	186, 991	687	776	19	56.00
57. 00	05700 CT SCAN	0	357, 386	1	11, 254	13	57.00
58.00	05800 MRI	0	157, 930		2, 770	29	58.00
60. 00 63. 00	06000 LABORATORY	0	1, 997, 617	1	0	95 0	60.00
64. 00	06300 BLOOD STORING, PROCESSING, & TRANS. 06400 INTRAVENOUS THERAPY	0	56, 013 624, 724		0	91	63. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY	0	711, 280		932	40	65.00
65. 01	06501 SLEEP LAB	0	107, 458		0	0	65. 01
66. 00	06600 PHYSI CAL THERAPY	0	889, 459	1	5, 043	175	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	178, 084		1, 029	23	67.00
68.00	06800 SPEECH PATHOLOGY	0	55, 665	101	o	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
69. 01	06901 ECHOCARDI OGRAPHY	0	7, 033	1	0	0	69. 01
69. 02	06902 CARDI OLOGY	0	22, 515	1	0	0	69. 02
69. 03	06903 PULMONARY REHAB	0	0	0	0	0	69.03
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 I MPLANTABLE DEVICES CHARGED TO	0		'	0	7 0	71. 00 72. 00
72.00	PATIENTS	0	109, 329		٩	U	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	1, 399, 882	791	0	14	73. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	o	0	75. 00
76.00	03020 CANCER CARE CENTER	0	92, 473	218	0	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	86, 122	531	o	0	76. 97
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
00.00	OUTPATIENT SERVICE COST CENTERS	1	F 057 007	0.004		004	00.00
88. 00 90. 00	08800 RURAL HEALTH CLINIC	0	5, 257, 007	8, 391	661	234	88. 00 90. 00
91.00	09000 CLI NI C 09100 EMERGENCY	0	2, 552, 708	4, 948	31, 804	0 307	90.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2, 332, 700	4, 740	31, 604	307	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102.00
	SPECIAL PURPOSE COST CENTERS				'		
113.00	11300 INTEREST EXPENSE						113.00
118.00		-5, 103, 448	25, 153, 402	68, 180	85, 906	2, 092	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	81, 763		0		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	10, 635		0		192.00
	19201 PHYSICIAN OFFICE PRIOR TO RHC CERT 07950 OTHER NRCC	0	4, 984, 279	4, 825 0	0		192. 01 194. 00
	07950 OTHER NRCC 07951 MARKETI NG	5, 098	224	_	O A		194.00
	07951 MARKETTING 07952 FOUNDATION		43, 062	1	٥		194.01
	07953 RESEARCH	0	0 10,302	0	ol O		194. 03
200.00					٦	· ·	200.00
201.00							201. 00

Health Fina	ncial Systems	MENDOTA COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
					From 10/01/2022 Fo 09/30/2023		
	Cost Center Description	Reconciliatio		OPERATION OF		HOUSEKEEPI NG	
		n	(ACCUM. COST)		LINEN SERVICE	(HOURS OF	
				(SQUARE FEET)	,	SERVI CE)	
					LAUNDRY)		
		5A. 05	5. 05	7. 00	8. 00	9. 00	
202. 00	Cost to be allocated (per Wkst. B,		5, 103, 448	1, 720, 24	3 131, 374	924, 179	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)		0. 168579	22. 45021	1. 529276	423. 352726	203. 00
204.00	Cost to be allocated (per Wkst. B,		88, 475	56, 40	2, 217	9, 146	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part		0. 002923	0. 73611	0. 025807	4. 189647	205.00
	[11]						
206. 00	NAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)						
·		•					-

	FINANCIAL SYSTEMS	MENDOTA COMMUNI		CN. 14 1210 D		Waskahaat D 1	
COST	NLLOCATION - STATISTICAL BASIS		Provi der C	F	eriod: rom 10/01/2022 o 09/30/2023		pared:
	Cost Center Description	DI ETARY (MEALS SERVED)	CAFETERI A (FTE' S)	NURSI NG ADMI NI STRATI O N (DI RECT	MEDICAL RECORDS & LIBRARY (TIME SPENT)	2/25/2024 7: 1 SOCIAL SERVICE (TIME SPENT)	O pm
		10. 00	11. 00	NRSI NG HRS) 13.00	16. 00	17. 00	
	GENERAL SERVICE COST CENTERS			ī			
1. 00 1. 01 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 7. 00 8. 00 9. 00 11. 00 13. 00 16. 00 17. 00	00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-OFFSI TE MOBS 00200 CAP REL COSTS-OFFSI TE MOBS 00200 CAP REL COSTS-WBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 01140 BUSINESS OFFI CE 00550 DATA PROCESSI NG 00570 ADMITTI NG 00560 PURCHASI NG RECEIVI NG AND STORES 00590 OTHER A&G 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LINEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMINI STRATI ON 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE INPATI ENT ROUTI NE SERVI CE COST CENTERS	9, 478 0 0 0 0	14, 690 214 0 0	102, 349 0	480	180	1. 00 1. 01 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 16. 00 17. 00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	8, 629 102	2, 305 140			180 0	
50. 00	ANCILLARY SERVICE COST CENTERS	0	500		0	0	
51. 00 53. 00 54. 01 54. 02 56. 00 57. 00 58. 00 60. 00 65. 01 66. 00 67. 00 68. 00 69. 01 69. 02 69. 03 71. 00 72. 00 73. 00 75. 00 76. 00	05100 RECOVERY ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRASOUND 05402 MAMMOGRAPHY 05600 RADI OI SOTOPE 05700 CT SCAN 05800 MRI 06000 LABORATORY 06300 BLOOD STORI NG, PROCESSI NG, & TRANS. 06400 I NTRAVENOUS THERAPY 06501 SLEEP LAB 06600 PHYSI CAL THERAPY 06501 SLEEP LAB 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPECH PATHOLOGY 06901 ECHOCARDI OGRAPHY 06902 CARDI OLOGY 06903 PULMONARY REHAB 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 I MPLANTABLE DEVI CES CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07500 ASC (NON-DI STI NCT PART) 03020 CANCER CARE CENTER	95 0 44 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	133 71 545 8 157 3 244 116 1, 138 0 430 594 104 676 147 54 0 0 0 0 0 2466 0 72	2, 761 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	80 0 8 5 4 4 3 38 9 56 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0	51. 00 53. 00 54. 01 54. 02 56. 00 57. 00 58. 00 60. 00 63. 00 64. 00 65. 01 66. 00 67. 00 68. 00 69. 01 69. 02 69. 03 71. 00 72. 00 73. 00 75. 00 76. 00
	07697 CARDIAC REHABILITATION 07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY 0UTPATIENT SERVICE COST CENTERS	0 0	100 0 0	0	_	0 0	
88. 00 90. 00 91. 00 92. 00	08800 RURAL HEALTH CLINIC 09000 CLINIC 09100 EMERGENCY	0 0 608	2, 689 0 1, 593	0	0	0 0 0	90.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
113. 00 118. 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	9, 478	12, 283	102, 349	480	180	113. 00 118. 00
190. 00 192. 00 192. 01 194. 00 194. 01 194. 02	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFI CES 19201 PHYSI CI AN OFFI CE PRI OR TO RHC CERT 07950 OTHER NRCC 07951 MARKETI NG 207952 FOUNDATI ON 07953 RESEARCH	0 0 0 0 0 0	0 0 2, 402 5 0 0	0	0	0 0 0 0 0	190.00 192.00 192.01 194.00 194.01 194.02 194.03 200.00

Health Fir	nancial Systems	MENDOTA COMMUNI	TY HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provi der C		Period: From 10/01/2022	Worksheet B-1	
					Го 09/30/2023	Date/Time Pre 2/25/2024 7:1	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	MEDI CAL	SOCI AL	
		(MEALS	(FTE'S)	ADMI NI STRATI O	RECORDS &	SERVI CE	
		SERVED)		N	LI BRARY	(TIME SPENT)	
				(DI RECT	(TIME SPENT)		
				NRSING HRS)			
		10. 00	11. 00	13.00	16.00	17. 00	
201.00	Negative Cost Centers						201.00
202. 00	Cost to be allocated (per Wkst. B, Part I)	319, 580	410, 968	830, 310	101, 313	284, 809	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	33. 718084	27. 976038	8. 11253	211. 068750	1, 582. 272222	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	32, 204	5, 428	3, 974	3, 991	1, 944	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	3. 397763	0. 369503	0. 038828	8. 314583	10. 800000	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems	MENDOTA COMMUN	ITY HOSPITAL		Inlie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	INC. VEG 17. COMMON	Provider Co		Period: From 10/01/2022	Worksheet C	pared:
		Title	XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	

			Title	XVIII	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	oost center beserretten	(from Wkst.	Adj.	l lotal oosts	Di sal I owance	10141 00313	
		B, Part I,	Auj.		Di Sai i Owance		
		col. 26)					
		1.00	2.00	3.00	4. 00	5. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
	33000 ADULTS & PEDIATRICS	5, 088, 256		5, 088, 256	0	0	30.00
	03100 INTENSIVE CARE UNIT	444, 986		444, 986			31.00
	NCILLARY SERVICE COST CENTERS	444, 900		444, 900		U	31.00
	05000 OPERATING ROOM	1 (00 (0)		1 (00 (0)	0	0	FO 00
		1, 680, 686		1, 680, 686			50.00
	D5100 RECOVERY ROOM	433, 430		433, 430			51.00
	D5300 ANESTHESI OLOGY	105, 117		105, 117			53.00
	05400 RADI OLOGY-DI AGNOSTI C	1, 365, 942		1, 365, 942		1	54.00
	05401 ULTRASOUND	417, 578		417, 578			54. 01
	05402 MAMMOGRAPHY	220, 921		220, 921	0		54.02
56.00	05600 RADI 01 S0T0PE	243, 885		243, 885	0	0	56.00
57.00 0	05700 CT SCAN	465, 589		465, 589	0	0	57.00
58.00 0	05800 MRI	229, 493		229, 493	0	0	58. 00
60.00	06000 LABORATORY	2, 458, 480		2, 458, 480	0	0	60.00
	06300 BLOOD STORING, PROCESSING, & TRANS.	67, 836		67, 836		0	63.00
	06400 I NTRAVENOUS THERAPY	881, 440	ŀ	881, 440			64.00
	06500 RESPIRATORY THERAPY	897, 482	0		_		65.00
	06501 SLEEP LAB	133, 849	1			•	65. 01
	06600 PHYSI CAL THERAPY	1, 197, 890		1, 197, 890			66.00
			0	229, 657			67.00
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	229, 657	0				68.00
		68, 827	0	68, 827			
	06900 ELECTROCARDI OLOGY	0	l	0			69.00
	06901 ECHOCARDI OGRAPHY	11, 696		11, 696			69. 01
	06902 CARDI OLOGY	28, 601		28, 601	0		69. 02
1	06903 PULMONARY REHAB	0	l	0			69. 03
1	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	126, 283		126, 283		1	71.00
72.00 0	07200 IMPLANTABLE DEVICES CHARGED TO	221, 246		221, 246	0	0	72.00
	PATI ENTS						
73.00 0	07300 DRUGS CHARGED TO PATIENTS	1, 707, 871		1, 707, 871	0	0	73.00
75. 00 C	07500 ASC (NON-DISTINCT PART)	0		0	0	0	75. 00
76. 00 C	03020 CANCER CARE CENTER	114, 970		114, 970	0	0	76. 00
76. 97 C	07697 CARDI AC REHABI LI TATI ON	115, 359		115, 359	0	0	76. 97
77. 00 C	07700 ALLOGENEIC HSCT ACQUISITION	0	l	1 0		0	77.00
	07800 CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
	OUTPATIENT SERVICE COST CENTERS	_		_	_		
	08800 RURAL HEALTH CLINIC	6, 506, 901		6, 506, 901	0	0	88. 00
	09000 CLI NI C	0,000,701		0			90.00
	09100 EMERGENCY	3, 634, 004	l	3, 634, 004			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	997, 403		997, 403	0	0	92.00
	THER REIMBURSABLE COST CENTERS	777, 403		777, 403		l 0	72.00
	10200 OPLOLD TREATMENT PROGRAM	0		0		0	102.00
	SPECIAL PURPOSE COST CENTERS]0			102.00
	1300 INTEREST EXPENSE						113. 00
200.00	Subtotal (see instructions)	30, 095, 678	0	30, 095, 678	0		200.00
		1	l e				
201.00	Less Observation Beds	997, 403	l e	997, 403			201.00
202.00	Total (see instructions)	29, 098, 275	0	29, 098, 275	0	l 0	202. 00

Health Financial Systems	MENDOTA COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-1310	Period: Worksheet C From 10/01/2022 Part I
		To 09/30/2023 Date/Time Prepared:

					To 09/30/2023	Date/Time Pre 2/25/2024 7:1	pared:
			Title	xVIII	Hospi tal	Cost	<u>o p</u>
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. (Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			T	- [
30.00	03000 ADULTS & PEDIATRICS	2, 897, 049		2, 897, 04			30.00
31.00	03100 NTENSI VE CARE UNI T	143, 548		143, 54	8		31.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	105, 166	2, 629, 987	2 725 15	3 0. 614476	0. 000000	50.00
50.00	05100 RECOVERY ROOM	9, 658	2, 629, 987 535, 607			0. 000000	
53. 00	05300 ANESTHESI OLOGY	80, 667	1, 443, 565	•		0. 000000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	159, 950	3, 615, 911			0. 000000	1
54. 01	05401 ULTRASOUND	80, 726	2, 499, 850			0. 000000	
54. 02	05402 MAMMOGRAPHY	3, 937	1, 501, 245			0. 000000	
56. 00	05600 RADI OI SOTOPE	30, 428	1, 223, 229			0. 000000	1
57. 00	05700 CT SCAN	689, 720	16, 021, 606			0. 000000	
58. 00	05800 MRI	122, 119	4, 252, 885			0. 000000	1
60.00	06000 LABORATORY	1, 698, 352	17, 859, 536			0. 000000	
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	60, 830	86, 577			0.000000	
64.00	06400 I NTRAVENOUS THERAPY	418	926, 147	926, 56	0. 951299	0.000000	64.00
65.00	06500 RESPIRATORY THERAPY	1, 061, 967	701, 936	1, 763, 90	0. 508805	0.000000	65.00
65. 01	06501 SLEEP LAB	0	667, 249	667, 24	9 0. 200598	0.000000	65. 01
66.00	06600 PHYSI CAL THERAPY	267, 324	3, 644, 291	3, 911, 61	0. 306239	0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	75, 274	721, 459	796, 73	0. 288248	0. 000000	67.00
68. 00	06800 SPEECH PATHOLOGY	9, 522	130, 901	140, 42		0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	0	0		0. 000000	0. 000000	
69. 01	06901 ECHOCARDI OGRAPHY	251, 882	2, 057, 068			0. 000000	1
69. 02	06902 CARDI OLOGY	87, 864	1, 636, 642			0. 000000	
69. 03	06903 PULMONARY REHAB	0	0	1	0. 000000	0. 000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	362	77, 500	•		0. 000000	
72.00	07200 IMPLANTABLE DEVICES CHARGED TO	0	2, 242, 177	2, 242, 17	7 0. 098675	0. 000000	72.00
70.00	PATIENTS	4 000 74/	/ 050 047	0.470.07	0 000047	0.00000	70.00
73. 00 75. 00	07300 DRUGS CHARGED TO PATIENTS	1, 920, 716	6, 250, 247	8, 170, 96		0.000000	
76. 00	07500 ASC (NON-DISTINCT PART) 03020 CANCER CARE CENTER	0	U F 3F0	E 25	0. 000000 0 21. 489720	0. 000000 0. 000000	1
76. 00	07697 CARDI AC REHABI LI TATI ON		5, 350 229, 352			0. 000000	1
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	229, 332		0. 302478	0. 000000	1
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0.00000	0. 000000	1
70.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>		L	0. 000000	0.000000	70.00
88. 00	08800 RURAL HEALTH CLINIC	0	7, 655, 278	7, 655, 27	8		88. 00
90.00	09000 CLI NI C	0	0		0. 000000	0. 000000	
91. 00	09100 EMERGENCY	346, 889	10, 277, 221	10, 624, 11		0. 000000	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	121, 993	816, 999			0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS			•			1
102.00	10200 OPIOID TREATMENT PROGRAM	0	0		0		102.00
	SPECIAL PURPOSE COST CENTERS						1
	11300 INTEREST EXPENSE						113.00
200.00	1 /	10, 226, 361	89, 709, 815	99, 936, 17	6		200.00
201.00		10.00/ 5::	00 700 -:-		,		201.00
202.00	Total (see instructions)	10, 226, 361	89, 709, 815	99, 936, 17	6		202. 00

Health Financial Systems	MENDOTA COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-131	From 10/01/2022	Worksheet C Part I Date/Time Prepared: 2/25/2024 7:10 pm

				2/25/2024 7:10 pm
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 000000			50.00
51. 00 05100 RECOVERY ROOM	0. 000000			51.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
54. 01 05401 ULTRASOUND	0. 000000			54. 01
54. 02 05402 MAMMOGRAPHY	0. 000000			54. 02
56. 00 05600 RADI 0I SOTOPE	0. 000000			56.00
57.00 05700 CT SCAN	0. 000000			57.00
58. 00 05800 MRI	0. 000000			58.00
60. 00 06000 LABORATORY	0. 000000			60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 000000			63.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000			64.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65.00
65. 01 06501 SLEEP LAB	0. 000000			65. 01
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
69. 01 06901 ECHOCARDI OGRAPHY	0. 000000			69. 01
69. 02 06902 CARDI OLOGY	0. 000000			69. 02
69. 03 06903 PULMONARY REHAB	0. 000000			69. 03
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71.00
72. 00 07200 I MPLANTABLE DEVICES CHARGED TO	0. 000000			72.00
PATIENTS	0.00000			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
75. 00 07500 ASC (NON-DISTINCT PART)	0. 000000			75. 00
76. 00 03020 CANCER CARE CENTER	0. 000000			76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000			78. 00
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC				88.00
90. 00 09000 CLI NI C	0. 000000			90.00
91. 00 09100 EMERGENCY	0. 000000			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92.00
OTHER REIMBURSABLE COST CENTERS	1 2. 22.200			121 00
102. 00 10200 OPI OI D TREATMENT PROGRAM				102.00
SPECIAL PURPOSE COST CENTERS				1321 00
113. 00 11300 NTEREST EXPENSE				113.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202. 00
	1			1=32.00

Health Financial Systems	MENDOTA COMMUNITY	HOSPI TAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT AN	NCILLARY SERVICE CAPITAL COSTS	Provider CCN: 14-1310	Peri od:	Worksheet D

From 10/01/2022 | Part II To 09/30/2023 | Date/Time Prepared: 2/25/2024 7:10 pm Title XVIII Hospi tal Cost Total Charges Capital Costs Cost Center Description Capi tal Ratio of Cost Inpati ent to Charges (column 3 x Related Cost (from Wkst. Program (from Wkst. C, Part I, (col. 1 ÷ Charges column 4) B, Part II, col. 8) col. 2) col. 26) 1. 00 2.00 4. 00 5. 00 3.00 ANCILLARY SERVICE COST CENTERS 50 00 50 00 05000 OPERATING ROOM 201.738 2, 735, 153 0.073757 6,969 514 05100 RECOVERY ROOM 22, 027 545, 265 0.040397 774 51.00 51.00 05300 ANESTHESI OLOGY 0.019242 6, 354 53.00 29, 329 1, 524, 232 122 53.00 73, 938 05400 RADI OLOGY-DI AGNOSTI C 0.019582 54.00 3, 775, 861 52,034 1,019 54.00 54.01 05401 ULTRASOUND 2,070 2, 580, 576 0.000802 28, 608 23 54.01 54.02 05402 MAMMOGRAPHY 18, 421 1, 505, 182 0.012238 3,063 37 54.02 56.00 05600 RADI OI SOTOPE 3, 461 1, 253, 657 0.002761 6, 405 18 56.00 05700 CT SCAN 171, 099 57 00 50, 016 16, 711, 326 0.002993 512 57.00 58.00 05800 MRI 4, 970 4, 375, 004 0.001136 56, 331 64 58.00 60.00 06000 LABORATORY 82, 463 19, 557, 888 0.004216 582, 699 2, 457 60.00 147, 407 41, 240 1, 395 06300 BLOOD STORING, PROCESSING, & TRANS. 4, 987 0.033832 63.00 63.00 06400 I NTRAVENOUS THERAPY 25,069 926, 565 64.00 0.027056 340 64.00 65.00 06500 RESPIRATORY THERAPY 33, 442 1, 763, 903 0.018959 386, 080 7,320 65.00 65.01 06501 SLEEP LAB 7, 477 667, 249 0.011206 0 65.01 06600 PHYSI CAL THERAPY 17.163 3, 911, 615 0.004388 66.00 48,690 214 66.00 67.00 06700 OCCUPATI ONAL THERAPY 1,834 796, 733 0.002302 18, 127 42 67.00 06800 SPEECH PATHOLOGY 0.004273 68.00 600 140, 423 5, 702 24 68.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 69.00 0 496 2, 308, 950 69.01 06901 ECHOCARDI OGRAPHY 0.000215 150, 372 32 69.01 69.02 06902 CARDI OLOGY 18, 476 1, 724, 506 0.010714 30, 224 324 69.02 06903 PULMONARY REHAB 69.03 0.000000 0 69.03 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 11 358 77, 862 0.145873 0 Ω 71 00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO 596 2, 242, 177 0.000266 0 0 72.00 PATI ENTS 73.00 07300 DRUGS CHARGED TO PATIENTS 49, 975 8, 170, 963 0.006116 73.00 566, 115 3, 462 07500 ASC (NON-DISTINCT PART) 0.000000 75.00 0 75.00 03020 CANCER CARE CENTER 1.190 5, 350 0.222430 76.00 0 0 76.00 76.97 07697 CARDIAC REHABILITATION 7, 326 229, 352 0.031942 0 0 76.97 07700 ALLOGENEIC HSCT ACQUISITION 77.00 77 00 0.000000 0 0 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0 78.00 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 68, 715 7, 655, 278 0.008976 0 88.00 0 90.00 09000 CLI NI C 0.000000 0 0 90.00 8, 962 91. 00 09100 EMERGENCY 71.586 10, 624, 110 0.006738 91.00 60 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 43, 386 938, 992 0.046205 9.990 462 92.00 852, 109 200.00 Total (lines 50 through 199) 96, 895, 579 2, 180, 178 18, 141 200. 00

Health Financial Systems	MENDOTA COMMUNITY	/ HOSPITAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCI LLARY SERVI CE OTHER PASS	Provi der CCN: 14-1310	Peri od: From 10/01/2022 To 09/30/2023	Worksheet D Part IV Date/Time Prepared:

					То	09/30/2023	Date/Time Pre 2/25/2024 7:1	
			Title	XVIII		Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Α	Allied Health	Allied Health	
		Anestheti st	Program	Program	P	Post-Stepdown		
		Cost	Post-Stepdown			Adjustments		
			Adjustments					
	T	1. 00	2A	2. 00		3A	3. 00	
	ANCILLARY SERVICE COST CENTERS			Г				
	05000 OPERATING ROOM	0	0		0	0	0	50.00
51. 00	05100 RECOVERY ROOM	0	0		0	0	0	51.00
53. 00	05300 ANESTHESI OLOGY	0	0		0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.00
54. 01	05401 ULTRASOUND	0	0		0	0	0	54. 01
54. 02	05402 MAMMOGRAPHY	0	0		0	0	0	54. 02
56. 00	05600 RADI OI SOTOPE	0	0		0	0	0	56.00
57.00	05700 CT SCAN	0	0		0	0	0	57.00
58. 00	05800 MRI	0	0		0	0	0	58.00
60.00	06000 LABORATORY	0	0		0	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		0	0	0	63.00
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
65. 01	06501 SLEEP LAB	0	0		0	0	0	65. 01
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
69.00	06900 ELECTROCARDI OLOGY	0	0		0	0	0	69. 00
69. 01	06901 ECHOCARDI OGRAPHY	0	0		0	0	0	69. 01
69. 02	06902 CARDI OLOGY	0	0		0	0	0	69. 02
69. 03	06903 PULMONARY REHAB	0	0		0	0	0	69. 03
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	0	71.00
72. 00	07200 IMPLANTABLE DEVICES CHARGED TO	0	0		0	0	0	72.00
70.00	PATIENTS						0	70.00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	73.00
	07500 ASC (NON-DISTINCT PART)	0	0		0	U	0	75.00
	03020 CANCER CARE CENTER	0	0		0	0	0	76.00
	07697 CARDI AC REHABI LI TATI ON	0	0		0	0	0	76. 97
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0	0		0	0	0	78. 00
88. 00	08800 RURAL HEALTH CLINIC		0		0	ol	0	88. 00
90.00	09000 CLINIC		0		0	0	0	90.00
	09100 EMERGENCY		0		0	0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		U		0	٩	0	91.00
200.00	1 1		0		0	О	- 1	200.00
200.00	/ Total (Tilles 50 till ough 177)	١	U	I	U	Ч	U ₁	200.00

Health Financial Systems	MENDOTA COMMUNITY	Y HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIEN THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 14-1310	Peri od: From 10/01/2022 To 09/30/2023	Worksheet D Part IV Date/Time Prepared:

			1	o 09/30/2023	Date/Time Pre 2/25/2024 7:1	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
· ·	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)	,	(see	
					instructions)	
	4. 00	5. 00	6.00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	C	2, 735, 153	0.000000	50.00
51.00 05100 RECOVERY ROOM	0	0		545, 265	0.000000	51.00
53. 00 05300 ANESTHESI OLOGY	0	0		1, 524, 232	0. 000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	1			0. 000000	54.00
54. 01 05401 ULTRASOUND	0	١		2, 580, 576	0. 000000	54. 01
54. 02 05402 MAMMOGRAPHY	0			1, 505, 182	0. 000000	54. 02
56. 00 05600 RADI 0I SOTOPE	0				0.000000	56.00
57. 00 05700 CT SCAN	0	0	1			
	0	0	0		0. 000000	57.00
58. 00 05800 MRI	0	0	0	.,,	0. 000000	58.00
60. 00 06000 LABORATORY	0	0		19, 557, 888	0. 000000	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	147, 407	0. 000000	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0	. = -,	0. 000000	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0	0	1, 763, 903	0.000000	65.00
65. 01 06501 SLEEP LAB	0	0	0	667, 249	0.000000	65. 01
66. 00 06600 PHYSI CAL THERAPY	0	0	0	3, 911, 615	0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	796, 733	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	140, 423	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0.000000	69.00
69. 01 06901 ECHOCARDI OGRAPHY	0	0	0	2, 308, 950	0.000000	69. 01
69. 02 06902 CARDI OLOGY	0	0		1, 724, 506	0.000000	69. 02
69. 03 06903 PULMONARY REHAB	0	l o	l 0		0.000000	69. 03
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		77, 862	0.000000	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0	0		2, 242, 177	0.000000	72.00
PATI ENTS	_	_		_,_,_,		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	1	8, 170, 963	0. 000000	73. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0	1	1	0, 1, 0, 700	0. 000000	75. 00
76. 00 03020 CANCER CARE CENTER	0	١		5, 350	0. 000000	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0			229, 352	0. 000000	76. 97
77. 00 07700 ALLOGENEIC HSCT ACQUISITION					0.000000	77.00
				-		
78.00 O7800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0	0		l U	0. 000000	78. 00
		0	1 0	7 (55 070	0.000000	00 00
	0			,	0.000000	88. 00
90. 00 09000 CLI NI C	0	0	1		0. 000000	90.00
91. 00 09100 EMERGENCY	0	0	0	,	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	,	0. 000000	92.00
200.00 Total (lines 50 through 199)	0	0	0	96, 895, 579		200. 00

Health Financial Systems	MENDOTA COMMUNITY	Y HOSPI TAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 14-1310	Period: Worksheet D From 10/01/2022 Part IV To 09/30/2023 Date/Time Prepared:

	656.16			Т	o 09/30/2023	Date/Time Pre 2/25/2024 7:1	
			Title	XVIII	Hospi tal	Cost	О рііі
	Cost Center Description	Outpati ent	Inpatient	Inpati ent	Outpati ent	Outpati ent	
	555 55mts. 5555. Pt. 5	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷	g	Costs (col. 8	g	Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11.00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 000000	6, 969	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0. 000000	774	0	0	0	51.00
53.00	05300 ANESTHESI OLOGY	0. 000000	6, 354	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	52, 034	0	0	0	54.00
54.01	05401 ULTRASOUND	0. 000000	28, 608	0	0	0	54.01
54.02	05402 MAMMOGRAPHY	0. 000000	3, 063	0	0	0	54.02
56.00	05600 RADI 01 SOTOPE	0. 000000	6, 405	0	0	0	56.00
57.00	05700 CT SCAN	0. 000000	171, 099	0	0	0	57.00
58.00	05800 MRI	0. 000000	56, 331	0	0	0	58.00
60.00	06000 LABORATORY	0. 000000	582, 699	0	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0. 000000	41, 240	0	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	340	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0. 000000	386, 080	0	0	0	65.00
65. 01	06501 SLEEP LAB	0. 000000	0	0	0	0	65. 01
66.00	06600 PHYSI CAL THERAPY	0. 000000	48, 690	0	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	18, 127	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	5, 702	0	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	0	0	0	0	69.00
69. 01	06901 ECHOCARDI OGRAPHY	0. 000000	150, 372	0	0	0	69. 01
69. 02	06902 CARDI OLOGY	0. 000000	30, 224	0	0	0	69. 02
69. 03	06903 PULMONARY REHAB	0. 000000	0	0	0	0	69. 03
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0	0	0	0	71.00
72. 00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0. 000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	566, 115	0	0	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0. 000000	0	0	0	0	75.00
76.00	03020 CANCER CARE CENTER	0. 000000	0	0	0	0	76.00
76. 97	07697 CARDI AC REHABILI TATI ON	0. 000000	0	0	0	0	76. 97
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0	0	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0	0	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0	0	0	0	88. 00
90.00	09000 CLI NI C	0. 000000	0	0	0	0	90.00
91. 00	09100 EMERGENCY	0. 000000	8, 962	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	9, 990		_	0	72.00
200.00	Total (lines 50 through 199)		2, 180, 178	0	0	0	200. 00

				rom 10/01/2022 o 09/30/2023	Part V Date/Time Pre	
		T: +1 o	xVIII	Hospi tal	2/25/2024 7:1 Cost	0 pm
		11116	Charges	поѕрі таі	Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Servi ces	
cost center bescription	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
	From	Services (see		Services Not	(366 11131.)	
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.	11131.	Ded. & Coins.	Ded. & Coins.		
	9		(see inst.)	(see inst.)		
	1. 00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 614476	0	490, 582	2 0	0	50.00
51. 00 05100 RECOVERY ROOM	0. 794898	0	94, 478	0	0	51.00
53. 00 05300 ANESTHESI OLOGY	0. 068964	0			0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 361756	0			0	54.00
54. 01 05401 ULTRASOUND	0. 161816	0			0	54. 01
54. 02 05402 MAMMOGRAPHY	0. 146774	0	1		0	54. 02
56. 00 05600 RADI 0I SOTOPE	0. 194539	0	,		0	56.00
57. 00 05700 CT SCAN	0. 027861	ĺ	,		0	57.00
58. 00 05800 MRI	0. 052455	ĺ			0	58.00
60. 00 06000 LABORATORY	0. 125703	0			0	60.00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 460195	0	-,		0	63.00
64. 00 06400 NTRAVENOUS THERAPY	0. 951299	0	,		0	64.00
65. 00 06500 RESPIRATORY THERAPY	0. 508805	0	1		0	65.00
65. 01 06501 SLEEP LAB	0. 200598	ĺ			o O	65. 01
66. 00 06600 PHYSI CAL THERAPY	0. 306239	ĺ			0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 288248				0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 490141	ĺ		_	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	ĺ	'	_	0	69.00
69. 01 06901 ECHOCARDI OGRAPHY	0. 005066	ĺ	-		0	69. 01
69. 02 06902 CARDI OLOGY	0. 016585	0			0	69. 02
69. 03 06903 PULMONARY REHAB	0. 000000	0		0	0	69. 03
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1. 621882	0	1		0	71.00
72. 00 07200 IMPLANTABLE DEVICES CHARGED TO	0. 098675	0	1		0	72.00
PATIENTS	0.070073	Ĭ	300, 400		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 209017	0	2, 709, 196	4, 808	0	73. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0. 000000	0			0	75. 00
76. 00 03020 CANCER CARE CENTER	21. 489720	0	1	_	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 502978	0			0	76. 97
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	ĺ			0	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0			0	78.00
OUTPATIENT SERVICE COST CENTERS	0. 000000		1	,		70.00
88. 00 08800 RURAL HEALTH CLINIC						88. 00
90. 00 09000 CLINI C	0. 000000	0		0	0	
91. 00 09100 EMERGENCY	0. 342053		1	_	0	70.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 062206	0			0	1
200.00 Subtotal (see instructions)	1. 002200	0			_	200.00
201.00 Less PBP Clinic Lab. Services-Program		Ĭ	20, 273, 327			201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	26, 293, 529	5, 136	n	202.00
1 1 2 2 3 3 4 (11112 = 22)	1	'	, ., _, , , , , , , , , , , , , , , , ,	2, .00	,	

Health Financial Systems	MENDOTA COMMUNIT	Y HOSPITAL	In Lieu	of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 14-1310	From 10/01/2022	Worksheet D Part V Date/Time Prepared:

			-	To 09/30/2023	Date/Time Pre 2/25/2024 7:1	epared:
		Title	: XVIII	Hospi tal	Cost	то ріп
	Cos		7,,,,,,	noop: tui	3001	
Cost Center Description	Cost	Cost				
occi conton pocon per on	Rei mbursed	Rei mbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7. 00	1			
ANCILLARY SERVICE COST CENTERS	0.00	7.00	l			
50. 00 05000 OPERATING ROOM	301, 451	0				50.00
51. 00 05100 RECOVERY ROOM	75, 100	0	1			51.00
53. 00 05300 ANESTHESI OLOGY	16, 133	0	•			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	378, 260	0	1			54.00
		0	i e			54.00
	113, 226	0	•			54.01
	40, 567		•			
56. 00 05600 RADI 01 SOTOPE	96, 687	0	I .			56.00
57. 00 05700 CT SCAN	158, 730	0	1			57.00
58. 00 05800 MRI	70, 202	0	1			58. 00
60. 00 06000 LABORATORY	728, 572	0				60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	21, 765	0	1			63.00
64.00 06400 INTRAVENOUS THERAPY	317, 325	0	1			64.00
65. 00 06500 RESPIRATORY THERAPY	116, 351	0				65.00
65. 01 06501 SLEEP LAB	39, 128	0				65. 01
66. 00 06600 PHYSI CAL THERAPY	385, 719	0	1			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	22, 397	0				67.00
68.00 06800 SPEECH PATHOLOGY	10, 667	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
69. 01 06901 ECHOCARDI OGRAPHY	4, 577	0				69. 01
69. 02 06902 CARDI OLOGY	9, 839	0				69. 02
69.03 06903 PULMONARY REHAB	0	0				69.03
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	14, 396	0				71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	36, 359	0				72.00
PATI ENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	566, 268	1, 005				73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0				75.00
76. 00 03020 CANCER CARE CENTER	35, 888	0				76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	59, 984	0				76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0				77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	1			78. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC						88. 00
90. 00 09000 CLI NI C	0	0				90.00
91. 00 09100 EMERGENCY	989, 424	112	•			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	386, 505		1			92.00
200.00 Subtotal (see instructions)	4, 995, 520	1, 117	1			200.00
201.00 Less PBP Clinic Lab. Services-Program	4, 773, 320	1, 117				201.00
Only Charges						201.00
202.00 Net Charges (line 200 - line 201)	4, 995, 520	1, 117				202. 00
202.00	1, 773, 320	1, (1)	I			1-02.00

Health Financial Systems	MENDOTA COMMUNITY	′ HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1310	Peri od: From 10/01/2022	Worksheet D-1	
			To 09/30/2023	Date/Time Pre 2/25/2024 7:1	
		Title XVIII	Hospi tal	Cost	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					
I NPATI ENT DAYS					1
1.00 Inpatient days (including private room da	ys and swing-bed day	s, excluding newborn)		3, 106	1.00
2.00 Inpatient days (including private room da	ys, excluding swing-	bed and newborn days)		2, 044	2.00
		\ c			

	Cost Center Description		
	DADT I ALL DOOM DED COMPONENTS	1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS		
1. 00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3, 106	1. 00
2. 00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2, 044	2. 00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	2,011	3. 00
0.00	do not complete this line.	ĭ	0.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1, 465	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	222	5.00
	reporting period		
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	667	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	43	7.00
	reporting period		
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	130	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 and	753	9. 00
10.00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	214	10.00
10. 00	through December 31 of the cost reporting period (see instructions)	214	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	388	11. 00
11.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	300	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
12.00	through December 31 of the cost reporting period	ĭ	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	ol	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	o	14.00
15.00	Total nursery days (title V or XIX only)	o	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17.00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		18. 00
40.00	reporting period	004 54	40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	201. 56	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	208. 70	20. 00
20.00	reporting period	200. 70	20.00
21. 00	Total general inpatient routine service cost (see instructions)	5, 088, 256	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line		22. 00
22.00	5 x line 17)	Ĭ	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	o	23.00
	x line 18)		
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	8, 667	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	27, 131	25.00
	x line 20)		
26.00	Total swing-bed cost (see instructions)	1, 567, 207	26.00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3, 521, 049	27. 00
20.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	0	20.00
28. 00		0	28. 00 29. 00
30. 00	Private room charges (excluding swing-bed charges) 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)	0.00000	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		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, 722. 62	38.00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	1, 297, 133	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	1, 297, 133	41.00

	reporting period		
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	667	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	43	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	130	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and	753	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	214	10. 00
11. 00	through December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	388	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
	through December 31 of the cost reporting period		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13. 00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	o	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18. 00
19. 00	Medicald rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	201. 56	19. 00
20. 00	Medicald 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)	5, 088, 256	21.00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	8, 667	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	27, 131	25. 00
26. 00	Total swing-bed cost (see instructions)	1, 567, 207	26 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3, 521, 049	
	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	
32.00	Average private room per diem charge (line 29 ÷ line 3)		32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		35.00
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line	0 3, 521, 049	36.00
37.00	27 minus line 36)	3, 321, 049	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 722. 62	38 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	1, 722. 62	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	1, 297, 133	40.00
	Total Program general inpatient routine service cost (line 39 + line 40)	1, 297, 133	
		, 211, 100	. ==

COMPUT	Financial Systems ATION OF INPATIENT OPERATING COST	MENDOTA COMMUNI	Provider C		Period: From 10/01/2022 To 09/30/2023	u of Form CMS-2 Worksheet D-1 Date/Time Pre 2/25/2024 7:1	pared:
			Title	e XVIII	Hospi tal	Cost	о рііі
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1. 00	2. 00	3.00	4.00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42.00
43. 00 44. 00		444, 986	62	7, 177. 1	9 25	179, 430	43. 00 44. 00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00
	·					1. 00	
48. 00	Program inpatient ancillary service cost (Wk					483, 391	48. 00
48. 01 49. 00	Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines				, column 1)	0 1, 959, 954	
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, su	m of Parts I and	0	50.00
51. 00	 Pass through costs applicable to Program inp	atient ancillar	ry services (f	rom Wkst. D,	sum of Parts II	0	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				0	52.00
53.00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		elated, non-ph	ysician anest	hetist, and	0	53.00
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00
55. 00	Target amount per discharge						55.00
55. 01	Permanent adjustment amount per discharge					0.00	
55. 02	Adjustment amount per discharge (contractor					0.00	
56. 00 57. 00	Target amount (line 54 x sum of lines 55, 55 Difference between adjusted inpatient operat			line 56 minus	line 53)	0	56.00 57.00
58. 00	Bonus payment (see instructions)	ring cost and te	inger amount (TTTIC 30 III TIGS	11110 33)	ő	58.00
59. 00	Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket)		n the cost rep	orting period	endi ng 1996,	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, market basket)		om prior year	cost report,	updated by the	0. 00	60.00
61. 00	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x	ser of 50% of t	the amount by	which operati	ng costs (line	0	61.00
62. 00	enter zero. (see instructions) Relief payment (see instructions)					0	
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ıcti ons)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	ember 31 of th	e cost report	ing period (See	368, 641	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	per 31 of the	cost reportin	g period (See	668, 377	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (line	64 plus line	65)(title XVI	<pre>II only); for</pre>	1, 037, 018	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31	of the cost r	eporting period	0	67.00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after [December 31 of	the cost rep	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N		`			0	69. 00
70.00	Skilled nursing facility/other nursing facil	ity/ICF/IID rou	ıtine service	cost (line 37)		70.00
71. 00 72. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line	,	ine /U ÷ line	2)			71. 00 72. 00
73.00	Medically necessary private room cost applic		n (line 14 x l	ine 35)			73.00
74. 00	Total Program general inpatient routine serv		•				74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from	Worksheet B,	Part II, column		75.00
76.00	Per diem capital related costs (line 75 ÷ li	. *					76.00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu	· .					77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces		rovi der recor	ds)			79.00
80.00	Total Program routine service costs for comp	arison to the c			nus line 79)		80.00
81.00	Inpatient routine service cost per diem limi						81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (•				82. 00 83. 00
84. 00	Program inpatient ancillary services (see in		/				84.00
85.00	Utilization review - physician compensation	(see instruction					85.00
86. 00	Total Program inpatient operating costs (sum		rough 85)				86.00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					579	87. 00
	Adjusted general inpatient routine cost per	•	1:00 2)			1, 722. 63	

Health Financial Systems	MENDOTA COMMUN	TY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 10/01/2022 To 09/30/2023		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions				997, 403	89.00
Cost Center Description	Cost	Routine Cost (from line 21)	col umn 1 ÷ col umn 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1. 00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST		•			
90.00 Capital -related cost	221, 334	5, 088, 256	0. 04349	997, 403	43, 386	90.00
91.00 Nursing Program cost	0	5, 088, 256	0. 00000	997, 403	0	91.00
92.00 Allied health cost	0	5, 088, 256	0. 00000	997, 403	0	92.00
93.00 All other Medical Education	0	5, 088, 256	0. 00000	997, 403	0	93.00

Health Fi	nancial Systems	MENDOTA COMMUNITY HOSPITA				In lie	u of Form CMS-2	2552_10
	T ANCILLARY SERVICE COST APPORTIONMENT			CN: 14-1310	Pe	eri od:	Worksheet D-3	
THE ATT LIN	THIS ELIKT SERVICE GOST ANTORTH CHIMENT	11 ovi dei	•	314. 11 1010		om 10/01/2022	Worksheet B o	
					To		Date/Time Pre	pared:
							2/25/2024 7:1	0 pm
		Ti	tl e	XVIII	Ц,	Hospi tal	Cost	
	Cost Center Description			Ratio of Cos		I npati ent	Inpatient	
				To Charges	•	Program	Program Costs	
						Charges	(col. 1 x	
				1.00	_	2.00	col. 2)	
LN	IDATI ENT DOUTINE CEDVICE COST CENTERS			1. 00		2. 00	3. 00	
	IPATIENT ROUTINE SERVICE COST CENTERS					001 044		20.00
	3000 ADULTS & PEDIATRICS					881, 944		30.00
	3100 INTENSIVE CARE UNIT					57, 786		31.00
	ICILLARY SERVICE COST CENTERS			0 (144	7/	(0(0	4 202	F0 00
				0. 6144		6, 969	4, 282	50.00
	5100 RECOVERY ROOM			0. 7948		774	615	51.00
	300 ANESTHESI OLOGY			0. 0689		6, 354	438	53.00
	7400 RADI OLOGY-DI AGNOSTI C			0. 3617		52, 034	18, 824	54.00
	5401 ULTRASOUND			0. 1618		28, 608	4, 629	54. 01
	5402 MAMMOGRAPHY			0. 1467	74	3, 063	450	54.02
	6600 RADI OI SOTOPE			0. 1945	39	6, 405	1, 246	56.00
57.00 05	5700 CT SCAN			0. 0278	61	171, 099	4, 767	57.00
58. 00 05	5800 MRI			0. 0524	55	56, 331	2, 955	58. 00
60.00 06	5000 LABORATORY			0. 1257	03	582, 699	73, 247	60.00
63. 00 06	300 BLOOD STORING, PROCESSING, & TRANS.			0. 4601	95	41, 240	18, 978	63.00
	5400 INTRAVENOUS THERAPY			0. 9512	99	340	323	64.00
	5500 RESPI RATORY THERAPY			0. 5088		386, 080	196, 439	65.00
	5501 SLEEP LAB			0. 2005		0	0	65. 01
	6600 PHYSI CAL THERAPY			0. 3062		48, 690	14, 911	66. 00
	5700 OCCUPATI ONAL THERAPY			0. 2882		18, 127	5, 225	67.00
	5800 SPEECH PATHOLOGY			0. 4901		5, 702	2, 795	68.00
	5900 ELECTROCARDI OLOGY			0. 0000		0, 702	2, 773	69.00
	5901 ECHOCARDI OGRAPHY			0.0050		150, 372	762	69. 01
	5901 CARDI OLOGY			0.0030		30, 224	501	69. 02
	5902 CARDI OLOGI 5903 PULMONARY REHAB			0.0163		30, 224	0	69.02
	l .					-	-	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	NTC		1. 6218		0	0	71.00
	7200 IMPLANTABLE DEVICES CHARGED TO PATIE	NIS		0. 0986		0	0	72.00
	7300 DRUGS CHARGED TO PATIENTS			0. 2090		566, 115	118, 328	73. 00
	7500 ASC (NON-DISTINCT PART)			0. 0000		0	0	75. 00
	3020 CANCER CARE CENTER			21. 4897		0	0	76. 00
	7697 CARDIAC REHABILITATION			0. 5029		0	0	76. 97
	7700 ALLOGENEIC HSCT ACQUISITION			0. 0000		0	0	77. 00
	7800 CAR T-CELL IMMUNOTHERAPY			0. 0000	00	0	0	78. 00
	ITPATIENT SERVICE COST CENTERS							
	8800 RURAL HEALTH CLINIC			0.0000			0	88. 00
	POOO CLI NI C			0.0000	00	0	0	90.00
91.00 09	P100 EMERGENCY			0. 3420	53	8, 962	3, 065	91.00
92.00 09	9200 OBSERVATION BEDS (NON-DISTINCT PART			1. 0622	06	9, 990	10, 611	92.00
200.00	Total (sum of lines 50 through 94 an	d 96 through 98)				2, 180, 178	483, 391	200. 00
201.00	Less PBP Clinic Laboratory Services-	Program only charges (line 6	1)			o		201. 00
202.00	Net charges (line 200 minus line 201)				2, 180, 178		202. 00
,		-		•				•

PATIENT ANCILLARY SERVICE	COST APPORTIONMENT	Provi der C	CN: 14-1310	Peri od:	Worksheet D-3	
		Component	CCN: 14-Z310	From 10/01/2022 To 09/30/2023	Date/Time Pre 2/25/2024 7:1	
		Title	: XVIII	Swing Beds - SNF		<u> </u>
Cost Center Des	cription		Ratio of Cos To Charges	st Inpatient	Inpatient Program Costs (col. 1 x	
			1.00	2.00	col. 2) 3.00	
INPATIENT ROUTINE SER	VICE COST CENTERS				2.22	
. 00 03000 ADULTS & PEDIAT	RLCS					30
. 00 03100 INTENSIVE CARE	UNI T					31
ANCILLARY SERVICE COS	T CENTERS					
. 00 05000 OPERATING ROOM			0. 6144		1, 803	50
.00 05100 RECOVERY ROOM			0. 7948		0	51
. 00 05300 ANESTHESI OLOGY			0. 0689		0	53
. 00 05400 RADI OLOGY-DI AGN	OSTI C		0. 3617	· ·	1, 813	
01 05401 ULTRASOUND			0. 1618		600	
. 02 05402 MAMMOGRAPHY			0. 1467		43	54
. 00 05600 RADI 01 SOTOPE			0. 1945		1, 246	
00 05700 CT SCAN			0. 0278		643	
00 05800 MRI			0. 0524		456	
00 06000 LABORATORY	DDOGEOGLUG & TRANS		0. 1257		17, 328	
00 06300 BLOOD STORING,	•		0. 4601	· ·	8, 848	
00 06400 I NTRAVENOUS THE			0. 9512		0	6
00 06500 RESPIRATORY THE	RAPY		0. 5088		63, 918	
01 06501 SLEEP LAB 00 06600 PHYSI CAL THERAP	.,		0. 2005		0	65
00 06700 OCCUPATIONAL TH			0. 3062 0. 2882		33, 641 6, 752	67
00 06800 SPEECH PATHOLOG			0. 2882		771	68
00 06900 ELECTROCARDI OLO			0. 0000	·	0	69
01 06901 ECHOCARDI OGRAPH			0.0050		21	6
02 06902 CARDI OLOGY	•		0. 0165	·	58	
03 06903 PULMONARY REHAB			0. 0000	·	0	
00 07100 MEDICAL SUPPLIE	S CHARGED TO PATIENT		1. 6218		Ö	7
1	ICES CHARGED TO PATIENTS		0. 0986		0	72
00 07300 DRUGS CHARGED T			0. 2090		64, 248	
00 07500 ASC (NON-DISTIN			0.0000		0.72.0	75
00 03020 CANCER CARE CEN			21. 4897		Ō	76
97 07697 CARDI AC REHABI L			0. 5029		0	76
00 07700 ALLOGENEIC HSCT	ACQUI SI TI ON		0.0000	00 0	0	7
00 07800 CAR T-CELL IMMU	NOTHERAPY		0.0000	00 0	0	78
OUTPATIENT SERVICE CO						
00 08800 RURAL HEALTH CL			0.0000	00	0	88
. 00 09000 CLI NI C			0.0000	00 0	0	90
. 00 09100 EMERGENCY			0. 3420		0	9
.00 09200 OBSERVATION BED			1.0622	06 1, 470		
, ,	ines 50 through 94 and 96 through	,		784, 264	203, 750	200
	Laboratory Services-Program only	charges (line 61)		0		201
2.00 Net charges (li	ne 200 minus line 201)			784, 264		202

Health Financial Systems	MENDOTA COMMUNITY HOSPITAL		In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CC	CCN: 14-1310		Worksheet E Part B Date/Time Prepared: 2/25/2024 7:10 pm

	Title XVI	11	Hospi tal	2/25/2024 7:1 Cost	0 pm
			110061 tai		
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1. 00	Medical and other services (see instructions)			4, 996, 637	1.00
2. 00	Medical and other services reimbursed under OPPS (see instructions)			0	2.00
3. 00 4. 00	OPPS or REH payments			0	3. 00 4. 00
4. 00	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			0	4.00
5. 00	Enter the hospital specific payment to cost ratio (see instructions)			0.000	
6. 00	Line 2 times line 5			0	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8. 00 9. 00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, lin	ne 200		0	8. 00 9. 00
10.00	Organ acquisitions	10 200		Ö	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			4, 996, 637	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
12 00	Reasonable charges Ancillary service charges			0	12.00
13. 00				Ö	
14.00				0	14.00
45.00	Customary charges		and the same through the		1 4 5 00
15. 00 16. 00	Aggregate amount actually collected from patients liable for payment for servamounts that would have been realized from patients liable for payment for servamounts.			0	
10.00	had such payment been made in accordance with 42 CFR §413.13(e)	or vi ccs (on a chargebasi's	Ĭ	10.00
17. 00				0. 000000	17.00
18.00	Total customary charges (see instructions)		44) (0	
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 explinstructions)	kceeds II	ne 11) (see	0	19.00
20.00		xceeds Li	ne 18) (see	0	20.00
	instructions)		, ,		
21.00	ů ,			5, 046, 603	
22. 00 23. 00	· · · · · · · · · · · · · · · · · · ·			0	
24. 00				0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	· · · · · · · · · · · · · · · · · · ·			45, 975	
26. 00 27. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of			3, 968, 492 1, 032, 136	1
27.00	instructions)	111163 22	z anu zsj (see	1, 032, 130	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0	28.00
28. 50	REH facility payment amount				28. 50
29. 00 30. 00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27, 28, 28.50 and 29)			0 1, 032, 136	
31.00				1, 032, 130	
32.00	Subtotal (line 30 minus line 31)			1, 032, 117	32.00
22.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			1 0	1 22 00
	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0 311, 321	
35.00				202, 359	
	Allowable bad debts for dual eligible beneficiaries (see instructions)			284, 071	
	Subtotal (see instructions)			1, 234, 476	
38. 00 39. 00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
39. 75				0	39. 75
39. 97	Demonstration payment adjustment amount before sequestration			0	
39. 98	Partial or full credits received from manufacturers for replaced devices (see	e instru	ctions)	0	39. 98
39. 99 40. 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 1, 234, 476	39. 99 40. 00
40. 01	Sequestration adjustment (see instructions)			24, 690	
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
40. 03	Sequestration adjustment-PARHM pass-throughs			0.475	40.03
41. 00 41. 01				2, 473, 162	41. 00 41. 0
42. 00	Interim payments-PARHM Tentative settlement (for contractors use only)			0	
42. 01	Tentative settlement-PARHM (for contractor use only)			I	42.0
43.00	Balance due provider/program (see instructions)			-1, 263, 376	
43. 01	Balance due provider/program-PARHM (see instructions)	1 - 1	chanter 1	4/ 550	43.0
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pul §115.2	J. 15-2,	cnapter I,	46, 550	44.0
	TO BE COMPLETED BY CONTRACTOR			·	1
	Original outlier amount (see instructions)			0	
91.00	, , , , , , , , , , , , , , , , , , , ,			0	
92. 00 93. 00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	92.00 93.00
	Total (sum of lines 91 and 93)			0	
	•			•	•

Health Financial Systems	MENDOTA COMMUNITY	HOSPI TAL		In Lieu	of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 14-		From 10/01/2022	Worksheet E Part B Date/Time Pre 2/25/2024 7:1	
		Title XVIII	l	Hospi tal	Cost	
					1. 00	
MEDICARE PART B ANCILLARY COSTS						
200.00 Part B Combined Billed Days					0	200.00

Peri od: Worksheet E-1 From 10/01/2022 Part I To 09/30/2023 Date/Time Prepared: 2/25/2024 7:10 pm

					2/25/2024 7: 10) pm
			XVIII	Hospi tal	Cost	
		I npati en	t 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		1, 611, 34	8	2, 788, 019	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
3.00	amount based on subsequent revision of the interim rate					3.00
	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	05/16/2023	80, 03		0	3. 01
3. 02		09/12/2023	13, 63		0	3. 02
3. 03				0	0	3. 03
3. 04				0	0	3.04
3. 05	Dravi dan ta Dragnam			0	0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM			0 05/16/2023	244, 997	3. 50
3. 51	ADJUSTIMENTS TO PROGRAM			0 09/12/2023	69, 860	3.50
3. 52				0	0	3. 52
3. 53				o o	l ol	3. 53
3.54				O	0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		93, 66	7	-314, 857	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 705, 01	5	2, 473, 162	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
3.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5.02				0	0	5. 02
5. 03				0	0	5. 03
F F0	Provider to Program TENTATIVE TO PROGRAM			ما	1 0	F F0
5. 50 5. 51	TENTATIVE TO PROGRAM			0		5. 50 5. 51
5. 51				0		5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0		5. 99
0. , ,	5. 50-5. 98)					0. , ,
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVI DER			0	0	6. 01
6. 02	SETTLEMENT TO PROGRAM		49, 43		1, 263, 376	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 655, 58		1, 209, 786	7. 00
				Contractor	NPR Date	
		,)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		J	1.00	2.00	8. 00
5. 00	Name of contractor			1	1 1	0.00

		Component	CCN. 14-2310 11	0 0773072023	2/25/2024 7: 10	
		Title	XVIII Sv	ving Beds - SNF	Cost	•
		Inpatien	t 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		1, 192, 606		0	1. 00
2.00	Interim payments payable on individual bills, either		0		o	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	05/16/2023	41, 988		0	3. 01
3. 02		09/12/2023	11, 189		0	3. 02
3. 03			0		0	3. 03
3. 04			0		0	3. 04
3. 05			0		0	3. 05
	Provider to Program	ı	_		_	
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3. 53			0		0	3. 53
3.54			50 177		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		53, 177		0	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 245, 783		0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
F 00	TO BE COMPLETED BY CONTRACTOR	I				F 00
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	TENTATI VE TO PROVIDER		0			5. 02
5. 02			0		0	5. 02
5. 05	Provider to Program	L	<u> </u>			5.05
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		l ol	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		0		0	6. 01
6.02	SETTLEMENT TO PROGRAM		30, 018		0	6.02
7.00	Total Medicare program liability (see instructions)		1, 215, 765		0	7.00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
	lu a a c)	1. 00	2. 00	
8.00	Name of Contractor	I .			1	8.00

Heal th	Financial Systems MENDOTA COMMUNIT	Y HOSPITAL	In Lie	u of Form CMS-	2552-10	
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 14-1310 Period:					
	From 10/01/2022 F					
			To 09/30/2023	Date/Time Pre 2/25/2024 7:1		
		Title XVIII	Hospi tal	Cost	Орш	
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	l				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 lin	e 14		1.00	
2.00	Medicare days (see instructions)				2.00	
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00	
4.00	Total inpatient days (see instructions)				4.00	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I				6.00	
7. 00	CAH only - The reasonable cost incurred for the purchase of o	certified HIT technology	Wkst. S-2, Pt. I		7.00	
	line 168					
8. 00	Calculation of the HIT incentive payment (see instructions)				8. 00	
9. 00	Sequestration adjustment amount (see instructions)				9. 00 10. 00	
10. 00	10.00 Calculation of the HIT incentive payment after sequestration (see instructions)					
	I NPATI ENT HOSPI TAL SERVI CES UNDER THE I PPS & CAH		T			
	Initial/interim HIT payment adjustment (see instructions)				30.00	
	Other Adjustment (specify)				31.00	
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instructio	ns)		32.00	

Health Financial Systems	MENDOTA COMMUNITY	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provi der CCN: 14-1310	Peri od: From 10/01/2022	Worksheet E-2	
		Component CCN: 14-Z310			
		Title XVIII	Swing Beds - SNF	Cost	
	_		Part A	Part B	

		Component CCN: 14-Z310	10 09/30/2023	Date/IIme Pre 2/25/2024 7:1	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
I/C	COMPLITATION OF NET COST OF COVERED SERVICES		1.00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES Inpatient routine services - swing bed-SNF (see instructions)		1, 047, 388	0	1.
	Inpatient routine services - swing bed-NF (see instructions)		1,047,300	O	2.
	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part	t A, and sum of Wkst. D,	205, 788	0	
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swir	ng-bed pass-through, see			
	instructions)				
1	Nursing and allied health payment-PARHM (see instructions)	,			3.
	Per diem cost for interns and residents not in approved teachi		0. 00	4.	
	instructions) Program days		602	0	5.
	Interns and residents not in approved teaching program (see in	nstructions)	002	0	
	Utilization review - physician compensation - SNF optional me	•	0	O	7.
	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		1, 253, 176	0	
00	Primary payer payments (see instructions)		0	0	9.
0. 00	Subtotal (line 8 minus line 9)		1, 253, 176	0	10.
. 00	Deductibles billed to program patients (exclude amounts applic	cable to physician	0	0	11.
- 1	professional services)				
	Subtotal (line 10 minus line 11)		1, 253, 176	0	
	Coinsurance billed to program patients (from provider records)	(exclude coinsurance	15, 329	0	13.
1	for physician professional services) 80% of Part B costs (line 12 x 80%)			0	14.
	Subtotal (see instructions)		1, 237, 847	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		1, 237, 047	0	
	Pioneer ACO demonstration payment adjustment (see instructions	5)		O	16
	Rural community hospital demonstration project (§410A Demonstr	•	0		16
	adjustment (see instructions)				
. 99	Demonstration payment adjustment amount before sequestration		0	0	16
	Allowable bad debts (see instructions)		4, 200	0	
	Adjusted reimbursable bad debts (see instructions)		2, 730	0	
1	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)	4, 200	0	
1	Total (see instructions)		1, 240, 577	0	
1	Sequestration adjustment (see instructions)		24, 812	0	
1	Demonstration payment adjustment amount after sequestration)		U	0	19
	Sequestration adjustment-PARHM pass-throughs Sequestration for non-claims based amounts (see instructions)			0	
	Interim payments		1, 245, 783	0	
	Interim payments-PARHM		1,210,700	O	20
	Tentative settlement (for contractor use only)		0	0	
	Tentative settlement-PARHM (for contractor use only)				21
. 00	Balance due provider/program (line 19 minus lines 19.01, 19.02	2, 19.25, 20, and 21)	-30, 018	0	22
. 01	Balance due provider/program-PARHM (see instructions)				22
	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2,	0	0	23
	chapter 1, §115.2				1
	Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per				1200
	Century Cures Act? Enter "Y" for yes or "N" for no.	Tod under the 21st			200
	Cost Reimbursement				
	Medicare swing-bed SNF inpatient routine service costs (from N	Wkst. D-1. Pt. II. line			201
	66 (title XVIII hospital))	,			
2.00	Medicare swing-bed SNF inpatient ancillary service costs (from	n Wkst. D-3, col. 3, lin	e		202
	200 (title XVIII swing-bed SNF))				
- 1	Total (sum of lines 201 and 202)				203
	Medicare swing-bed SNF discharges (see instructions)		<u> </u>		204
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-year demons	tration	
	period) Medicare swing-bed SNF target amount				205
1	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti	mes line 204)			206
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				1200
	Program reimbursement under the §410A Demonstration (see insti				207
1	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2	•	1		208
	and 3)	, , , , , , , , , , , , , , , , , , , ,			
9. 00	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	ctions)			209
	Reserved for future use				210
	Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare swing-bed SNF PPS payment (line 2				
					215

Health Financial Systems	MENDOTA COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-1	From 10/01/2022	Worksheet E-3 Part V Date/Time Prepared: 2/25/2024 7:10 pm
	Title XVIII	Hospi tal	Cost

		T		2/25/2024 /: 1	U pm
		Title XVIII	Hospi tal	Cost	
				1.00	
	DADT V. CALOURATION OF BELMBURGENENT CETTLEMENT FOR MEDICARE	DART A CERVILORS COST	DELMBURGEMENT	1. 00	
1 00	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - CUST	KETMBURSEMENT	1 050 054	1 00
1.00	Inpatient services			1, 959, 954	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction	ons)		0	2.00
3. 00	Organ acquisition			0	3. 00
3. 01	Cellular therapy acquisition cost (see instructions)			0	3. 01
4.00	Subtotal (sum of lines 1 through 3.01)			1, 959, 954	4.00
5.00	Primary payer payments			0	5. 00
6. 00	Total cost (line 4 less line 5). For CAH (see instructions)			1, 979, 554	6. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges			_	
7. 00	Routine service charges			0	7. 00
8.00	Ancillary service charges			0	8. 00
9. 00	Organ acquisition charges, net of revenue			0	9. 00
10.00	Total reasonable charges			0	10.00
	Customary charges				
11. 00	Aggregate amount actually collected from patients liable for patients and actually collected from patients liable for patients.			0	
12.00	Amounts that would have been realized from patients liable for		n 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	
14. 00	Total customary charges (see instructions)			0	14.00
15. 00	Excess of customary charges over reasonable cost (complete on	ly if line 14 exceeds li	ne 6) (see	0	15.00
	instructions)				
16. 00	Excess of reasonable cost over customary charges (complete on	ly if line 6 exceeds lin	e 14) (see	0	16.00
	instructions)				
17. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	17. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			_	
18. 00	Direct graduate medical education payments (from Worksheet E-	4, line 49)		-	18.00
19. 00	Cost of covered services (sum of lines 6, 17 and 18)			1, 979, 554	
20.00	Deductibles (exclude professional component)			303, 367	
21. 00	Excess reasonable cost (from line 16)			0	21.00
22. 00	Subtotal (line 19 minus line 20 and 21)			1, 676, 187	
23.00	Coinsurance			0	
24. 00	Subtotal (line 22 minus line 23)			1, 676, 187	
25.00	Allowable bad debts (exclude bad debts for professional servi	ces) (see instructions)		20, 277	
26. 00	Adjusted reimbursable bad debts (see instructions)			13, 180	
27. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		16, 515	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)			1, 689, 367	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29. 00
29. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)		0	
29. 98	Recovery of accelerated depreciation.			0	29. 98
29. 99	Demonstration payment adjustment amount before sequestration			0	
30.00	Subtotal (see instructions)			1, 689, 367	
30. 01	Sequestration adjustment (see instructions)			33, 787	
30. 02	Demonstration payment adjustment amount after sequestration			0	30. 02
30. 03	Sequestration adjustment-PARHM				30. 03
31.00	Interim payments			1, 705, 015	31.00
31. 01	Interim payments-PARHM				31. 01
32.00	Tentative settlement (for contractor use only)			0	32.00
32. 01	Tentative settlement-PARHM (for contractor use only)				32. 01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.0)			-49, 435	
33. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, mi	inus lines 30.03, 31.01,	and 32.01)		33. 01
34.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	chapter 1,	1, 860	34.00
	§115. 2				

Health Financial Systems

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

Provider CCN: 14-1310

Peri od: Worksheet G From 10/01/2022 To 09/30/2023 Date/Ti me Prepared: 2/25/2024 7:10 pm

		General Fund	Speci fi c	Endowment	Plant Fund	O pili
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	3. 00	4. 00	
1.00	Cash on hand in banks	-10, 928, 029		0	0	
2.00	Temporary investments	0	0	0	0	2.00
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	14, 128, 042	0	0	0	3. 00 4. 00
5. 00	Other recei vable	14, 120, 042	0	0	0	5.00
6. 00	Allowances for uncollectible notes and accounts receivable	-8, 062, 869	0	0	0	6.00
7.00	Inventory	512, 016	0	0	0	7. 00
8. 00	Prepai d expenses	157 000	0	0	0	8.00
9. 00 10. 00	Other current assets Due from other funds	157, 802 151, 896	0	0	0	9. 00 10. 00
11. 00	Total current assets (sum of lines 1-10)	-4, 041, 142		0	0	1
	FIXED ASSETS					
12.00	Land	2, 427, 000		0	0	
13.00	Land improvements	2, 117, 935		0	0	
14.00	Accumulated depreciation Buildings	-1, 235, 446 19, 184, 923		0	0	
16. 00	Accumul ated depreciation	-7, 507, 014	0	0	0	16.00
17. 00		0	0	0	0	17. 00
18.00	· ·	0	0	0	0	18.00
19. 00		0	0	0	0	19.00
20.00	· ·	0	0	0	0	20.00
21.00	Automobiles and trucks Accumulated depreciation	0	0	0	0	21. 00 22. 00
23. 00	•	14, 975, 090		0	0	23.00
	Accumulated depreciation	-12, 106, 700	0	0	0	24.00
25.00	Mi nor equi pment depreci abl e	0	0	0	0	25.00
26.00	•	0	0	0	0	26. 00
27. 00		0	0	0	0	
28. 00 29. 00	Accumul ated depreciation Minor equipment-nondepreciable	228, 029	0	0	0	28. 00 29. 00
	Total fixed assets (sum of lines 12-29)	18, 083, 817	0	0		30.00
00.00	OTHER ASSETS	10,000,017	<u> </u>	<u> </u>	<u> </u>	00.00
31.00	Investments	241, 309	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	
33.00	Due from owners/officers	0	0	0	0	
34. 00 35. 00	Other assets Total other assets (sum of lines 31-34)	12, 749, 334 12, 990, 643		0	0	34. 00 35. 00
36.00		27, 033, 318		0	0	36.00
	CURRENT LIABILITIES					
37. 00	Accounts payable	660, 633		0	0	
38.00	1 3 1	150, 681	0	0	0	
39. 00 40. 00	3	0	0	0	0	39. 00 40. 00
41. 00	, , , , , , , , , , , , , , , , , , , ,	Ö	0	0	0	ł
42.00	Accel erated payments	0		-		42.00
43.00		2, 631, 567	0	0	0	
	Other current liabilities	64, 460		0	0	
45.00	Total current liabilities (sum of lines 37 thru 44)	3, 507, 341	0	0	0	45.00
46. 00	LONG TERM LIABILITIES Mortgage payable	0	0	0	0	46.00
47. 00	Notes payable	Ö	1	0	0	
48. 00	Unsecured Loans	0	0	0	0	
49.00	Other long term liabilities	24, 538	0	0	0	
50.00	Total long term liabilities (sum of lines 46 thru 49)	24, 538		0	0	
51. 00	Total liabilities (sum of lines 45 and 50)	3, 531, 879	0	0	0	51.00
52. 00	CAPITAL ACCOUNTS General fund balance	23, 501, 439				52.00
53.00	Specific purpose fund	23, 301, 437	0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion					58. 00
59. 00	Total fund balances (sum of lines 52 thru 58)	23, 501, 439	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	27, 033, 318		0	0	
	[59]					

Provi der CCN: 14-1310

				T	0 09/30/2023	Date/Time Pre 2/25/2024 7:1	
		General	Fund	Speci al Pu	rpose Fund	Endowment Fund	
		1. 00	2.00	3. 00	4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) TEMP RESTRICTED FUNDS	100, 614 0 0 0	19, 068, 672 4, 332, 153 23, 400, 825	0 0 0 0 0	0	0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0 0 0 0 0	100, 614 23, 501, 439 0 23, 501, 439	0 0 0 0 0		0 0 0 0 0	10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
		6. 00	7. 00	8. 00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) TEMP RESTRICTED FUNDS Total additions (sum of line 4-9)	0	0 0 0 0 0	0			1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0	0 0 0 0 0	0			11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

Health Financial Systems ME STATEMENT OF PATLENT REVENUES AND OPERATING EXPENSES Provi der CCN: 14-1310

			10 09/30/2023	2/25/2024 7:1	
	Cost Center Description	Inpatient	Outpati ent	Total	O pili
		1.00	2.00	3. 00	
	PART I - PATIENT REVENUES			•	
	General Inpatient Routine Services				
1.00	Hospi tal	1, 801, 50	1	1, 801, 501	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVI DER - I RF				3.00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF	917, 08	3	917, 083	5. 00
6.00	Swing bed - NF	178, 46	5	178, 465	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, 897, 04	.9	2, 897, 049	10.00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT	143, 54	.8	143, 548	
12.00	CORONARY CARE UNIT				12.00
13.00	BURN I NTENSI VE CARE UNI T				13.00
14.00	SURGI CAL INTENSI VE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16. 00	Total intensive care type inpatient hospital services (sum of lines	143, 54	.8	143, 548	16. 00
47.00	11-15)	0.040.50	.=	0.040.507	47.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3, 040, 59		3, 040, 597	17.00
18. 00 19. 00	Ancillary services	6, 716, 88			18. 00 19. 00
	Outpatient services	468, 88			
20. 00 21. 00	RURAL HEALTH CLINIC		0 7, 655, 278 0 0		20. 00 21. 00
22. 00	FEDERALLY QUALIFIED HEALTH CENTER HOME HEALTH AGENCY		0	0	22.00
23. 00	AMBULANCE SERVI CES				23. 00
24. 00	CMHC				24.00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE				26.00
27. 00	PROFESSIONAL FEES	34	.0 650, 696	651, 036	27.00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	10, 226, 70			
20.00	G-3, line 1)	10, 220, 70	70,000,011	100, 700, 010	20.00
	PART II - OPERATING EXPENSES				
29. 00			37, 256, 142		29. 00
30.00	ADD (SPECIFY)		0		30.00
31.00			0		31.00
32.00			0		32.00
33.00			0		33. 00
34.00			0		34.00
35.00			0		35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)		0		37.00
38. 00			0		38. 00
39. 00			0		39. 00
40.00			0		40.00
41.00			0		41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfe	er	37, 256, 142		43.00
	to Wkst. G-3, line 4)	I		I	

	Financial Systems MENDOTA COMMUNITY			u of Form CMS-2	
STATE	MENT OF REVENUES AND EXPENSES	Provider CCN: 14-1310	Peri od: From 10/01/2022	Worksheet G-3	
			To 09/30/2023	Date/Time Pre	pared:
				2/25/2024 7:1	O pm
		>		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin			103, 783, 315	1.00
2. 00	Less contractual allowances and discounts on patients' accoun	its		64, 175, 302	2.00
3. 00	Net patient revenues (line 1 minus line 2)			39, 608, 013	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		37, 256, 142	4.00
5. 00	Net income from service to patients (line 3 minus line 4)			2, 351, 871	5. 00
,	OTHER I NCOME			10.015	,
6.00	Contributions, donations, bequests, etc			69, 845	
7.00	Income from investments			22, 769	
8.00	Revenues from telephone and other miscellaneous communication	Services		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase 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			7/ 121	
14.00	Revenue from meals sold to employees and guests			76, 121	14.00
	Revenue from rental of living quarters	han nationto		0	15. 00 16. 00
	Revenue from sale of medical and surgical supplies to other t Revenue from sale of drugs to other than patients	nan patrents		- 1	17.00
	Revenue from sale of medical records and abstracts			318, 251	18.00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0 840	
20.00	Revenue from gifts, flowers, coffee shops, and canteen			60, 034	
21. 00	Rental of vending machines			624	20.00
21.00	Rental of hospital space			40, 310	
23. 00	· '			40, 310	22.00
24. 00	Governmental appropriations OTHER INCOME				
	COVID-19 PHE Funding			1, 776, 700 0	24.00
	Total other income (sum of lines 6-24)			2, 365, 494	
	, ,				
	Total (line 5 plus line 25) EQUITY TRANSFERS			4, 717, 365 385, 212	
	Total other expenses (sum of line 27 and subscripts)			385, 212	
	Net income (or loss) for the period (line 26 minus line 28)				
∠9. 00	liver income (or ross) for the period (fine 20 illinus fine 28)		I	4, 332, 153	29.00

NALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 14-1310	Peri od: From 10/01/2022	Worksheet M-1	
			Component	CCN: 14-8535	To 09/30/2023	Date/Time Pre 2/25/2024 7:1	
					RHC I	Cost	
		Compensation	Other Costs		1 Reclassificat	Recl assi fi ed	
				+ col . 2)	i ons	Tri al Bal ance	
						(col. 3 +	
	•	1. 00	2. 00	3. 00	4. 00	col . 4) 5.00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3.00	4.00	3.00	
. 00	Physi ci an	1, 272, 178	0	1, 272, 1	78 -13, 481	1, 258, 697	1.0
2. 00	Physician Assistant	110, 859	0		· ·	105, 254	2.0
3. 00	Nurse Practitioner	550, 241	0	550, 2	-1, 599	548, 642	3.0
1. 00	Visiting Nurse	0	0		0 0	0	4. C
5. 00	Other Nurse	1, 163, 009	0	1, 163, 0	901	1, 163, 910	5.0
6. 00	Clinical Psychologist	0	0		0 0	0	6.0
7. 00	Clinical Social Worker	0	0		0	0	
3. 00	Laboratory Techni ci an	0	0		0	0	
0.00	Other Facility Health Care Staff Costs	0	0		0 0	0	
0.00	Subtotal (sum of lines 1 through 9)	3, 096, 287	0	3, 096, 2	-19, 784	3, 076, 503	
1.00	Physician Services Under Agreement	0	0		0	0	
2.00	Physician Supervision Under Agreement	0	0		0 0	0	
3. 00 4. 00	Other Costs Under Agreement Subtotal (sum of lines 11 through 13)	0	0		0	0	
5. 00	Medical Supplies	0	311, 372	311, 3	72 0	311, 372	
6. 00	Transportation (Health Care Staff)	0	311, 372	311, 3	0 0	0	1
7. 00	Depreciation-Medical Equipment	0	0		0 0	0	
8. 00	Professional Liability Insurance	0	8, 973	8, 9	73 0	8, 973	
9. 00	Other Health Care Costs	Ö	0	-, .	0 0	0	1
20.00	Allowable GME Costs						20. (
1.00	Subtotal (sum of lines 15 through 20)	0	320, 345	320, 3	45 0	320, 345	21.
22.00	Total Cost of Health Care Services (sum of	3, 096, 287	320, 345	3, 416, 6	32 -19, 784	3, 396, 848	22. (
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES	-1					
23.00	Pharmacy	0	0		0 0	0	
4. 00	Dental	0	0		0 0	0	
5. 00	Optometry Telehealth	0	0		0 0 26, 742	0 26, 742	
5. 01		0	0		0 20, 742	26, 742	
26.00	All other nonreimbursable costs	0	0		0 0	0	
27.00	Nonallowable GME costs	U	U		0	U	27.
8. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 26, 742	26, 742	
.0. 00	through 27)	ŏ	0		20, 142	20, 142	20.0
	FACILITY OVERHEAD				<u> </u>		1
9. 00	Facility Costs	0	72, 957	72, 9	57 -35, 395	37, 562	29. (
0. 00	Administrative Costs	283, 570	1, 413, 657	1, 697, 2	-764, 640	932, 587	30.
1.00	Total Facility Overhead (sum of lines 29 and	283, 570	1, 486, 614	1, 770, 1	-800, 035	970, 149	31. (
	30)						
32.00	Total facility costs (sum of lines 22, 28	3, 379, 857	1, 806, 959	5, 186, 8	16 - 793, 077	4, 393, 739	32. (

Health Financial Systems	MENDOTA COMMUN	JITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der	CCN: 14-1310	Peri od:	Worksheet M-1	
		Component	CCN: 14-8535	From 10/01/2022 To 09/30/2023		
				RHC I	Cost	
	Adjustments	Net Expenses				
		for				
		Allocation				

					2/25/2024 /: 1	U pili
				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	1, 258, 697			1.00
2.00	Physician Assistant	0	105, 254			2.00
3.00	Nurse Practitioner	0	548, 642			3.00
4.00	Visiting Nurse	0	0			4.00
5. 00	Other Nurse	0	1, 163, 910			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	Ö			8.00
9. 00	Other Facility Health Care Staff Costs	0	0			9.00
10.00	Subtotal (sum of lines 1 through 9)	0	3, 076, 503			10.00
11. 00	Physician Services Under Agreement	0	3,070,303			11.00
12. 00	Physician Supervision Under Agreement	0	0			12.00
13. 00	Other Costs Under Agreement	0	0			13.00
	Subtotal (sum of lines 11 through 13)	0	0			14.00
14.00	1 ,	0	-			15.00
15.00	Medical Supplies	0	311, 372			
16.00	Transportation (Health Care Staff)	0	0			16.00
17.00	Depreciation-Medical Equipment	0	0 073			17.00
18.00	Professional Liability Insurance	0	8, 973			18.00
19.00	Other Health Care Costs	U	0			19.00
20.00	Allowable GME Costs		200 245			20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	320, 345			21.00
22. 00	Total Cost of Health Care Services (sum of	0	3, 396, 848			22. 00
	lines 10, 14, and 21)					-
00.00	COSTS OTHER THAN RHC/FQHC SERVICES	0				00.00
23. 00	Pharmacy	0	0			23.00
24. 00	Dental	0	0			24.00
25. 00	Optometry	0	0			25.00
25. 01	Tel eheal th	0	26, 742			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	26, 742			28. 00
	through 27)					1
	FACILITY OVERHEAD					l
	Facility Costs	0	0,,002			29. 00
30. 00	Administrative Costs	-268, 457				30.00
31. 00	Total Facility Overhead (sum of lines 29 and	-268, 457	701, 692			31.00
	30)					
32. 00	Total facility costs (sum of lines 22, 28	-268, 457	4, 125, 282			32. 00
	and 31)					1

Heal th	n Financial Systems	MENDOTA COMMUN	IITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOC	ATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 10/01/2022 To 09/30/2023	Date/Time Pre 2/25/2024 7:1	
					RHC I	Cost	
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons		10.50/	1			
1.00	Physi ci an	2. 80					1.00
2.00	Physici an Assistant	0. 67					2.00
3.00	Nurse Practitioner	3. 86	•			04.440	3.00
4.00	Subtotal (sum of lines 1 through 3)	7. 33		1	21, 273	·	4.00
5.00	Visiting Nurse	0.00		1		0	5.00
6.00	Clinical Psychologist	0.00	l .			0	6.00
7.00	Clinical Social Worker	0.00				0	7.00
7. 01 7. 02	Medical Nutrition Therapist (FOHC only)	0.00	l .			0	7. 01 7. 02
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			Ü	7.02
8. 00	Total FTEs and Visits (sum of lines 4	7. 33	24, 443			24, 443	8. 00
0.00	through 7)	7.33	24, 443			24, 443	0.00
9. 00	Physician Services Under Agreements		0			0	9. 00
7.00	Thysrerain services under Agreements						7.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	0 HOSPI TAL-BASI	ED RHC/FQHC SEI	RVI CES			
10.00	Total costs of health care services (from Wk					3, 396, 848	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line :	28)			26, 742	11.00
12.00	Cost of all services (excluding overhead) (s	um of lines 10	and 11)			3, 423, 590	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I	ine 10 divided	by line 12)			0. 992189	13.00
14.00	Total hospital-based RHC/FQHC overhead - (fr	om Worksheet. I	M-1, col. 7, l	ine 31)		701, 692	14.00
15.00	Parent provider overhead allocated to facili	ty (see instru	ctions)			2, 381, 619	15.00
16.00	Total overhead (sum of lines 14 and 15)					3, 083, 311	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					3, 083, 311	18.00
	Overhead applicable to hospital-based RHC/FQ					3, 059, 227	
20. 00	Total allowable cost of hospital-based RHC/F	QHC services (sum of lines 1	0 and 19)		6, 456, 075	20.00

	Financial Systems MENDOTA COMMUNITY ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC		Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI CE		Trovider CCN. 14-1310	From 10/01/2022	WOLKSHEET W-3	
		Component CCN: 14-8535	To 09/30/2023	Date/Time Pre	
		Title XVIII	RHC I	2/25/2024 7: 1 Cost	о рііі
		,	1	3331	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES		1		
- 1	Total Allowable Cost of hospital-based RHC/FQHC Services (fro	· · · · · · · · · · · · · · · · · · ·		6, 456, 075	
- 1	Cost of injections/infusions and their administration (from W		392, 591 6, 063, 484	2.0	
. 00	Total allowable cost excluding injections/infusions (line 1 m Total Visits (from Wkst. M-2, column 5, line 8)	irius irrie 2)		24, 443	
	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		24, 443	5. (
4	Total adjusted visits (line 4 plus line 5)			24, 443	1
- 1	Adjusted cost per visit (line 3 divided by line 6)			248. 07	7. (
			Cal cul ati on	of Limit (1)	
			Rate Period 1	Rate Period 2	
			(10/01/2022	(01/01/2023	
			through	through	
			12/31/2022)	09/30/2023)	
3. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or vour contractor)	1. 00	2. 00 278. 61	8.0
0.00	Rate for Program covered visits (see instructions)		248. 07	248. 07	1
	CALCULATION OF SETTLEMENT Program covered visits excluding mental health services (from	contractor records)	1, 604	4, 569	10.
	Program cost excluding costs for mental health services (line		397, 904	1, 133, 432	1
	Program covered visits for mental health services (from contr	•	0	0	1
	Program covered cost from mental health services (line 9 x li		O	0	13.
4.00	Limit adjustment for mental health services (see instructions)	0	0	14.
	Graduate Medical Education Pass Through Cost (see instruction		0		15.
- 1	5.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *			1, 531, 336	1
1	Total program charges (see instructions)(from contractor's re Total program preventive charges (see instructions)(from prov	•		1, 706, 814 17, 173	1
4	Total program preventive charges (see This factions)(Trom prov Total program preventive costs ((line 16.02/line 16.01) times	•		15, 407	1
4	Total Program non-preventive costs ((line 16 minus lines 16.0	•		1, 081, 801	1
	(Titles V and XIX see instructions.)			.,,	
6. 05	Total program cost (see instructions)		0	1, 097, 208	16.
	Primary payer amounts			0	17. (
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		163, 678	18. (
19. 00	records) Beneficiary coinsurance for RHC/FQHC services (see instructio	ns) (from contractor		304, 158	19. (
0.00	records) Net Medicare cost excluding vaccines (see instructions)			1, 097, 208	20. (
- 1	Program cost of vaccines and their administration (from Wkst.	M-4 line 16)		114, 055	
	Total reimbursable Program cost (line 20 plus line 21)	,		1, 211, 263	
	Allowable bad debts (see instructions)			0	
3. 01	Adjusted reimbursable bad debts (see instructions)			0	23.
	Allowable bad debts for dual eligible beneficiaries (see inst	ructi ons)		0	
	00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	50 Pioneer ACO demonstration payment adjustment (see instructions)			0	
- 1	99 Demonstration payment adjustment amount before sequestration			0 1, 211, 263	25.
1	Net reimbursable amount (see instructions) Sequestration adjustment (see instructions)			24, 225	
1	Demonstration adjustment (see Firstructions)			24, 229	
1	Interim payments			1, 017, 657	
1	Tentative settlement (for contractor use only)			0	
	Balance due component/program (line 26 minus lines 26.01, 26.			169, 381	29.
	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15-II	. 1	0	30.

COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CO	CN: 14-1310	Peri od:	Worksheet M-4	
		Component (CCN: 14-8535	From 10/01/2022 To 09/30/2023	Date/Time Pre 2/25/2024 7:1	
			XVIII	RHC I	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2. 02	
1. 00 2. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	3, 076, 503 0. 002500	3, 076, 50 0. 00849			
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	7, 691	26, 14	5, 885	0	3. 00
4. 00	Injections/infusions and related medical supplies costs (from your records)	118, 974	47, 86	0	0	4. 00
5. 00 6. 00	Direct cost of injections/infusions (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	126, 665 3, 396, 848	74, 0° 3, 396, 84	· ·	0 3, 396, 848	5. 00 6. 00
7. 00 8. 00	Total overhead (from Wkst. M-2, line 19) Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	3, 059, 227 0. 037289	3, 059, 22 0. 02178		3, 059, 227 0. 000000	7. 00 8. 00
9. 00 10. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	114, 076 240, 741	66, 65 140, 66	· ·	0	9. 00 10. 00
11. 00 12. 00	Total number of injections/infusions (from your records) Cost per injection/infusion (line 10/line 11)	571 421, 61	1, 94 72. 4		-	
13. 00	Number of injection/infusion administered to Program beneficiaries	149	64		0	
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 01
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	62, 820	46, 52	26 4, 709	0	14.00
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATIO N	
				1. 00	2. 00	
15. 00	Total cost of injections/infusions and their administratio 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.	•	f columns 1,		392, 591	15. 00
16. 00	Total Program cost of injections/infusions and their admin		s (sum of		114, 055	16.00

Health Financial Systems	MENDOTA COMMUNITY	/ HOSPI TAL		In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED I SERVICES RENDERED TO PROGRAM BENEFICIARI			CCN: 14-1310 CCN: 14-8535	Peri od: From 10/01/2022 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 2/25/2024 7:10 pm
				DUC I	Cost

		Component CCN. 14-0333	10 07/30/2023	2/25/2024 7: 10	
			RHC I	Cost	-
			Par	t B	
			mm/dd/yyyy	Amount	
			1, 00	2.00	
00	Total interim payments paid to hospital-based RHC/FQHC			1, 151, 682	1.
00	Interim payments payable on individual bills, either submit	ted or to be submitted to		l	2
	the contractor for services rendered in the cost reporting				
	"NONE" or enter a zero	•			
00	List separately each retroactive lump sum adjustment amount	based on subsequent			3
	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				
)1				0	3
)2				0	3
)3				0	3
)4				0	
)5				0	;
	Provider to Program				
0			05/16/2023	102, 673	
1			05/16/2023	31, 352	
2				0	;
3				0	,
4				0	,
9	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			-134, 025	;
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line		1, 017, 657	4
	27)				
	TO BE COMPLETED BY CONTRACTOR		_1	I	
00	List separately each tentative settlement payment after des	sk review. Also show date o	Ť		í
	each payment. If none, write "NONE" or enter a zero. (1)				
)1	Program to Provider			0	
)2				0	
3					į
	Provider to Program			U	•
0	Frovider to Frogram			0	ļ
1				0	į
2				l ől	į
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	į
Ó	Determined net settlement amount (balance due) based on the cost report. (1)				
1	SETTLEMENT TO PROVIDER			169, 381	è
2	SETTLEMENT TO PROGRAM			0	
00	Total Medicare program liability (see instructions)			1, 187, 038	-
	,		Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	