Health Financial Systems GRAHAM HOSPI TAL ASSOCIATION

In Lieu of Form CMS-2552-10

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

Worksheet S Parts I-III HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 14-0001 From 07/01/2022 AND SETTLEMENT SUMMARY

		10 06/30/2023 Date/II me Prepared:
		11/30/2023 12:56 pm
PART I - COST	REPORT STATUS	
Provi der	 [X] Electronically prepared cost report 	Date: 11/30/2023 Time: 12:56 pm
use only	2. [] Manually prepared cost report	
	3.[0] If this is an amended report enter the number of 4.[F] Medicare Utilization. Enter "F" for full, "L"	of times the provider resubmitted this cost report for low, or "N" for no.
Contractor	5. [1]Cost Report Status 6. Date Received:	10. NPR Date:
use only	(1) As Submitted 7. Contractor No.	11. Contractor's Vendor Code: 4
, , , ,	(2) Settled without Audit 8. [N] Initial Report for	this Provider CCN 12. [O]If line 5, column 1 is 4: Enter
	(3) Settled with Audit 9. [N] Final Report for t	this Provider CCN 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 GRAHAM HOSPITAL ASSOCIATION (14-0001) for the cost reporting period beginning 07/01/2022 and ending 06/30/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		
	1	2	SI GNATURE STATEMENT	
Jul	ie Reeder	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2 Signatory Printed Name	Julie Reeder			2
3 Signatory Title	CF0			3
4 Date	11/30/2023 12: 56: 38 PM			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	-748, 420	-163, 508	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	0	0		0	5. 00
6.00	SWING BED - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	67, 317	9		0	7.00
8.00	NURSING FACILITY	0				0	8.00
10.00	RURAL HEALTH CLINIC I	0		163, 818		0	10.00
10.01	ELMWOOD RHC II	0		30, 319		0	10. 01
10.02	WILLIAMSFIELD RHC III	0		2, 154		0	10. 02
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	TOTAL	0	-681, 103	32, 792	0	0	200.00
The ab	ove amounts represent "due to" or "due from"	the applicable	program for t	he element of	the above comp	lex 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 GRAHAM HOSPI TAL

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,

In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 14-0001 Peri od: Worksheet S-2 From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 11/30/2023 12:56 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 210 WEST WALNUT 1.00 PO Box: 1.00 2.00 City: CANTON State: IL Zi p Code: 61520-County: FULTON 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 GRAHAM HOSPITAL 140001 37900 07/19/1966 N N 3.00 ASSOCIATION Subprovi der - IPF 4.00 4.00 Subprovi der - IRF 5.00 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7 00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospital -Based SNF GRAHAM HOSPITAL 145572 99914 07/02/1987 Ρ Ν 9.00 ASSOCIATION ECF 10.00 10.00 Hospital -Based NF GRAHAM HOSPITAL 99914 07/02/1987 0 145572 N ASSOCIATION ECF 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospital -Based HHA 12.00 Separately Certified ASC 13.00 13 00 14.00 Hospi tal -Based Hospi ce 14.00 15.00 Hospital -Based Health Clinic - RHC GRAHAM MEDICAL GROUP -143493 99914 01/01/2008 0 Ν 15.00 LEWI STOWN Hospital-Based Health Clinic - RHC GRAHAM MEDICAL GROUP -148603 99914 0 Ν 15.01 15.01 10/23/2019 Ν FLMWOOD GRAHAM MEDICAL GROUP -99914 15.02 15.02 Hospital-Based Health Clinic - RHC 148636 02/17/2023 N 0 N $\Pi\Pi$ WI LLI AMSFI ELD 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) 07/01/2022 06/30/2023 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 Υ 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 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 Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to N N 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 ves 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

ves or "N" for no

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GRAHAM HOSPITAL ASSOCIATION

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0001

Period

Provi der CCN: 14-0001 Peri od: Worksheet S-2 From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 11/30/2023 12:56 pm 1.00 2.00 3.00 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 Ν 23.00 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. In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State State Medi cai d HMO days paid days el i gi bl e Medi cai d Medi cai d days pai d days el i gi bl e unpai d days unpai d 3. 00 5. 00 1.00 2.00 4.00 6.00 24.00 If this provider is an IPPS hospital, enter the 24.00 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 O 0 0 0 25.00 0 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 27 00 enter the effective date of the geographic reclassification in column 2. If this is a sole community hospital (SCH), enter the number of periods SCH status in 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 07/01/2022 06/30/2023 36,00 of periods in excess of one and enter subsequent dates. 37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 37.00 is in effect in the cost reporting period. 37.01 \mid 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) 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 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 40.00 N Ν "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) ٧ XVIII XIX 1. 00 2. 00 3. 00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance Ν N Ν 45.00 with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exception for extraordinary circumstances 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 Pt III 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. 47 00 Ν N N Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. 48.00 Ν Ν Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For Ν 56.00 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.

In Lieu of Form CMS-2552-10

GRAHAM HOSPITAL ASSOCIATION

Health Financial Systems GRAHAM HOSPI HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA In Lieu of Form CMS-2552-10 Provider CCN: 14-0001

				11	0 06/30/2	023	11/30/2		
			<u>'</u>	'		V	XVIII	XIX	. оо р
						1. 00	2.00	3. 00	
	For cost reporting periods beginning prior to December is this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no in residents start training in the first month of this of "N" for no in column 2. If column 2 is "Y", complete complete Wkst. D, Parts III & IV and D-2, Pt. II, if beginning on or after December 27, 2020, under 42 CFW which month(s) of the cost report the residents were for yes, enter "Y" for yes in column 1, do not complete If line 56 is yes, did this facility elect cost reimforting in CNP. Details 15.1	residen colum cost re e Works applic R 413.7 on dut ete col	ents in approve on 1. If column opporting period cheet E-4. If c cable. For cost 77(e)(1)(iv) a y, if the resp umn 2, and com ent for physici	ed GME programs 1 1 is "Y", did 1? Enter "Y" f column 2 is "N" c reporting per ind (v), regard conse to line 5 aplete Workshee	trained for yes or , iods less of 6 is "Y" t E-4.	N			57. 00 58. 00
50 00	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes			D+ I		N			59. 00
37. 00	prie costs cramied on time 100 of worksheet A: Tr yes	s, comp	riete wkst. b-2	NAHE 413. 85 Y/N	Worksheet Li ne #	Α	Pass-Th Qual i fi o Cri ter Cod 3.0	cation ion e	37.00
60.00	Are you claiming nursing and allied health education	(NAHE)	costs for	1.00 Y	2.00 Y		3.0	U	60. 00
	any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent (adjustment? Enter "Y" for yes or "N" for no in col ur If line 60 is yes, complete columns 2 and 3 for each	85? (umn 1. CR) NAH mn 2.	see If column 1 IE MA payment	, i	·	0. 00	1		60. 01
	instructions)	Y/N	I ME	Direct GME	I ME		Di rect	GME	
		1 00	2.00	2.00	4.00		F O	0	
61. 00	Did your hospital receive FTE slots under ACA	1.00	2.00	3. 00	4.00	0. 00	5. 0		61. 00
	section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care								61. 01
	FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)								
61. 02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)								61. 02
61. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see								61.03
61. 04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the								61. 04
61. 05	current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line								61.05
61. 06	61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)								61.06
		Pro	ogram Name	Program Code	Unweighte IME FTE Co		Unweig Direct FTE Co	GME	
			1. 00	2. 00	3. 00		4. 0	0	
	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see					0. 00			61. 10
	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.								

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I DENTIFICATION DATA Provider CCN: 14-0001 Period:

1. 00

Worksheet S-2 From 07/01/2022 Part I 06/30/2023 Date/Time Prepared: 11/30/2023 12:56 pm 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 62.01 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) 63.00 63.00 Unwei ghted Ratio (col Unwei ghted 1/ (col. 1 + col. 2)) FTEs FTEs in Nonprovi der Hospi tal Si te 1. 00 2. 00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.00 0.00 0.000000 64.00 in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Unwei ghted Ratio (col. 3/ (col. 3 + col. 4)) FTEs FTEs in Nonprovi der Hospi tal Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0.000000 65.00 0.00 0.00 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) Unwei ghted Unwei ghted Ratio (col. **FTEs** FTEs in 1/(col.1 +Nonprovi der Hospi tal col. 2)) Si te 3.00 2.00 1.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Unwei ghted Unwei ghted Ratio (col. Program Name Program Code FTĔs FTEs in 3/(col. 3 +col. 4)) Nonprovi der Hospi tal

Si te

3.00

4. 00

5.00

2.00

In Lieu of Form CMS-2552-10

Health Financial Systems GRAHAM HOSP
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA In Lieu of Form CMS-2552-10 Peri od: Worksheet S-2 From 07/01/2022 Part I Prepared: 11/30/2023 12:56 pm Provider CCN: 14-0001

				00/30/2023	11/30/2023 12	
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
			FTEs Nonprovi der	FTEs in Hospital	3/ (col. 3 + col. 4))	
			Si te		5511 1,77	
(7.00 E.L., 1	1. 00	2. 00	3. 00	4. 00	5.00	(7.00
67.00 Enter in column 1, the program name associated with each of			0.00	0.00	0. 000000	67.00
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)						
					1.00	
Direct GME in Accordance with t					1.00	
68.00 For a cost reporting period beg					N	68. 00
MAC to apply the new DGME formu (August 10, 2022)?	ra in accordance wrth	the FY 2023 TPPS FIT	iai kure, 87 FK	49065-49072		
				1.00		
Inpatient Psychiatric Facility	PPS			1.00	0 2.00 3.00	
70.00 Is this facility an Inpatient P	sychiatric Facility (IPF), or does it cont	tain an IPF sub	provi der? N		70. 00
Enter "Y" for yes or "N" for no 71.00 If line 70 is yes: Column 1: Di		n approved GME teachi	na program in	the most		71. 00
recent cost report filed on or	before November 15, 2	004? Enter "Y" for y	es or "N" for	no. (see		71.00
42 CFR 412. 424(d)(1)(iii)(c)) C						
program in accordance with 42 C Column 3: If column 2 is Y, ind						
(see instructions)				5		
Inpatient Rehabilitation Facili 75.00 Is this facility an Inpatient R		v (IRF) or does it d	contain an IRE	l N		75. 00
subprovider? Enter "Y" for yes	and "N" for no.					
76.00 If line 75 is yes: Column 1: Direcent cost reporting period en					0	76. 00
no. Column 2: Did this facility						
CFR 412.424 (d)(1)(iii)(D)? Ent				,		
indicate which program year beg	an during this cost r	eporting period. (see	e instructions)			
					1.00	
Long Term Care Hospital PPS 80.00 Is this a long term care hospital	al (ITCH)2 Enter "V"	for wes and "N" for	no		N	80. 00
81.00 Is this a LTCH co-located within	n another hospital fo	r part or all of the	cost reporting	period? Enter		81.00
"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? Ente	er "Y" for yes	or "N" for no.	N	85. 00
86.00 Did this facility establish a n	ew Other subprovider	(excluded unit) under				86. 00
§413.40(f)(1)(ii)? Enter "Y" for 87.00 Is this hospital an extended new			under section		N	87. 00
1886(d) (1) (B) (vi)? Enter "Y" fo		- Hospital Crassifica	under Seetron			
				Approved for	Number of	
				Permanent Adjustment	Approved Permanent	
				(Y/N)	Adjustments	
88.00 Column 1: Is this hospital appro	oved for a nermanent	adiustment to the TFF	-RA target	1. 00	2.00	88. 00
amount per discharge? Enter "Y"						55. 00
89. (see instructions) Column 2: Enter the number of a	oproved permanent adi	uetmonte				
portuini 2. Litter the number of a	pproved permanent adj	us tillettts.		I		

Health Financial Systems GRAHAM HOSPI HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 14-0001

			From 07/01/2022 To 06/30/2023	Part I Date/Time Pro 11/30/2023 12	
		Wkst. A Line No.	e Effective Date	Approved Permanent Adjustment Amount Per Discharge	
		1.00	2. 00	3. 00	
89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A on which the per discharge permanent adjustment approval w Column 2: Enter the effective date (i.e., the cost reporti beginning date) for the permanent adjustment to the TEFRA per discharge. Column 3: Enter the amount of the approved permanent adjustment adjustmen	as based. ng period target amount	0.0	00		0 89.00
			1. 00	XI X 2. 00	-
Title V and XIX Services			1.00	2.00	
90.00 Does this facility have title V and/or XIX inpatient hospi yes or "N" for no in the applicable column.	tal services? E	Enter "Y" for	N	Y	90.00
91.00 Is this hospital reimbursed for title V and/or XIX through			N	N	91.00
full or in part? Enter "Y" for yes or "N" for no in the ap 92.00 Are title XIX NF patients occupying title XVIII SNF beds (instructions) Enter "Y" for yes or "N" for no in the appli	dual certificat	ı. tion)? (see		Y	92.00
93.00 Does this facility operate an ICF/IID facility for purpose "Y" for yes or "N" for no in the applicable column.		nd XIX? Enter	N	N	93.00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes applicable column.	s, and "N" for r	no in the	N	N	94.00
95.00 If line 94 is "Y", enter the reduction percentage in the a	pplicable colum	nn.	0.00	0. 00	95.00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for y applicable column.			N	N	96.00
97.00 If line 96 is "Y", enter the reduction percentage in the a			0.00	0.00	97.00
98.00 Does title V or XIX follow Medicare (title XVIII) for the stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" column 1 for title V, and in column 2 for title XIX.			Y	Y	98.00
98.01 Does title V or XIX follow Medicare (title XVIII) for the C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title XIX.				Y	98. 01
98.02 Does title V or XIX follow Medicare (title XVIII) for the bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes for title V, and in column 2 for title XIX.			Y	Y	98. 02
98.03 Does title V or XIX follow Medicare (title XVIII) for a cr reimbursed 101% of inpatient services cost? Enter "Y" for for title V, and in column 2 for title XIX.				N	98. 03
98.04 Does title V or XIX follow Medicare (title XVIII) for a CA outpatient services cost? Enter "Y" for yes or "N" for no in column 2 for title XIX.			N	N	98. 04
98.05 Does title V or XIX follow Medicare (title XVIII) and add Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 2 for title XIX.				Y	98. 05
98.06 Does title V or XIX follow Medicare (title XVIII) when cos Pts. I through IV? Enter "Y" for yes or "N" for no in colu column 2 for title XIX.			Y	Y	98. 06
Rural Providers 105.00 Does this hospital qualify as a CAH?			N		105.00
106.00 f this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)	I-inclusive met	thod of paymer			106. 00
107.00 Column 1: If line 105 is Y, is this facility eligible for training programs? Enter "Y" for yes or "N" for no in colu Column 2: If column 1 is Y and line 70 or line 75 is Y, d approved medical education program in the CAH's excluded Enter "Y" for yes or "N" for no in column 2. (see instructions)	ımn 1. (see ins Ho you train I&F IPF and/or IRF	structions) Rs in an	N		107. 00
108.00 Is 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	2 N		108. 00
	Physi cal	Occupati ona	<u> </u>	Respiratory	4
109.00 If this hospital qualifies as a CAH or a cost provider, ar	1.00	2. 00	3. 00	4.00	109.00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					107.00

Health Financial Systems M HOSPI TAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 14-0001 Peri od:

In Lieu of Form CMS-2552-10 Worksheet S-2

From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 11/30/2023 12:56 pm 1.00 110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes 110. 00 N complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as appl i cabl e. 1. 00 2.00 111.00|If this facility qualifies as a CAH, did it participate in the Frontier Community 111.00 Ν Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services. 1.00 2.00 3.00 112.00 Did this hospital participate in the Pennsylvania Rural Health Model 112.00 (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no N 0115.00 in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" for yes or 116.00 Ν "N" for no. 117.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no. 117.00 Υ 118.00|s the malpractice insurance a claims-made or occurrence policy? Enter 1 118.00 if the policy is claim-made. Enter 2 if the policy is occurrence. Premi ums Losses Insurance 2.00 3.00 1.00 1, 527, 696 118. 01 118.01 List amounts of malpractice premiums and paid losses: 1. 00 2.00 118.02 Are mal practice premiums and paid losses reported in a cost center other than the 118. 02 Ν Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. 119.00 DO NOT USE THIS LINE 119.00 120.00 s this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA N 120.00 §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for ves or 'N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no. 121 00 122.00 Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the 5.00 122.00 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included. 123.00 Did the facility and/or its subproviders (if applicable) purchase professional 123.00 services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "N" for no. Certified Transplant Center Information 125.00 Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes Ν 125.00 and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 of this is a Medicare-certified kidney transplant program, enter the certification date 126.00 in column 1 and termination date, if applicable, in column 2. |127.00| If this is a Medicare-certified heart transplant program, enter the certification date 127.00 in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare-certified liver transplant program, enter the certification date 128.00 in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare-certified lung transplant program, enter the certification date 129.00 in column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare-certified pancreas transplant program, enter the certification 130.00 date in column 1 and termination date, if applicable, in column 2.

Heal th Fi nanci al Systems GRAHAM HOSPITAL ASSOCIATION
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I DENTIFICATION DATA Provider CCN: 14-0001 Period:

Worksheet S-2 From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 11/30/2023 12:56 pm 1. 00 2.00 131.00|f this is a Medicare-certified intestinal transplant program, enter the certification 131.00 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 132.00 in column 1 and termination date, if applicable, in column 2. 133.00 Removed and reserved 133.00 134.00 If this is a hospital-based organ procurement organization (OPO), enter the OPO number 134.00 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, N 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: Contractor's Name: 141.00 Contractor's Number: 142.00|Street: PO Box: 142.00 143.00 Ci ty: 143.00 State: Zip Code: 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144.00 1. 00 2.00 145.00|If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is 145. 00 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? Ν 146.00 Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, \$4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 147. 00 Ν 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. Ν 148.00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no 149. 00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155. 00 Hospi tal 155.00 156.00 Subprovi der - IPF N Ν Ν N 156 00 157.00 Subprovi der - IRF Ν Ν Ν Ν 157.00 158. 00 SUBPROVI DER 158.00 159.00 SNF Ν Ν Ν Ν 159. 00 160.00 HOME HEALTH AGENCY N Ν Ν N 160.00 161.00 CMHC 161.00 Ν Ν Ν 1.00 Mul ti campus 165.00|s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. FTE/Campus State Zip Code CBSA Name County Λ 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0. 00 166. 00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 167.00 168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the 168.00 reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 168 01 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 9. 99169. 00

In Lieu of Form CMS-2552-10

transition factor. (see instructions)

Heal th Fi nanci al Systems GRAHAM HOSPI TAL ASSOCIATION

In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 14-0001 Worksheet S-2 Peri od: From 07/01/2022 To 06/30/2023 Part I Date/Time Prepared: 11/30/2023 12:56 pm Begi nni ng Endi ng 1. 00 2.00 170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy) 170.00 1. 00 2. 00 171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 0171.00 Ν 1876 Medicare days in column 2. (see instructions)

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Health Financial Systems In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 14-0001 Peri od: Worksheet S-2

From 07/01/2022

Part II

Date/Time Prepared: 06/30/2023 11/30/2023 12:56 pm Y/N Date 1.00 2.00 PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1.00 Has the provider changed ownership immediately prior to the beginning of the cost Ν 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) Date V/I 1.00 2.00 3.00 2.00 Has the provider terminated participation in the Medicare Program? If N 2 00 yes, enter in column 2 the date of termination and in column $\hat{\textbf{3}},$ "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management Ν 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Type 1.00 2.00 3.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Α 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from Υ 5.00 those on the filed financial statements? If yes, submit reconciliation Legal Oper. Y/N 1.00 2.00 Approved Educational Activities 6.00 Are costs claimed for a nursing program? Column 2: If yes, is the provider 6.00 the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7 00 7 00 N 8.00 Were nursing programs and/or allied health programs approved and/or renewed during the Ν 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 N 10.00 cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved 11.00 Ν Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 12.00 13.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see Ν 14.00 instructions. Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions N 15.00 Part A Part B Y/N Date Y/N Date 1.00 2.00 3.00 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R Report only? Ν N 16.00 If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for 11/06/2023 11/06/2023 17.00 Υ ٧ 17.00 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R 18.00 Ν 18.00 N Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R 19.00 Ν Ν Report data for corrections of other PS&R Report information? If yes, see instructions.

Heal th Fi nanci al Systems GRAHAM HOSPI TAL ASSOCIATION
HOSPI TAL AND HOSPI TAL HEALTH CARE REIMBURSEMENT QUESTI ONNAI RE Provi der CCN: 14-0001 Peri od:

Worksheet S-2 From 07/01/2022 Part II Date/Time Prepared: 06/30/2023 11/30/2023 12:56 pm Description Y/N 1.00 3.00 20.00 | If line 16 or 17 is yes, were adjustments made to PS&R N Ν 20.00 Report data for Other? Describe the other adjustments: Y/N Date Y/N Date 3.00 1.00 2.00 4.00 21.00 Was the cost report prepared only using the provider's 21 00 N N records? If yes, see instructions. 1. 00 COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost 22.00 Have assets been relifed for Medicare purposes? If yes, see instructions 22.00 Ν Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost Ν 23 00 reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases entered into during this cost reporting period? Ν 24.00 24.00 If yes, see instructions 25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see Ν 25.00 i nstructi ons. Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Ν 26,00 26,00 instructions. 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit Ν 27.00 сору. Interest Expense Were new loans, mortgage agreements or letters of credit entered into during the cost reporting N 28.00 28.00 period? If yes, see instructions. Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) Ν 29.00 29.00 treated as a funded depreciation account? If yes, see instructions Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see Ν 30.00 instructions. 31 00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see Ν 31 00 <u>i nstructi ons</u> Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual Ν 32.00 arrangements with suppliers of services? If yes, see instructions.

If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If 33.00 Ν 33.00 no, see instructions. Provi der-Based Physi ci ans Were services furnished at the provider facility under an arrangement with provider-based physicians? 34.00 If ves see instructions If line 34 is yes, were there new agreements or amended existing agreements with the provider-based Ν 35 00 physicians during the cost reporting period? If yes, see instructions. Date 1. 00 2.00 Home Office Costs 36.00 Were home office costs claimed on the cost report? N 36 00 If line 36 is yes, has a home office cost statement been prepared by the home office? 37.00 Ν If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 38.00 Ν 38.00 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, N 39.00 see instructions. If line 36 is yes, did the provider render services to the home office? If yes, see 40.00 instructions. 2.00 1.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position KELLY BETH 41.00 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel y. 42.00 Enter the employer/company name of the cost report WIPFLI LLP 42.00 preparer. Enter the telephone number and email address of the cost 414. 259. 6738 KBETH@WI PFLI . COM 43.00

In Lieu of Form CMS-2552-10

report preparer in columns 1 and 2, respectively.

al th Financial Systems GRAHAM HOSPITAL ASSOCIATION

Heal th Financial Systems GRAHAM HOSPITAL ASSOCIATION In Lieu of Form CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 14-0001 From 07/01/2022 Part II
To 06/30/2023 Date/Time Prepared:

			11/30/2023 12	
		3. 00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position	MANAGER		41.00
	held by the cost report preparer in columns 1, 2, and 3,			
	respecti vel y.			
42.00	Enter the employer/company name of the cost report			42.00
	preparer.			
43.00	Enter the telephone number and email address of the cost			43.00
	report preparer in columns 1 and 2, respectively.			

Health Financial Systems GRAHAM H
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

In Lieu of Form CMS-2552-10

Peri od: Worksheet S-3
From 07/01/2022 Part I
To 06/30/2023 Date/Time Prepared: 11/30/2023 12:56 pm Provider CCN: 14-0001

						11/30/2023 12	: 56 pm
						I/P Days /	
						0/P Visits /	
					0411 /0511 11	Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	Title V	
		Li ne No. 1. 00	2.00	Available 3.00	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	33	12, 045	0.00	0	1.00
1.00	8 exclude Swing Bed, Observation Bed and	30.00	33	12,043	0.00	U	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7. 00	Total Adults and Peds. (exclude observation		33	12, 045	0.00	0	7. 00
	beds) (see instructions)					_	
8. 00	INTENSIVE CARE UNIT	31.00	10	3, 650	0. 00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00 11.00
11. 00 12. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY	43.00				0	13.00
14. 00	Total (see instructions)	43.00	43	15, 695	0. 00	0	14.00
15. 00	CAH visits		10	10,070	0.00	0	15.00
15. 10	REH hours and visits					Ü	15. 10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY	44.00	20	7, 300		0	19. 00
20.00	NURSING FACILITY	45. 00	18	6, 570		0	20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPICE	20.00					24.00
24. 10 25. 00	HOSPICE (non-distinct part) CMHC - CMHC	30.00					24. 10 25. 00
26. 00	RHC (CONSOLI DATED)	88. 00				0	26.00
26. 00	ELMWOOD RHC	88. 01				0	26. 00
26. 02	WILLIAMSFIELD RHC	88. 02				0	26. 02
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26. 25
27. 00	Total (sum of lines 14-26)	07.00	81			Ü	27. 00
28. 00	Observation Bed Days					0	28. 00
29.00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32. 01	Total ancillary labor & delivery room						32. 01
00.6-	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
	LTCH site neutral days and discharges Temporary Expansion COVID-19 PHE Acute Care	30. 00	0	0		0	33. 01 34. 00
34.00	Tremporary Expansion Covid-19 PRE Acute Care	30.00	ı	1	1	U	34.00

Health Financial Systems GRAHAM H
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA GRAHAM HOSPITAL ASSOCIATION

Provider CCN: 14-0001 Peri od: From 07/01/2022 To 06/30/2023

In Lieu of Form CMS-2552-10
Worksheet S-3
Part I
30/2023 Date/Time Prepared:
11/30/2023 12:56 pm

		I/P Days / O/P Visits / Trips			Full Time I	. 50 piii	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA	0.00	7.00	0.00	7. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	2, 427	925	5, 164			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)	1, 739	119				2.00
3.00	HMO IPF Subprovi der	0	0				3.00
4. 00 5. 00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF	0	ol Ol	0			4. 00 5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF	٩	0	0			6.00
7. 00	Total Adults and Peds. (exclude observation	2, 427	925	5, 164			7.00
7.00	beds) (see instructions)	2, .2,	,23	0, 10 .			7.00
8.00	INTENSIVE CARE UNIT	477	136	1, 144			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)			05/			12.00
13.00	NURSERY	2 004	232	356		470.0/	13.00
14. 00 15. 00	Total (see instructions) CAH visits	2, 904	1, 293 0	6, 664	0.00	472. 86	14. 00 15. 00
15. 00	REH hours and visits	٩	U	U			15. 00
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	1, 308	19	2, 262	0.00	12. 75	19.00
20.00	NURSING FACILITY		3, 427	5, 384	0. 00	13. 24	20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE			0			24.00
24. 10 25. 00	HOSPICE (non-distinct part) CMHC - CMHC			0			24. 10 25. 00
26. 00	RHC (CONSOLI DATED)	16, 166	30, 005	100, 911	0.00	113. 22	1
26. 01	ELMWOOD RHC	770	1, 264	5, 659		l e	•
26. 02	WILLIAMSFIELD RHC	0	0	1, 894		l e	1
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	o	o	0		l e	1
27.00	Total (sum of lines 14-26)				0.00	621. 41	27.00
28. 00	Observation Bed Days		0	1, 590			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		40	0			31.00
32.00	Labor & delivery days (see instructions)	0	40	96			32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32. 01
33. 00	LTCH non-covered days	0					33.00
33. 01	LTCH site neutral days and discharges	ol					33. 01
	Temporary Expansion COVID-19 PHE Acute Care	o	o	0			34.00
	, , , ,	'	'		*	•	•

Health Financial Systems GRAHAM H
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA GRAHAM HOSPITAL ASSOCIATION

Provider CCN: 14-0001

In Lieu of Form CMS-2552-10

Period: Worksheet S-3
From 07/01/2022 Part I
To 06/30/2023 Date/Time Prepared: 11/30/2023 12:56 pm

	1/30/2023 12:	56 pm
Full Time Discharges		
Equivalents Component Nonpaid Title V Title XVIII Title XIX To	Total All	
	Total All Patients	
11. 00 12. 00 13. 00 14. 00	15. 00	
PART I - STATISTICAL DATA	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 0 663 323	1, 633	1.00
8 exclude Swing Bed, Observation Bed and	,	
Hospi ce days) (see instructions for col. 2		
for the portion of LDP room available beds)		
2.00 HMO and other (see instructions) 375 0		2.00
3.00 HMO IPF Subprovider 0		3.00
4.00 HMO IRF Subprovi der 0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF		5.00
6.00 Hospital Adults & Peds. Swing Bed NF		6.00
7.00 Total Adults and Peds. (exclude observation		7. 00
beds) (see instructions) 8.00 INTENSIVE CARE UNIT		8. 00
9. 00 CORONARY CARE UNIT		9. 00
10. 00 BURN INTENSIVE CARE UNIT		10.00
11. 00 SURGI CAL INTENSIVE CARE UNIT		11. 00
12.00 OTHER SPECIAL CARE (SPECIFY)		12.00
13. 00 NURSERY		13.00
14.00 Total (see instructions) 0.00 0 663 323	1, 633	14.00
15.00 CAH visits		15.00
15.10 REH hours and visits		15. 10
16.00 SUBPROVI DER - I PF		16.00
17. 00 SUBPROVI DER - I RF		17.00
18. 00 SUBPROVI DER		18.00
19. 00 SKILLED NURSING FACILITY 0. 00		19.00
20. 00 NURSI NG FACI LI TY 0. 00		20.00
21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY		21. 00 22. 00
23. 00 AMBULATORY SURGI CAL 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. 01 ELMWOOD RHC 0. 00		26. 01
26. 02 WI LLI AMSFI ELD RHC 0. 00		26.02
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0. 00		26. 25
27.00 Total (sum of lines 14-26) 0.00		27.00
28.00 Observation Bed Days		28. 00
29.00 Ambul ance Tri ps		29.00
30.00 Employee discount days (see instruction)		30.00
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions)		31. 00 32. 00
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room		32.00
outpatient days (see instructions)		JZ. U1
33. 00 LTCH non-covered days		33. 00
33.01 LTCH site neutral days and discharges		33. 01
34.00 Temporary Expansi on COVID-19 PHE Acute Care		34.00

Health Financial Systems HOSPI TAL

In Lieu of Form CMS-2552-10 HOSPITAL WAGE INDEX INFORMATION Provider CCN: 14-0001 Peri od: Worksheet S-3 From 07/01/2022

Part II

06/30/2023 Date/Time Prepared: 11/30/2023 12:56 pm Wkst. A Line Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Number Reported ion of Sal ari es Related to Sal ari es (col. 2 ± col. Salaries in (from Wkst 3) col. 4 A-6)1.00 2.00 3.00 4.00 5.00 6.00 PART II - WAGE DATA SALARI ES 1.00 200 00 49, 902, 322 49, 902, 322 Total salaries (see 1, 292, 553. 60 38.61 1.00 instructions) 2.00 Non-physician anesthetist Part 0.00 0.00 2.00 12.084.80 3 00 1, 756, 721 145 37 3 00 Non-physician anesthetist Part 1, 756, 721 Ω 4.00 Physician-Part A -463, 047 463, 047 2,008.12 230.59 4.00 Administrative 4.01 Physicians - Part A - Teaching 0.00 0.00 4.01 9, 862, 192 5.00 Physician and Non 9, 862, 192 74, 603. 08 132. 20 5.00 Physician-Part B 6.00 Non-physician-Part B for 3, 877, 796 3, 877, 796 65, 062. 40 59.60 6.00 hospital-based RHC and FQHC servi ces Interns & residents (in an 21.00 7.00 7.00 0 0.00 0.00 0 approved program) 7.01 Contracted interns and 0 0.00 0.00 7.01 residents (in an approved programs) 8.00 Home office and/or related 0 0.00 0.00 8.00 organization personnel 9 00 44.00 870, 727 SNF 870, 727 26, 520, 00 32 83 9 00 10.00 Excluded area salaries (see 1, 968, 923 121, 956 2,090,879 58, 655. 97 35.65 10.00 instructions) OTHER WAGES & RELATED COSTS 1, 552, 662 107. 36 11.00 Contract labor: Direct Patient 1, 552, 662 14, 461. 65 11.00 Contract Labor: Top Level 0.00 0.00 12.00 12.00 0 0 management and other management and administrative servi ces 13.00 Contract Labor: Physician-Part 57,000 0 57,000 500.00 114.00 13.00 A - Administrative 14.00 Home office and/or related 0 0 0.00 0.00 14.00 organization salaries and wage-related costs 14.01 Home office salaries 0 0.00 0.00 14.01 Related organization salaries 0.00 14.02 14.02 0 0.00 15.00 Home office: Physician Part A 0 0.00 0.00 15.00 - Administrative 0 16.00 Home office and Contract 0.00 0.00 16.00 Physicians Part A - Teaching 16.01 Home office Physicians Part A О 0.00 0.00 16.01 - Teachi ng Home office contract 16.02 0 0.00 0.00 16.02 Physicians Part A - Teaching WAGE-RELATED COSTS 17.00 Wage-related costs (core) (see 5, 096, 280 5, 096, 280 17.00 instructions) 18.00 18 00 Wage-related costs (other) (see instructions) 19.00 Excluded areas 647, 715 647, 715 19.00 20.00 Non-physician anesthetist Part 20.00 21.00 Non-physician anesthetist Part 21.00 577, 771 577, 771 22.00 Physician Part A -152, 291 152, 291 22.00 Administrative 22.01 Physician Part A - Teaching 22.01 Physician Part B 1, 724, 606 1, 724, 606 23 00 23.00 24.00 Wage-related costs (RHC/FQHC) 4, 048, 614 4,048,614 24.00 25.00 Interns & residents (in an 25.00 approved program) Home office wage-related C 25.50 0 0 25.50 (core) 25.51 Related organization 0 25.51 wage-related (core) 25.52 Home office: Physician Part A 0 25.52 - Administrative wage-related (core)

Heal th Fi nanci al Systems GRAHAM HOSPI TAL ASSOCIATION

Health Financial Systems | GRAHAM HOSPITAL ASSOCIATION | In Lieu of Form CMS-2552-10 | HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0001 | Period: | Worksheet S-3

From 07/01/2022 Part II Date/Time Prepared: 06/30/2023 11/30/2023 12:56 pm Wkst. A Line Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Number Sal ari es Related to Reported ion of (col. 2 ± col. Sal ari es Salaries in (from Wkst. 3) col. 4 A-6) 1.00 2.00 3.00 4.00 5.00 6.00 25.53 Home office: Physicians Part A 25. 53 0 - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4.00 253, 801 253, 801 9, 401. 60 27. 00 26.00 27.00 Administrative & General 5.00 9, 582, 701 9, 582, 701 276, 452. 80 34.66 27.00 28.00 925, 283 925, 283 10, 920. 00 84. 73 28.00 Administrative & General under 0 contract (see inst.) 29.00 Maintenance & Repairs 6.00 0.00 0.00 29.00 30.00 Operation of Plant 7.00 1,081,721 1, 081, 258 48, 235. 20 22. 42 30.00 -463 Laundry & Linen Service 8.00 49, 732 3, 286. 00 16. 47 31.00 31.00 4.385 54.117 32.00 -49, 732 18. 90 Housekeepi ng 9.00 1, 193, 257 1, 143, 525 60, 507. 00 32.00 33.00 Housekeeping under contract 0.00 0.00 33.00 (see instructions) 34.00 Dietary 10.00 939, 061 -526, 062 412, 999 19, 356. 83 21. 34 34.00 Dietary under contract (see 35.00 0.00 0.00 35.00 instructions) 36.00 Cafeteri a 11.00 0 526, 062 526, 062 24, 655. 97 21. 34 36.00 0.00 37.00 Maintenance of Personnel 12.00 0.00 37.00 Nursing Administration 18, 075. 20 37. 72 38.00 38.00 13.00 681, 707 Ω 681, 707 39.00 Central Services and Supply 14.00 0 0.00 0.00 39.00 893, 701 893, 701 25, 334. 40 40.00 Pharmacy 15.00 0 35. 28 40.00 Medical Records & Medical Records Library 41.00 16.00 662, 814 0 662, 814 29, 265. 60 22. 65 41.00 42.00 Social Service 17.00 0 0 0 0.00 0.00 42.00 43.00 Other General Service 18.00 0 0 0.00 0.00 43.00 ealth Financial Systems GRAHAM HOSPITAL ASSOCIATION

Health Financial Systems GRAHAM HOSPITAL ASSOCIATION In Lieu of Form CMS-2552-10
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 14-0001 From 07/01/2022 Part III
To 06/30/2023 Date/Time Prepared:

					1	0 06/30/2023	11/30/2023 12:	
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Pai d Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1. 00	Net salaries (see		35, 330, 896	0	35, 330, 896	1, 151, 723. 32	30. 68	1. 00
	instructions)							
2. 00	Excluded area salaries (see		2, 839, 650	121, 956	2, 961, 606	85, 175. 97	34. 77	2.00
	instructions)							
3. 00	Subtotal salaries (line 1		32, 491, 246	-121, 956	32, 369, 290	1, 066, 547. 35	30. 35	3.00
	minus line 2)		4 (00 ((0		4 /00 //0	44.044.5	407.50	
4. 00	Subtotal other wages & related		1, 609, 662	0	1, 609, 662	14, 961. 65	107. 59	4.00
F 00	costs (see inst.)		E 040 E74		F 040 F74	0.00	4, 04	F 00
5. 00	Subtotal wage-related costs		5, 248, 571	0	5, 248, 571	0. 00	16. 21	5.00
	(see inst.)		20 240 470	101 05/	20 227 522	1 001 500 00	27 27	/ 00
6.00	Total (sum of lines 3 thru 5)		39, 349, 479					
7. 00	Total overhead cost (see		16, 218, 431	-463	16, 217, 968	525, 490. 60	30. 86	7. 00
	instructions)							

Health Financial Systems
HOSPITAL WAGE RELATED COSTS

In Lieu of Form CMS-2552-10

Period: Worksheet S-3
From 07/01/2022 Part IV
To 06/30/2023 Date/Time Prepared: 11/30/2023 12:56 pm Provider CCN: 14-0001

		11/30/2023 12	:56 pm
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1, 034, 939	1.00
2. 00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3. 00	Nonqualified Defined Benefit Plan Cost (see instructions)	ol	3.00
4. 00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)	_	
5. 00	401K/TSA Plan Administration fees	5, 044	5.00
6. 00	Legal /Accounting/Management Fees-Pension Plan	7, 000	6.00
7. 00	Employee Managed Care Program Administration Fees	-13, 631	7. 00
,, ,,	HEALTH AND INSURANCE COST	10,001	7.00
8. 00	Heal th Insurance (Purchased or Self Funded)	0	8.00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	6, 736, 405	8. 02
8. 03	Heal th Insurance (Purchased)	0, 700, 100	8. 03
9. 00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	0	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	12, 588	
12. 00	Accident Insurance (If employee is owner or beneficiary)	12, 500	12.00
13. 00	Disability Insurance (If employee is owner or beneficiary)	232, 968	
14. 00	Long-Term Care Insurance (If employee is owner or beneficiary)	232, 700	14.00
15. 00	'Workers' Compensation Insurance	741, 805	
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	741,005	16.00
10.00	Noncumulative portion)	O	10.00
	TAXES		
17. 00		3, 274, 388	17 00
18. 00	Medicare Taxes - Employers Portion Only	0, 274, 300	18.00
19. 00		-5, 369	
	State or Federal Unemployment Taxes	0, 307	
20.00	OTHER	0	20.00
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	164, 517	21. 00
21.00	instructions))	104, 517	21.00
22 00	Day Care Cost and Allowances	56, 624	22. 00
23. 00	Tui ti on Rei mbursement	30, 024	23.00
24. 00	Total Wage Related cost (Sum of lines 1 -23)	12, 247, 278	
24.00	Part B - Other than Core Related Cost	12, 241, 210	24.00
25 00	OTHER WAGE RELATED COSTS		25. 00
25.00	TOTHER MADE RELATED 00010		23.00

Health Financial Systems
HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0001

In Lieu of Form CMS-2552-10

Period:
From 07/01/2022 Part V
To 06/30/2023 Date/Time Prepared:
11/30/2023 12:56 pm

			11/30/2023 12:	:56 pm
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	1, 552, 662	12, 247, 278	1.00
2.00	Hospi tal	1, 552, 662	12, 247, 278	2.00
3.00	SUBPROVI DER - I PF			3.00
4.00	SUBPROVI DER - I RF			4.00
5.00	Subprovi der - (0ther)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY	0	0	8.00
9.00	NURSING FACILITY	0	0	9. 00
10.00	OTHER LONG TERM CARE I			10.00
11. 00	Hospi tal -Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D. P.) I			12.00
13.00	Hospi tal -Based Hospi ce			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14. 01	Hospital-Based Health Clinic RHC 1	0	0	14.01
14. 02	Hospital-Based Health Clinic RHC 2	0	0	14.02
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospi tal -Based-CMHC			16.00
17.00	RENAL DIALYSIS I			17.00
18. 00	Other	0	0	18.00

Health Financial Systems HOSPITAL-BASED RHC/FQHC STATISTICAL DATA Provider CCN: 14-0001 Peri od:

From 07/01/2022 Component CCN: 14-3493 06/30/2023 Date/Time Prepared: 11/30/2023 12:56 pm RHC I Cost 1.00 Clinic Address and Identification 1.00 Street 180 S MAIN STREET 1.00 City ZIP Code State 1.00 2.00 2.00 City, State, ZIP Code, County CANTON IL 61520 2.00 1. 00 3.00 HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban 0 3.00 Grant Award Date 1.00 2.00 Source of Federal Funds Community Health Center (Section 330(d), PHS Act) 4.00 4.00 5.00 Migrant Health Center (Section 329(d), PHS Act) 5.00 Health Services for the Homeless (Section 340(d), PHS Act) 6.00 6.00 Appalachian Regional Commission 7 00 7 00 8.00 Look-Alikes 8.00 9.00 OTHER (SPECIFY) 9.00 1. 00 2.00 10.00 Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for n 10.00 yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.) Sunday Monday Tuesday from from 1.00 2.00 3.00 4.00 5.00 Facility hours of operations (1) 11. 00 CLINIC 08: 30 15: 00 07: 30 07: 30 17: 30 11.00 1.00 2.00 12.00 Have you received an approval for an exception to the productivity standard? Ν 12.00 Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 3 13.00 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below. Provi der name CCN 1.00 2.00 14.00 RHC/FQHC name, CCN FARMINGTON CLINIC 143494 14. 00 14.01 CANTON CLINIC 143492 14.01 EWISTOWN CLINIC 14.02 143493 14.02 Y/N ٧ XVIII XIX Total Visits 1. 00 2.00 3.00 4. 00 5. 00 Have you provided all or substantially all 15.00 GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions) County 4.00 2.00 City, State, ZIP Code, County FULTON 2.00 Tuesday Wednesday Thursday from from to to to 6.00 9.00 10.00

7.00

07: 30

17: 30

8.00

07: 30

17: 30

11.00

17: 30

In Lieu of Form CMS-2552-10

Worksheet S-8

11.00 CLINIC

Facility hours of operations (1)

th Financial Systems GRAHAM HOSPITAL ASSOCIATION

Heal th Financial Systems GRAHAM HOSPITAL ASSOCIATION In Lieu of Form CMS-2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA Provider CCN: 14-0001 Period: Worksheet S-8

Provider CCN: 14-0001 | Period: From 07/01/2022 | To 06/30/2023 | Date/Time Prepared: 11/30/2023 12:56 pm

| Trom to from to | Trom t

Heal th Fi nanci al Systems GRAHAM HOSPI TAL ASSOCIATION
HOSPI TAL-BASED RHC/FOHC STATISTICAL DATA Provider CCN: 14-0001 Period:

From 07/01/2022 Component CCN: 14-8603 06/30/2023 Date/Time Prepared: 11/30/2023 12:56 pm RHC II Cost 1.00 Clinic Address and Identification 1.00 Street 1024 N MAGNOLIA STREET 1.00 City State ZIP Code 1.00 2.00 3.00 2.00 City, State, ZIP Code, County ELMWOOD IL 61529 2.00 1. 00 3.00 HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban 0 3.00 Grant Award Date 1.00 2.00 Source of Federal Funds Community Health Center (Section 330(d), PHS Act) 4.00 4.00 5.00 Migrant Health Center (Section 329(d), PHS Act) 5.00 Health Services for the Homeless (Section 340(d), PHS Act) 6.00 6.00 Appalachian Regional Commission 7 00 7 00 8.00 Look-Alikes 8.00 9.00 OTHER (SPECIFY) 9.00 1. 00 2.00 10.00 Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for 0 10.00 yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.) Sunday Monday Tuesday from from from 1.00 2.00 3.00 4.00 5.00 Facility hours of operations (1) 11. 00 CLINIC 08: 00 08: 00 17: 30 11.00 1.00 2.00 12.00 Have you received an approval for an exception to the productivity standard? N 12.00 Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section N 0 13.00 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below. Provi der name CCN 1.00 2.00 14.00 RHC/FQHC name, CCN 14. 00 Total Visits Y/N V XVIII XIX 1.00 2.00 3.00 4.00 5.00 Have you provided all or substantially all 15.00 GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions) County 4.00 2.00 City, State, ZIP Code, County PEORI A 2.00 Tuesday Wednesday Thursday to from to from to 6. 00 9.00 10.00 7.00 8.00

17: 30

08.00

17: 30

08: 00

17: 30

11 00

In Lieu of Form CMS-2552-10

Worksheet S-8

11. 00 CLINI C

Facility hours of operations (1)

th Financial Systems STATE GRAHAM HOSPITAL ASSOCIATION

Heal th Financial Systems GRAHAM HOSPITAL ASSOCIATION In Lieu of Form CMS-2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA
Provider CCN: 14-0001 | Period: From 07/01/2022 | To 06/30/2023 | Date/Time Prepared: 11/30/2023 12:56 pm

				RHC II	Cost	
	Fri day		Satu	rday		
	from	to	from	to		
	11. 00	12. 00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	17: 30				11. 00

Heal th Fi nanci al Systems

HOSPI TAL-BASED RHC/FOHC STATI STI CAL DATA

GRAHAM HOSPI TAL ASSOCIATION

Provi der CCN: 14-0001 | Peri od:

Provider CCN: 14-0001 Worksheet S-8 From 07/01/2022 Component CCN: 14-8636 06/30/2023 Date/Time Prepared: 11/30/2023 12:56 pm RHC III Cost 1.00 Clinic Address and Identification 1.00 Street 120 E GALE ST 1.00 ZIP Code City State 1.00 2.00 2.00 City, State, ZIP Code, County WILLI AMSFIELD IL 64189 2.00 1. 00 3.00 HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban 0 3.00 Grant Award Date 1.00 2.00 Source of Federal Funds Community Health Center (Section 330(d), PHS Act) 4.00 4.00 5.00 Migrant Health Center (Section 329(d), PHS Act) 5.00 Health Services for the Homeless (Section 340(d), PHS Act) 6.00 6.00 Appalachian Regional Commission 7 00 7 00 8.00 Look-Alikes 8.00 9.00 OTHER (SPECIFY) 9.00 1. 00 2.00 10.00 Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for 0 10.00 yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.) Sunday Monday Tuesday from from from 1.00 2.00 3.00 4.00 5.00 Facility hours of operations (1) 11. 00 CLINIC 08: 00 16: 30 11.00 1. 00 2.00 12.00 Have you received an approval for an exception to the productivity standard? 12.00 Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section N 0 13.00 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below. Provi der name CCN 1.00 2.00 14.00 RHC/FQHC name, CCN 14. 00 Total Visits Y/N V XVIII XIX 1.00 2.00 3.00 4.00 5.00 Have you provided all or substantially all 15.00 GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions) County 4.00 2.00 City, State, ZIP Code, County KNOX 2.00 Tuesday Wednesday Thursday to from to from to

6. 00

7.00

08.00

8.00

16: 30

In Lieu of Form CMS-2552-10

9.00

10.00

11 00

11. 00 CLINI C

Facility hours of operations (1)

al th Financial Systems STATE GRAHAM HOSPITAL ASSOCIATION

Heal th Financial Systems GRAHAM HOSPITAL ASSOCIATION In Lieu of Form CMS-2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA Provider CCN: 14-0001 Period: Worksheet S-8

MCRI F32 - 21. 2. 177. 0

In Lieu of Form CMS-2552-10 Worksheet S-10

			o 06/30/2023	Date/Time Pre 11/30/2023 12			
				1. 00			
	Uncompensated and indigent care cost computation			1.00			
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by I Medicaid (see instructions for each line)	ine 202 column	8)	0. 355656	1.00		
2. 00	Net revenue from Medicaid			8, 319, 458	2.00		
3. 00	Did you receive DSH or supplemental payments from Medicaid?			Υ Υ	3.00		
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental paymen	Υ	4.00				
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medica	i d		0	5.00		
6.00	Medicaid charges			63, 312, 071	6.00		
7.00	Medicaid cost (line 1 times line 6)			22, 517, 318	7.00		
8. 00	Difference between net revenue and costs for Medicaid program (line 7 mi < zero then enter zero)	nus sum of lin	es 2 and 5; if	14, 197, 860	8. 00		
	Children's Health Insurance Program (CHIP) (see instructions for each li	ne)		l			
9.00	Net revenue from stand-alone CHIP	,		0	9.00		
10.00	Stand-alone CHIP charges			0	10.00		
11. 00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00		
12. 00	Difference between net revenue and costs for stand-alone CHIP (line 11 m enter zero)	inus line 9; i	f < zero then	0	12. 00		
	Other state or local government indigent care program (see instructions	for each line)					
13.00	Net revenue from state or local indigent care program (Not included on I)	0	13.00		
14.00	Charges for patients covered under state or local indigent care program	(Not included	in lines 6 or	0	14.00		
	10)						
15.00	State or local indigent care program cost (line 1 times line 14)		. 45	0	15.00		
16. 00	Difference between net revenue and costs for state or local indigent car 13; if < zero then enter zero)	e program (IIn	e 15 minus iine	0	16. 00		
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and sta	te/Local indic	ent care progra	l ams (see			
	instructions for each line)	terrocal inarg	cire care progre	(300			
17.00	Private grants, donations, or endowment income restricted to funding cha	rity care		0	17. 00		
18.00	Government grants, appropriations or transfers for support of hospital o	perati ons		0	18.00		
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent 8, 12 and 16)	care programs	(sum of lines	14, 197, 860	19. 00		
	o, 12 and 10)	Uni nsured	Insured	Total (col. 1			
		patients	patients	+ col . 2)			
		1.00	2. 00	3. 00			
	Uncompensated Care (see instructions for each line)						
20. 00	Charity care charges and uninsured discounts for the entire facility (see instructions)	2, 028, 469	804, 549	2, 833, 018	20. 00		
21. 00	Cost of patients approved for charity care and uninsured discounts (see	721, 437	804, 549	1, 525, 986	21.00		
	instructions)						
22. 00	Payments received from patients for amounts previously written off as charity care		0	0	22. 00		
23. 00	Cost of charity care (line 21 minus line 22)	721, 437	804, 549	1, 525, 986	23. 00		
				1. 00			
24. 00	Does the amount on line 20 column 2, include charges for patient days be	yond a Length	of stay limit	N	24. 00		
25. 00	imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of 0						
24 00	stay limit	`		4 510 1/0	24 00		
26. 00 27. 00	Total bad debt expense for the entire hospital complex (see instructions Medicare reimbursable bad debts for the entire hospital complex (see ins			4, 510, 160 302, 372			
27. 00 27. 01	Medicare allowable bad debts for the entire hospital complex (see instru	,		302, 372 465, 187			
28. 00	Non-Medicare bad debt expense (see instructions)	CT UIIS)		4, 044, 973			
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see	instructions)		1, 601, 434			
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	5 (1 45 (1 5115)		3, 127, 420			
	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			17, 325, 280	•		

Health Financial Systems HOSPI TAL RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CCN: 14-0001

In Lieu of Form CMS-2552-10

Worksheet A

Peri od:

From 07/01/2022 06/30/2023 Date/Time Prepared: 11/30/2023 12:56 pm Recl assi fi ed Cost Center Description Sal ari es 0ther 1 Reclassi fi cat Total (col. + col. 2) ions (See Trial Balance (col. 3 +-col. 4) A-6) 1. 00 4. 00 5.00 2.00 3.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 7, 384, 159 7, 384, 159 -1, 765, 619 5, 618, 540 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 2 00 1, 821, 321 1, 821, 321 3.00 00300 OTHER CAP REL COSTS 3.00 00400 EMPLOYEE BENEFITS DEPARTMENT 253, 801 13, 031, 042 13, 284, 843 -73, 107 13, 211, 736 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 9, 582, 701 8, 105, 955 17, 688, 656 -146, 919 17, 541, 737 5.00 00700 OPERATION OF PLANT 7.00 2,008,407 3, 090, 128 3,089,665 1, 081, 721 -463 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 4, 385 307, 254 311, 639 49, 732 361, 371 8.00 9 00 00900 HOUSEKEEPI NG 1, 193, 257 240, 712 1, 433, 969 -49, 732 1, 384, 237 9.00 01000 DI ETARY 750, 952 939, 061 1, 707, 486 -956, 534 10.00 10.00 768, 425 01100 CAFETERI A 956, 534 11.00 956, 534 11.00 13.00 01300 NURSING ADMINISTRATION 681, 707 78, 295 760,002 760,002 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 0 01500 PHARMACY 893, 701 991, 923 991, 923 15.00 98, 222 0 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 662, 814 311, 695 974, 509 0 974, 509 16.00 20.00 02000 NURSING PROGRAM 1,010,979 213, 972 1, 224, 951 1, 224, 951 20.00 INPATIENT ROUTINE SERVICE COST CENTERS 3, 268, 089 30.00 03000 ADULTS & PEDIATRICS 952, 180 4, 220, 269 1, 313, 785 5, 534, 054 30.00 31.00 03100 INTENSIVE CARE UNIT 964, 284 134, 035 1,098,319 -3, 905 1, 094, 414 31.00 04300 NURSERY 8,873 43.00 8,873 43.00 04400 SKILLED NURSING FACILITY 870, 727 68, 384 939, 111 939, 111 44.00 44.00 04500 NURSING FACILITY <u>36, 05</u>1 45.00 867, 465 903, 516 903, 516 45.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 1, 922, 906 4, 985, 099 6, 908, 005 -3, 275, 438 3, 632, 567 50.00 52 00 05200 DELIVERY ROOM & LABOR ROOM 52 00 0 0 05201 DELIVERY ROOM & LABOR ROOM 52.01 0 17,090 17,090 52.01 05300 ANESTHESI OLOGY 1, 756, 721 38, 605 1, 795, 326 1, 795, 326 53.00 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 234, 807 1, 298, 223 2, 533, 030 2, 530, 577 54.00 -2.453 05700 CT SCAN 57.00 346, 495 346, 495 346, 495 57.00 58.00 05800 MRI 18,620 313, 840 332, 460 332, 460 58.00 06000 LABORATORY 60.00 1, 904, 962 3, 195, 993 5, 100, 955 0 5, 100, 955 60.00 654, 771 65 00 06500 RESPIRATORY THERAPY 127, 984 782, 755 782, 755 65 00 06600 PHYSI CAL THERAPY 66.00 1, 751, 446 67, 797 1,819,243 1, 819, 243 66.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 987, 031 987, 031 71.00 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 2, 325, 354 2, 325, 354 72.00 07300 DRUGS CHARGED TO PATIENTS 2, 368, 856 2, 368, 856 73 00 2, 368, 856 73 00 07697 CARDIAC REHABILITATION 123,008 343, 596 76.97 220, 588 5,893 349, 489 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 13, 644, 132 10, 980, 398 24, 624, 530 -2, 954, 663 21, 669, 867 88.00 08801 ELMWOOD RHC 1, 231, 183 1, 231, 183 88.01 0 88 01 88.02 08802 WILLIAMSFIELD RHC 0 C 0 134, 067 134, 067 88.02 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00 09000 CLI NI C 90.00 90.00 0 0 0 0 1, 219, 669 570, 418 1, 157, 964 61, 705 90 01 09001 WOUND CLINIC 587, 546 90.01 63, 688 91.00 09100 EMERGENCY 3, 233, 034 906, 688 4, 139, 722 4, 203, 410 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED 607, 618 948, 788 1, 556, 406 15, 316 1, 571, 722 96.00 96.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 0 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 49, 811, 843 60, 010, 980 109, 822, 823 109, 585, 562 118. 00 118.00 -237, 261 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 190.00 192.00 19200 PHYSICIANS PRIVATE OFFICES 1, 534 192. 00 0 1,071 1,071 463 192. 01 19201 CANTON RHC RENTED SPACE 0 0 0 192.01 193. 00 19300 NONPALD WORKERS 0 0 0 0 193.00 193. 02 19302 FOUNDATI ON 0 193.02 0 0 0 194. 00 07950 PHYSICIANS CLINIC 0 0 0 194, 00 194. 01 07951 PROCTOR CHEMICAL DEPENDENCY C 0 0 0 194.01 194. 02 07952 FRESENI US 0 194. 02 194. 03 07953 RUCHFORD POB 0 0 5, 683 17, 448 194. 03 11, 765 11, 765 194.04 07954 EP COLEMAN RENTAL SPACE 0 194, 04 0 194. 05 07955 FARMI NGTON POB 0 0 194.05 194.06 07956 LEWI STON POB 0 194.06 0 0 0 194. 07 07957 OTHER RENTAL PROPERTY 0 0 194.07 194. 08 07958 KELLEY HOME 0 194.08 0 194. 09 07959 EMPLOYEE PURCHASE 0 0 0 194.09 194. 10 07960 RETAIL PHARMACY 0 194. 10 194. 11 07961 WELLNESS CENTER 90, 479 112, 082 0 112, 082 194. 11 21, 603 194. 12 07962 AVON CLINIC 0 194. 12 194. 13 07963 WILLIAMSFIELD CLINIC 231, 115 194. 13 231, 115 200.00 TOTAL (SUM OF LINES 118 through 199) 49, 902, 322 60, 045, 419 109, 947, 741 109, 947, 741 200. 00

Health Financial Systems GRAHAM HOSP
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES GRAHAM HOSPITAL ASSOCIATION

In Lieu of Form CMS-2552-10

Provider CCN: 14-0001

Peri od: From 07/01/2022 To 06/30/2023 Date/Ti me Prepared: 11/30/2023 12:56 pm

			11/30/2023 12	2:56 pm
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For		
		Allocation		
OFNEDAL CEDIUSE SOCT SENTEDS	6. 00	7.00		
GENERAL SERVICE COST CENTERS 1. 00 O0100 CAP REL COSTS-BLDG & FIXT	7/5 /0/	4 052 044		1 00
1. 00 00100 CAP REL COSTS-BLDG & FLXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP	-765, 496 -14, 344	4, 853, 044 1, 806, 977		1.00
3. 00 00300 OTHER CAP REL COSTS	-14, 344	1, 800, 477		3.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	-840, 438	12, 371, 298		4.00
5. 00 00500 ADMINISTRATIVE & GENERAL	-3, 489, 006	14, 052, 731		5.00
7. 00 00700 OPERATION OF PLANT	-1, 859	3, 087, 806		7.00
8. 00 00800 LAUNDRY & LINEN SERVICE	0	361, 371		8.00
9. 00 00900 HOUSEKEEPI NG	l ol	1, 384, 237		9.00
10. 00 01000 DI ETARY	-365, 232	385, 720		10.00
11. 00 01100 CAFETERI A	-293, 890	662, 644		11.00
13.00 01300 NURSING ADMINISTRATION	-1, 613	758, 389		13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	o	0		14.00
15.00 01500 PHARMACY	-100, 563	891, 360		15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	-5, 622	968, 887		16.00
20. 00 02000 NURSI NG PROGRAM	-253, 708	971, 243		20.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS	0	5, 534, 054		30.00
31.00 03100 INTENSIVE CARE UNIT	0	1, 094, 414		31.00
43. 00 04300 NURSERY	0	8, 873		43.00
44.00 04400 SKILLED NURSING FACILITY	-1, 040	938, 071		44.00
45. 00 04500 NURSING FACILITY	0	903, 516		45. 00
ANCILLARY SERVICE COST CENTERS		2 (22 5/7		
50.00 05000 0PERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0	3, 632, 567 0		50. 00 52. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 52. 01 05201 DELIVERY ROOM & LABOR ROOM	0	17, 090		52.00
53. 00 05300 ANESTHESI OLOGY	-1, 756, 721	38, 605		53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	-1, 750, 721	2, 530, 577		54.00
57. 00 05700 CT SCAN	0	346, 495		57.00
58. 00 05800 MRI	Ŏ	332, 460		58.00
60. 00 06000 LABORATORY	-58, 353	5, 042, 602		60.00
65. 00 06500 RESPIRATORY THERAPY	0	782, 755		65.00
66. 00 06600 PHYSI CAL THERAPY	l ol	1, 819, 243		66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIE	ENT O	987, 031		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	2, 325, 354		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	-7	2, 368, 849		73.00
76. 97 07697 CARDIAC REHABILITATION	-47, 147	302, 342		76. 97
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC	-476, 563	21, 193, 304		88. 00
88. 01 08801 ELMWOOD RHC	0	1, 231, 183		88. 01
88. 02 08802 WI LLI AMSFI ELD RHC	0	134, 067		88. 02
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	8 0	0		89.00
90. 00 09000 CLI NI C	0	0		90.00
90. 01 09001 WOUND CLINIC	-222, 052	997, 617		90. 01
91. 00 09100 EMERGENCY	-2, 460, 715	1, 742, 695		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PA	AK I			92.00
96.00 OTHER REIMBURSABLE COST CENTERS 96.00 O9600 DURABLE MEDICAL EQUIP-RENTED	-18, 684	1, 553, 038		96.00
SPECIAL PURPOSE COST CENTERS	- 10, 004	1, 555, 056		70.00
113. 00 11300 I NTEREST EXPENSE	O	0		113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through	117) -11, 173, 053	98, 412, 509		118.00
NONREI MBURSABLE COST CENTERS	,, 2, 000	.,,,		1
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTE	EN O	0		190. 00
192.00 19200 PHYSICIANS PRIVATE OFFICES	0	1, 534		192.00
192.01 19201 CANTON RHC RENTED SPACE	o	0		192. 01
193.00 19300 NONPALD WORKERS	0	0		193.00
193. 02 19302 FOUNDATI ON	0	0		193. 02
194.00 07950 PHYSICIANS CLINIC	0	0		194.00
194. 01 07951 PROCTOR CHEMICAL DEPENDENCY	0	0		194. 01
194. 02 07952 FRESENI US	0	0		194. 02
194. 03 07953 RUCHFORD POB	0	17, 448		194. 03
194. 04 07954 EP COLEMAN RENTAL SPACE	0	0		194. 04
194. 05 07955 FARMI NGTON POB	0	0		194. 05
194. 06 07956 LEWI STON POB	0	0		194.06
194. 07 07957 OTHER RENTAL PROPERTY	0	0		194. 07
194. 08 07958 KELLEY HOME	0	0		194.08
194. 09 07959 EMPLOYEE PURCHASE		0		194. 09
194. 10 07960 RETALL PHARMACY 194. 11 07961 WELLNESS CENTER	0	112, 082		194. 10 194. 11
194. 11 07961 WELLINESS CENTER 194. 12 07962 AVON CLINIC	0	112, 082		194. 11
194. 12 07962 AVON CLINIC 194. 13 07963 WILLI AMSFIELD CLINIC	0	231, 115		194. 12
200.00 TOTAL (SUM OF LINES 118 through 1	- 1			200.00
	11, 170, 000	.5, , , , , , 550		,_00.00

tems STATE GRAHAM HOSPI TAL ASSOCIATION

Health Financial Systems | GRAHAM HOSPITAL ASSOCIATION | In Lieu of Form CMS-2552-10 | RECLASSIFICATIONS | Provider CCN: 14-0001 | Period: | Worksheet A-6

From 07/01/2022

500.00

06/30/2023 Date/Time Prepared: 11/30/2023 12:56 pm Increases Cost Center Sal ary 0ther Line # 2.00 3.00 4.00 5.00 - CAFETERIA RECLASS 1.00 CAFETERI A 11.00 526, 062 430, 472 1.00 TOTALS 526, 062 430, 472 B - MAINTENANCE LABOR RECLAS 1.00 PHYSICIANS PRIVATE OFFICES 192.00 463 1.00 Ō TOTALS 463 C - OFFSITE CAPITAL RECLASS DURABLE MEDICAL EQUIP-RENTED 1.00 96.00 0 15, 316 1.00 2.00 RURAL HEALTH CLINIC 88.00 0 55, 220 2.00 RUCHFORD POB 0 3.00 1<u>94.</u> 03 4, 121 3.00 TOTALS 74,657 D - PROPERTY INSURANCE RECLASS 1.00 OTHER CAP REL COSTS 3.00 0 133, 313 1.00 2.00 RUCHFORD POB 194.03 0 2.00 1, 562 ō TOTALS 134, 875 E - DEPRECIATION RECLASS 1.00 CARDIAC REHABILITATION 76. 97 0 2, 954 1.00 CAP REL COSTS-MVBLE EQUIP 2. 00 2.00 0 1, 790, 390 2.00 1, 793, 344 TOTAL S RHC EXPENSE RECLASS 1.00 ADULTS & PEDIATRICS 1, 349, 661 1.00 30.00 ELMWOOD RHC 583. 974 2 00 88 01 647, 209 2 00 3.00 WILLIAMSFIELD RHC 88.02 70, 476 63, 591 3.00 4.00 WOUND CLINIC 90.01 63, 857 4.00 5.00 WILLIAMSFIELD CLINIC 121, 493 109, 622 5.00 194.13 TOTALS 2, 252, 696 757, 187 G - EMPLOYEE BENEFIT AUDIT RECLASS 1.00 EMPLOYEE BENEFITS DEPARTMENT 12, 044 4.00 1.00 TOTALS 12, 044 H - IMPLANT RECLASS 1.00 IMPL. DEV. CHARGED TO 72.00 0 2, 325, 354 1.00 PATI ENTS o 2, 325, 354 TOTALS I - MED SUP CHARGE TO PATIENTS RECLASS 1.00 MEDICAL SUPPLIES CHARGED TO 71.00 0 987, 031 1.00 PATI ENT 2.00 0.00 0 0 2.00 3 00 0 00 0 0 3 00 4.00 0.00 0 0 4.00 5.00 0.00 0 5.00 0 6.00 0.00 0 6.00 0 TOTALS 987, 031 J - RECLASS PHYSICIAN BENEFITS 76. 97 1.00 CARDIAC REHABILITATION 0 2, 939 1.00 WOUND CLINIC 90. 01 0 10, 190 2.00 2.00 7<u>2, 0</u>22 3.00 **EMERGENCY** 91.00 0 3.00 TOTALS O 85, 151 K - RECLASS OB SALARIES 1.00 NURSERY 43.00 8.873 1.00 0 DELIVERY ROOM & LABOR ROOM 1<u>7, 0</u>90 2.00 52.01 0 2.00 25, 963 L - LAUNDRY & LINEN SALARIES LAUNDRY & LINEN SERVICE 49, 732 1.00 1.00 8. 00

49, 732

6, 600, 115

2, 854, 916

TOTALS

500.00 Grand Total: Increases

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Provider CCN: 14-0001 Peri od: From 07/01/2022 To 06/30/2023 Date/Time Prepared: 11/30/2023 12:56 pm

						11/30/2023 12:5	36 PM
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7.00	8. 00	9. 00	10. 00		
	A - CAFETERIA RECLASS						
1.00	DI ETARY	10. 00	526, 062	430, 472	0		1.00
	TOTALS	T	526, 062	430, 472			
	B - MAINTENANCE LABOR RECLASS						
1.00	OPERATION OF PLANT	7. 00	463	C	0		1.00
1.00	TOTALS		463	ö			1.00
	C - OFFSITE CAPITAL RECLASS		403		<u>'</u>		
1 00		1 00	ما	74 / 57			1 00
1.00	CAP REL COSTS-BLDG & FLXT	1. 00	0	74, 657			1.00
2.00		0. 00	0	O			2.00
3.00		0.00		0	<u> </u>		3.00
	TOTALS		0	74, 657	7		
	D - PROPERTY INSURANCE RECLAS	S					
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	134, 875	12		1.00
2.00		0.00	ol	0	ol ol		2.00
	TOTALS			134, 875			
	E - DEPRECIATION RECLASS		-1	,	'		
1. 00	CAP REL COSTS-BLDG & FLXT	1.00	O	1, 793, 344	9		1. 00
2. 00	INCL COSTS-DEDU & ITAL	0.00	0	1, 793, 344			2.00
2.00	TOTALS — — — —	<u> </u>					2.00
			U U	1, 793, 344	!		
	F - RHC EXPENSE RECLASS						
1. 00	RURAL HEALTH CLINIC	88. 00	2, 252, 696	757, 187			1.00
2.00		0. 00	0	0	0		2.00
3.00		0. 00	0	0	0		3.00
4.00		0. 00	0	0	o		4.00
5.00		0.00	o	0	ol ol		5.00
	TOTALS		2, 252, 696		 		
	G - EMPLOYEE BENEFIT AUDIT RE	CLASS			'		
1. 00	ADMINISTRATIVE & GENERAL	5. 00	0	12, 044	0		1.00
1.00	TOTALS		— — — }	12, 044			1.00
	H - IMPLANT RECLASS		<u> </u>	12, 044			
1 00		F0.00	ما	2 225 254			1 00
1. 00	OPERATI NG ROOM	5000	0	<u>2, 325, 354</u>			1. 00
	TOTALS		0	2, 325, 354	ł l		
	I - MED SUP CHARGE TO PATIENT						
1.00	ADULTS & PEDIATRICS	30. 00	0	9, 913			1.00
2.00	INTENSIVE CARE UNIT	31.00	0	3, 905			2.00
3.00	OPERATING ROOM	50.00	0	950, 084	↓ 0		3.00
4.00	RADI OLOGY-DI AGNOSTI C	54.00	0	2, 453	o o		4.00
5.00	WOUND CLINIC	90. 01	ol	12, 342	el ol		5.00
6.00	EMERGENCY	91.00	ol	8, 334			6.00
	TOTALS	+		987, 031			
	J - RECLASS PHYSICIAN BENEFIT	S	٦	7077001			
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	O	85, 151	0		1. 00
2. 00	LIVII LOTEL DEINETTIS DEFARTMENT	0.00	0	05, 151			2. 00
			o	0			
3. 00			إ		0		3.00
	TOTALS		0	85, 151			
	K - RECLASS OB SALARIES						
1.00	ADULTS & PEDIATRICS	30. 00	25, 963	0			1.00
2.00		0.00	o	0	o o		2.00
	TOTALS		25, 963	0			
	L - LAUNDRY & LINEN SALARIES		.,	-			
1. 00	HOUSEKEEPI NG	9. 00	49, 732	C	0		1.00
1.00	TOTALS	— — /	49, 732	š	 		1.00
500 00	Grand Total: Decreases		2, 854, 916	6, 600, 115	<u></u>	= /	00.00
300.00	piranu rotar. Decreases		2,004,910	0,000,115	ין	50	00.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0001

In Lieu of Form CMS-2552-10

Period: Worksheet A-7

From 07/01/2022 Part I

To 06/30/2023 Date/Time Prepared:
11/30/2023 12:56 pm

						11/30/2023 12	:56 pm
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	6, 392, 453	5, 885, 501	0	5, 885, 501	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	101, 009, 218	1, 483, 708	0	1, 483, 708	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	13, 155, 219	2, 738, 257	0	2, 738, 257	171, 894	5.00
6.00	Movable Equipment	37, 307, 806	3, 490, 300	0	3, 490, 300	1, 373, 811	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	157, 864, 696	13, 597, 766	0	13, 597, 766	1, 545, 705	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	157, 864, 696	13, 597, 766	0	13, 597, 766	1, 545, 705	10.00
		Endi ng	Ful l y				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	12, 277, 954	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	102, 492, 926	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fi xed Equi pment	15, 721, 582	0				5.00
6.00	Movable Equipment	39, 424, 295	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	169, 916, 757	0				8.00
9. 00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	169, 916, 757	0				10.00

eal th Fi nanci al Systems GRAHAM HOSPI TAL ASSOCIATION

Heal th Financial Systems GRAHAM HOSPITAL ASSOCIATION In Lieu of Form CMS-2552-10

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0001 | Period: From 07/01/2022 | To 06/30/2023 | Provider CCN: 14-0001 | Period: From 07/01/2022 | Period: Provider CCN: 14-0001 | Period: From 07/01/2022 | Period: 11/30/2023 | Period: Provider CCN: 14-0001 |

						11/30/2023 12	:56 pm
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
					(see	instructions)	
					instructions)		
		9. 00	10. 00	11.00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	MN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FLXT	7, 384, 159	0		0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0	0	2.00
3.00	Total (sum of lines 1-2)	7, 384, 159	0		0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	0ther	Total (1)				
		Capi tal -Relat	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	MN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	7, 384, 159				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	7, 384, 159				3.00

Heal th Fi nanci al Systems GRAHAM HOSPI TAL ASSOCIATION

Health Financial Systems GRAHAM HOSPITAL ASSOCIATION In Lieu of Form CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 14-0001 Period: Worksheet A-7

From 07/01/2022

Part III

06/30/2023 Date/Time Prepared: 11/30/2023 12:56 pm COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPITAL Cost Center Description Gross Assets Capi tal i zed Gross Assets Ratio (see Insurance for Ratio instructions) Leases (col. 1 col. 2) 1.00 2.00 3.00 4.00 5.00 PART III - RECONCILIATION OF CAPITAL COSTS CENTERS
CAP REL COSTS-BLDG & FIXT 130 130, 492, 461 1.00 130, 492, 461 0.767979 102, 382 1.00 CAP REL COSTS-MVBLE EQUIP 2.00 39, 424, 296 39, 424, 296 0. 232021 30, 931 2.00 Total (sum of lines 1-2) 169, 916, 757 169, 916, 757 1.000000 133, 313 3.00 3.00 ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL Cost Center Description Taxes 0ther Total (sum of Depreciation Lease Capi tal -Rel at cols. 5 ed Costs through 7) 6.00 7.00 9.00 10.00 8.00 PART III - RECONCILIATION OF CAPITAL COSTS CENTERS CAP REL COSTS-BLDG & FIXT 0 102, 382 5, 516, 158 -424, 080 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 30, 931 1, 776, 046 2.00 0 133, 313 7, 292, 204 Total (sum of lines 1-2) -424, 080 3.00 3.00 SUMMARY OF CAPITAL Other Total (2) Capital-Relat (sum of cols. Cost Center Description Interest Insurance Taxes (see instructions) (see 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
CAP REL COSTS-BLDG & FIXT 1.00 102, 382 4, 853, 044 1.00 -341, 416 0 0 CAP REL COSTS-MVBLE EQUIP 30, 931 0 2 00 1, 806, 977 2.00 3.00 Total (sum of lines 1-2) -341, 416 133, 313 0 6, 660, 021 3.00 Heal th Fi nanci al Systems GRAHAM HOSPI TAL ASSOCIATION

Health Financial Systems | GRAHAM HOSPITAL ASSOCIATION | In Lieu of Form CMS-2552-10 |
ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0001 | Period: | Worksheet A-8

From 07/01/2022 06/30/2023 Date/Time Prepared: 11/30/2023 12:56 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Wkst. A-7 Cost Center Description Amount (2) Ref. 1.00 2.00 3.00 4.00 5. 00 1.00 Investment income - CAP REL -239, 557 CAP REL COSTS-BLDG & FIXT 1. 00 1.00 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 3.00 (chapter 2) -38, 382 ADMI NI STRATI VE & GENERAL 4.00 Trade, quantity, and time В 5.00 4.00 discounts (chapter 8) 5.00 Refunds and rebates of -212 ADMINISTRATIVE & GENERAL 5.00 B 5.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) Tel ephone services (pay 7.00 0.007.00 stations excluded) (chapter 8.00 Television and radio service -3, 967 CAP REL COSTS-MVBLE EQUIP 2.00 8.00 (chapter 21) 9.00 Parking lot (chapter 21) 0.00 9.00 -2, 593, 421 10.00 Provi der-based physici an 10.00 A-8-2 adjustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) Related organization 12.00 12.00 A-8-1 transactions (chapter 10) 13.00 13.00 Laundry and linen service 0.00 Cafeteria-employees and guests -293, 890 CAFETERI A 11.00 14.00 В 14.00 15.00 Rental of quarters to employee 0.00 15.00 and others Sale of medical and surgical 16.00 16.00 0 0.00 supplies to other than pati ents 17.00 Sale of drugs to other than 0.00 17.00 pati ents Sale of medical records and 18.00 -5, 622 MEDI CAL RECORDS & LI BRARY 18.00 В 16.00 abstracts 19.00 Nursing and allied health 0 0.00 19.00 education (tuition, fees, books, etc.) 20.00 Vending machines 0.00 20.00 21.00 Income from imposition of 0.00 21.00 interest, finance or penalty charges (chapter 21) Interest expense on Medicare 22 00 0 00 ol 22.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory ORESPIRATORY THERAPY 65.00 23.00 A-8-3 therapy costs in excess of limitation (chapter 14) Adjustment for physical OPHYSICAL THERAPY 24.00 24.00 A-8-3 66.00 therapy costs in excess of limitation (chapter 14) 0 *** Cost Center Deleted *** 25.00 25.00 Utilization review 114.00 physicians' compensation (chapter 21) OCAP REL COSTS-BLDG & FIXT 26.00 Depreciation - CAP REL 1.00 26.00 COSTS-BLDG & FLXT 27.00 Depreciation - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 27.00 COSTS-MVBLE EQUIP 0 *** Cost Center Deleted *** 28.00 Non-physician Anesthetist 19.00 28.00 Physicians' assistant 29 00 0.00 29 00 Adjustment for occupational 0 *** Cost Center Deleted *** 30.00 A-8-3 67.00 30.00

OADULTS & PEDIATRICS

30.00

30.99

instructions)

therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see ASSOCI ATI ON Provi der CCN: 14-0001

Health Financial Systems ADJUSTMENTS TO EXPENSES

In Lieu of Form CMS-2552-10

Worksheet A-8 Peri od:

From 07/01/2022 To 06/30/2023 Date/Time Prepared:

					06/30/2023	11/30/2023 12	pared: :56 pm
				Expense Classification on	Worksheet A	117 007 2020 12	, 00 piii
				To/From Which the Amount is			
	Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	5551 551151 25551 P 11 511	(2)	7 11110 01110	0001 0011101	2	Ref.	
		1. 00	2. 00	3.00	4. 00	5. 00	
31. 00	Adjustment for speech	A-8-3		*** Cost Center Deleted ***	68. 00	3. 00	31.00
31.00	pathology costs in excess of	N 0 3		Cost center bereted	00.00		31.00
	limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0. 00	0	32.00
32.00	Depreciation and Interest				0.00	O	32.00
33. 00	DI ETARY VENDOR REBATES/REFUNDS	В	6 246	DI ETARY	10. 00	0	33.00
33. 01	MEDICAL STAFF DUES	В		ADMINISTRATIVE & GENERAL	5. 00	0	33.00
33. 01	ADMIN OTHER INCOME	В		ADMINISTRATIVE & GENERAL	5. 00	0	33.01
		В		OPERATION OF PLANT	l l	0	1
33. 03	PLANT OPS OTHER INCOME	В		HOUSEKEEPI NG	7. 00	-	33. 03
33. 04	HOUSEKEEPING OTHER INCOME				9. 00	0	33. 04
33. 05	DIETARY CONSULTANT AND EMP	В	-358, 986	DIETARY	10. 00	0	33. 05
00.07	PURCHASE		4 (40	AULIDOL NO. ADMINISCEDATION	10.00		00.07
33. 06	NURSING & ADMIN CPR CLASS FEES			NURSI NG ADMI NI STRATI ON	13. 00	0	33.06
33. 07	PHARMACY OTHER I NCOME	В		PHARMACY	15. 00	0	33. 07
33. 08	SALE OF DRUGS TO OTEHR THAN	В	-100, 563	PHARMACY	15. 00	0	33. 08
	PATIENTS	_	_			_	
33. 09	REFUNDS & REBATES - PHARMACY	В		PHARMACY	15. 00	0	33. 09
33. 10	CARDIAC REHAB OTHER INCOME	В	1	CARDIAC REHABILITATION	76. 97	0	33. 10
33. 11	RHC OTHER INCOME	В	1	RURAL HEALTH CLINIC	88. 00	0	33. 11
33. 12	WOUND CLINIC OTHER INCOME	В		WOUND CLINIC	90. 01	0	33. 12
33. 13	DME NON-PATIENT SALES	В	-9, 018	DURABLE MEDICAL EQUIP-RENTED	96. 00	0	33. 13
33. 14	DME OTHER INCOME	В	-5, 891	DURABLE MEDICAL EQUIP-RENTED	96. 00	0	33. 14
33. 15	LAB OTHER INCOME	В	0	LABORATORY	60.00	0	33. 15
33. 16	NURSING SCHOOL REVENUE	В	-253, 708	NURSING PROGRAM	20. 00	0	33. 16
33. 17	DONATI ONS	В	-13, 525	ADMINISTRATIVE & GENERAL	5. 00	0	33. 17
33. 18	DONATI ONS	В	-32	CARDIAC REHABILITATION	76. 97	0	33. 18
33. 19	DONATI ONS	В	-7	DRUGS CHARGED TO PATIENTS	73. 00	0	33. 19
33. 20	CRNA CONTRACTED EXPENSES	Α	0	ANESTHESI OLOGY	53. 00	0	33. 20
33. 21	CRNA SALARIES	Α	-1, 756, 721	ANESTHESI OLOGY	53. 00	0	33. 21
33. 22	CRNA BENEFITS	Α	-352, 902	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 22
33. 23	REFUNDS & REBATES - LAB	Α	0	LABORATORY	60.00	0	33. 23
33. 24	ILLINOIS MA PROVIDER TAX	Α	-2, 984, 628	ADMINISTRATIVE & GENERAL	5. 00	0	33. 24
33. 25	PHONE SALARIES	А	-2, 488	ADMINISTRATIVE & GENERAL	5. 00	0	33. 25
33. 26	PHONE BENEFITS	А	-500	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 26
33. 27	PHONE OTHER EXP	Α	-985	ADMINISTRATIVE & GENERAL	5. 00	0	33. 27
33. 28	PHONE DEPR	Α		CAP REL COSTS-MVBLE EQUIP	2. 00	9	33. 28
33. 29	I HA & AHA DUES LOBBYING	Α		ADMINISTRATIVE & GENERAL	5. 00	0	33. 29
	PORTI ON						
33. 30	IL HEALTHCARE ASSOCIATION	Α	-1, 040	SKILLED NURSING FACILITY	44.00	0	33. 30
	LOBBYI NG						
33. 31	MARKETING SALARIES	Α	-90, 739	ADMINISTRATIVE & GENERAL	5. 00	0	33. 31
	MARKETING BENEFITS	А		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	•
33. 33	MARKETING OTHER EXPENSE	А		ADMINISTRATIVE & GENERAL	5. 00	0	33. 33
33. 34	MARKETING DEPR	А		CAP REL COSTS-MVBLE EQUIP	2. 00	9	33. 34
33. 35	PHYSI CI AN RECRUI TMENT	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 35
33. 36	LOAN FORGI VENESS EXPENSE	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 36
33. 37	OTHER ADJUSTMENTS (SPECIFY)	^	400, 000 n	Land Stee Server 113 Server MENT	0.00	0	33. 37
55.57	(3)				0.00	0	33.37
33. 38	SWAP INTEREST RATE EXPENSE	А	_101 950	CAP REL COSTS-BLDG & FIXT	1. 00	11	33. 38
33. 39	DME EMPLOYEE & GUEST REVENUE	В	1	DURABLE MEDICAL EQUIP-RENTED	96. 00	0	33. 39
33. 40	EMERGENCY ROOM OTHER REVENUE	В		EMERGENCY	91.00	0	
33. 40	RENTAL REVENUE	В	4	CAP REL COSTS-BLDG & FIXT	1.00	10	
50. 00	TOTAL (sum of lines 1 thru 49)	ט	-11, 173, 053	1	1.00	10	50.00
50.00	(Transfer to Worksheet A,		-11, 1/3, 053				30.00
	column 6, line 200.)						
	COLUMN O, TITLE 200.)		<u> </u>				L

⁽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.

In Lieu of Form CMS-2552-10

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Peri od: From 07/01/2022 To 06/30/2023 Date/Ti me Prepared: 11/30/2023 12:56 pm Provider CCN: 14-0001

With the color of the color o								11/30/2023 12	2:56 pm
Identifier Remuneration Component Component Iden Component Hours Flourist Florist Flourist		Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
1.00									
1.00			ruenti i i ei	Reliurier at 1 Ori	Component	Component			
1.00									
2.00		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
2.00 90.01 MUNDIND CLINIC 66.918 30.918 30.000 171, 400 144 2.00	1.00	91, 00	EMERGENCY	2, 610, 443	2, 069, 037	541, 406	171, 400	1, 817	1. 00
3.00									
4. 00						30,000			
5.00						U			
Continuing Con	4.00	60.00	LABORATORY	57, 000	0	57, 000	171, 400	500	4. 00
Continuing Con	5.00	60.00	LABORATORY	42, 555	42, 555	0	0	O	5.00
7.00				1,	,	0	0	٥	
8.00					0	0	0	٥	
9.00				0	U	0	0	l ol	
10.00	8. 00	0.00		0	0	0	0	0	8. 00
10.00	9.00	0.00		0	0	0	0	o	9.00
Number Cost Center/Physician Cost Center/Physician Identifier Cost Center/Physician Cost C				0	0	0	0	٥	
Wkst. A Line # Cost Center/Physician Identifier Unadjusted RCE Limit Unadjusted RCE Unadjusted RCE Limit Unadjusted RCE Unit Unadjusted RCE Unit Unadjusted RCE Unit Uni		0.00		0 70, 017	0 4/4 044		0	0 44	
Identifier									200.00
Limit Continuing Education 12 1.00 1.00 2.00 8.00 9.00 12.00 13.00 14.00		Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
Limit Continuing Education 12 1.00 1.00 2.00 8.00 9.00 12.00 13.00 14.00			l denti fi er	Limit	Unadiusted RCE	Memberships &	Component	lof Mal practice	
1.00					,	•		'	
1.00					21 1111 (Tribui dilec	
1.00		4 00	0.00	0.00	0.00			14.00	
2. 00									
3.00	1. 00	91. 00	EMERGENCY			0	0	0	1. 00
3.00	2.00	90. 01	WOUND CLINIC	11, 866	593	0	0	0	2.00
4. 00 60. 00 LABORATORY	3 00	76 97	CARDIAC REHABILITATION	·	n	0	n	٥	3 00
S. 00				41 202	2.040	0	0	ا	
6. 00				41, 202	2,000	0	0	U	
7. 00				0	0	0	0	0	
8.00	6.00	0.00		0	0	0	0	0	6.00
8.00	7.00	0.00		0	0	0	0	0	7.00
9.00 0.00 0.00 0 0 0 0 0				0	0	0	0	٥	
10.00					0	0	0	٥	
200.00 200.00 202,796 10,139 0 0 0 0 200.00				0	U	U	0	l o	
Wkst. A Line # Cost Center/Physician I dentifier Provider Component Share of col. 14	10. 00	0.00		0	0	0	0	0	10. 00
Wkst. A Line # Cost Center/Physician I dentifier Provider Component Share of col. 14	200.00			202, 796	10, 139	0	0	0	200.00
Identifier Component Share of col. Li mi t Di sal I owance		Wkst Aline #	Cost Center/Physician				Adiustment		
Share of col. 14		mest: // Eine //			,		riaj astilioni		
14			ruenti i i ei		LIIIII C	Di Sai i Owance			
1. 00 2. 00 15. 00 16. 00 17. 00 18. 00 1. 00 91. 00 EMERGENCY 0 149, 728 391, 678 2, 460, 715 1. 00 2. 00 90. 01 WOUND CLINIC 0 11, 866 24, 134 55, 052 2. 00 3. 00 76. 97 CARDIAC REHABILITATION 0 0 0 19, 301 3. 00 4. 00 60. 00 LABORATORY 0 41, 202 15, 798 15, 798 4. 00 5. 00 60. 00 LABORATORY 0 0 0 42, 555 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 9. 00 9. 00 0. 00 0 0 0 9. 00 10. 00 0 0 0 0 9. 00									
1. 00 91. 00 EMERGENCY 0 149, 728 391, 678 2, 460, 715 1. 00 2. 00 90. 01 WOUND CLINIC 0 11, 866 24, 134 55, 052 2. 00 3. 00 76. 97 CARDI AC REHABILITATION 0 0 0 19, 301 3. 00 4. 00 60. 00 LABORATORY 0 41, 202 15, 798 15, 798 4. 00 5. 00 60. 00 LABORATORY 0 0 0 42, 555 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 0 9. 00 9. 00 0. 00 0 0 0 0 9. 00 10. 00									
2. 00 90. 01 WOUND CLINIC 0 11,866 24,134 55,052 2.00 3. 00 76. 97 CARDI AC REHABILITATION 0 0 0 19,301 3.00 4. 00 60. 00 LABORATORY 0 41,202 15,798 15,798 4.00 5. 00 60. 00 LABORATORY 0 0 0 42,555 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 0 8.00 9. 00 0. 00 0 0 0 0 9.00 10. 00 0 0 0 0 0 9.00 10. 00 0 0 0 0 0 10.00		1.00	2. 00	15. 00	16. 00	17. 00	18. 00		
2. 00 90. 01 WOUND CLINIC 0 11,866 24,134 55,052 2.00 3. 00 76. 97 CARDI AC REHABILITATION 0 0 0 19,301 3.00 4. 00 60. 00 LABORATORY 0 41,202 15,798 15,798 4.00 5. 00 60. 00 LABORATORY 0 0 0 42,555 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 0 8.00 9. 00 0. 00 0 0 0 0 9.00 10. 00 0 0 0 0 0 9.00 10. 00 0 0 0 0 0 10.00	1 00	91 00	FMFRGFNCY	0	149 728	391 678	2 460 715		1 00
3. 00				٥ م					
4. 00 60. 00 LABORATORY 0 41, 202 15, 798 15, 798 4. 00 5. 00 60. 00 LABORATORY 0 0 0 42, 555 5. 00 6. 00 0. 00 0 0 0 0 6. 00 7. 00 0. 00 0 0 0 0 6. 00 8. 00 0. 00 0 0 0 0 0 7. 00 8. 00 0. 00 0 0 0 0 9. 00 10. 00 0. 00 0 0 0 0 9. 00 10. 00 0 0 0 0 0 10. 00					11,000	24, 134			
5. 00 60. 00 LABORATORY 0 0 42,555 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 0 8. 00 9. 00 0. 00 0 0 0 0 9. 00 10. 00 0 0 0 0 0 10. 00				0	U	0			
6.00 0.00 7.00 0.00 8.00 0.00 9.00 0.00 10.00 0.00 0 0 </td <td>4.00</td> <td>60.00</td> <td>LABORATORY</td> <td>0</td> <td>41, 202</td> <td>15, 798</td> <td>15, 798</td> <td></td> <td>4.00</td>	4.00	60.00	LABORATORY	0	41, 202	15, 798	15, 798		4.00
6.00 0.00 7.00 0.00 8.00 0.00 9.00 0.00 10.00 0.00 0 0 </td <td>5.00</td> <td>60.00</td> <td>LABORATORY</td> <td>0</td> <td>0</td> <td>0</td> <td>42, 555</td> <td></td> <td>5.00</td>	5.00	60.00	LABORATORY	0	0	0	42, 555		5.00
7.00 0.00 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 0 0 0 0 10.00				١	n	0			
8. 00 0. 00 9. 00 0. 00 10. 00 0. 00							0		
9.00 0.00 0 0 0 0 9.00 9.00 10.00 0 0 0 10.00				0	0	0	0		
10.00 0.00 0 0 0 10.00				0	0	0	0		8. 00
10.00 0.00 0 0 0 10.00	9. 00	0.00		0	0	0	0		9.00
				l n	n	n	n		
200. 00 0 202, 790 431, 610 2, 593, 421 200. 00]			202 704	421 410	2 502 421		
	200.00	1		ı	202, 790	431,010	2, 373, 421	1	200.00

eal th Financial Systems GRAHAM HOSPITAL ASSOCIATION

Heal th Financial Systems GRAHAM HOSPITAL ASSOCIATION In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0001
From 07/01/2022
To 06/30/2023 Date/Time Prepared:

			To	06/30/2023	Date/Time Pre 11/30/2023 12	
		CAPI TAL REI	LATED COSTS		117 307 2023 12	. 30 piii
Cost Contar Doscarintian	Not Evpoped	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
Cost Center Description	Net Expenses for Cost	BLUG & FIXI	MARTE EGOLA	BENEFITS	Subtotal	
	Allocation			DEPARTMENT		
	(from Wkst A					
	col . 7)	1.00	2.00	4.00	4.0	
GENERAL SERVICE COST CENTERS	0	1. 00	2. 00	4. 00	4A	
1. 00 O0100 CAP REL COSTS-BLDG & FLXT	4, 853, 044	4, 853, 044				1.00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP	1, 806, 977		1, 806, 977			2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	12, 371, 298	19, 371		12, 397, 882		4.00
5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT	14, 052, 731 3, 087, 806	463, 375 438, 113		2, 549, 195 290, 463	17, 237, 833 3, 979, 508	5. 00 7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	361, 371	95, 277		1, 178	493, 301	8.00
9. 00 00900 HOUSEKEEPI NG	1, 384, 237	77, 031		320, 549	1, 810, 498	9.00
10. 00 01000 DI ETARY	385, 720	69, 346	25, 820	110, 946	591, 832	10.00
11. 00 01100 CAFETERI A	662, 644	88, 343		141, 318	925, 198	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	758, 389 0	37, 029 51, 581		183, 130 0	992, 335 70, 787	13. 00 14. 00
15. 00 01500 PHARMACY	891, 360	49, 975		240, 078	1, 200, 021	15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	968, 887	76, 040		178, 054	1, 251, 294	16.00
20. 00 02000 NURSI NG PROGRAM	971, 243	438, 073	163, 111	271, 583	1, 844, 010	20.00
INPATIENT ROUTINE SERVICE COST CENTERS	E E24 OE4	220, 200	127 220	1 222 510	7 222 102	1 20 00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	5, 534, 054 1, 094, 414	339, 288 33, 816		1, 233, 510 259, 039	7, 233, 182 1, 399, 860	30. 00 31. 00
43. 00 04300 NURSERY	8, 873	11, 928		2, 384	27, 626	43.00
44.00 04400 SKILLED NURSING FACILITY	938, 071	80, 471		233, 907	1, 282, 412	44.00
45.00 O4500 NURSING FACILITY	903, 516	70, 859	26, 384	233, 031	1, 233, 790	45. 00
ANCILLARY SERVICE COST CENTERS	2 (22 5(7	2/0 222	100.24/	F1/ FF0	4 510 702	 FO 00
50.00 05000 0PERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	3, 632, 567	269, 232 0	100, 246 0	516, 558	4, 518, 603 0	50. 00 52. 00
52. 01 05201 DELIVERY ROOM & LABOR ROOM	17, 090	6, 305	T .	4, 591	30, 334	52.00
53. 00 05300 ANESTHESI OLOGY	38, 605	4, 217	1, 570	0	44, 392	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 530, 577	94, 715		331, 711	2, 992, 269	54.00
57. 00 05700 CT SCAN 58. 00 05800 MRI	346, 495	78, 517		0	454, 247	57. 00 58. 00
60. 00 06000 LABORATORY	332, 460 5, 042, 602	22, 357 179, 015		5, 002 511, 738	368, 143 5, 800, 009	60.00
65. 00 06500 RESPIRATORY THERAPY	782, 755	26, 507		175, 894	995, 026	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 819, 243	102, 560	38, 187	470, 498	2, 430, 488	66. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	987, 031	0	0	0	987, 031	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	2, 325, 354 2, 368, 849	37, 096	13, 812	0	2, 325, 354 2, 419, 757	72. 00 73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	302, 342	114, 997		54, 540	514, 697	76. 97
OUTPATIENT SERVICE COST CENTERS		,				
88. 00 08800 RURAL HEALTH CLINIC	21, 193, 304	790, 962		3, 060, 147	25, 338, 921	88. 00
88. 01 08801 ELMWOOD RHC 88. 02 08802 WI LLI AMSFI ELD RHC	1, 231, 183	45, 303		173, 862	1, 467, 216 165, 841	88. 01
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	134, 067	9, 358 0	3, 484	18, 932 0	105, 641	88. 02 89. 00
90. 00 09000 CLI NI C	0	0	Ö	Ö	0	90.00
90. 01 09001 WOUND CLINIC	997, 617	56, 387		168, 303	1, 243, 302	
91. 00 09100 EMERGENCY	1, 742, 695	158, 412	58, 983	437, 447	2, 397, 537	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS					0	92.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	1, 553, 038	2, 048	763	163, 227	1, 719, 076	96. 00
SPECIAL PURPOSE COST CENTERS		·		·		
113. 00 11300 INTEREST EXPENSE	00 440 500		4 (50 (05	10 010 015	07 705 700	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	98, 412, 509	4, 437, 904	1, 652, 405	12, 340, 815	97, 785, 730	118.00
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	7, 296	2, 717	ol	10, 013	190. 00
192.00 19200 PHYSICIANS PRIVATE OFFICES	1, 534	47, 538		124	66, 896	192. 00
192.01 19201 CANTON RHC RENTED SPACE	0	137, 314	1	0	188, 441	
193. 00 19300 NONPALD WORKERS	0	0	0	0		193.00
193. 02 19302 FOUNDATI ON 194. 00 07950 PHYSI CI ANS CLI NI C	0	37, 203	13, 852	0		193. 02 194. 00
194. 01 07951 PROCTOR CHEMICAL DEPENDENCY	i o	0,,200	0	o		194. 01
194. 02 07952 FRESENI US	0	80, 324	29, 908	O	110, 232	
194. 03 07953 RUCHFORD POB	17, 448	0	0	0	17, 448	
194. 04 07954 EP COLEMAN RENTAL SPACE 194. 05 07955 FARMINGTON POB	0	89, 333 0	33, 262	0	122, 595	194. 04 194. 05
194. 05 07955 FARMINGTON POB 194. 06 07956 LEWI STON POB		0		0		194.05
194. 07 07957 OTHER RENTAL PROPERTY	O	0		ő		194. 07
194.08 07958 KELLEY HOME	0	0	0	О		194. 08
194. 09 07959 EMPLOYEE PURCHASE	0	0	0	0		194. 09
194. 10 07960 RETALL PHARMACY 194. 11 07961 WELLNESS CENTER	0 112, 082	0	0	0 24, 306	0 136, 388	194. 10 194. 11
194. 12 07962 AVON CLINIC	0	0		24, 300		194. 11
			1	-1		·

eal th Financial Systems GRAHAM HOSPITAL ASSOCIATION

Heal th Financial Systems GRAHAM HOSPITAL ASSOCIATION In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0001
From 07/01/2022
To 06/30/2023 Date/Time Prepared:

						11/30/2023 12	:56 pm
			CAPI TAL REL	LATED COSTS			
Cost	Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
		for Cost			BENEFI TS		
		Allocation			DEPARTMENT		
		(from Wkst A					
		col. 7)					
		0	1.00	2.00	4.00	4A	
194. 13 07963 WI LLI	AMSFIELD CLINIC	231, 115	16, 132	6, 006	32, 637	285, 890	194. 13
200.00 Cross	Foot Adjustments					0	200.00
201.00 Negat	ive Cost Centers		0	0	0	0	201.00
202. 00 TOTAL	(sum lines 118 through 201)	98, 774, 688	4, 853, 044	1, 806, 977	12, 397, 882	98, 774, 688	202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0001

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 07/01/2022 Part I
To 06/30/2023 Date/Time Prepared:
11/30/2023 12:56 pm

					11/30/2023 12	
Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	E & GENERAL 5.00	7. 00	LINEN SERVICE 8.00	9. 00	10. 00	
GENERAL SERVICE COST CENTERS	0.00	7.00	0.00	7, 00		
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUI P						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	47 007 000					4.00
5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT	17, 237, 833 841, 316	4, 820, 824				5. 00 7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	104, 290	116, 809	1			8.00
9. 00 00900 HOUSEKEEPI NG	382, 761	94, 439		2, 287, 698		9.00
10. 00 01000 DI ETARY	125, 120	85, 018	1	65, 097	867, 067	10.00
11. 00 01100 CAFETERI A	195, 598	108, 307	1	82, 930	0	11.00
13. 00 01300 NURSI NG ADMINI STRATI ON	209, 792	45, 398	1	34, 761	0	13.00
14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY	14, 965	63, 238	1	48, 421	0	14.00
15. 00 O1500 PHARMACY 16. 00 O1600 MEDI CAL RECORDS & LI BRARY	253, 699 264, 539	61, 269 93, 224	1		0	15. 00 16. 00
20. 00 02000 NURSI NG PROGRAM	389, 846	537, 073	1		0	20.00
INPATIENT ROUTINE SERVICE COST CENTERS	221,212	2217 212	-	, = = = [
30. 00 03000 ADULTS & PEDIATRICS	1, 529, 181	415, 964	256, 085	318, 500	310, 810	30.00
31.00 03100 INTENSIVE CARE UNIT	295, 947	41, 459		31, 744	68, 855	31.00
43. 00 04300 NURSERY	5, 840	14, 624			21, 427	43.00
44.00 04400 SKILLED NURSING FACILITY 45.00 04500 NURSING FACILITY	271, 117	98, 657			136, 145	44. 00 45. 00
ANCILLARY SERVICE COST CENTERS	260, 838	86, 872	200, 993	66, 518	324, 052	45.00
50. 00 05000 OPERATING ROOM	955, 287	330, 076	0	252, 736	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0	0	52.00
52.01 05201 DELIVERY ROOM & LABOR ROOM	6, 413	7, 730	4, 761	5, 919	5, 778	52. 01
53. 00 05300 ANESTHESI OLOGY	9, 385	5, 170	1	3, 959	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	632, 602	116, 120	1	88, 912	0	54.00
57. 00 05700 CT SCAN	96, 033	96, 261	1	73, 706	0	57.00
58. 00 05800 MRI	77, 830	27, 409	1	,	0	58.00
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	1, 226, 192	219, 471	0	,	0	60. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	210, 360 513, 834	32, 497 125, 738	1	24, 883 96, 276	0	66.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	208, 670	125, 736	1	90, 270	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	491, 608	0	Ö	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	511, 566	45, 480		0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	108, 813	140, 985	1	0	0	76. 97
OUTPATIENT SERVICE COST CENTERS			1			
88. 00 08800 RURAL HEALTH CLINIC	5, 356, 914	969, 712	1		0	88.00
88. 01 08801 ELMWOOD RHC	310, 187	55, 541	0	_	0	88. 01
88.02 08802 WILLIAMSFIELD RHC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	35, 061 0	11, 472 0	0	0	0	88. 02 89. 00
90. 00 009000 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	90.00
90. 01 09001 WOUND CLINIC	262, 849	69, 130	Ö	52, 933	0	90.01
91. 00 09100 EMERGENCY	506, 868	194, 212		148, 706	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART				·		92.00
OTHER REIMBURSABLE COST CENTERS						
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	363, 433	2, 511	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE						112 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	17, 028, 754	4, 311, 866	714, 400	2, 201, 299	867, 067	113.00
NONREI MBURSABLE COST CENTERS	17,020,734	4, 311, 000	714,400	2,201,277	007,007	1110.00
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	2, 117	8, 945	0	6, 849	0	190. 00
192.00 19200 PHYSICIANS PRIVATE OFFICES	14, 143	58, 282	0	44, 626	0	192. 00
192.01 19201 CANTON RHC RENTED SPACE	39, 839	168, 345	0	0		192. 01
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
193. 02 19302 FOUNDATION	0	0	0	-		193. 02
194. 00 07950 PHYSICIANS CLINIC 194. 01 07951 PROCTOR CHEMICAL DEPENDENCY	10, 794	45, 611	0	34, 924		194. 00 194. 01
194. 02 07952 FRESENI US	23, 304	98, 476		0		194.01
194. 03 07953 RUCHFORD POB	3, 689	70, 470 N		0		194. 02
194. 04 07954 EP COLEMAN RENTAL SPACE	25, 918	109, 522	0	0		194. 04
194. 05 07955 FARMI NGTON POB	0	0	Ō	o		194. 05
194.06 07956 LEWISTON POB	o	0	0	0	0	194. 06
194.07 07957 OTHER RENTAL PROPERTY	0	0	0	0		194. 07
194. 08 07958 KELLEY HOME	0	0	0	0		194. 08
194. 09 07959 EMPLOYEE PURCHASE	0	0	0	0		194. 09
194. 10 07960 RETAIL PHARMACY	0 00 4	0] 0	0		194. 10
194. 11 07961 WELLNESS CENTER	28, 834	0		0		194. 11 194. 12
194. 12 07962 AVON CLINIC 194. 13 07963 WILLIAMSFIELD CLINIC	60, 441	19, 777		0		194. 12
200.00 Cross Foot Adjustments	00, 441	17, ///		١	U	200.00
201. 00 Negati ve Cost Centers	0	0	o	o	0	201.00
202.00 TOTAL (sum lines 118 through 201)	17, 237, 833	4, 820, 824	714, 400	2, 287, 698	867, 067	
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Heal th Fi nanci al Systems GRAHAM HOSPI TAL ASSOCIATION

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0001 | Period: | Worksheet B

Peri od: Worksheet B From 07/01/2022 Part I To 06/30/2023 Date/Ti me Prepared:

11/30/2023 12:56 pm Cost Center Description CAFETERI A NURSI NG CENTRAL PHARMACY MEDI CAL ADMI NI STRATI O SERVICES & RECORDS & **SUPPLY** LI BRARY Ν 15.00 11 00 13.00 16.00 14 00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 |OO4OO|EMPLOYEE BENEFITS DEPARTMENT 4 00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 1, 312, 033 11.00 01300 NURSING ADMINISTRATION 28, 604 1, 310, 890 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 197, 411 14 00 15.00 01500 PHARMACY 37,500 0 1, 599, 402 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 27, 812 0 1, 708, 250 16.00 Ω 02000 NURSI NG PROGRAM 20.00 279 42, 421 0 48 0 20.00 INPATIENT ROUTINE SERVICE COST CENTERS 19 097 03000 ADULTS & PEDIATRICS 192, 671 450, 613 5,822 118, 665 30.00 03100 INTENSIVE CARE UNIT 33, 309 31.00 40, 461 1,843 116, 082 8,925 31.00 04300 NURSERY 43 00 372 1,093 \cap Ω 1, 288 43 00 04400 SKILLED NURSING FACILITY 126, 716 2, 963 7, 231 44.00 36, 536 1, 161 44.00 04500 NURSING FACILITY 45.00 36, 399 131, 586 739 3, 972 6, 627 45.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 80, 688 243, 195 34, 935 20, 505 232, 820 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 05201 DELIVERY ROOM & LABOR ROOM 717 2, 087 5, 306 52.01 0 0 52.01 05300 ANESTHESI OLOGY 53.00 0 31, 306 585 205 80,600 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 51,813 C 5, 217 5, 671 143, 338 54.00 05700 CT SCAN 1,711 57.00 170 118,888 57.00 58.00 05800 MRI 781 714 33, 825 C 0 58.00 06000 LABORATORY 79. 932 234, 559 60.00 C 17, 246 353 60.00 65.00 06500 RESPIRATORY THERAPY 27, 474 2,544 199 28, 241 65.00 06600 PHYSI CAL THERAPY 66.00 73, 491 0 288 39 82,743 66.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 31 333 0 32 946 71 00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 0 73,822 44,641 72.00 07300 DRUGS CHARGED TO PATIENTS 0 1, 147, 847 80, 306 73.00 73.00 820 07697 CARDIAC REHABILITATION 76.97 8,525 0 183 527 10,009 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 478,000 0 8,084 340, 690 161, 952 88.00 19, 357 08801 ELMWOOD RHC 88.01 459 5, 490 88.01 88 02 08802 WILLIAMSFIELD RHC 0 0 50 2, 107 472 88.02 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 C 0 0 0 89.00 09000 CLI NI C 0 90.00 90.00 0 90.01 09001 WOUND CLINIC 17, 126 8,720 30, 573 90.01 4,846 208, 212 09100 EMERGENCY 91 00 50.710 3.951 213, 607 91 00 13, 287 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 908 0 96, 00 0 96,00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 1, 312, 033 1, 310, 890 197, 309 1, 594, 913 1, 707, 436 118.00 118.00 NONREI MBURSABLE COST CENTERS 0 190, 00 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 0 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 16 0 0 192.00 192. 01 19201 CANTON RHC RENTED SPACE 0 0 0 0 0 192.01 0 0 193. 00 19300 NONPALD WORKERS 0 193.00 0 0 0 193. 02 193. 02 19302 FOUNDATI ON Ω 0 194. 00 07950 PHYSICIANS CLINIC 00000000 0 0 0 0 0 0 0 0 194.00 194. 01 07951 PROCTOR CHEMICAL DEPENDENCY 0 194. 01 194. 02 07952 FRESENI US 0 194, 02 0 0 0 194. 03 07953 RUCHFORD POB C 0 194.03 194.04 07954 EP COLEMAN RENTAL SPACE 0 194.04 194. 05 07955 FARMI NGTON POB 0 0 0 194.05 194.06 07956 LEWISTON POB C 0 0 194, 06 194. 07 07957 OTHER RENTAL PROPERTY 0 194.07 194.08 07958 KELLEY HOME 0 0 0 0 0 0 194.08 194. 09 07959 EMPLOYEE PURCHASE C 0 0 0 194, 09 194. 10 07960 RETAIL PHARMACY 0 0 194. 10 C 0 0 194. 11 07961 WELLNESS CENTER 0 194. 11 0 857 194. 12 07962 AVON CLINIC C 0 194. 12 194. 13 07963 WILLI AMSFIELD CLINIC 0 814 194, 13 86 3,632 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00 1, 312, 033 1, 310, 890 197, 411 1, 599, 402 1, 708, 250 202. 00 202 00 TOTAL (sum lines 118 through 201)

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Health Financial Systems GRAHAM HOSPITAL ASSOCIATION In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0001 | Period: From 07/01/2022 | Part I | To 06/30/2023 | Date/Time Prepared:

				Γ	o 06/30/2023	Date/Time Prepared: 11/30/2023 12:56 pm
	Cost Center Description	NURSI NG	Subtotal	Intern &	Total	117 307 2023 12. 30 piii
		PROGRAM		Residents Cost & Post		
				Stepdown		
		20.00	24.00	Adjustments	27.00	
	GENERAL SERVICE COST CENTERS	20. 00	24. 00	25. 00	26. 00	
1.00	00100 CAP REL COSTS-BLDG & FLXT					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL					4. 00 5. 00
7. 00	00700 OPERATION OF PLANT					7.00
8.00	00800 LAUNDRY & LINEN SERVICE					8. 00
9.00	00900 HOUSEKEEPI NG 01000 DI ETARY					9.00
10. 00 11. 00	01100 CAFETERI A					11.00
13.00	01300 NURSING ADMINISTRATION					13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY					14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY					15. 00 16. 00
20. 00	02000 NURSI NG PROGRAM	3, 224, 909				20. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	1, 322, 512 548, 905	12, 173, 102			30.00
43.00	04300 NURSERY	548, 905	2, 644, 121 101, 121		,	43.00
44. 00	04400 SKILLED NURSING FACILITY	106, 670	2, 257, 323	C		44. 00
45. 00	04500 NURSING FACILITY	0	2, 418, 388	(2, 418, 388	45. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	412, 975	7, 081, 820	C	7, 081, 820	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		, ,	52.00
52. 01	05201 DELIVERY ROOM & LABOR ROOM	O	69, 045	C		52. 01
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	39 530	175, 602			53.00
57. 00	05700 CT SCAN	38, 520 0	4, 074, 462 841, 016		4, 074, 462 841, 016	54. 00 57. 00
58. 00	05800 MRI	0	529, 689	C		58. 00
60.00	06000 LABORATORY	0	7, 745, 809	C	.,,	60.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0 77, 780	1, 321, 224 3, 400, 677			65. 00 66. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 259, 980			71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	2, 935, 425	C		72.00
73. 00 76. 97	07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION	39, 260 80, 743	4, 245, 036 864, 482			73. 00 76. 97
70. 77	OUTPATIENT SERVICE COST CENTERS	60, 743	004, 402		004, 402	70. 77
88. 00	08800 RURAL HEALTH CLINIC	91, 003	32, 745, 276	C		88.00
88. 01 88. 02	08801 ELMWOOD RHC 08802 WI LLI AMSFI ELD RHC	3, 326 356	1, 861, 576 215, 359		1,,	88. 01 88. 02
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	213, 337			89.00
90.00	09000 CLI NI C	0	0	C	o	90.00
90. 01	09001 WOUND CLINIC	37, 038	1, 726, 517			90. 01
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	465, 199	4, 202, 289	(1,,,	92.00
	OTHER REIMBURSABLE COST CENTERS					
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED SPECIAL PURPOSE COST CENTERS	0	2, 085, 928		2, 085, 928	96.00
113. 00	11300 INTEREST EXPENSE					113.00
118.00	3 /	3, 224, 287	96, 975, 267	c	96, 975, 267	118. 00
100 00	NONREIMBURSABLE COST CENTERS D 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	O	27, 924		27, 924	190. 00
	19200 PHYSI CLANS PRI VATE OFFI CES	0	183, 963	-		192.00
192. 01	1 19201 CANTON RHC RENTED SPACE	0	396, 625	C	396, 625	192. 01
	19300 NONPALD WORKERS	0	0		-	193.00
	2 19302 FOUNDATION DO7950 PHYSICIANS CLINIC	0	142, 384		-	193. 02 194. 00
	1 07951 PROCTOR CHEMI CAL DEPENDENCY	o	0	Č	0	194. 01
	2 07952 FRESENI US	0	232, 012	C	232, 012	194. 02
	3 07953 RUCHFORD POB 4 07954 EP COLEMAN RENTAL SPACE	0	21, 137 258, 035		21, 137 258, 035	194. 03 194. 04
	5 07955 FARMI NGTON POB	o	230, 033		0	194. 05
	07956 LEWISTON POB	O	0	C	o	194. 06
	7 07957 OTHER RENTAL PROPERTY	0	0			194. 07 194. 08
	3 07958 KELLEY HOME 9 07959 EMPLOYEE PURCHASE		0			194. 08
194. 10	07960 RETAIL PHARMACY	0	Ö		o o	194. 10
	1 07961 WELLNESS CENTER	0	166, 079	0	166, 079	194. 11
	2 07962 AVON CLINIC 3 07963 WILLIAMSFIELD CLINIC	0 622	0 371, 262	(371, 262	194. 12 194. 13
200.00		0	0			200. 00

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COST ALLOCATION - GENERAL SERVICE COSTS

GRAHAM HOSPITAL ASSOCIATION

Provider CCN: 14-0001 | Period

Worksheet B Part I Date/Time Prepared: 11/30/2023 12:56 pm Peri od: From 07/01/2022 To 06/30/2023 Provi der CCN: 14-0001 Cost Center Description NURSI NG Intern & Total Subtotal Residents Cost & Post Stepdown PROGRAM Adj ustments 25.00 20. 00 24. 00 26.00 201.00 Negative Cost Centers 201.00 202.00 TOTAL (sum lines 118 through 201) 3, 224, 909 98, 774, 688 0 98, 774, 688 202.00

In Lieu of Form CMS-2552-10

ealth Financial Systems GRAHAM HOSPITAL ASSOCIATION

Health Financial Systems GRAHAM HOSPITAL ASSOCIATION In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0001 | Period: From 07/01/2022 | Part II | To 06/30/2023 | Date/Time Prepared: 14/20 (2020 1257)

				То	06/30/2023	Date/Time Pre 11/30/2023 12	pared: :56 pm
			CAPI TAL REI	LATED COSTS		1	, 00 p
	Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	odst denter bescription	Assigned New	DEDO & TIXI	WARE EGOLL	Subtotal	BENEFITS	
		Capi tal				DEPARTMENT	
		Related Costs 0	1. 00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS	U	1.00	2.00	Zn	4.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P	0	10 271	7 212	24 504	24 504	2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	0	19, 371 463, 375		26, 584 635, 907	26, 584 5, 466	4. 00 5. 00
7. 00	00700 OPERATION OF PLANT	0	438, 113		601, 239	623	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	95, 277		130, 752	3	8. 00
9.00	00900 HOUSEKEEPI NG	0	77, 031		105, 712	687	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	0	69, 346 88, 343		95, 166 121, 236	238 303	10.00 11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	37, 029		50, 816	393	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	51, 581		70, 787	0	14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	49, 975 76, 040		68, 583 104, 353	515 382	15. 00 16. 00
20. 00	02000 NURSI NG PROGRAM	0			601, 184	582	20.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	339, 288		465, 618	2, 645	30.00
31. 00 43. 00	03100 I NTENSI VE CARE UNI T 04300 NURSERY	0	33, 816 11, 928		46, 407 16, 369	555 5	31. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	80, 471		110, 434	502	44.00
45.00	04500 NURSING FACILITY	0	70, 859	26, 384	97, 243	500	45.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	269, 232	100, 246	369, 478	1, 108	50.00
50.00	05200 DELIVERY ROOM & LABOR ROOM	0	209, 232 0		309, 478	1, 108	50.00
52. 01	05201 DELIVERY ROOM & LABOR ROOM	0	6, 305	2, 348	8, 653	10	52. 01
53.00	05300 ANESTHESI OLOGY	0	4, 217		5, 787	0	53.00
54. 00 57. 00	05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	0	94, 715 78, 517		129, 981 107, 752	711 0	54. 00 57. 00
58. 00	05800 MRI	0	22, 357		30, 681	11	58.00
60.00	06000 LABORATORY	0	179, 015		245, 669	1, 097	60.00
65.00	06500 RESPI RATORY THERAPY	0	26, 507		36, 377	377	65.00
66. 00 71. 00	06600 PHYSICAL THERAPY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	102, 560 0		140, 747	1, 009 0	66. 00 71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		o	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	37, 096		50, 908	0	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	114, 997	42, 818	157, 815	117	76. 97
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	790, 962	294, 508	1, 085, 470	6, 560	88. 00
88. 01	08801 ELMWOOD RHC	0	45, 303		62, 171	373	88. 01
88. 02	08802 WILLIAMSFIELD RHC	0	9, 358	1	12, 842	41	88. 02
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0	0		0	0	89. 00 90. 00
90. 01	09001 WOUND CLINIC	0	56, 387	20, 995	77, 382	361	
	09100 EMERGENCY	0	158, 412		217, 395	938	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
96. 00	OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED	0	2, 048	763	2, 811	350	96.00
	SPECIAL PURPOSE COST CENTERS		=, =		=, =		
	11300 I NTEREST EXPENSE		4 407 004	4 (50 405	, ,,,,,	0/ 4/0	113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	4, 437, 904	1, 652, 405	6, 090, 309	26, 462	118. 00
190.00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	7, 296	2, 717	10, 013	0	190. 00
	19200 PHYSICIANS PRIVATE OFFICES	0	47, 538	17, 700	65, 238		192. 00
	19201 CANTON RHC RENTED SPACE	0	137, 314		188, 441		192.01
) 19300 NONPALD WORKERS 2 19302 FOUNDATI ON	0	0		0		193. 00 193. 02
	07950 PHYSICIANS CLINIC	0	37, 203	13, 852	51, 055		194.00
	07951 PROCTOR CHEMICAL DEPENDENCY	0	0	0	O		194. 01
	207952 FRESENI US	0	80, 324	29, 908	110, 232		194. 02
	307953 RUCHFORD POB 107954 EP COLEMAN RENTAL SPACE	0	89, 333	33, 262	122, 595		194. 03 194. 04
	07955 FARMI NGTON POB	0	0	0	0		194. 05
	07956 LEWI STON POB	0	0	0	0		194. 06
	7 07957 0THER RENTAL PROPERTY 3 07958 KELLEY HOME	0	0		0		194. 07 194. 08
	07959 EMPLOYEE PURCHASE		0		ol		194.00
194. 10	07960 RETAIL PHARMACY	0	0	o o	ō	0	194. 10
	07961 WELLNESS CENTER	0	0	0	0		194. 11
	2 07962 AVON CLINIC 3 07963 WILLIAMSFIELD CLINIC	0	16, 132	6, 006	0 22, 138		194. 12 194. 13
		1	10, 102	., 550	22, 130	70	1

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Health Financial Systems GRAHAM HOSPITAL ASSOCIATION In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0001 | Period: From 07/01/2022 | To 06/30/2023 | Date/Time Prepared: 11/30/2023 12:56 pm

						11/30/2023 12	2:56 pm
			CAPI TAL REI	_ATED COSTS			
	Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New				BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs					
		0	1. 00	2. 00	2A	4. 00	
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	4, 853, 044	1, 806, 977	6, 660, 021	26, 584	202.00

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Health Financial Systems | GRAHAM HOSPITAL ASSOCIATION | In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0001 | Period: | Worksheet B

From 07/01/2022 Part II Date/Time Prepared: 06/30/2023 11/30/2023 12:56 pm Cost Center Description ADMINISTRATIV OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY E & GENERAL PLANT LINEN SERVICE 9.00 5.00 10.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 00500 ADMINISTRATIVE & GENERAL 5.00 641, 373 5.00 7.00 00700 OPERATION OF PLANT 31, 303 633, 165 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 3,880 15, 342 149, 977 8.00 00900 HOUSEKEEPI NG 14, 241 12, 404 133 044 9 00 9 00 0 10.00 01000 DI ETARY 4,655 11, 166 0 3,786 115, 011 10.00 4, 823 01100 CAFETERI A 7, 278 0 11.00 14, 225 0 11.00 13.00 01300 NURSING ADMINISTRATION 7,806 5, 962 0 2,022 0 13.00 01400 CENTRAL SERVICES & SUPPLY 0 2.816 14 00 557 8.306 0 14.00 0 15.00 01500 PHARMACY 9, 439 8,047 2, 728 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 9.843 12, 244 0 4, 151 0 16.00 02000 NURSING PROGRAM 23, 918 20.00 14, 505 70, 539 0 20.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 56, 896 54, 633 53, 761 18, 523 41, 227 30.00 03100 INTENSIVE CARE UNIT 31.00 11,011 5, 445 11,910 1, 846 9, 133 31.00 3, 706 04300 NURSERY 1, 921 2, 842 43.00 43.00 217 651 04400 SKILLED NURSING FACILITY 44.00 10.087 12, 958 23.549 4.393 18,059 44 00 04500 NURSING FACILITY <u>11</u>, 410 <u>56</u>, 052 42, 984 45.00 45.00 9,705 3,868 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 35, 543 43, 352 0 14,698 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 52.01 05201 DELIVERY ROOM & LABOR ROOM 239 1,015 999 344 766 52.01 05300 ANESTHESI OLOGY 349 230 53.00 679 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 23.537 15, 251 0 5, 171 0 54.00 05700 CT SCAN 3,573 0 4, 286 0 57.00 57.00 12,643 05800 MRI 58.00 2,896 3,600 0 1, 221 58.00 0 06000 LABORATORY 45, 623 28, 825 60.00 0 9,773 0 60.00 06500 RESPIRATORY THERAPY 0 65.00 7,827 4, 268 1, 447 0 65.00 5, 599 66.00 06600 PHYSI CAL THERAPY 19, 118 16, 514 0 66.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 7,764 0 71.00 0 0 07200 IMPL. DEV. CHARGED TO PATIENTS 18, 291 72.00 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 19,034 5, 973 0 0 73.00 07697 CARDIAC REHABILITATION 0 0 76.97 4,049 18, 517 0 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 88.00 08800 RURAL HEALTH CLINIC 199, 321 127, 358 0 0 0 88.01 08801 ELMWOOD RHC 11, 541 7, 295 0 0 0 88.01 08802 WILLIAMSFIELD RHC 88.02 1, 305 1,507 0 0 0 88.02 89 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 Ω 89 00 0 Γ 0 90.00 09000 CLI NI C 0 0 0 90.00 09001 WOUND CLINIC 9, 780 9,080 0 3, 078 0 90.01 90.01 91.00 09100 EMERGENCY 18, 859 25, 508 0 8,648 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 13, 522 330 0 0 0 96.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113 00 633, 594 149, 977 115, 011 118. 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 566, 317 128, 020 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 1.1750 190 00 79 0 398 192.00 19200 PHYSICIANS PRIVATE OFFICES 526 7,655 0 2,595 0 192.00 192. 01 19201 CANTON RHC RENTED SPACE 1, 482 0 0 192.01 22, 110 193. 00 19300 NONPALD WORKERS 0 ol 0 193.00 0 0 193.02 193. 02 19302 FOUNDATI ON 0 0 0 194. 00 07950 PHYSICIANS CLINIC 402 5, 991 2,031 0 194.00 194. 01 07951 PROCTOR CHEMICAL DEPENDENCY 0 0 194.01 0 194. 02 07952 FRESENI US 12, 934 0 194. 02 867 0 0 194. 03 07953 RUCHFORD POB 0 137 0 0 194 03 194.04 07954 EP COLEMAN RENTAL SPACE 14, 385 0 0 0 194.04 964 194. 05 07955 FARMI NGTON POB 0 0 194.05 0 0 0 194.06 07956 LEWI STON POB 0 0 194.06 0 C 194. 07 07957 OTHER RENTAL PROPERTY 0 0 C 0 194.07 194. 08 07958 KELLEY HOME 0 0 194.08 0 0 194. 09 07959 EMPLOYEE PURCHASE 0 0 0 194.09 194. 10 07960 RETAIL PHARMACY 0 0 194, 10 0 C 194. 11 07961 WELLNESS CENTER 0 1,073 C 0 194, 11 194. 12 07962 AVON CLINIC 0 0 0 194. 12 194. 13 07963 WILLIAMSFIELD CLINIC 2.249 2, 598 0 0 0 194. 13 200.00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118 through 201) 641, 373 633, 165 149, 977 133, 044 115, 011 202. 00

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In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-0001 Peri od: Worksheet B

Part II

From 07/01/2022 Date/Time Prepared: 06/30/2023 11/30/2023 12:56 pm Cost Center Description CAFETERI A NURSI NG CENTRAL PHARMACY MEDI CAL ADMI NI STRATI O SERVICES & RECORDS & SUPPLY LI BRARY Ν 15.00 11 00 13.00 16.00 14 00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 147, 865 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 3, 224 70, 223 01400 CENTRAL SERVICES & SUPPLY 14.00 82, 466 14 00 15.00 01500 PHARMACY 4, 226 C 0 93, 538 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 3, 134 0 134, 107 16.00 0 02000 NURSI NG PROGRAM 4, 781 20.00 20 0 16 0 20.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 21, 715 9, 312 24, 138 2, 432 1, 117 30.00 03100 INTENSIVE CARE UNIT 2, 614 31.00 6, 218 31.00 770 4,560 522 04300 NURSERY 43.00 42 59 0 0 101 43.00 04400 SKILLED NURSING FACILITY 4, 118 6, 788 485 44.00 44.00 173 567 04500 NURSING FACILITY 45.00 4, 102 7,049 309 232 520 45.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 9.094 13,028 14, 594 1, 199 18.270 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 05201 DELIVERY ROOM & LABOR ROOM 81 0 52.01 112 0 416 52.01 05300 ANESTHESI OLOGY 53.00 1,677 245 12 6, 325 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 5,839 C 2, 179 332 11, 248 54.00 05700 CT SCAN 57.00 715 10 9, 329 57.00 58.00 05800 MRI 88 298 2.654 C 0 58.00 06000 LABORATORY 9,009 21 60.00 C 7, 204 18, 465 60.00 65.00 06500 RESPIRATORY THERAPY 3,096 1,063 12 2, 216 65.00 06600 PHYSI CAL THERAPY 66.00 8, 283 0 120 2 6, 493 66.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 13 089 0 2 585 71 00 Ω 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 0 30, 837 0 3,503 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 67, 130 6, 302 73.00 73.00 342 07697 CARDIAC REHABILITATION 76.97 961 0 77 31 785 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 53,867 0 3, 377 19,925 12, 709 88.00 08801 ELMWOOD RHC 88.01 192 1, 132 431 88.01 88 02 08802 WILLIAMSFIELD RHC 0 0 21 123 88 02 37 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 C 0 0 0 89.00 09000 CLI NI C 0 90.00 90.00 0 0 90.01 09001 WOUND CLINIC 1,930 2,025 2, 399 90.01 510 09100 EMERGENCY 91 00 5.715 11, 154 777 16, 762 91 00 1,650 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 379 0 96, 00 0 96,00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 147, 865 70, 223 82, 423 93, 276 134, 043 118. 00 118.00 NONREI MBURSABLE COST CENTERS 0 190, 00 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 0 0 192.00 192. 01 19201 CANTON RHC RENTED SPACE 0 0 0 192.01 0 0 0 0 193. 00 19300 NONPALD WORKERS 0 193.00 0 0 0 0 193.02 193. 02 19302 FOUNDATI ON 0 194. 00 07950 PHYSICIANS CLINIC 00000000 0 0 0 0 0 0 0 0 0 0 194.00 194. 01 07951 PROCTOR CHEMICAL DEPENDENCY 0 194.01 0 194. 02 07952 FRESENI US 0 194, 02 0 0 0 194. 03 07953 RUCHFORD POB C 0 194.03 194.04 07954 EP COLEMAN RENTAL SPACE 0 194.04 194. 05 07955 FARMI NGTON POB 0 0 0 194.05 194.06 07956 LEWISTON POB 0 0 0 194, 06 194. 07 07957 OTHER RENTAL PROPERTY C 0 194.07 0 194.08 07958 KELLEY HOME 0 194.08 0 0 0 0 194. 09 07959 EMPLOYEE PURCHASE C 0 0 194, 09 194. 10 07960 RETAIL PHARMACY 0 0 0 194. 10 C 194. 11 07961 WELLNESS CENTER 0 0 50 0 194. 11 0 194. 12 07962 AVON CLINIC 0 0 0 194. 12 C 194. 13 07963 WILLI AMSFIELD CLINIC 0 64 194. 13 36 212 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00 202.00 147.865 70, 223 82, 466 93. 538 134, 107 202. 00 TOTAL (sum lines 118 through 201)

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Health Financial Systems GRAHAM HOSPITAL ASSOCIATION In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0001 | Period: From 07/01/2022 | Part II | To 06/30/2023 | Date/Time Prepared: 14/20 (2020 1257)

				To	06/30/2023	Date/Time Prepared: 11/30/2023 12:56 pm
	Cost Center Description	NURSI NG	Subtotal	Intern &	Total	117 307 2023 12. 30 piii
		PROGRAM		Residents		
				Cost & Post Stepdown		
				Adjustments		
		20. 00	24. 00	25. 00	26. 00	
	GENERAL SERVICE COST CENTERS			I		
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP					1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5. 00	00500 ADMINISTRATIVE & GENERAL					5. 00
7.00	00700 OPERATION OF PLANT					7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE					8.00
9.00	00900 HOUSEKEEPI NG					9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A					10. 00 11. 00
13. 00	01300 NURSING ADMINISTRATION					13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY					14. 00
	01500 PHARMACY					15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	715 545				16.00
20. 00	02000 NURSI NG PROGRAM NPATI ENT ROUTI NE SERVI CE COST CENTERS	715, 545				20.00
30.00	03000 ADULTS & PEDI ATRI CS		752, 017	0	752, 017	30.00
31.00	03100 INTENSIVE CARE UNIT		100, 991	0	100, 991	31.00
43.00	04300 NURSERY		25, 913		25, 913	43.00
44. 00	04400 SKILLED NURSING FACILITY		192, 113	0	192, 113	44.00
45. 00	04500 NURSING FACILITY ANCILLARY SERVICE COST CENTERS		233, 974	<u> </u>	233, 974	45. 00
50.00	05000 OPERATING ROOM		520, 364	0	520, 364	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0	0	0	52. 00
52. 01	05201 DELIVERY ROOM & LABOR ROOM		12, 635		12, 635	52. 01
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C		15, 304	0	15, 304	53.00
57.00	05700 CT SCAN		194, 249 138, 308	0	194, 249 138, 308	54. 00 57. 00
58. 00	05800 MRI		41, 449	·	41, 449	58.00
60.00	06000 LABORATORY		365, 686	0	365, 686	60. 00
65.00	06500 RESPI RATORY THERAPY		56, 683	0	56, 683	65.00
66.00	06600 PHYSICAL THERAPY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		197, 885 23, 438		197, 885 23, 438	66. 00 71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS		52, 631	0	52, 631	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS		149, 689		149, 689	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON		182, 352	0	182, 352	76. 97
00.00	OUTPATIENT SERVICE COST CENTERS		1 500 507		1 500 507	00.00
88. 00 88. 01	O8800 RURAL HEALTH CLINIC O8801 ELMWOOD RHC		1, 508, 587 83, 135	0	1, 508, 587 83, 135	88. 00 88. 01
88. 02	08802 WI LLI AMSFI ELD RHC		15, 876		15, 876	88. 02
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	o	89. 00
90.00	09000 CLINIC		0	0	0	90.00
90. 01	09001 WOUND CLINIC		106, 545		106, 545	90.01
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART		307, 406	0	307, 406	91. 00 92. 00
72.00	OTHER REIMBURSABLE COST CENTERS			<u> </u>		72.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED		17, 392	0	17, 392	96.00
440.00	SPECIAL PURPOSE COST CENTERS	1	-	1		110.00
113.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	o	5, 294, 622	0	5, 294, 622	113. 00 118. 00
110.00	NONREI MBURSABLE COST CENTERS	<u> </u>	5, 274, 022	<u> </u>	5, 274, 022	110.00
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN		11, 665	0	11, 665	190. 00
	19200 PHYSI CI ANS PRI VATE OFFI CES		76, 021	0	76, 021	192. 00
	19201 CANTON RHC RENTED SPACE 19300 NONPALD WORKERS		212, 033 0	0	212, 033	192. 01 193. 00
	19302 FOUNDATION		0	0	0	193. 02
	07950 PHYSI CI ANS CLI NI C		59, 479	Ö	59, 479	194. 00
	07951 PROCTOR CHEMICAL DEPENDENCY		0	0	o	194. 01
	07952 FRESENI US		124, 033	0	124, 033	194. 02
	07953 RUCHFORD POB 07954 EP COLEMAN RENTAL SPACE		137 137, 944	0	137 137, 944	194. 03 194. 04
	07955 FARMINGTON POB		0	Ö	0	194. 05
	07956 LEWISTON POB		0	0	o	194. 06
	07957 OTHER RENTAL PROPERTY		0	0	o	194. 07
	07958 KELLEY HOME		0	0	0	194. 08
	07959 EMPLOYEE PURCHASE 07960 RETAI L PHARMACY		0	0	0	194. 09 194. 10
	07961 WELLNESS CENTER		1, 175	0	1, 175	194. 10
194. 12	07962 AVON CLINIC		0	O	0	194. 12
	07963 WILLIAMSFIELD CLINIC		27, 367		27, 367	194. 13
200.00	Cross Foot Adjustments	715, 545	715, 545	0	715, 545	200.00

Heal th Fi nanci al Systems GRAHAM HOSPI TAL ASSOCIATION
ALLOCATION OF CAPI TAL RELATED COSTS Provi der CCN: 14-0001 Peri od:

Worksheet B Part II Date/Time Prepared: 11/30/2023 12:56 pm Provider CCN: 14-0001 Peri od: From 07/01/2022 To 06/30/2023 Cost Center Description NURSI NG Intern & Total Subtotal Residents Cost & Post Stepdown PROGRAM Adj ustments 25.00 20. 00 24. 00 26.00 0 201.00 Negative Cost Centers 201.00 202.00 TOTAL (sum lines 118 through 201) 6, 660, 021 6, 660, 021 202.00 715, 545

In Lieu of Form CMS-2552-10

leal th Financial Systems GRAHAM HOSPITAL ASSOCIATION

Heal th Financial Systems GRAHAM HOSPITAL ASSOCIATION In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0001 | Period: From 07/01/2022 | To 06/30/2023 | Date/Time Prepared: 11/30/2023 12:56 pm

COST CONTOR DESCRIPTION RECEIPT SUBMER FEET SUBMER FEET SUBMER FEET SUBMER FEET					'	0 06/30/2023	11/30/2023 12	
BREENL SERVICE GIST CERTERS			CAPI TAL REI	LATED COSTS				
BREENL SERVICE GIST CERTERS		Overland Development all an	DI DO A FLYT	INVIDITE FOLLID	EMBLOVEE	D	ADMINI CEDATIN	
		Cost Center Description						
CREADY SERVICE COST CENTRIES 1.00 2.00 4.00 5A 5.00			(SQUARE FEET)	(SQUARE FEET)		n		
BREATH, SCHRIFTE CRIST CEMBERS 1.00							(ACCOM. COST)	
0.000 CAP SEL COSTS - SILDS & FEXT 3-02, 511 4-04 1, 4-44 1, 4			1. 00	2.00		5A	5. 00	
0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000000								
4.00 00-000 DUPLOYUSE BENEFITS DEPARTMENT 1, 447 1, 447 1, 447 1, 477 3, 401 3, 401 3, 401 4, 615			362, 511	l .				
DOCSON DIAMEN STRATE VIF A GINERAL 34, 613 34, 613 34, 613 34, 613 37, 600 57, 700 007			1 447	1	4/ 151 400			
0.000 0.0700 OPERATION OF PLANT 32,726 32,726 1,081,258 0 3,795,080 7,090 1,000 1,				1			Q1 536 Q55	
0.00 0.0000 UANIDATY & LINEN SERVICE 7.117 7.117 4.385 0 493, 301 8.00 1.000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.00000 0.00000 0.00000 0.00000000				1				1
0.000 00/0000 00/00000 00/00000 00/00000 00/00000 00/00000 00/00000 00/00000 00/00000 00/00000 00/00000 00/000000 00/00000000				1				
11.00 0 1100 (CAFFTER A) 6.509 6.509 50.600 0 925.198 11.00 11.00 0 1100 (MESIN A) MINIST MATION 2.2.766 2.766 681.707 0 922.338 13.00 11.00 0 1100 (MESIN A) MINIST MATION 2.2.766 2.766 681.707 0 922.338 13.00 11.00 0 1100 (MARMACY 3.3.833 3.893.700 0 1.200.701 15.00 11.00 0 1100 (MARMACY 3.3.833 3.893.700 0 1.200.701 15.00 11.00 0 1100 (MARMACY 3.3.833 3.893.700 0 1.200.701 15.00 11.00 0 1100 (MARMACY 3.3.833 3.893.700 0 1.200.701 15.00 11.00 0 1100 (MARMACY 3.3.833 3.893.700 0 1.200.701 15.00 11.00 0 1100 (MARMACY 3.3.833 3.893.700 0 1.200.701 15.00 11.00 0 1100 (MARMACY 3.3.833 3.893.700 0 1.200.701 15.00 11.00 0 1100 (MARMACY 3.3.833 3.893.700 0 1.200.701 15.00 11.00 0 1100 (MARMACY 3.3.833 3.893.700 0 1.200.701 15.00 11.00 0 1100 (MARMACY 3.3.833 3.893.700 0 1.200.701 15.00 11.00 0 1100 (MARMACY 3.3.833 3.893.700 0 1.200.701 15.00 11.00 0 1100 (MARMACY 3.3.833 3.893.700 0 1.200.701 15.00 11.00 0 1100 (MARMACY 3.3.833 3.893.700 0 1.200.701 15.00 11.00 0 1100 (MARMACY 3.3.833 3.893.700 0 1.200.701 15.00 11.00 0 1100 (MARMACY 3.3.833 3.893.700 0 1.200.701 15.00 11.00 0 1100 (MARMACY 3.3.833 3.893.700 0 1.200.701 15.00 11.00 0 1100 (MARMACY 3.3.833 3.893.700 0 1.200.701 15.00 11.00 0 1100 (MARMACY 3.3.834 3.800 0 1.00 11.00 0 1100 (MARMACY 3.3.834 3.8	9. 00	00900 HOUSEKEEPI NG		1		0		
13.00 01300 NURSING ADMINISTRATION 2,766 2,766 691,707 0 992,335 13.00 15.00 01500 PHUMBARY 3,733 3,733 8,93,700 0 1,200,021 15.00 01500 PHUMBARY 3,733 3,733 8,93,700 0 1,200,021 15.00 02.00 15.00 02.00		I I				0		1
14.00 01400 PARMANCY 3.8 B.S 3.8 B.S 0 0 70,787 14.00 16.00 01600 PARMANCY 5.6 60 5.6 60 6.6 814 0 1.251.294 16.00 1.251.294 16.		1 1		1		0		1
15.00 01500 PHARMACY 3, 733 3, 733 933, 700 0 1, 200, 021 15.00 0200 UNICS IN CROORS 1 1844, 010 0 0.00 0.000 UNICS IN CROORS 32, 723 32, 723 1, 010, 979 0 1, 844, 010 0.00 0.000 0						0		
16. 00 01600 MEDICAL RECORDS & LIBRARY 5. 600 5. 600 6.02,814 0 1,251,294 10. 00 1. 01600 MESIN OF RODRAGEM 03. 27.732 32. 732 1. 7010,797 0 1.844,010 2. 00 03000 MESIN OF RODRAGEM 03. 00 03. 00 03000 MESIN OF RODRAGEM 03. 00		I I				0		1
INPATI ENT ROUTINE SERVICE COST CENTERS								1
33.00 0.3100 INTENSIVE CARE UNIT							, ,	
43. 00 04300 NIRSERY 891 8,971 727 0 1,282,412 44.00 04400 SKILLED NIRSING FACILITY 6,011 6,011 870,727 0 1,282,412 44.00 04500 NIRSING FACILITY 5,293 5,293 867,465 0 1,233,790 45.00 1,233,790 45.00 1,233,790 45.00 1,200	30.00	03000 ADULTS & PEDIATRICS	25, 344	25, 344	4, 591, 787	0	7, 233, 182	30.00
44.00 04-400 SKILLED NURSING FACILITY		I I						1
5. 09 04500 NURSING FACILITY 5. 293 5. 293 867, 465 0 1. 233, 790 45. 00								1
AMCILLARY SERVICE COST CENTERS								•
50.00	45.00		5, 293	5, 293	867, 465	0	1, 233, 790	45.00
1.00 0.00	50 00		20 111	20, 111	1 922 906	0	4 518 603	50 00
10,000 0							., ,	
54.00 OS400 RADIOLGOY-DIAGNOSTIC 7, 075	52. 01		471	471	17, 090	0	30, 334	52. 01
57.00 03700 CT SCAN	53.00	1		l .	0	0	44, 392	53.00
S80.00 OSBOO MRI 1,670 1,670 1,670 1,904 962 0 3,68,143 58,00 0.00				1	1, 234, 807	0		1
60.00 06000 06000 CABORATORY 13, 372 13, 372 1, 904, 962 0 5, 800, 009 60.00		1			10 (20	0		1
66. 00 0.600 RESPIRATORY THERAPY 1, 980 1, 980 6.54, 771 0 995, 0.26 65. 00 0.600 0.000		1				0		1
66. 00 0600 0600 04951 CAL THERAPY 7, 661 7, 661 1, 751, 446 0 2, 430, 488 66. 00 71. 00 71. 00 71. 00 72. 00 072. 00		· · · · · · · · · · · · · · · · · · ·		1		0		1
171.00			1			0		1
73.00 07300 DRUGS CHARGED TO PATIENTS 2,771 2,771 0 0 2,419,757 73.00 76.97 O7597 (ARDIA CREHABILITATION 8,590 8,590 203,026 0 514,697 76.97 O7597 (ARDIA CREHABILITATION 8,590 8,590 203,026 0 514,697 76.97 O7597 (ARDIA CREHABILITATION 8,590 8,590 203,026 0 514,697 76.97 O7597 (ARDIA CREHABILITATION 8,590 8,590 203,026 0 514,697 76.97 O7597 (ARDIA CREMABILITATION 8,590 8,590 203,026 0 0 0 1,467,216 76.97 O7597 (ARDIA CREMABILITATION 8,590 0 0 0 0 0 1,467,216 76.97 O75900 08801 LLIMMODO RIC 3,384 3,384 647,209 0 1,467,216 88.01 76.90 O75900 EEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 0 76.90 O75900 EEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 0	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1		0	0		71.00
76. 97 07697 CARDI AC REHABILITATION 8, 590 8, 590 203, 026 0 514, 697 76, 97			0	0	0	0		1
BB 00 BBS00 RURAL HEALTH CLINIC 59, 083 59, 083 11, 391, 426 0 25, 338, 921 88, 00 88, 01 08801 ELMWOOD RHC 3, 384 3, 384 647, 209 0 1, 467, 216 88, 01 88, 02 08802 WILLI AMSFI ELID RHC 699 699 70, 476 0 165, 841 88, 02 0890 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 0					0	_		
88. 00 08800 RIPAL HEALTH CLINIC 59, 083 59, 083 11, 391, 436 0 25, 338, 921 88. 00 88. 01 08801 ELMWOOD RHC 3, 384 3, 384 647, 209 0 1, 467, 216 88. 01 88. 02 08802 WILLI AMSFIELD RHC 6699 6699 70, 476 0 165, 841 88. 02 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 0	76.97		8, 590	8, 590	203, 026	0	514, 697	/6.9/
88 01 08801 ELMMOOD RHC 3,384 3,384 647,209 0 1,467,216 88,01	88 00		59 083	59 083	11 391 436	0	25 338 921	88 00
88 02 08802 ILLI AMSFIELD RHC 699 699 70, 476 0 165, 841 88. 02 99. 00 08900 EDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 0								
90. 00 090.00 CLINI C								
90. 01 090.01 WOUND CLINIC 4, 212 4, 212 626, 515 0 1, 243, 302 90. 01 91. 00 090.00 EMERGENCY 11, 833 11, 833 11, 833 1, 628, 411 0 2, 397, 537 91. 00 92. 00 090.00 09			0	0	0	0	0	
91. 00 09100 EMERGENCY 11, 833 1, 628, 411 0 2, 397, 537 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 07 092. 00 OBSERVATION BEDS (NON-DISTINCT PART 07 092. 00 OBSERVATION BEDS (NON-DISTINCT PART 07 092. 00 OBSERVATION BEDS (NON-DISTINCT PART 07 094. 00 OBSERVATION BEDS (NON-DISTINCT PART 094. 00 OBSERVATION BEDS (NON			1	0	0	0		
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0FIER REI MBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 153 153 607, 618 0 1,719, 076 96. 00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 331, 501 331, 501 45, 939, 064 -17, 237, 833 80, 547, 897 118. 00 NONNER IMBURSABLE COST CENTERS 119.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 545 545 0 0 10, 013 190. 00 192. 00 19201 CANTON RIC RENTED SPACE 10, 257 10, 257 0 0 188, 441 192. 01 193. 00 193. 02 19302 FOUNDATI ON 0 0 0 0 0 193. 02 194. 00 07950 PHYSI CI ANS CLI NI C 2, 779 2, 779 0 0 51, 055 194. 00 194. 01 194. 01 07951 PROCTOR CHEMI CAL DEPENDENCY 0 0 0 0 0 110, 232 194. 02 194. 03 07953 RUCHFORD POB 0 0 0 0 0 194. 03 194. 04 07954 EP COLEMAN RENTAL SPACE 6, 673 6, 673 0 0 0 194. 05 194. 06 07956 LEWI STON POB 0 0 0 0 0 194. 06 194. 07 07957 OTHER REINTAL PROPERTY 0 0 0 0 0 0 194. 06 194. 07 07957 OTHER REINTAL PROPERTY 0 0 0 0 0 0 194. 06 194. 07 07957 OTHER REINTAL PROPERTY 0 0 0 0 0 0 194. 07 194. 01 07956 EMPLOYEE PURCHASE 0 0 0 0 0 194. 07 194. 01 07960 RETAIL PHARMACY 0 0 0 0 0 194. 07 194. 01 107961 WELLNESS CENTER 0 0 0 0 0 136, 38 194. 11 07961 WELLNESS CENTER 0 0 0 0 0 0 136, 38 194. 11 07961 WELLNESS CENTER 0 0 0 0 0 0 136, 38 194. 11 07961 WELLNESS CENTER 0 0 0 0 0 0 136, 38 194. 11 07961 WELLNESS CENTER 0 0 0 0 0 0 0 0 0								
96. 00 OFFICE RELIBBURSABLE COST CENTERS 96. 00 OFFICE ALL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 INTEREST EXPENSE 113. 00 INTEREST EXPENSE 113. 00 INTEREST EXPENSE 113. 00 INTEREST EXPENSE 114. 00 INTEREST EXPENSE 115. 00 INTEREST EXPENSE 115. 00 INTEREST EXPENSE 116. 00 INTEREST EXPENSE 117. 00 INTEREST EXPENSE 118. 00 INTEREST EXPENSE 119. 00 IN			11, 833	11, 833	1, 628, 411	0	2, 397, 537	
96. 00	92.00							92.00
113. 00 130 17 130 17 130 17 130 17 130 17 130 17 130 17 130 17 130 130 17 130 130 17 130	96. 00		153	153	607, 618	0	1, 719, 076	96.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 331,501 331,501 45,939,064 -17,237,833 80,547,897 118.00					55.75.5		., ,	
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 545 545 0 0 10, 013 190. 00 19200 19200 19200 19200 19200 19200 19200 19200 19201 19201 CANTON RIC RENTED SPACE 10, 257 10, 257 0 0 188, 441 192. 01 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 193. 00 193. 00 19300	113.00							
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 545 545 0 0 10, 013 190. 00 192. 00 19200 PHYSI CI ANS PRI VATE OFFI CES 3, 551 3, 551 463 0 66, 896 192. 00 192. 01 19201 CANTON RHC RENTED SPACE 10, 257 10, 257 0 0 188, 441 192. 01 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 193. 00 1	118. 00		331, 501	331, 501	45, 939, 064	-17, 237, 833	80, 547, 897	118. 00
192. 00 19200 PHYSI CI ANS PRI VATE OFFI CES 3, 551 3, 551 463 0 66, 896 192. 00 192. 01 19201 CANTON RHC RENTED SPACE 10, 257 10, 257 0 0 188, 441 192. 01 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 193. 02 19302 FOUNDATI ON 0 0 0 0 194. 00 07950 PHYSI CI ANS CLI NI C 2, 779 2, 779 0 0 51, 055 194. 00 194. 01 07951 PROCTOR CHEMI CAL DEPENDENCY 0 0 0 0 194. 02 07952 FRESENI US 6, 000 6, 000 0 0 194. 03 07953 RUCHFORD POB 0 0 0 194. 04 07954 EP COLEMAN RENTAL SPACE 6, 673 6, 673 0 0 194. 05 07955 FARMI NGTON POB 0 0 0 194. 06 07956 LEWI STON POB 0 0 0 194. 07 07957 OTHER RENTAL PROPERTY 0 0 0 0 194. 08 07958 KELLEY HOME 0 0 0 0 194. 09 07959 EMPLOYEE PURCHASE 0 0 0 0 194. 11 07961 WELLNESS CENTER 0 0 0 0 194. 11 07961 WELLNESS CENTER 0 0 0 0 136, 388 194. 11	100.0		F.45	T 545		1	10.010	1.00.00
192. 01 19201 CANTON RHC RENTED SPACE 10, 257 0 0 188, 441 192. 01 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 193. 00 193. 00 193. 02 193.02 1								
193. 00 19300 NONPAI D WORKERS 193. 02 19302 FOUNDATI ON 194. 00 07950 PHYSI CI ANS CLI NI C 2, 779 2, 779 0 0 51, 055 194. 00 194. 01 07951 PROCTOR CHEMI CAL DEPENDENCY 0 0 0 0 0 0 0 0 110, 232 194. 01 194. 02 07952 FRESENI US 6, 000 6, 000 0 0 110, 232 194. 02 194. 03 07953 RUCHFORD POB 0 0 0 0 17, 448 194. 03 194. 04 07954 FARMI NGTON POB 0 0 0 0 122, 595 194. 04 194. 05 07955 FARMI NGTON POB 0 0 0 0 0 194. 05 194. 06 07956 LEWI STON POB 0 0 0 0 0 0 194. 05 194. 08 07958 KELLEY HOME 0 0 0 0 0 0 0 0 194. 07 194. 08 07958 KELLEY HOME 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
193. 02 19302 FOUNDATION 0 0 0 0 0 193. 02 194. 00 07950 PHYSI CI ANS CLI NI C 2, 779 2, 779 0 0 51, 055 194. 00 194. 01 07951 PROCTOR CHEMI CAL DEPENDENCY 0 0 0 0 0 0 110, 232 194. 01 194. 01 194. 02 07952 FRESENI US 6, 000 6, 000 0 0 110, 232 194. 02 194. 03 07953 RUCHFORD POB 0 0 0 0 0 17, 448 194. 03 194. 04 07954 EP COLEMAN RENTAL SPACE 6, 673 6, 673 0 0 122, 595 194. 04 194. 05 194. 06 07956 LEWI STON POB 0 0 0 0 0 0 194. 05 194. 06 194. 07 07957 OTHER RENTAL PROPERTY 0 0 0 0 0 0 194. 06 194. 07 194. 08 07958 KELLEY HOME 0 0 0 0 0 0 0 0 194. 08 194. 09 07959 EMPLOYEE PURCHASE 0 0 0 0 0 0 0 0 0 194. 08 194. 09 07959 EMPLOYEE PURCHASE 0 0 0 0 0 0 0 0 194. 10 194. 10 1994. 11 10 1994 WELLNESS CENTER					1	_		
194. 01 07951 PROCTOR CHEMI CAL DEPENDENCY 0 0 0 0 194. 01 194. 02 194. 02 194. 03 194. 03 194. 04 194. 04 194. 05 194. 06 194. 07 194. 08 19757 194. 08 19758 EVENTAL PROPERTY 0 0 0 0 194. 08 194. 09 19758 EVENTAL PROPERTY 0 0 0 0 194. 08 194. 09 19758 EVENTAL PROPERTY 0 0 0 0 194. 08 194. 09 19758 EVENTAL PROPERTY 0 0 0 0 0 194. 08 194. 09 19758 EVENTAL PROPERTY 0 0 0 0 0 194. 08 194. 09 19758 EVENTAL PROPERTY 0 0 0 0 0 194. 08 194. 10 19758 EVENTAL PROPERTY 0 0 0 0 0 194. 08 194. 10 19758 EVENTAL PROPERTY 0 0 0 0 0 194. 08 194. 10 19758 EVENTAL PROPERTY 0 0 0 0 0 194. 08 194. 11 19758 EVENTAL PROPERTY 0 0 0 0 194. 08 194. 11 19758 EVENTAL PROPERTY 0 0 0 0 0 194. 10 194. 10 194. 11 19758 EVENTAL PROPERTY 0 0 0 0 194. 10 194. 10 194. 11 19758 EVENTAL PROPERTY 0 0 0 0 194. 10 194. 11 19758 EVENTAL PROPERTY 0 0 0 0 194. 10 194. 11 19758 EVENTAL PROPERTY 0 0 0 0 194. 10 194. 10 194. 11 19758 EVENTAL PROPERTY 0 0 0 0 194. 10 194. 10 194. 11 19758 EVENTAL PROPERTY 0 0 0 0 194. 10 194. 10 194. 11 19758 EVENTAL PROPERTY 0 0 0 0 194. 10 194. 10 194. 11 19758 EVENTAL PROPERTY 0 0 0 0 194. 10			0	Ō	0	0		
194. 02 07952 FRESENI US 6, 000 6, 000 0 110, 232 194. 02 194. 03 07953 RUCHFORD POB 0 0 0 0 17, 448 194. 03 194. 04 07954 EP COLEMAN RENTAL SPACE 6, 673 6, 673 0 0 122, 595 194. 04 194. 05 07955 FARMI NGTON POB 0 0 0 0 0 194. 05 194. 06 194. 07 07957 OTHER RENTAL PROPERTY 0 0 0 0 0 194. 07 194. 08 07958 KELLEY HOME 0 0 0 0 0 0 0 194. 07 194. 08 194. 09 07959 EMPLOYEE PURCHASE 0 0 0 0 0 0 194. 09 194. 10 194. 11 07961 WELLNESS CENTER 0 0 0 0 0 136, 388 194. 11			2, 779	2, 779	0	0	51, 055	194. 00
194. 03 07953 RUCHFORD POB 0 0 0 17, 448 194. 03 194. 04 07954 EP COLEMAN RENTAL SPACE 6, 673 6, 673 0 0 122, 595 194. 04 194. 05 194. 06 07955 FARMI NGTON POB 0 0 0 0 0 194. 05 194. 06 194. 07 07957 OTHER RENTAL PROPERTY 0 0 0 0 0 194. 07 194. 08 07958 KELLEY HOME 0 0 0 0 0 0 194. 07 194. 08 194. 10 07960 RETAIL PHARMACY 0 0 0 0 0 194. 10 194. 11 07961 WELLNESS CENTER			0	0	0	0		
194. 04 07954 EP COLEMAN RENTAL SPACE 6, 673 0 0 122, 595 194. 04 194. 05 07955 FARMI NGTON POB 0 0 0 0 194. 05 194. 06 07956 LEWI STON POB 0 0 0 0 0 194. 06 194. 07 07957 OTHER RENTAL PROPERTY 0 0 0 0 0 194. 07 194. 08 097958 KELLEY HOME 0 0 0 0 0 0 194. 08 194. 09 07950 RETAI L PHARMACY 0 0 0 0 0 0 194. 10 194. 11 07961 WELLNESS CENTER 0 0 90, 479 0 136, 388 194. 11			6, 000	6, 000	0	0		
194. 05 07955 FARMI NGTON POB 0 0 0 0 194. 05 194. 06 07956 LEWI STON POB 0 0 0 0 194. 06 194. 07 07957 OTHER RENTAL PROPERTY 0 0 0 0 0 194. 07 194. 08 07958 KELLEY HOME 0 0 0 0 0 0 194. 08 194. 09 07959 EMPLOYEE PURCHASE 0 0 0 0 0 0 194. 10 194. 10 07960 RETAI L PHARMACY 0 0 0 0 0 194. 10 194. 11 07961 WELLNESS CENTER 0 0 90, 479 0 136, 388 194. 11			0	0	0	0		
194. 06 07956 LEWI STON POB 0 0 0 0 0 194. 06 194. 07 194. 08 07957 OTHER RENTAL PROPERTY 0 0 0 0 0 0 194. 07 194. 08 07958 KELLEY HOME 0 0 0 0 0 0 0 194. 08 194. 09 07959 EMPLOYEE PURCHASE 0 0 0 0 0 0 0 194. 09 194. 10 194. 11 07961 WELLNESS CENTER 0 0 0 90, 479 0 136, 388 194. 11						0		
194. 07 07957 OTHER RENTAL PROPERTY 0 0 0 0 0 194. 07 194. 08 07958 KELLEY HOME 0 0 0 0 0 194. 08 194. 09 07959 EMPLOYEE PURCHASE 0 0 0 0 0 194. 09 194. 10 07960 RETAIL PHARMACY 0 0 0 0 0 194. 10 194. 11 07961 WELLNESS CENTER 0 0 90, 479 0 136, 388 194. 11		I I	_	_	0	0		
194. 08 07958 KELLEY HOME 0 0 0 0 194. 08 194. 09 194. 09 07959 EMPLOYEE PURCHASE 0 0 0 0 0 194. 09 194. 10 07960 RETAIL PHARMACY 0 0 0 0 0 194. 10 194. 11 07961 WELLNESS CENTER 0 90, 479 0 136, 388 194. 11					0	0		
194. 10 07960 RETAIL PHARMACY 0 0 0 0 194. 10 194. 11 07961 WELLNESS CENTER 0 0 90, 479 0 136, 388 194. 11			0	Ō	0	0		
194. 11 07961 WELLNESS CENTER 0 0 90, 479 0 136, 388 194. 11			0	0	0	0		
		I I			ľ	0		
194. 12 U/962 AVUN CLINIC U U U U O O 194. 12								
	194. 1.	ZUTAOZI WANN CELINI C	1 0	0	1 0	1 0	0	1194. 12

ealth Financial Systems GRAHAM HOSPITAL ASSOCIATION

Heal th Financial Systems GRAHAM HOSPITAL ASSOCIATION In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS
Provider CCN: 14-0001 Period: From 07/01/2022 To 06/30/2023 Date/Time Prepared:

				'	0 00/30/2023	11/30/2023 12	
		CAPI TAL REL	ATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliatio	ADMINISTRATIV	
		(SQUARE FEET)	(SQUARE FEET)	BENEFITS	n	E & GENERAL	
				DEPARTMENT		(ACCUM. COST)	
				(GROSS SALA			
				RIE)			
		1. 00	2. 00	4. 00	5A	5. 00	
194. 13 07963	WILLIAMSFIELD CLINIC	1, 205	1, 205	121, 493	0	285, 890	194. 13
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201.00
202. 00	Cost to be allocated (per Wkst. B,	4, 853, 044	1, 806, 977	12, 397, 882		17, 237, 833	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	13. 387301	4. 984613	0. 268634		0. 211412	203. 00
204.00	Cost to be allocated (per Wkst. B,			26, 584		641, 373	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part			0. 000576		0. 007866	205. 00
	[11]						
206. 00	NAHE adjustment amount to be allocated						206. 00
207.00	(per Wkst. B-2)						007.00
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)		l				l

leal th Financial Systems GRAHAM HOSPITAL ASSOCIATION

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

Provider CCN: 14-0001 | Period: From 07/01/2022 | To 06/30/2023 | Date/Financial Systems | Date/Financial Systems | Propagation | Provider CCN: 14-0001 | Period: From 07/01/2022 | To 06/30/2023 | Date/Financial Systems | Propagation |

			1	0 06/30/2023	Date/lime Pre 11/30/2023 12	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	, oo piii
·	PLANT	LINEN SERVICE	(SQUARE FEET)	(TOTAL	(GROSS	
	(SQUARE FEET)	(TOTAL		PATIENT DAYS)	SALARI ES)	
	7. 00	PATI ENT DAYS) 8. 00	9.00	10.00	11. 00	
GENERAL SERVICE COST CENTERS	7.00	0.00	7.00	10.00	11.00	
1. 00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINI STRATI VE & GENERAL						5.00
7. 00 00700 OPERATION OF PLANT	293, 725					7.00
8. 00 00800 LAUNDRY & LINEN SERVICE	7, 117	14, 406	1			8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	5, 754 5, 180		182, 039 5, 180			9. 00 10. 00
11. 00 01100 CAFETERI A	6, 599		6, 599		31, 268, 304	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	2, 766		2, 766	1	681, 707	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	3, 853	ł .	3, 853		0	14.00
15. 00 01500 PHARMACY	3, 733	0	3, 733	0	893, 700	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	5, 680		-,	1	662, 814	16.00
20. 00 02000 NURSI NG PROGRAM	32, 723	0	32, 723	0	1, 010, 979	20.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	25, 344	5, 164	25, 344	E 141	4 EO1 707	30.00
31. 00 03000 ADDETS & PEDIATRICS	25, 344		1	5, 164 1, 144	4, 591, 787 964, 284	31.00
43. 00 04300 NURSERY	891	356	1	356	8, 873	43.00
44.00 04400 SKILLED NURSING FACILITY	6, 011	2, 262	l .	2, 262	870, 727	44.00
45.00 04500 NURSING FACILITY	5, 293		1		867, 465	45.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	20, 111	0	1	0	1, 922, 984	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0				0	52.00
52. 01 05201 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	471 315	96 0	l .	96 0	17, 090 0	52. 01 53. 00
54. 00 05400 RADI OLOGY 54. 00 05400 RADI OLOGY DI AGNOSTI C	7, 075				1, 234, 807	54.00
57. 00 05700 CT SCAN	5, 865		5, 865		1, 254, 007	57.00
58. 00 05800 MRI	1, 670		1		18, 620	58.00
60. 00 06000 LABORATORY	13, 372	0	1	0	1, 904, 962	60.00
65. 00 06500 RESPIRATORY THERAPY	1, 980	0	1, 980	0	654, 771	65.00
66. 00 06600 PHYSI CAL THERAPY	7, 661	0	7, 661	0	1, 751, 446	66.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	2, 771	0		0	0	72. 00 73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	8, 590			0	203, 170	76. 97
OUTPATIENT SERVICE COST CENTERS	0,370			<u> </u>	203, 170	70.77
88. 00 08800 RURAL HEALTH CLINIC	59, 083	0	0	0	11, 391, 436	88. 00
88. 01 08801 ELMWOOD RHC	3, 384	0	0	0	0	88. 01
88. 02 08802 WI LLI AMSFI ELD RHC	699	0	0	0	0	88. 02
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90. 00 09000 CLI NI C 90. 01 09001 WOUND CLI NI C	0	0	4 212	0	0 408, 153	90. 00 90. 01
91. 00 09100 EMERGENCY	4, 212 11, 833				1, 208, 529	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	11,033	Ĭ	11,000		1, 200, 327	92.00
OTHER REIMBURSABLE COST CENTERS		'	•	,		
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	153	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 INTEREST EXPENSE	2/2 715	14 40/	175 1/4	14 40/	21 2/0 204	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	262, 715	14, 406	175, 164	14, 406	31, 268, 304	Ji 18. UU
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	545	n	545	0	n	190. 00
192. 00 19200 PHYSI CI ANS PRI VATE OFFI CES	3, 551		3, 551			192.00
192.01 19201 CANTON RHC RENTED SPACE	10, 257		0	0		192. 01
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
193. 02 19302 FOUNDATI ON	0	0	0	0		193. 02
194. 00 07950 PHYSI CLANS CLINIC	2, 779	0	2, 779	0		194.00
194. 01 07951 PROCTOR CHEMI CAL DEPENDENCY 194. 02 07952 FRESENI US	4 000	0		0		194. 01 194. 02
194. 03 07953 RUCHFORD POB	6, 000	0		0		194. 02
194. 04 07954 EP COLEMAN RENTAL SPACE	6, 673	0	0	0		194.04
194. 05 07955 FARMI NGTON POB	0	Ö	Ö	o		194. 05
194. 06 07956 LEWI STON POB	0	0	0	o	0	194. 06
194. 07 07957 OTHER RENTAL PROPERTY	0	0	0	0		194. 07
194. 08 07958 KELLEY HOME	0	0	0	0		194. 08
194. 09 07959 EMPLOYEE PURCHASE	0		0	0		194. 09
194. 10 07960 RETAI L PHARMACY 194. 11 07961 WELLNESS CENTER	0			0		194. 10 194. 11
194. 11 07961 WELLINESS CENTER 194. 12 07962 AVON CLINIC	0	0		ا		194. 11
194. 13 07963 WILLI AMSFIELD CLINIC	1, 205	0	0	0		194. 12
200.00 Cross Foot Adjustments	,					200.00
201.00 Negative Cost Centers		<u> </u>	<u> </u>	<u> </u>		201. 00

eal th Fi nanci al Systems GRAHAM HOSPI TAL ASSOCIATION

Heal th Financial Systems GRAHAM HOSPITAL ASSOCIATION In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0001 | Period: From 07/01/2022 | To 06/30/2023 | Date/Time Prepared:

						11/30/2023 12	:56 pm
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE	(SQUARE FEET)	(TOTAL	(GROSS	
		(SQUARE FEET)	(TOTAL		PATIENT DAYS)	SALARI ES)	
			PATIENT DAYS)				
		7. 00	8. 00	9. 00	10.00	11. 00	
202.00	Cost to be allocated (per Wkst. B,	4, 820, 824	714, 400	2, 287, 698	867, 067	1, 312, 033	202.00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	16. 412713	49. 590448	12. 567076	60. 187908	0. 041960	203. 00
204.00	Cost to be allocated (per Wkst. B,	633, 165	149, 977	133, 044	115, 011	147, 865	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	2. 155639	10. 410732	0. 730854	7. 983549	0.004729	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)						

Heal th Financial Systems GRAHAM HOSPITAL ASSOCIATION

COST ALLOCATION - STATISTICAL BASIS

In Lieu of Form CMS-2552-10

Worksheet B-1

From 07/01/2022 06/30/2023 Date/Time Prepared: 11/30/2023 12:56 pm Cost Center Description NURSI NG CENTRAL **PHARMACY** MEDI CAL NURSI NG ADMI NI STRATI O (COSTED RECORDS & PROGRAM SERVICES & **SUPPLY** REQUIS.) LI BRARY (ASSI GNED Ν (FTES) (COSTED (GROSS TIME) CHARGES) REQUIS.) 13.00 14. 00 15.00 16.00 20.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 11 00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13, 190 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 6, 218, 657 14.00 15.00 01500 PHARMACY 3, 267, 003 15.00 0 01600 MEDICAL RECORDS & LIBRARY 16.00 0 0 268, 653, 301 16.00 20.00 02000 NURSING PROGRAM 1,516 570 435, 350 20.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 4.534 183, 412 39, 008 18, 661, 024 178, 534 30.00 31.00 03100 INTENSIVE CARE UNIT 1, 168 58,061 18, 231 5, 238, 075 74, 100 31.00 04300 NURSERY 43.00 11 202, 555 0 43.00 04400 SKILLED NURSING FACILITY 1, 275 36, 588 6,052 1, 137, 182 44.00 14.400 44.00 45.00 04500 NURSING FACILITY 1, 324 23, 288 8, 113 1, 042, 154 0 45.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 2, 447 1, 100, 486 41, 885 36, 612, 743 55, 750 50.00 52 00 05200 DELIVERY ROOM & LABOR ROOM 52 00 0 0 0 05201 DELIVERY ROOM & LABOR ROOM 52.01 21 0 834, 415 0 52.01 05300 ANESTHESI OLOGY 315 18, 442 418 12, 674, 970 53.00 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 164, 334 11,583 22, 541, 009 5, 200 54.00 0 05700 CT SCAN 18, 696, 015 57 00 53, 900 57 00 348 0 0 58.00 05800 MRI 22, 501 0 5, 319, 271 0 58.00 06000 LABORATORY 0 543, 272 722 36, 904, 058 60.00 60.00 0 65.00 06500 RESPIRATORY THERAPY 0 0 0 80, 138 406 4, 441, 158 0 65.00 66.00 06600 PHYSI CAL THERAPY 66.00 9.076 79 13, 011, 960 10,500 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 987, 031 0 5, 181, 055 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 7, 020, 200 72.00 2, 325, 354 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 25, 820 2.344.636 12, 628, 698 5, 300 73.00 07697 CARDIAC REHABILITATION 10, 900 76.97 0 5.775 1.077 1, 574, 036 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 254, 664 695, 908 25, 468, 092 12, 285 88 00 08801 ELMWOOD RHC 0 88.01 39.540 863, 288 14, 470 449 88.01 08802 WILLIAMSFIELD RHC 0 88.02 1, 575 4.304 74, 231 48 88 02 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89.00 09000 CLI NI C 90.00 0 90.00 0 0 0 09001 WOUND CLINIC 90.01 90 01 0 152, 667 17,812 4, 807, 884 5.000 62, 800 91.00 09100 EMERGENCY 2,095 124, 458 27, 141 33, 591, 263 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 0 0 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 28,608 0 96.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 4<u>35, 266</u> 118. 00 13, 190 3, 257, 833 268, 525, 336 118.00 6, 215, 436 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT FLOWER COFFEE SHOP & CANTEEN 0 190.00 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 192.00 506 0 0 192. 01 19201 CANTON RHC RENTED SPACE 0 0 192. 01 C 0 193. 00 19300 NONPALD WORKERS 0 0 193.00 193. 02 19302 FOUNDATI ON 0000000000000 0 193.02 0 0 0 0 0 0 0 0 0 0 194. 00 07950 PHYSICIANS CLINIC 0 0 0 194.00 194. 01 07951 PROCTOR CHEMI CAL DEPENDENCY 0 0 194, 01 C 194. 02 07952 FRESENI US 0 0 194.02 194. 03 07953 RUCHFORD POB 0 194.03 0 194.04 07954 EP COLEMAN RENTAL SPACE 0 0 194.04 194. 05 07955 FARMI NGTON POB 0 194.05 C 194.06 07956 LEWISTON POB 0 0 194.06 194. 07 07957 OTHER RENTAL PROPERTY 0 0 0 194.07 194. 08 07958 KELLEY HOME 0 0 194. 08 Ω 194. 09 07959 EMPLOYEE PURCHASE C 0 0 0 194.09 194. 10 07960 RETAIL PHARMACY 0 194. 10 0 0 194. 11 07961 WELLNESS CENTER 1, 751 o 0 194, 11 C 0 194. 12 07962 AVON CLINIC 0 0 194. 12 194. 13 07963 WILLIAMSFIELD CLINIC 7, 419 127, 965 84 194. 13 2,715 200.00 Cross Foot Adjustments 200.00

Provider CCN: 14-0001

Peri od:

eal th Financial Systems GRAHAM HOSPITAL ASSOCIATION

Heal th Financial Systems GRAHAM HOSPITAL ASSOCIATION In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0001 | Period: From 07/01/2022 | To 06/30/2023 | Date/Time Prepared:

						11/30/2023 12	:56 pm
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	NURSI NG	
		ADMI NI STRATI O	SERVICES &	(COSTED	RECORDS &	PROGRAM	
		N	SUPPLY	REQUIS.)	LI BRARY	(ASSI GNED	
		(FTES)	(COSTED		(GROSS	TIME)	
			REQUIS.)		CHARGES)		
		13. 00	14. 00	15. 00	16.00	20.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	1, 310, 890	197, 411	1, 599, 402	1, 708, 250	3, 224, 909	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	99. 385140	0. 031745	0. 489562	0. 006359	7. 407624	203.00
204.00	Cost to be allocated (per Wkst. B,	70, 223	82, 466	93, 538	134, 107	715, 545	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	5. 323958	0. 013261	0. 028631	0. 000499	1. 643609	205.00
	11)						
206.00	NAHE adjustment amount to be allocated					0	206. 00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,					0.000000	207.00
	Parts III and IV)						

Heal th Fi nanci al Systems GRAHAM HOSPI TAL ASSOCIATION

Health Financial Systems GRAHAM HOSPITAL ASSOCIATION In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 14-0001 Period: Worksheet C

From 07/01/2022

Part I

2, 865, 737 201. 00

97, 406, 877 202. 00

06/30/2023 Date/Time Prepared: 11/30/2023 12:56 pm Title XVIII Hospi tal Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs Di sal I owance (from Wkst. Adj B, Part I, col. 26) 1. 00 2.00 3.00 4.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 12, 173, 102 12, 173, 102 12, 173, 102 30.00 03100 INTENSIVE CARE UNIT 2, 644, 121 0 31.00 2, 644, 121 2, 644, 121 31.00 43.00 04300 NURSERY 101, 121 101, 121 0 101, 121 43.00 04400 SKILLED NURSING FACILITY 2.257.323 0 2, 257, 323 44.00 2, 257, 323 44 00 45.00 04500 NURSING FACILITY 2, 418, 388 2, 418, 388 2, 418, 388 45.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 7, 081, 820 7, 081, 820 50.00 7, 081, 820 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 Λ 52.00 52.01 05201 DELIVERY ROOM & LABOR ROOM 69, 045 69,045 0 69,045 52.01 53.00 05300 ANESTHESI OLOGY 175, 602 175, 602 o 175, 602 53.00 05400 RADI OLOGY-DI AGNOSTI C 4, 074, 462 4,074,462 4,074,462 0 54.00 54.00 57.00 05700 CT SCAN 841,016 841,016 0 841, 016 57.00 58.00 05800 MRI 529, 689 529, 689 529, 689 58.00 06000 LABORATORY 60.00 7, 745, 809 7, 745, 809 15, 798 7, 761, 607 60.00 06500 RESPIRATORY THERAPY 1, 321, 224 1.321.224 1, 321, 224 65.00 0 65.00 66.00 06600 PHYSI CAL THERAPY 3, 400, 677 3, 400, 677 0 3, 400, 677 66.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 1, 259, 980 1, 259, 980 0 1, 259, 980 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS o 2, 935, 425 72.00 72.00 2, 935, 425 2, 935, 425 07300 DRUGS CHARGED TO PATIENTS 4, 245, 036 4, 245, 036 73.00 4, 245, 036 0 73.00 76. 97 07697 CARDIAC REHABILITATION 864, 482 864, 482 864, 482 76.97 OUTPATIENT SERVICE COST CENTERS 32, 745, 276 32, 745, 276 88.00 08800 RURAL HEALTH CLINIC 32, 745, 276 0 88 00 0 1, 861, 576 88.01 08801 ELMWOOD RHC 1,861,576 1,861,576 88.01 88.02 08802 WILLIAMSFIELD RHC 215, 359 215, 359 0 215, 359 88.02 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER ol 89.00 0 0 0 09000 CLI NI C 90.00 0 0 0 Ω 90.00 90.01 09001 WOUND CLINIC 1, 726, 517 1, 726, 517 24, 134 1, 750, 651 90.01 09100 EMERGENCY 4, 593, 967 91.00 4, 202, 289 4, 202, 289 391, 678 91.00 2, 865, 737 2, 865, 737 92 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 2, 865, 737 92 00 OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED 2, 085, 928 2, 085, 928 0 2, 085, 928 96.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113 00 99, 841, 004 431, 610 100, 272, 614 200. 00 200.00 Subtotal (see instructions) 99, 841, 004 0

2, 865, 737

96, 975, 267

2, 865, 737

431, 610

96, 975, 267

201.00

202.00

Less Observation Beds

Total (see instructions)

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES

In Lieu of Form CMS-2552-10

Worksheet C Part I Date/Time Prepared: 11/30/2023 12:56 pm Provider CCN: 14-0001 Peri od: From 07/01/2022 To 06/30/2023

			T: ±1 -	V() / I I	Hanni kal	PPS	. 30 piii
				XVIII	Hospi tal	PP5	
	0		Charges	T. I. I. (I /		TEEDA	
	Cost Center Description	I npati ent	Outpati ent		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			r			
30.00	03000 ADULTS & PEDIATRICS	12, 236, 702		12, 236, 70			30.00
31.00	03100 INTENSIVE CARE UNIT	5, 238, 075		5, 238, 07			31.00
43.00	04300 NURSERY	202, 555		202, 55	5		43.00
44.00	04400 SKILLED NURSING FACILITY	1, 137, 182		1, 137, 18	2		44.00
45.00	04500 NURSING FACILITY	1, 042, 154		1, 042, 15	4		45.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	7, 317, 712	29, 295, 031	36, 612, 74	0. 193425	0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0. 000000	0.000000	52.00
52. 01	05201 DELIVERY ROOM & LABOR ROOM	826, 777	7, 638	834, 41	0. 082747	0.000000	52. 01
53.00	05300 ANESTHESI OLOGY	3, 004, 008	9, 670, 962		0. 013854	0. 000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 805, 274	20, 735, 735			0.000000	54.00
57. 00	05700 CT SCAN	2, 218, 446	16, 477, 569			0. 000000	1
58. 00	05800 MRI	268, 755	5, 050, 515			0. 000000	
60.00	06000 LABORATORY	4, 997, 270	31, 906, 788		1	0. 000000	1
65. 00	06500 RESPIRATORY THERAPY	1, 616, 436	2, 824, 722		1	0. 000000	
66. 00	06600 PHYSI CAL THERAPY	1, 815, 363	11, 196, 597		1	0. 000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 907, 587	2, 273, 468			0. 000000	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3, 125, 364	3, 894, 837			0. 000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	6, 288, 012	6, 340, 686			0.000000	
76. 97	07697 CARDIAC REHABILITATION	13, 775	1, 560, 262			0.000000	
10.91	OUTPATIENT SERVICE COST CENTERS	13,773	1, 300, 202	1, 374, 03	0. 349213	0.000000	10.91
88. 00	08800 RURAL HEALTH CLINIC		25 440 002	25, 468, 09	n		88. 00
		0	25, 468, 092				
88. 01	08801 ELMWOOD RHC	0	863, 288		1		88. 01
88. 02	08802 WI LLI AMSFI ELD RHC	0	74, 231				88. 02
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89.00
90.00	09000 CLI NI C	0	0		0. 000000	0. 000000	
90. 01	09001 WOUND CLINIC	22, 511	4, 785, 372		1	0. 000000	1
91.00	09100 EMERGENCY	5, 205, 850	28, 385, 413			0. 000000	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 948, 768	4, 475, 554	6, 424, 32	0. 446076	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	4, 140, 892	4, 140, 89	0. 503739	0.000000	96.00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE						113.00
200.00		63, 238, 576	209, 427, 652	272, 666, 22	3		200. 00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	63, 238, 576	209, 427, 652	272, 666, 22	3		202.00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES

In Lieu of Form CMS-2552-10

Period:
From 07/01/2022 Part I
To 06/30/2023 Date/Time Prepared:
11/30/2023 12:56 pm

Hospital PPS Provider CCN: 14-0001 Title XVIII

			litle XVIII	Hospi tai	PPS
	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
	04300 NURSERY				43.00
44.00	04400 SKILLED NURSING FACILITY				44.00
45.00	04500 NURSING FACILITY				45. 00
	ANCILLARY SERVICE COST CENTERS				
	05000 OPERATI NG ROOM	0. 193425			50.00
	05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
52.01	05201 DELIVERY ROOM & LABOR ROOM	0. 082747			52. 01
53.00	05300 ANESTHESI OLOGY	0. 013854			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 180758			54.00
57.00	05700 CT SCAN	0. 044984			57.00
58.00	05800 MRI	0. 099579			58.00
60.00	06000 LABORATORY	0. 210319			60.00
65.00	06500 RESPIRATORY THERAPY	0. 297495			65.00
66.00	06600 PHYSI CAL THERAPY	0. 261350			66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 243190			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 418140			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 336142			73.00
76. 97	07697 CARDI AC REHABILI TATI ON	0. 549213			76. 97
	OUTPATIENT SERVICE COST CENTERS				
88. 00	08800 RURAL HEALTH CLINIC				88.00
88. 01	08801 ELMWOOD RHC				88. 01
88. 02	08802 WILLI AMSFI ELD RHC				88. 02
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	09000 CLI NI C	0. 000000			90.00
90. 01	09001 WOUND CLINIC	0. 364121			90. 01
91.00	09100 EMERGENCY	0. 136761			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 446076			92.00
	OTHER REIMBURSABLE COST CENTERS				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 503739			96.00
	SPECIAL PURPOSE COST CENTERS				
113.00	11300 I 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
		•			•

Heal th Fi nanci al Systems

GRAHAM HOSPI TAL ASSOCIATION

ORDER TO BE SHOULD BE SHOUL

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider Co		Period: From 07/01/2022 To 06/30/2023	Worksheet D Part I Date/Time Pre 11/30/2023 12	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col . 2)			
	1. 00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	752, 017	0	752, 01	7 6, 754	111. 34	30.00
31.00 INTENSIVE CARE UNIT	100, 991		100, 99	1, 144	88. 28	31.00
43. 00 NURSERY	25, 913		25, 91	3 356	72. 79	43.00
44.00 SKILLED NURSING FACILITY	192, 113		192, 11	3 2, 262	84. 93	44.00
45.00 NURSING FACILITY	233, 974		233, 97	4 5, 384	43. 46	45.00
200.00 Total (lines 30 through 199)	1, 305, 008		1, 305, 00	15, 900		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	2, 427	270, 222				30.00
31.00 INTENSIVE CARE UNIT	477	42, 110				31.00
43. 00 NURSERY	0	0				43.00
44.00 SKILLED NURSING FACILITY	1, 308	111, 088				44.00
45.00 NURSING FACILITY	0	0				45.00
200.00 Total (lines 30 through 199)	4, 212	423, 420				200. 00

In Lieu of Form CMS-2552-10

Heal th Financial Systems GRAHAM HOSPITAL ASSOCIATION

Health Financial Systems | GRAHAM HOSPITAL ASSOCIATION | In Lieu of Form CMS-2552-10 |
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0001 | Period: | Worksheet D

From 07/01/2022 Part II Date/Time Prepared: 06/30/2023 11/30/2023 12:56 pm Title XVIII Hospi tal Total Charges Capital Costs Cost Center Description Capi tal Ratio of Cost Inpati ent to Charges Related Cost (column 3 x (from Wkst. Program column 4) (from Wkst. C, Part I, (col. 1 ÷ Charges 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 43, 481 50 00 05000 OPERATING ROOM 520, 364 36, 612, 743 0.014213 3, 059, 232 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 05201 DELIVERY ROOM & LABOR ROOM 0. 015142 52.01 12, 635 834, 415 0 0 52.01 05300 ANESTHESI OLOGY 15, 304 12, 674, 970 775, 263 0.001207 936 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 22, 541, 009 54.00 194, 249 0.008618 801, 252 6, 905 54.00 57.00 05700 CT SCAN 138, 308 18, 696, 015 0.007398 996, 779 7, 374 57.00 58.00 05800 MRI 41, 449 5, 319, 270 0.007792 116, 042 904 58.00 06000 LABORATORY 365, 686 60.00 36, 904, 058 0.009909 2, 036, 431 20, 179 60.00 06500 RESPIRATORY THERAPY 65.00 56, 683 4, 441, 158 0.012763 966, 490 12, 335 65.00 66.00 06600 PHYSI CAL THERAPY 197, 885 13, 011, 960 0.015208 933, 455 14, 196 66.00 5, 181, 055 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 23, 438 0.004524 1, 243, 866 5, 627 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.007497 1, 420, 278 72.00 72.00 52, 631 7, 020, 201 10, 648 73.00 07300 DRUGS CHARGED TO PATIENTS 149, 689 12, 628, 698 0.011853 2, 511, 640 29, 770 73.00 07697 CARDIAC REHABILITATION 76. 97 182, 352 1, 574, 037 0.115850 8,035 931 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 1, 508, 587 25, 468, 092 0.059234 0 88.00 08801 ELMWOOD RHC 83, 135 863, 288 0.096300 0 0 88.01 88.01 08802 WILLIAMSFIELD RHC 15, 876 74, 231 0.213873 0 88.02 88.02 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 C 0.000000 0 0 89.00 90.00 09000 CLI NI C 0 0.000000 0 0 90.00 09001 WOUND CLINIC 90. 01 106, 545 4,807,883 0.022160 15, 092 334 90.01 33, 591, 263 91 00 09100 EMERGENCY 307, 406 0.009151 2, 432, 209 22 257 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 177, 037 6, 424, 322 0.027557 995, 477 27, 432 92.00 OTHER REIMBURSABLE COST CENTERS 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 17, 392 4, 140, 892 0.004200 0 96.00

4, 166, 651

252, 809, 560

203, 309 200. 00

18, 311, 541

200.00

Total (lines 50 through 199)

Heal th Fi nanci al Systems

GRAHAM HOSPI TAL ASSOCIATION

In Lieu of Form CMS-2552-10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS Provider CCN: 14-0001 Peri od: Worksheet D From 07/01/2022 Part III Date/Time Prepared: 06/30/2023 11/30/2023 12:56 pm Title XVIII Hospi tal Cost Center Description Nursi ng Allied Health Allied Health All Other Nursi ng Post-Stepdown Medi cal Program Program Cost Post-Stepdown Educati on Adjustments Adjustments Cost 2A 2.00 1.00 3. 00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDI ATRI CS 30.00 30.00 1, 322, 512 0 0 0 0 0 0 0 03100 INTENSIVE CARE UNIT 31.00 548, 905 0 31.00 43. 00 04300 NURSERY 43.00 0 0 0 44.00 04400 SKILLED NURSING FACILITY 106, 670 44.00 0 45.00 | 04500 NURSING FACILITY 0 45.00 200.00 Total (lines 30 through 199) 1, 978, 087 200.00 Cost Center Description Swi ng-Bed Total Costs Total Patient Per Diem I npati ent Adjustment (sum of cols. Days (col. 5 ÷ Program Days Amount (see 1 through 3, col. 6) instructions) minus col. 4. 00 5.00 6.00 7. 00 8.00 INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 1, 322, 512 6, 754 2, 427 195. 81 30 00 31.00 03100 INTENSIVE CARE UNIT 548, 905 1, 144 479.81 477 31.00 43.00 04300 NURSERY 356 0.00 0 43.00 04400 SKILLED NURSING FACILITY 47. 16 1, 308 44.00 2, 262 44.00 106, 670 0.00 45.00 04500 NURSING FACILITY 5, 384 0 45.00 200.00 Total (lines 30 through 199) 1, 978, 087 15, 900 4, 212 200. 00 Cost Center Description I npati ent Program Pass-Through Cost (col. x col. 8) 9. 00 INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 475, 231 30.00 31.00 03100 INTENSIVE CARE UNIT 228, 869 31.00 43.00 04300 NURSERY 43.00 44.00 04400 SKILLED NURSING FACILITY 61, 685 44.00 45.00 04500 NURSING FACILITY 45.00 0

765, 785

200.00

200.00

Total (lines 30 through 199)

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APPORTI ONMENT OF I NPATI ENT/OUTPATI ENT ANCI LLARY SERVI CE OTHER PASS Provi der CCN: 14-0001

In Lieu of Form CMS-2552-10

Worksheet D Part IV Date/Time Prepared: 11/30/2023 12:56 pm Peri od: From 07/01/2022 To 06/30/2023 THROUGH COSTS

			Title	: XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	1	1				
50.00	05000 OPERATING ROOM	0	0	412, 975	0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52. 01	05201 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 01
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	38, 520	0	0	54.00
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
65.00	06500 RESPI RATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	77, 780	0	0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	39, 260		0	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	80, 743	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	91, 003		0	
88. 01	08801 ELMWOOD RHC	0	0	3, 326		0	88. 01
88. 02	08802 WILLIAMSFIELD RHC	0	0	356	0	0	88. 02
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90.00	09000 CLI NI C	0	0	0	0	0	90.00
90. 01	09001 WOUND CLINIC	0	0	37, 038		0	90. 01
91.00	09100 EMERGENCY	0	0	465, 199	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		311, 339		0	92.00
	OTHER REIMBURSABLE COST CENTERS						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	70.00
200.00	Total (lines 50 through 199)	0	0	1, 557, 539	0	0	200. 00

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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 14-0001

THROUGH COSTS

Provider CCN: 14-0001

From 07/01/2022
To 06/30/2023 12:56 pm 11/30/2023 12:56 pm

						11/30/2023 12	:56 pm_
				XVIII	Hospi tal	PPS	
	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	412, 975	412, 975	36, 612, 743	0. 011280	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	o	0	(0	0.000000	52.00
52. 01	05201 DELIVERY ROOM & LABOR ROOM	o	0		834, 415	0.000000	52. 01
53.00	05300 ANESTHESI OLOGY	o	0		12, 674, 970	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	o	38, 520	38, 520	22, 541, 009	0.001709	54.00
57. 00	05700 CT SCAN	o	0	(18, 696, 015		57.00
58. 00		o	0		5, 319, 270		58.00
	06000 LABORATORY	0	0	(36, 904, 058		
65. 00		0	0	(4, 441, 158		
66. 00	06600 PHYSI CAL THERAPY		77, 780	77, 780	1		
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0	,	5, 181, 055		
	07200 IMPL. DEV. CHARGED TO PATIENTS		0		7, 020, 201		
73. 00	07300 DRUGS CHARGED TO PATIENTS		39, 260	39, 260	1		
	07697 CARDI AC REHABI LI TATI ON		80, 743				76. 97
70. 77	OUTPATIENT SERVICE COST CENTERS	<u>۷</u>	00,710	00,710	1, 0, 1, 00,	0.001277	70.77
88. 00			91, 003	91, 003	25, 468, 092	0.003573	88. 00
88. 01	08801 ELMWOOD RHC		3, 326		1		88. 01
88. 02	08802 WILLIAMSFIELD RHC		356				
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00	330) 74, 231	0.000000	89.00
90.00	09000 CLINIC		0			0. 000000	90.00
90. 01	09001 WOUND CLINIC		37, 038	37, 038	4, 807, 883		90.00
91. 00	09100 EMERGENCY		465, 199		1		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		311, 339		1		92.00
72. UU	OTHER REIMBURSABLE COST CENTERS	ı o	311, 339	311, 33	0,424,322	0.046403	72.00
06 00	09600 DURABLE MEDICAL EQUIP-RENTED		0		4, 140, 892	0.000000	96.00
200.00			1, 557, 539				200.00
200.00	p Total (Tries 50 till ough 199)	١	1, 007, 039	1, 337, 339	252, 609, 300	l	1200.00

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Heal th Financial Systems GRAHAM HOSPITAL ASSOCIATION In Lieu of Form CMS-2552-10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

THROUGH COSTS

Provider CCN: 14-0001 From 07/01/2022 To 06/30/2023 Date/Time Prepared: 11/30/2023 12:56 pm

						11/30/2023 12	:56 pm
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	·	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷	Ü	Costs (col. 8	3	Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11.00	12.00	13.00	
ANC	ILLARY SERVICE COST CENTERS	•			*		
50.00 050	OO OPERATING ROOM	0. 011280	3, 059, 232	34, 50	5, 263, 823	59, 376	50.00
52. 00 052	OO DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52.00
52. 01 052	01 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52. 01
53. 00 053	00 ANESTHESI OLOGY	0. 000000	775, 263		0 1, 196, 407	0	53.00
54.00 054	OO RADI OLOGY-DI AGNOSTI C	0. 001709	801, 252	1, 36	9 4, 834, 203	8, 262	54.00
	OO CT SCAN	0. 000000	996, 779		0 4, 388, 842		57.00
	OO MRI	0. 000000	116, 042		0 1, 037, 358	l .	58.00
	00 LABORATORY	0. 000000	2, 036, 431		2, 983, 500		60.00
65.00 065	00 RESPIRATORY THERAPY	0. 000000	966, 490		0 486, 718		65.00
66, 00 066	00 PHYSI CAL THERAPY	0. 005978	933, 455		· ·		66.00
71. 00 071	00 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	1, 243, 866		336, 274		71.00
72. 00 072	00 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	1, 420, 278		995, 902		72.00
	OO DRUGS CHARGED TO PATIENTS	0. 003109	2, 511, 640				73.00
	97 CARDI AC REHABI LI TATI ON	0. 051297	8, 035				76. 97
	PATIENT SERVICE COST CENTERS						
	OO RURAL HEALTH CLINIC	0. 003573	0		0 0	0	88.00
	01 ELMWOOD RHC	0. 003853	0		0	0	88. 01
88. 02 088	02 WILLIAMSFIELD RHC	0. 004796	0		0	0	88. 02
89.00 089	OO FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0	0	89.00
90.00 090	OO CLINIC	0. 000000	0		0	0	90.00
90. 01 090	01 WOUND CLINIC	0. 007704	15, 092	11	6 1, 538, 516	11, 853	90. 01
91.00 091	OO EMERGENCY	0. 013849	2, 432, 209				91.00
92.00 092	OO OBSERVATION BEDS (NON-DISTINCT PART	0. 048463	995, 477				92.00
	ER REIMBURSABLE COST CENTERS				, , , , , , , , , , , , , , , , , , , ,	, , , = .	1
	OO DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0	0	96.00
200.00	Total (lines 50 through 199)		18, 311, 541			272, 129	
	, ,					•	

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Health Financial Systems GRAHAM HOSPITAL ASSOCIATION In Lieu of Form CMS-2552-10

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 14-0001 Period: From 07/01/2022 To 06/30/2023 12:56 pm

			Title	XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	·	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see	Servi ces	Services Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins.	Ded. & Coins.		
		9		(see inst.)	(see inst.)		
		1. 00	2.00	3.00	4. 00	5. 00	
ANCI I	LARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0. 193425	5, 263, 823	C	0	1, 018, 155	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52.00
52. 01 0520°	1 DELIVERY ROOM & LABOR ROOM	0. 082747	0		0	0	52. 01
53.00 05300	ANESTHESI OLOGY	0. 013854	1, 196, 407		0	16, 575	53.00
	RADI OLOGY-DI AGNOSTI C	0. 180758			0	873, 821	54.00
57.00 05700	OCT SCAN	0. 044984	4, 388, 842	1 0	0	197, 428	57.00
58. 00 05800	MRI	0. 099579			0	103, 299	
60.00 06000	LABORATORY	0. 209890			0	626, 207	60.00
	RESPIRATORY THERAPY	0. 297495			0	144, 796	
	PHYSI CAL THERAPY	0. 261350			0	9, 627	66.00
	OMEDICAL SUPPLIES CHARGED TO PATIENT	0. 243190			0	81, 778	
	OIMPL. DEV. CHARGED TO PATIENTS	0. 418140			0	416, 426	
	D DRUGS CHARGED TO PATIENTS	0. 336142			2, 250	505, 083	
	7 CARDI AC REHABI LI TATI ON	0. 549213				376, 809	
	ATIENT SERVICE COST CENTERS	0.017210	000,007			070,007	70.77
	RURAL HEALTH CLINIC						88. 00
	1 ELMWOOD RHC						88. 01
	2 WILLIAMSFIELD RHC						88. 02
	FEDERALLY QUALIFIED HEALTH CENTER						89.00
	O CLINIC	0. 000000	1	1	0	0	90.00
	1 WOUND CLINIC	0. 359101	1, 538, 516		Ô	552, 483	
	DEMERGENCY	0. 125101	5, 446, 210		0	681, 326	
	O OBSERVATION BEDS (NON-DISTINCT PART	0. 446076				709, 915	
	R REIMBURSABLE COST CENTERS	0.440070	1, 371, 400		0	707, 713	72.00
	D DURABLE MEDICAL EQUIP-RENTED	0. 503739	0		0	0	96. 00
200. 00	Subtotal (see instructions)	0.303737	32, 324, 730		2, 250	6, 313, 728	
201.00	Less PBP Clinic Lab. Services-Program	1	32, 324, 730		2, 230	0,313,720	201.00
201.00	Only Charges			١			201.00
202. 00	Net Charges (line 200 - line 201)		32, 324, 730	O	2, 250	6, 313, 728	202 00
202.00	inct onal ges (True 200 - True 201)	I	1 32, 324, 730	1	2, 250	0, 313, 720	1202.00

GRAHAM HOSPI TAL ASSOCIATION

Health Financial Systems GRAHAM HOSPITA
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

In Lieu of Form CMS-2552-10
Worksheet D
Part V
Borel Date/Time Prepared:
11/30/2023 12:56 pm
tal PPS Provider CCN: 14-0001 Peri od: From 07/01/2022 To 06/30/2023 Title XVIII Hospi tal

				7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	1103pi tui	110	
		Cos	sts				
Cost Center	Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00	1			
ANCI LLARY SERVI CE	COST CENTERS						
50. 00 05000 OPERATING F	ROOM	0	0)			50.00
52. 00 05200 DELI VERY RO	OOM & LABOR ROOM	0	0				52.00
52. 01 05201 DELI VERY RO	OOM & LABOR ROOM	0	l o				52. 01
53. 00 05300 ANESTHESI OL		0	0				53.00
54. 00 05400 RADI 0L0GY-D		0	0				54.00
57. 00 05700 CT SCAN		0	0				57. 00
58. 00 05800 MRI		l o	0				58. 00
60. 00 06000 LABORATORY		0	١				60.00
65. 00 06500 RESPIRATORY	THERADY	i o	١				65. 00
66. 00 06600 PHYSI CAL TH		0	0				66.00
	PPLIES CHARGED TO PATIENT	0	0				71.00
72. 00 07200 I MPL. DEV.		0					71.00
73. 00 07300 DRUGS CHARG		0	756	(73.00
76. 97 07697 CARDI AC REF		0	730	1			76. 97
OUTPATIENT SERVICE		0	0	′			70.97
88. 00 08800 RURAL HEALT				I			88. 00
88. 01 08801 ELMWOOD RHC		-					88. 01
88. 02 08802 WI LLI AMSFI E							88.01
							88. 02 89. 00
90. 00 08900 FEDERALLY C	DUALIFIED HEALTH CENTER						90.00
	0	0	0	<u>'</u>			
90. 01 09001 WOUND CLINI	C	0	0	?			90. 01
91. 00 09100 EMERGENCY	L DEDG (NON BLOTHNOT BART	0	0	<u>'</u>			91.00
	I BEDS (NON-DISTINCT PART	0	0)			92.00
OTHER REI MBURSABI		_	_				
	DICAL EQUIP-RENTED	0	ı	1			96. 00
	see instructions)	0	756]			200. 00
	inic Lab. Services-Program	0					201. 00
Only Charge							
202.00 Net Charges	s (line 200 - line 201)	0	756	p			202. 00

GRAHAM HOSPI TAL ASSOCIATION

Health Financial Systems GRAHAM HOSPITAL A
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS In Lieu of Form CMS-2552-10 Provi der CCN: 14-0001

Peri od: Worksheet D
From 07/01/2022 Part IV
To 06/30/2023 Date/Time Prepared: 11/30/2023 12:56 pm
Skilled Nursing PPS THROUGH COSTS Component CCN: 14-5572 Title XVIII Skilled Nursing

			11.616	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	F!!!	119	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Facility	Allied Health	
	cost center bescription	Anesthetist	Program	Program	Post-Stepdown	Airreu near tii	
		Cost	Post-Stepdown		Adjustments		
		0031	Adjustments		Aujustilients		
		1. 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	271	2.00	- Ort	0.00	
50.00	05000 OPERATING ROOM	0	C	412, 97	5 0	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0		,	0	0	52.00
52. 01	05201 DELIVERY ROOM & LABOR ROOM	0			0	0	52. 01
53. 00	05300 ANESTHESI OLOGY	0			0	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0		38, 520	0	0	54.00
57. 00	05700 CT SCAN	0		1	0	0	57.00
58. 00	05800 MRI	0			o o	Ō	58.00
60.00	06000 LABORATORY	0			0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0			0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	l c	77, 780	0	0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C		0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	C)	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	C	39, 260	0	0	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	C	80, 74	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	C	91, 00	3 0	0	88. 00
88. 01	08801 ELMWOOD RHC	0	C	3, 320	5 0	0	88. 01
88. 02	08802 WILLIAMSFIELD RHC	0	C	350	5 0	0	88. 02
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C		0	0	89. 00
90.00	09000 CLI NI C	0	C		0	0	90.00
90. 01	09001 WOUND CLINIC	0	C	37, 03	3 0	0	90. 01
91.00	09100 EMERGENCY	0	C	465, 199	9 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		(0	92.00
	OTHER REIMBURSABLE COST CENTERS				_		
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	C)	0	0	, 0. 00
200.00	Total (lines 50 through 199)	0	C	1, 246, 200	0	0	200. 00

ealth Financial Systems GRAHAM HOSPITAL ASSOCIATION In L

Heal th Financial Systems GRAHAM HOSPITAL ASSOCIATION In Lieu of Form CMS-2552-10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 14-0001

THROUGH COSTS Provider CCN: 14-5572

Component CCN: 14-5572

Title XVIII Skilled Nursing PPS

All Other Medical Education Cost Cost Cost Cost (sum of cols. Col. 8) Col. 7) Col. 8) Col. 7) Col. 8 Col. 7 Col. 7 Col. 8 Col. 7						<u>Facility</u>		
ANCILLARY SERVICE COST CENTERS		Cost Center Description						
ANCILLARY SERVICE COST CENTERS				•				
ANCILLARY SERVICE COST CENTERS				1, 2, 3, and				
ANCI LLARY SERVI CE COST CENTERS			Cost	4)		col. 8)		
ANCI LLARY SERVI CE COST CENTERS					and 4)			
ANCILLARY SERVICE COST CENTERS 50.00 G5000 DEPRATI IN GROWN 0 412,975 36,612,743 0.011280 50.00 50.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 0 8.34,415 0.000000 52.01 53.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 8.34,415 0.000000 52.01 53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 12,674,970 0.000000 53.00 0.000000 53.00 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.00000000								
50. 00 05000 OPERATI NG ROOM 0 412, 975 412, 975 36, 612, 743 0. 011280 50. 00 52. 00 0 0 0 0 0 0 0 0 0			4. 00	5. 00	6. 00	7. 00	8. 00	
52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0								1
52. 01 05201 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 12, 674, 970 0.000000 53. 00 05400 ANESTHESI OLOGY 0 0 0 0 0 12, 674, 970 0.000000 53. 00 05400 ANESTHESI OLOGY 0 0 0 38, 520 32, 521, 1009 0.001709 54. 00 05400 ARDI OLOGY-DI AGNOSTI C 0 38, 520 38, 520 38, 520 22, 541, 009 0.001709 54. 00 57. 00 57. 00 05700 CT SCAN 0 0 0 0 18, 696, 015 0.000000 57. 00 58. 00 05800 MRI 0 0 0 0 0 0 5, 319, 270 0.000000 58. 00 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000			0	412, 975	412, 975	36, 612, 743		
53. 00 05300 ANESTHESI OLOGY 0 0 0 0 12, 674, 970 0.000000 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 38, 520 38, 520 22, 541, 009 0.001709 54. 00 57. 00 05700 CT SCAN 0 0 0 0 18, 696, 015 0.000000 57. 00 58. 00 05800 MRI 0 0 0 0 5, 319, 270 0.000000 58. 00 60. 00 06000 LABORATORY 0 0 0 0 36, 904, 058 0.000000 65. 00 65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 4, 441, 158 0.00000 65. 00 66. 00 06600 RESPIRATORY THERAPY 0 0 77, 780 13, 011, 960 0.005978 66. 00 66. 00 06600 LABORATORY 0 0 77, 780 13, 011, 960 0.005978 66. 00 67. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 5, 181, 055 0.000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 39, 260 39, 260 39, 260 26, 8698 0.003109 73. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 39, 260 39, 260 39, 260 26, 8698 0.003109 73. 00 74. 97 07697 CARDI AC REHABI LI TATI ON 0 80, 743 80, 743 1, 574, 037 0.051297 76. 97 88. 00 08800 RURAL HEALTH CLINIC 0 91, 003 91, 003 25, 468, 092 0.003573 88. 01 88. 01 08801 ELMWOOD RHC 0 356 336 74, 231 0.004796 88. 02 89. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 0 0 0.000000 90. 00 90. 01 09001 WOUND CLINIC 0 37, 038 37, 038 4, 807, 883 0.007704 90. 01 91. 00 09100 EMERGENCY 0 465, 199 33, 591, 263 0.013849 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 4, 140, 892 0.000000 96. 00 09600 DURABLE MEDI CAL EQUIP-RENTED 0 0 0 4, 140, 892 0.000000 96. 00 09600 DURABLE MEDI CAL EQUIP-RENTED 0 0 0 4, 140, 892 0.000000 96. 00 09600 00000000000000000000000000			0	0	0	0		1
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 38, 520 38, 520 22, 541, 009 0. 001709 54. 00 57. 00 05700 CT SCAN 0 0 0 0 0 18, 696, 015 0.000000 57. 00 0.000000 57. 00 0.000000 58. 00 0.000000 58. 00 0.000000 59. 00 0.0000000 0.000000 0.000000 0.0000000 0.000000 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.00000000			0	0	0	·		1
57. 00 05700 CT SCAN 0 0 0 0 18, 696, 015 0.000000 57. 00 58. 00 05800 MRI 0 0 0 0 5, 319, 270 0.000000 58. 00 0 0 0 36, 319, 270 0.000000 58. 00 0 0 0 0 36, 319, 270 0.000000 58. 00 0 0 0 0 0 36, 904, 058 0.000000 60. 00 0 0 0 0 0 0 0 0 0 0 0 0			0	0	0			
58.00 05800 MRI 0 0 0 0 5,319,270 0.000000 58.00 60.00 06000 LABORATORY 0 0 0 0 36,904,058 0.000000 60.00 65.00 65.00 66500 RESPIRATORY THERAPY 0 0 77,780 77,780 13,011,960 0.005978 66.00 66.00 66.00 67,000 67,000 67,780 77,780 77,780 13,011,960 0.005978 66.00 67,000 67			0	38, 520	38, 520	22, 541, 009		1
60. 00	57.00		0	0	0	18, 696, 015		
65. 00	58.00	05800 MRI	0	0	0	5, 319, 270	0.000000	58.00
66. 00	60.00	06000 LABORATORY	0	0	0	36, 904, 058	0.000000	60.00
71. 00	65.00	06500 RESPI RATORY THERAPY	0	0	0	4, 441, 158		
72. 00	66.00	06600 PHYSI CAL THERAPY	0	77, 780	77, 780	13, 011, 960	0. 005978	66.00
73. 00	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5, 181, 055	0.000000	71.00
76. 97 O7697 CARDI AC REHABI LI TATI ON O 80, 743 80, 743 1, 574, 037 0. 051297 76. 97 OUTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINI C 0 91, 003 91, 003 25, 468, 092 0. 003573 88. 00 8802 RURAL HEALTH CLINI C 0 3, 326 863, 288 0. 003573 88. 00 88. 01 08801 ELMWOOD RHC 0 356 356 74, 231 0. 004796 88. 02 89. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 0 0 0 0 0 0 0. 000000 89. 00 90. 00 0000 CLINI C 0 37, 038 37, 038 4, 807, 883 0. 007704 90. 01 09001 WOUND CLINI C 0 37, 038 37, 038 4, 807, 883 0. 007704 90. 01 90. 00 09100 EMERGNCY 0 465, 199 465, 199 33, 591, 263 0. 013849 91. 00 00 00 00 00 00 00 00 00 00 00 00 00	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7, 020, 201	0.000000	72.00
SECTION SUBSIDIARY SUBSTRICT SubsT	73.00	07300 DRUGS CHARGED TO PATIENTS	0	39, 260	39, 260	12, 628, 698	0.003109	73.00
88. 00 08800 RURAL HEALTH CLINIC 0 91,003 91,003 25,468,092 0.003573 88. 00 08801 ELMWOOD RHC 0 3,326 3,326 863,288 0.003853 88. 01 88. 02 08802 WI LLI AMSFI ELD RHC 0 356 356 74,231 0.004796 88. 02 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0.000000 89. 00 90. 00 0.0000000 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	76. 97	07697 CARDIAC REHABILITATION	0	80, 743	80, 743	1, 574, 037	0. 051297	76. 97
88. 01 08801 ELMWOOD RHC 0 3,326 3,326 863,288 0.003853 88. 01 88. 02 08802 WI LLI AMSFI ELD RHC 0 356 356 74,231 0.004796 88. 02 89. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 0 0 0 0 0.000000 90. 00 09000 CLI NI C 0 0 0 0 0.000000 90. 01 09001 WOUND CLI NI C 0 37,038 37,038 4,807,883 0.007704 91. 00 09100 EMERGENCY 0 465,199 33,591,263 0.013849 91. 00 09200 085ERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 6,424,322 0.000000 92. 00 OTHER REI MBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 4,140,892 0.000000 96. 00								
88. 02 08802 WILLIAMSFIELD RHC 0 356 356 74, 231 0.004796 88. 02 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0.000000 89. 00 90. 00 09000 CLINIC 0 0 0 0 0 0.000000 90. 00	88.00	08800 RURAL HEALTH CLINIC	0	91, 003	91, 003	25, 468, 092	0. 003573	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 0	88. 01	08801 ELMWOOD RHC	0	3, 326	3, 326	863, 288	0. 003853	88. 01
90. 00 09000 CLI NI C 0 0 0 0 0 0 0 0 0	88. 02	08802 WILLIAMSFIELD RHC	0	356	356	74, 231	0. 004796	88. 02
90. 01 09001 WOUND CLINIC 0 37, 038 37, 038 4, 807, 883 0. 007704 90. 01 91. 00 09100 EMERGENCY 0 465, 199 465, 199 33, 591, 263 0. 013849 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 6, 424, 322 0. 0000000 92. 00 00000000000000000000000000000000	89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89. 00
91. 00 09100 EMERGENCY 0 465, 199 33, 591, 263 0. 013849 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 0 0 0 0 0	90.00	09000 CLI NI C	0	0	0	0	0.000000	90.00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 6,424,322 0.000000 92. 00 0THER REIMBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 4,140,892 0.000000 96. 00 00 00 00 00 00 00 00	90.01	09001 WOUND CLINIC	0	37, 038	37, 038	4, 807, 883	0. 007704	90. 01
OTHER REI MBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 4, 140, 892 0. 000000 96. 00	91.00	09100 EMERGENCY	0	465, 199	465, 199	33, 591, 263	0. 013849	91.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 4, 140, 892 0. 000000 96. 00	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	6, 424, 322	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS]
200.00 Total (Lines 50 through 199) 0 1,246,200 1,246,200 252,809,560 200.00	96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	4, 140, 892	0. 000000	96.00
	200.00	Total (lines 50 through 199)	0	1, 246, 200	1, 246, 200	252, 809, 560		200.00

GRAHAM HOSPI TAL ASSOCIATION

Health Financial Systems GRAHAM HOSPITAL A
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS In Lieu of Form CMS-2552-10 Provi der CCN: 14-0001

Peri od: Worksheet D Part IV To 06/30/2023 Date/Time Prepared: 11/30/2023 12:56 pm THROUGH COSTS Component CCN: 14-5572 Title XVIII Skilled Nursing

					Facility		
Cost Center Description		Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷		Costs (col. 8		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						
	05000 OPERATING ROOM	0. 011280	0	0	0	0	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	0	0	0	52.00
	05201 DELIVERY ROOM & LABOR ROOM	0. 000000	0	0	0	0	52. 01
	05300 ANESTHESI OLOGY	0. 000000	216	0	0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 001709	7, 097	12	0	0	54.00
57.00 0	05700 CT SCAN	0. 000000	111	0	0	0	57.00
58.00 0	05800 MRI	0. 000000	0	0	0	0	58. 00
60.00 0	06000 LABORATORY	0.000000	28, 828	0	0	0	60.00
65.00 0	06500 RESPI RATORY THERAPY	0. 000000	14, 559	0	0	0	65.00
66.00 0	06600 PHYSI CAL THERAPY	0. 005978	859, 405	5, 138	0	0	66.00
71.00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	233, 531	0	0	0	71.00
72.00 0	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0	0	0	0	72.00
73.00 0	07300 DRUGS CHARGED TO PATIENTS	0. 003109	143, 009	445	0	0	73.00
76. 97 0	7697 CARDIAC REHABILITATION	0. 051297	0	0	0	0	76. 97
0	UTPATIENT SERVICE COST CENTERS						
88. 00 0	08800 RURAL HEALTH CLINIC	0. 003573	0	0	0	0	88. 00
88. 01 0	08801 ELMWOOD RHC	0. 003853	0	0	0	0	88. 01
88. 02 0	08802 WILLIAMSFIELD RHC	0. 004796	0	0	0	0	88. 02
89.00 0	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0	0	0	0	89.00
90.00 0	99000 CLI NI C	0. 000000	0	0	0	0	90.00
90. 01 0	99001 WOUND CLINIC	0. 007704	4, 826	37	0	0	90. 01
91.00 0	9100 EMERGENCY	0. 013849	0	0	0	0	91.00
92.00 0	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00 0	99600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0	0	0	0	, , , , , ,
200.00	Total (lines 50 through 199)		1, 291, 582	5, 632	0	0	200. 00

Health Financial Systems GRAHAM HOSPITA
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST GRAHAM HOSPI TAL ASSOCIATION

In Lieu of Form CMS-2552-10

Provider CCN: 14-0001 Component CCN: 14-5572

Worksheet D Part V Date/Time Prepared: 11/30/2023 12:56 pm PPS Peri od: From 07/01/2022 To 06/30/2023

Title XVIII

Skilled Nursing Facility

				Facility		
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		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. 193425	0	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	0	0	0	52.00
52.01 05201 DELIVERY ROOM & LABOR ROOM	0. 082747	0	C	0	0	52. 01
53. 00 05300 ANESTHESI OLOGY	0. 013854	0	C	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 180758	0	0	0	0	54.00
57. 00 05700 CT SCAN	0. 044984	0	0	0	0	57.00
58. 00 05800 MRI	0. 099579	0	0	0	0	58.00
60. 00 06000 LABORATORY	0. 209890	0		0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 297495	0		0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 261350	0	1 0	0	0	66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 243190	0		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 418140	0	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 336142	0	0	352	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 549213	0	0		0	76. 97
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC						88. 00
88. 01 08801 ELMWOOD RHC						88. 01
88. 02 08802 WILLIAMSFIELD RHC						88. 02
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER						89. 00
90. 00 09000 CLI NI C	0. 000000	0	0	0	0	1
90. 01 09001 WOUND CLINIC	0. 359101	0	0	0	0	90. 01
91. 00 09100 EMERGENCY	0. 125101	0		0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 446076	0		0	0	92.00
OTHER REIMBURSABLE COST CENTERS	0. 1.0070					/2:00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 503739	0	С	0	0	96.00
200.00 Subtotal (see instructions)		0	0	352	0	200.00
201.00 Less PBP Clinic Lab. Services-Program			l o	0.00		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	l o	352	0	202.00
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	T.	ľ	'	1 002	·	,

GRAHAM HOSPI TAL ASSOCIATION

Health Financial Systems GRAHAM HOSPITA
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST In Lieu of Form CMS-2552-10 Provider CCN: 14-0001

Peri od: Worksheet D From 07/01/2022 Part V To 06/30/2023 Date/Time Prepared: 11/30/2023 12:56 pm Component CCN: 14-5572 Skilled Nursing Facility Title XVIII PPS

				Facility		
		Co	sts			
	Cost Center Description	Cost	Cost			
		Rei mbursed	Rei mbursed			
		Servi ces	Services Not			
		Subject To	Subject To			
		Ded. & Coins.	Ded. & Coins.			
		(see inst.)	(see inst.)			
		6. 00	7. 00			
	LLARY SERVICE COST CENTERS					
	O OPERATING ROOM	C	0	0	50.00	
	ODELIVERY ROOM & LABOR ROOM	0	0	0	52.00	
	1 DELIVERY ROOM & LABOR ROOM	C	0		52. 01	
53.00 0530	O ANESTHESI OLOGY	C	0		53.00	
	O RADI OLOGY-DI AGNOSTI C	C	0		54.00	
	O CT SCAN	C	0		57.00	
58.00 0580	O MRI	C	0		58.00	
60.00 0600	O LABORATORY	C	0		60.00	
65. 00 0650	O RESPIRATORY THERAPY	C	0		65.00	
66.00 0660	O PHYSI CAL THERAPY	C	0		66.00	
71.00 0710	O MEDICAL SUPPLIES CHARGED TO PATIENT	C	0		71.00	
72. 00 0720	O IMPL. DEV. CHARGED TO PATIENTS	C	0		72.00	
73.00 0730	O DRUGS CHARGED TO PATIENTS	C	118	3	73.00	
76. 97 0769	7 CARDIAC REHABILITATION	C	0		76. 97	
OUTP	ATIENT SERVICE COST CENTERS					
88. 00 0880	O RURAL HEALTH CLINIC				88. 00	
88. 01 0880	1 ELMWOOD RHC				88. 01	
88. 02 0880	2 WILLIAMSFIELD RHC				88. 02	
89.00 0890	O FEDERALLY QUALIFIED HEALTH CENTER				89. 00	
90.00 0900	O CLI NI C	C	0		90.00	
90. 01 0900	1 WOUND CLINIC	C	0		90. 01	
91.00 0910	O EMERGENCY	C	0		91.00	
92.00 0920	O OBSERVATION BEDS (NON-DISTINCT PART	C	0		92.00	
OTHER REI MBURSABLE COST CENTERS						
96. 00 0960	O DURABLE MEDICAL EQUIP-RENTED	C	0		96.00	
200. 00	Subtotal (see instructions)	0	118	3	200.00	
201. 00	Less PBP Clinic Lab. Services-Program	0)		201.00	
	Only Charges					
202. 00	Net Charges (line 200 - line 201)		118	3	202. 00	

Heal th Financial Systems GRAHAM HOSPITAL ASSOCIATION In Lieu of Form CMS-2552-10

COMPUTATION OF INPATIENT OPERATING COST
Provider CCN: 14-0001 Period: From 07/01/2022 To 06/30/2023 Date/Time Prepared: 11/30/2023 12:56 pm

Title XVIII Hospital PPS

		Title XVIII	Hospi tal	PPS	
	Cost Center Description			1 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day			6, 754	1.00
2. 00	Inpatient days (including private room days, excluding swing-			6, 754	2.00
3. 00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ys). If you have only pri	ivate room days,	0	3. 00
4. 00	Semi-private room days (excluding swing-bed and observation b	ed days)		5, 164	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private ro		r 31 of the cost	0	5. 00
	reporting period				
6. 00	Total swing-bed SNF type inpatient days (including private reporting period (if calendar year, enter 0 on this line)	om days) after December :	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7. 00
7.00	reporting period	iii days) trii dagii beeciibei	or or the cost	O	7.00
8.00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	1 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)	5		0 407	
9. 00	Total inpatient days including private room days applicable t newborn days) (see instructions)	o the Program (excluding	swing-bed and	2, 427	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o	nlv (including private r	oom davs)	0	10.00
	through December 31 of the cost reporting period (see instruc		,		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		n room days)	0	12. 00
12.00	through December 31 of the cost reporting period	A only (Therdaring private	e room days)	U	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including private	e room days)	0	13.00
	after December 31 of the cost reporting period (if calendar y				
14.00	Medically necessary private room days applicable to the Progr	am (excluding swing-bed o	days)	0	14. 00 15. 00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	16. 00
10.00	SWI NG BED ADJUSTMENT			0	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0. 00	17.00
10.00	reporting period	 D		0.00	10.00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es arter becember 31 or	the cost	0.00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0.00	19.00
	reporting period				
20. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s after December 31 of th	ne cost	0.00	20. 00
21. 00	Total general inpatient routine service cost (see instruction	s)		12, 173, 102	21.00
22. 00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost report	ing period (line	0	22.00
22.00	5 x line 17)	21 -6	(22.00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (iine o	0	23. 00
24.00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	0	24.00
	7 x line 19)			_	
25. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		12, 173, 102	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		, ,		
28. 00 29. 00	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	d and observation bed cha	arges)	0	28. 00 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)			0. 00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	22)	+:>	0.00	
34. 00 35. 00					
36. 00					36. 00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	12, 173, 102	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	LISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 802. 35	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	38)		4, 374, 303	39.00
40.00	Medically necessary private room cost applicable to the Progr			0	40.00
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		4, 374, 303	41.00

Heal th Fi nancial Systems GRAHAM HOSPITAL ASSOCIATION COMPUTATION OF INPATIENT OPERATING COST Provider CCN: 14-0001 Period:

In Lieu of Form CMS-2552-10

Worksheet D-1

From 07/01/2022 06/30/2023 Date/Time Prepared: 11/30/2023 12:56 pm Title XVIII Hospi tal Cost Center Description Total Total Average Per Program Days Program Cost (col. 3 x Inpati ent Inpati ent Diem (col. Cost Days ÷ col. 2) col. 4) 1.00 2.00 3.00 4.00 5.00 42.00 NURSERY (title V & XIX only) 0.00 0 42.00 0 0 Intensive Care Type Inpatient Hospital Units 1, 144 477 43.00 43 00 INTENSIVE CARE UNIT 2.311.29 1, 102, 485 2.644.121 44.00 CORONARY CARE UNIT 44.00 BURN INTENSIVE CARE UNIT 45.00 45.00 46.00 SURGICAL INTENSIVE CARE UNIT 46.00 OTHER SPECIAL CARE (SPECIFY) 47.00 47.00 Cost Center Description 1.00 48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) 4, 290, 719 48.00 48.01 Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1) 48 01 9, 767, 507 Total Program inpatient costs (sum of lines 41 through 48.01) (see instructions) 49.00 PASS THROUGH COST ADJUSTMENTS 50.00 50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and 1, 016, 432 $\Pi\Pi$ 51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II 335, 031 51.00 and IV) Total Program excludable cost (sum of lines 50 and 51) 1, 351, 463 52.00 52.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 53.00 8, 416, 044 53.00 medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION 54.00 Program di scharges 54.00 55.00 Target amount per discharge 0.00 55.00 55.01 Permanent adjustment amount per discharge 0.00 55.01 Adjustment amount per discharge (contractor use only) 0.00 55.02 Target amount (line 54 x sum of lines 55, 55.01, and 55.02) 56.00 56,00 0 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0 57.00 Bonus payment (see instructions) 58.00 0 58.00 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, 0.00 59.00 59.00 updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the 0.00 60.00 60.00 market basket) Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 0 61.00 61.00 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions) 62.00 62.00 Relief payment (see instructions) 0 Allowable Inpatient cost plus incentive payment (see instructions) 0 63.00 PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See 64.00 0 64.00 instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See 0 65.00 65.00 instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for 0 66.00 66.00 CAH, see instructions Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period 67.00 0 67.00 (line 12 x line 19) Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period 68.00 68.00 0 (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 69.00 69.00 0 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 70.00 70.00 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 71.00 Program routine service cost (line 9 x line 71) 72.00 72.00 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 73.00 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 74.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 75.00 75.00 26, line 45) Per diem capital-related costs (line 75 ÷ line 2) 76.00 76.00 77.00 Program capital -related costs (line 9 x line 76) 77.00 78.00 Inpatient routine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79 00 79 00 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 81.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82 00 82 00 83.00 Reasonable inpatient routine service costs (see instructions) 83.00 84.00 Program inpatient ancillary services (see instructions) 84.00 85.00 Utilization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) 86.00 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 1, 590 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1, 802. 35 88. 00 Heal th Fi nanci al Systems

GRAHAM HOSPI TAL ASSOCIATION

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COMPUTATION OF INPATIENT OPERATING COST Provi der CCN: 14-0001 Peri od: Worksheet D-1 From 07/01/2022 To 06/30/2023 Date/Time Prepared: 11/30/2023 12:56 pm Title XVIII Hospi tal PPS Cost Center Description 1. 00 89.00 Observation bed cost (line 87 x line 88) (see instructions) 2, 865, 737 89.00 Cost Center Description Routine Cost column 1 ÷ Total Observati on (from line column 2 Observati on Bed Pass 21) Bed Cost Through Cost (col. 3 x col. 4) (see (from line 89) instructions) 1. 00 2.00 3.00 4. 00 5.00 COMPUTATION OF OBSERVATION BED PASS THROUGH COST 90.00 90.00 Capital-related cost 752, 017 12, 173, 102 0.061777 2, 865, 737 177, 037 2, 865, 737 2, 865, 737 91.00 Nursing Program cost 1, 322, 512 12, 173, 102 0.108642 311, 339 91.00 12, 173, 102 12, 173, 102 92.00 Allied health cost 0 0.000000 0 92.00 93.00 All other Medical Education 0 0.000000 0 93.00 2, 865, 737

In Lieu of Form CMS-2552-10

Heal th Fi nanci al Systems

COMPUTATION OF INPATIENT OPERATING COST

GRAHAM HOSPITAL ASSOCIATION

Provi der CCN: 14-0001 Perior

DMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0001
Component CCN: 14-5572
To 06/30/2023
Date/Time Prepared: 11/30/2023 12:56 pm
Title XVIII
Skilled Nursing Facility
Provider CCN: 14-0001
From 07/01/2022
To 06/30/203 12:56 pm
PPS

In Lieu of Form CMS-2552-10

	Cost Center Description		
	DART I ALL DROWLDED COMPONENTS	1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS		
1. 00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2, 262	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2, 262	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3.00
	do not complete this line.		
4. 00	Semi-private room days (excluding swing-bed and observation bed days)	2, 262	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	Ĭ	0.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7.00
	reporting period	_	
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8. 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	1, 308	9. 00
7. 00	newborn days) (see instructions)	1, 300	7. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	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)	o	12. 00
12.00	through December 31 of the cost reporting period	٥	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	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)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT	0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
17.00	reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18.00
	reporting period		
19. 00	Medical drate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
20.00	reporting period	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)	2, 257, 323	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22.00
	5 x line 17)		
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	o	24.00
24.00	7 x line 19)	٥	24.00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25.00
	x line 20)		
26.00	Total swing-bed cost (see instructions)	0	
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2, 257, 323	27. 00
28 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
	Pri vate room charges (excluding swing-bed charges)	0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)	ő	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	
34. 00 35. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31)	0. 00 0. 00	
36.00	Private room cost differential adjustment (line 3 x line 35)	0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line		37. 00
07.00	27 minus line 36)	2,207,020	07.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
	Medically necessary private room cost applicable to the Program (line 14 x line 35) Total Program general inpatient routine service cost (line 39 + line 40)		40. 00 41. 00
- 1.00	Total Trogram general impatient routine service cost (Time 37 + Time 40)	ı	Ŧ 1. UU

Heal th Fi nancial Systems GRAHAM HOSPITAL ASSOCIATION

In Lieu of Form CMS-2552-10 COMPUTATION OF INPATIENT OPERATING COST Provider CCN: 14-0001 Peri od: Worksheet D-1 From 07/01/2022 Component CCN: 14-5572 То 06/30/2023 Date/Time Prepared: 11/30/2023 12:56 pm Title XVIII Skilled Nursing Facility Cost Center Description Total Total Average Per Program Days Program Cost Inpati ent Diem (col. 1 (col. 3 x Inpati ent ÷ col. 2) Cost Days col. 4) 1.00 3.00 4.00 5.00 42.00 NURSERY (title V & XIX only) 42.00 Intensive Care Type Inpatient Hospital Units 43 00 INTENSIVE CARE UNIT 43 00 CORONARY CARE UNIT 44.00 44.00 BURN INTENSIVE CARE UNIT 45.00 45.00 SURGICAL INTENSIVE CARE UNIT 46,00 46.00 47.00 OTHER SPECIAL CARE (SPECIFY) 47.00 Cost Center Description 1.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) 48.00 48 00 48.01 Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1) 48.01 49.00 Total Program inpatient costs (sum of lines 41 through 48.01) (see instructions) 49.00 PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and 50.00 50.00 $\Pi\Pi$ Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts II 51.00 51.00 and IV) 52.00 Total Program excludable cost (sum of lines 50 and 51) 52.00 53 00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 53.00 medical education costs (line 49 minus line 52) FARGET AMOUNT AND LIMIT COMPUTATION Program di scharges 54.00 54.00 Target amount per discharge 55.00 55.00 55.01 Permanent adjustment amount per discharge 55.01 55.02 Adjustment amount per discharge (contractor use only) 55.02 56.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02) 56.00 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 57.00 58.00 Bonus payment (see instructions) 58.00 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, 59.00 59.00 updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the 60.00 60.00 market basket) 61.00 Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 61.00 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions) 62.00 Relief payment (see instructions) 62.00 Allowable Inpatient cost plus incentive payment (see instructions) 63.00 PROGRAM INPATIENT ROUTINE SWING BED COST 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See 64.00 instructions) (title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See 65.00 65.00 instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for 66.00 CAH, see instructions 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period 67.00 (line 12 x line 19) Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period 68.00 68.00 (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 69.00 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 2, 257, 323 70.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 997. 93 71.00 71.00 72.00 Program routine service cost (line 9 x line 71) 1, 305, 292 72.00 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 73.00 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 1, 305, 292 74.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 75.00 75.00 0 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 0.00 76.00 Program capital -related costs (line 9 x line 76) 77.00 0 Inpatient routine service cost (line 74 minus line 77) 78.00 78.00 0 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 0 79 00 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 0 80.00 81.00 Inpatient routine service cost per diem limitation 0.00 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 82.00 0 83.00 Reasonable inpatient routine service costs (see instructions) 1, 305, 292 83.00 Program inpatient ancillary services (see instructions) 342, 910 84.00 84.00 Utilization review - physician compensation (see instructions) 85.00 85.00 0 Total Program inpatient operating costs (sum of lines 83 through 85) 1, 648, 202 86.00 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST

0 87.00

87.00 Total observation bed days (see instructions)

Heal th Financial Systems

GRAHAM HOSPITAL ASSOCIATION

COMPUTATION OF INDATIENT OPERATING COST

Provider CCN: 14-0001 Period

COMPUTATION OF INPATIENT OPERATING COST Provi der CCN: 14-0001 Worksheet D-1 Peri od: From 07/01/2022 Date/Time Prepared: 11/30/2023 12:56 pm Component CCN: 14-5572 То 06/30/2023 Title XVIII Skilled Nursing PPS Facili ty Cost Center Description 1.00 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 0.00 88.00 89.00 Observation bed cost (line 87 x line 88) (see instructions)

Cost Center Description Cost 0 89.00 Routine Cost Total column 1 ÷ Observati on column 2 Bed Pass (from line Observation 21) Bed Cost Through Cost (col. 3 x col. 4) (see instructions) (from line 89) 1. 00 2.00 3.00 4. 00 COMPUTATION OF OBSERVATION BED PASS THROUGH COST 90.00 Capital-related cost 0 0.000000 0 90.00 91.00 Nursing Program cost 0.000000 91.00 0 0 0 0 0 92.00 Allied health cost 0.000000 92.00 0 0 93.00 All other Medical Education 0 0.000000 0 93.00

In Lieu of Form CMS-2552-10

Heal th Financial Systems GRAHAM HOSPITAL ASSOCIATION

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provider CCN: 14-0001 Peri od: Worksheet D-3 From 07/01/2022 06/30/2023 Date/Time Prepared: 11/30/2023 12:56 pm Title XVIII Hospi tal Inpati ent Cost Center Description Ratio of Cost Inpati ent To Charges Program Costs Program (col. 1 x Charges col. 2) 1.00 2.00 3. 00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 4, 153, 634 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 1, 633, 470 31.00 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 0. 193425 50.00 05000 OPERATING ROOM 3, 059, 232 591, 732 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 52.01 05201 DELIVERY ROOM & LABOR ROOM 0.082747 0 52.01 05300 ANESTHESI OLOGY 0.013854 775, 263 10, 740 53.00 53.00 |05400| RADI OLOGY-DI AGNOSTI C 0.180758 54.00 801, 252 144, 833 54.00 57.00 05700 CT SCAN 0.044984 996, 779 44, 839 57.00 58.00 05800 MRI 0.099579 116, 042 11, 555 58.00 06000 LABORATORY 428, 300 0.210319 60.00 2, 036, 431 60.00 06500 RESPIRATORY THERAPY 65.00 0.297495 966, 490 287, 526 65.00 66.00 06600 PHYSI CAL THERAPY 0.261350 933, 455 243, 958 66.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0.243190 1, 243, 866 302, 496 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.418140 1, 420, 278 593, 875 72 00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.336142 2, 511, 640 844, 268 73.00 07697 CARDIAC REHABILITATION 0.549213 8,035 4, 413 76.97 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 88.00 88.01 08801 ELMWOOD RHC 0.000000 0 88.01 08802 WILLIAMSFIELD RHC 88.02 0.000000 0 88.02 89 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 89 00 0 90.00 09000 CLI NI C 0.000000 0 90.00 09001 WOUND CLINIC 90.01 0.364121 15, 092 5, 495 90.01 91.00 09100 EMERGENCY 0.136761 2, 432, 209 332, 631 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 995, 477 92.00 0.446076 444, 058 92.00

0.503739

18, 311, 541

18, 311, 541

In Lieu of Form CMS-2552-10

0 96.00

201.00

202.00

4, 290, 719 200. 00

OTHER REIMBURSABLE COST CENTERS

09600 DURABLE MEDICAL EQUIP-RENTED

Total (sum of lines 50 through 94 and 96 through 98)

Net charges (line 200 minus line 201)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

96.00

200.00

201.00

202.00

leal th Fi nanci al Systems GRAHAM HOSPI TAL ASSOCIATION

Health Financial Systems GRAHAM HOSPITAL ASSOCIATION In Lieu of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT
Provider CCN: 14-0001 From 07/01/2022 To 06/30/2023 Date/Time Prepared: 11/30/2023 12:56 pm
Title XVIII Skilled Nursing Facility

		11116	NVIII 3	Facility	113	
	Cost Center Description		Ratio of Cost	Inpatient	Inpati ent	
	Cost Center Description		To Charges	Program	Program Costs	
			To charges	Charges	(col. 1 x	
				charges	col. 2)	
			1.00	2. 00	3. 00	
I NP	PATIENT ROUTINE SERVICE COST CENTERS					
30.00 030	000 ADULTS & PEDIATRICS					30.00
31.00 031	OO INTENSIVE CARE UNIT					31.00
43.00 043	NURSERY					43.00
ANC	ILLARY SERVICE COST CENTERS					
50.00 050	OOO OPERATING ROOM		0. 193425	0	0	50.00
52.00 052	200 DELIVERY ROOM & LABOR ROOM		0. 000000	0	0	52.00
52. 01 052	201 DELIVERY ROOM & LABOR ROOM		0. 082747	0	0	52.01
53.00 053	300 ANESTHESI OLOGY		0. 013854	216	3	53.00
54.00 054	RADI OLOGY-DI AGNOSTI C		0. 180758	7, 097	1, 283	54.00
57.00 057	700 CT SCAN		0. 044984	111	5	57.00
58. 00 058	800 MRI		0. 099579	0	0	58.00
60.00 060	DOO LABORATORY		0. 210319	28, 828	6, 063	60.00
65. 00 065	RESPI RATORY THERAPY		0. 297495	14, 559	4, 331	65.00
66.00 066	OO PHYSI CAL THERAPY		0. 261350	859, 405	224, 605	66.00
71.00 071	00 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 243190	233, 531	56, 792	71.00
72. 00 072	200 IMPL. DEV. CHARGED TO PATIENTS		0. 418140	0	0	72.00
73. 00 073	OO DRUGS CHARGED TO PATIENTS		0. 336142	143, 009	48, 071	73.00
76. 97 076	97 CARDIAC REHABILITATION		0. 549213	0	0	76. 97
OUT	PATIENT SERVICE COST CENTERS					
	BOO RURAL HEALTH CLINIC		0. 000000		0	
	BO1 ELMWOOD RHC		0. 000000		0	88. 01
	302 WILLIAMSFIELD RHC		0. 000000		0	88. 02
	POO FEDERALLY QUALIFIED HEALTH CENTER		0. 000000		0	89.00
90.00 090	DOO CLINIC		0. 000000	0	0	90.00
90. 01 090	001 WOUND CLINIC		0. 364121	4, 826	1, 757	90. 01
91.00 091	OO EMERGENCY		0. 136761	0	0	91.00
92.00 092	200 OBSERVATION BEDS (NON-DISTINCT PART		0. 446076	0	0	92.00
OTH	IER REIMBURSABLE COST CENTERS					
96.00 096	OO DURABLE MEDICAL EQUIP-RENTED		0. 503739	0	0	96.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)			1, 291, 582	342, 910	
201. 00	Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		0		201. 00
202.00	Net charges (line 200 minus line 201)			1, 291, 582		202. 00

eal th Fi nanci al Systems GRAHAM HOSPI TAL ASSOCIATION

Heal th Financial Systems GRAHAM HOSPITAL ASSOCIATION In Lieu of Form CMS-2552-10

CALCULATION OF REIMBURSEMENT SETTLEMENT
Provider CCN: 14-0001 Period: From 07/01/2022 Form 06/30/2023 Date/Time Prepared: 11/30/2023 12:56 pm

Title XVIII Hospital PPS

			11/30/2023 12	:56 pm
	Title XVIII	Hospi tal	PPS	
			1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring prior to October 1 (see	e	0 1, 417, 514	1. 00 1. 01
1. 02	instructions) DRG amounts other than outlier payments for discharges occurring on or after October 1 instructions)	(see	3, 922, 522	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring pr 1 (see instructions)	ior to October	0	1.03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring or October 1 (see instructions)	or after	0	1.04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount		0	2. 00 2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2. 02
2. 03	Outlier payments for discharges occurring prior to October 1 (see instructions)		16, 527	2.03
2. 04 3. 00	Outlier payments for discharges occurring on or after October 1 (see instructions) Managed Care Simulated Payments		13, 792 2, 958, 940	2. 04 3. 00
4. 00	Bed days available divided by number of days in the cost reporting period (see instruct	i ons)	38. 64	4.00
	Indirect Medical Education Adjustment			
5. 00	FTE count for allopathic and osteopathic programs for the most recent cost reporting per or before 12/31/1996. (see instructions)	eriod ending on	0. 00	5. 00
5. 01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions	5)	0.00	5. 01
6. 00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on new programs in accordance with 42 CFR 413.79(e)	.	0.00	6.00
6. 26	Rural track program FTE cap limitation adjustment after the cap-building window closed the CAA 2021 (see instructions)		0.00	6. 26
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1 ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv) cost report straddles July 1, 2011 then see instructions.		0. 00 0. 00	7. 00 7. 01
7. 02	Adjustment (increase or decrease) to the hospital's rural track programs FTE limitation(track programs with a rural track for Medicare GME affiliated programs in accordance will and 87 FR 49075 (August 10, 2022) (see instructions)		0.00	7. 02
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic prograffiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 1998), and 67 FR 50069 (August 1, 2002).		0. 00	8. 00
8. 01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the AC	A. If the cost	0. 00	8. 01
8. 02	report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slots from a closed teaching under § 5506 of ACA. (see instructions)	hospi tal	0.00	8. 02
8. 21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA instructions)	2021 (see	0.00	8. 21
9. 00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7 minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	.01, plus or	0. 00	9. 00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	i		10.00
11. 00 12. 00	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)			11. 00 12. 00
13. 00	Total allowable FTE count for the prior year.			13.00
14. 00	Total allowable FTE count for the penultimate year if that year ended on or after Septe otherwise enter zero.	mber 30, 1997,	0. 00	
15. 00	Sum of lines 12 through 14 divided by 3.			15. 00
16.00	Adjustment for residents in initial years of the program (see instructions)			16.00
17. 00 18. 00	Adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count		0. 00 0. 00	•
19. 00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	1
20. 00	Prior year resident to bed ratio (see instructions)		0. 000000	
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22. 00	IME payment adjustment (see instructions)		0	22.00
22. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		0	22. 01
23. 00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFF $(f)(1)(iv)(C)$.	412. 105	0. 00	23. 00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25. 00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 2 instructions)	4 (see	0. 00	25. 00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26. 00
27. 00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28. 00 28. 01	IME add-on adjustment amount (see instructions) IME add-on adjustment amount - Managed Care (see instructions)		0	28. 00 28. 01
29. 00	Total IME payment (sum of lines 22 and 28)		0	29.00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29. 01
00	Di sproporti onate Share Adjustment			
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructi	ons)	3. 86	•
31. 00 32. 00	Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31		20. 89 24. 75	
	Allowable disproportionate share percentage (see instructions)			33.00
	· · · · · · · · · · · · · · · · · · ·			

Heal th Fi nancial Systems GRAHAM HOSPITAL ASSOCIATION CALCULATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 14-0001 Period:

Worksheet E From 07/01/2022 Part A Date/Time Prepared: 06/30/2023 11/30/2023 12:56 pm Title XVIII Hospi tal PPS 1.00 128, 562 34.00 Disproportionate share adjustment (see instructions) 34.00 Prior to 10/1 On/After 10/1 1.00 2.00 Uncompensated Care Payment Adjustment 35.00 Total uncompensated care amount (see instructions) 7, 192, 008, 710 6, 874, 403, 459 35.00 0.000099299 0.000098479 35.01 Factor 3 (see instructions) 35.01 Hospital UCP, including supplemental UCP (If line 34 is zero, enter zero on this line) 714, 159 676, 984 35.02 35.02 (see instructions) 35.03 Pro rata share of the hospital UCP, including supplemental UCP (see instructions) 180,007 506, 347 35.03 Total UCP adjustment (sum of columns 1 and 2 on line 35.03) 686, 354 36.00 Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46) 40.00 Total Medicare discharges (see instructions) 40.00 Before 1/1 On/After 1/1 41.00 Total ESRD Medicare discharges (see instructions) 41.00 0 0 41.01 Total ESRD Medicare covered and paid discharges (see instructions) 0 0 41.01 Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment) 0.00 42.00 43 00 Total Medicare ESRD inpatient days (see instructions) 43.00 Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 44.00 0.000000 44.00 davs) 45.00 Average weekly cost for dialysis treatments (see instructions) 0.00 0.00 45.00 Total additional payment (line 45 times line 44 times line 41.01) 46.00 46.00 Subtotal (see instructions) 6, 185, 271 47.00 47.00 48.00 Hospital specific payments (to be completed by SCH and MDH, small rural hospitals 6, 652, 656 48.00 only. (see instructions) Amount 1.00 49.00 | Total payment for inpatient operating costs (see instructions) 6, 652, 656 49 00 50.00 Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable) 398, 268 50.00 Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions) 51.00 51.00 Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions). 52.00 52.00 0 53.00 Nursing and Allied Health Managed Care payment 495, 237 53.00 54.00 Special add-on payments for new technologies 39,809 54.00 54.01 Islet isolation add-on payment 54.01 0 55.00 Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69) 55 00 0 55.01 Cellular therapy acquisition cost (see instructions) 0 55.01 Cost of physicians' services in a teaching hospital (see intructions) 56.00 57.00 Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35). 704, 100 57.00 58.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) 131, 722 58.00 59.00 Total (sum of amounts on lines 49 through 58) 8, 421, 792 59.00 60.00 Primary payer payments 11,777 60.00 Total amount payable for program beneficiaries (line 59 minus line 60) 8, 410, 015 61.00 61.00 62.00 Deductibles billed to program beneficiaries 780, 428 62.00 Coinsurance billed to program beneficiaries 12, 323 63.00 64.00 Allowable bad debts (see instructions) 228, 389 64.00 Adjusted reimbursable bad debts (see instructions) 148, 453 65.00 65.00 66.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 159, 568 66.00 67.00 Subtotal (line 61 plus line 65 minus lines 62 and 63) 7, 765, 717 67.00 Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions) Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions) 0 68.00 68.00 69 00 69 00 0 70.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 70.00 Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions) 0 70.50 N95 respirator payment adjustment amount (see instructions) 70.75 70.75 0 70.87 Demonstration payment adjustment amount before sequestration 0 70.87 70.88 SCH or MDH volume decrease adjustment (contractor use only) 0 70.88 70.89 Pioneer ACO demonstration payment adjustment amount (see instructions) 70.89 70 90 HSP bonus payment HVBP adjustment amount (see instructions) Ω 70 90 HSP bonus payment HRR adjustment amount (see instructions) 70. 91 0 70.91 Bundled Model 1 discount amount (see instructions) 0 70.92 HVBP payment adjustment amount (see instructions) 70.93 70.93 0 70.94 HRR adjustment amount (see instructions) -44, 619 70.94

In Lieu of Form CMS-2552-10

0 70.95

70.95 Recovery of accelerated depreciation

eal th Financial Systems GRAHAM HOSPITAL ASSOCIATION

Heal th Financial Systems GRAHAM HOSPITAL ASSOCIATION In Lieu of Form CMS-2552-10

CALCULATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 14-0001 Period: From 07/01/2022 To 06/30/2023 Date/Time Prepared: 11/30/2023 12:56 pm

		Title >	0/111	Hooni tol	11/30/2023 12	:56 pm
		II tie 7		Hospi tal (yyyy)	PPS Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	column 0)22	268, 588	70.96
70.70	the corresponding federal year for the period prior to 10/1)	001 4		/	2007 000	70.70
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in	column 0	20)23	741, 842	70. 97
	the corresponding federal year for the period ending on or aft			-	, , , , ,	
70. 98	Low Volume Payment-3	· 1		0	0	70. 98
70. 99	HAC adjustment amount (see instructions)				0	70. 99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 6	9 & 70)			8, 731, 528	71.00
71. 01	Sequestration adjustment (see instructions)				174, 631	71. 01
71. 02	Demonstration payment adjustment amount after sequestration				0	71. 02
71. 03	Sequestration adjustment-PARHM pass-throughs					71. 03
72.00	Interim payments				9, 305, 317	
72. 01	Interim payments-PARHM					72. 01
73. 00	Tentative settlement (for contractor use only)				0	
73. 01	Tentative settlement-PARHM (for contractor use only)					73. 01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02	, 72, and			-748, 420	74.00
7. 0.	73)					7. 0.
74. 01	Balance due provider/program-PARHM (see instructions)					74. 01
75. 00	Protested amounts (nonallowable cost report items) in accordan	ce with			0	75. 00
	CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96)					
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum o	£ 2.02			38, 892	90.00
90.00	plus 2.04 (see instructions)	1 2.03			30, 092	90.00
91. 00	1'				3, 834	91.00
	Operating outlier reconciliation adjustment amount (see instru	ctions)			0,034	92.00
93. 00					0	93.00
94. 00	, ,				0. 00	
95. 00	1	(10113)			0.00	95. 00
	Time value of money for capital related expenses (see instruct	ions)			0	96.00
	1 · · · · · · · · · · · · · · · · · · ·			Prior to 10/1		
				1.00	2. 00	
	HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	0	100.00
	HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)			0. 0000000000	0. 0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
	HRR Adjustment for HSP Bonus Payment					
	HRR adjustment factor (see instructions)			0.0000	0. 0000	
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstra					
200.00	Is this the first year of the current 5-year demonstration per	iod under th	e 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.					
004 00	Cost Reimbursement	40)				004 00
	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	49)				201.00
	Medicare discharges (see instructions)					202.00
203.00	Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in	First veer a	f the ourses	+ F voor demone		203. 00
		iiist year o	i the curren	t 5-year delilons	tration	
204 00	peri od)					204.00
	Medicare target amount					204.00
205.00	Medicare target amount Case-mix adjusted target amount (line 203 times line 204)					205. 00
205.00	Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)					
205. 00 206. 00	Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	uctions)				205. 00 206. 00
205. 00 206. 00 207. 00	Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instr					205. 00 206. 00 207. 00
205. 00 206. 00 207. 00 208. 00	Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instr Medicare Part A inpatient service costs (from Wkst. E, Pt. A,					205. 00 206. 00 207. 00 208. 00
205. 00 206. 00 207. 00 208. 00 209. 00	Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instr Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions)					205. 00 206. 00 207. 00 208. 00 209. 00
205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instr Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use					205. 00 206. 00 207. 00 208. 00
205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instr Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)					205. 00 206. 00 207. 00 208. 00 209. 00 210. 00
205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00	Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instr Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use	line 59)				205. 00 206. 00 207. 00 208. 00 209. 00 210. 00
205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00	Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instr Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	line 59)				205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00
205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 212. 00 213. 00	Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instr Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 2	line 59)	ursement)			205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 212. 00
205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 212. 00 213. 00	Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instr Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 2 Low-volume adjustment (see instructions)	line 59)	ursement)			205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 212. 00 213. 00

Heal th Fi nanci al Systems GRAHAM HOSPITAL ASSOCIATION

From 07/01/2022 06/30/2023 Date/Time Prepared: 11/30/2023 12:56 pm Title XVIII Hospi tal W/S E, Part A Amounts (from Period Prior Total (Col 2 Pre/Post Peri od Entitlement to 10/01 On/After through 4) I i ne E. Part A) 10/01 0 1.00 2.00 3.00 4.00 5.00 1.00 DRG amounts other than outlier 1. 00 1.00 payments 1.01 DRG amounts other than outlier 1.01 1, 417, 514 1.01 1, 417, 514 0 1, 417, 514 payments for discharges occurring prior to October 1 1.02 DRG amounts other than outlier 1.02 3, 922, 522 3, 922, 522 3, 922, 522 1.02 payments for discharges occurring on or after October 1 03 DRG for Federal specific 1.03 0 \cap 1.03 operating payment for Model 4 BPCI occurring prior to October 1 DRG for Federal specific 1 04 1 04 1.04 operating payment for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for 2.00 2.00 discharges (see instructions) Outlier payments for 2.01 2.02 C 2.01 discharges for Model 4 BPCI Outlier payments for 16, 527 16, 527 16, 527 2.02 2.03 2.02 discharges occurring prior to October 1 (see instructions) Outlier payments for 2.03 13, 792 13, 792 13, 792 2.04 2.03 discharges occurring on or after October 1 (see instructions) Operating outlier 3.00 2.01 0 3.00 reconciliation 4.00 Managed care simulated 3.00 2, 958, 940 0 2, 958, 940 2, 958, 940 4.00 payments Indirect Medical Education Adjustment Amount from Worksheet E, Part 21. 00 0.000000 0.000000 0.000000 0.000000 5 00 5 00 A, line 21 (see instructions) 6.00 IME payment adjustment (see 22.00 0 0 0 6.00 instructions) 6.01 IME payment adjustment for 22. 01 0 0 6.01 managed care (see instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor 27. 00 0. 000000 0.000000 0.000000 0.000000 7.00 (see instructions) IME adjustment (see 28.00 8.00 0 8.00 instructions) IME payment adjustment add on 8.01 28.01 0 8.01 for managed care (see instructions) 9.00 Total IME payment (sum of 29.00 9.00 lines 6 and 8) 9 01 Total IME payment for managed 29 01 9.01 care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 0.0963 0.0963 10.00 Allowable disproportionate 33.00 0.0963 0.0963 share percentage (see instructions) Disproporti onate share 128, 562 128, 562 11.00 34.00 34, 127 94, 435 11.00 adjustment (see instructions) Uncompensated care payments 180, 007 11.01 36, 00 686.354 506, 347 686, 354 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment 46. 00 12.00 (see instructions) 13.00 Subtotal (see instructions) 47.00 6, 185, 271 1, 648, 175 4. 537. 096 6, 185, 271 13 00 14.00 Hospital specific payments 48.00 6, 652, 656 1, 778, 163 4, 874, 493 6, 652, 656 14.00 (completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient 6, 652, 656 15.00 15.00 49.00 6, 652, 656 1, 778, 163 4, 874, 493 operating costs (see instructions)

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Health Financial Systems GRAHAM HOSPITAL ASSOCIATION In Lieu of Form CMS-2552-10

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0001

Period:
From 07/01/2022
To 06/30/2023
Part A Exhibit 4
Date/Time Prepared:
11/30/2023 12:56 pm

							11/30/2023 12	:56 pm
				Title	XVIII	Hospi tal	PPS	•
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After	through 4)	
						10/01		
		0	1.00	2.00	3.00	4.00	5. 00	
16. 00	Payment for inpatient program	50.00	398, 268	0	106, 66	291, 606	398, 268	16.00
	capital (from Wkst. L, Pt. I,		·			·	·	
	if applicable)							
17.00	Special add-on payments for	54.00	39, 809	0		0 39, 809	39, 809	17.00
	new technologies		- 1, - 2 1	_				
17. 01	Net organ aquisition cost							17. 01
17. 02	Credits received from	68. 00	0	0		0 0	0	
17.02	manufacturers for replaced	00.00	Ĭ	O			Ĭ	17.02
	devices for applicable MS-DRGs							
18 00	Capital outlier reconciliation		0	0		0 0	0	18.00
10.00	adjustment amount (see	73.00	ŏ	0		0	0	10.00
	instructions)							
19 00	SUBTOTAL			0	1, 884, 82	5, 205, 908	7, 090, 733	19 00
17.00	JOBTOTAL	W/S L, line	(Amounts from		1, 004, 02	3, 203, 700	7,070,733	17.00
		W/ 3 L, TITIC	L)					
		0	1, 00	2.00	3.00	4. 00	5. 00	
20. 00	Capital DRG other than outlier		396, 051	0				20.00
20. 01	Model 4 BPCI Capital DRG other		0	0	, .	0 270,010		1
20.01	than outlier	1.01	Ĭ	O			Ĭ	20.01
21. 00	Capital DRG outlier payments	2. 00	2, 217	0	1, 22	996	2, 217	21.00
21. 01	Model 4 BPCI Capital DRG	2. 01	2,217	0	1,22	0 0		1
21.01	outlier payments	2.01	ŏ	O				21.01
22. 00		5. 00	0. 0000	0. 0000	0.000	0. 0000		22.00
22.00	percentage (see instructions)	0.00	0.0000	0.0000	0.000	0.0000		22.00
23. 00	Indirect medical education	6. 00	0	0		0 0	0	23. 00
20.00	adjustment (see instructions)	0.00	Ĭ	O			Ĭ	20.00
24. 00	Allowable disproportionate	10.00	0. 0000	0. 0000	0.000	0.0000		24.00
21.00	share percentage (see	10.00	0.0000	0.0000	0.000	0.0000		21.00
	instructions)							
25 00	Di sproporti onate share	11. 00	0	0		0	0	25.00
20.00	adjustment (see instructions)		Ĭ	· ·			Ĭ	20.00
26. 00	Total prospective capital	12. 00	398, 268	0	106, 66	291, 606	398, 268	26 00
20.00	payments (see instructions)	12.00	070,200	· ·	100,00	271,000	0,0,200	20.00
	paymente (see Thethaethene)	W/S E, Part A	(Amounts to					
		line	E, Part A)					
		0	1. 00	2. 00	3.00	4. 00	5. 00	
27. 00	Low volume adjustment factor	-			0. 14250	0. 142500		27. 00
28. 00	Low volume adjustment	70. 96			268, 58		268, 588	
2. 20	(transfer amount to Wkst. E,]			
	Pt. A, line)							
29. 00	Low volume adjustment	70. 97				741, 842	741, 842	29 00
00	(transfer amount to Wkst. E,					, , , , 5 12	, 5 12	
	Pt. A, line)							
100.00	Transfer low volume		Υ					100.00
	adjustments to Wkst. E, Pt. A.							
			'			•	•	•

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Health Financial Systems GRAHAM HOSPITAL ASSOCIATION In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 14-0001 From 07/01/2022 Form 07/01/2022 Form 06/30/2023 Date/Time Prepared: 11/30/2023 12:56 pm

Title XVIII Hospital PPS

	Till Maria		11/30/2023 12	:56 pm
	Title XVIII	Hospi tal	PPS	
			1. 00	
P.A	ART B - MEDICAL AND OTHER HEALTH SERVICES		1.00	
	Medical and other services (see instructions)		756	1.00
1	Medical and other services reimbursed under OPPS (see instructions)		6, 041, 599	2. 00
1	OPPS or REH payments		5, 478, 376	•
	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)		7, 471 0	4. 00 4. 01
1	Enter the hospital specific payment to cost ratio (see instructions)		0. 862	5.00
1	Line 2 times line 5		5, 207, 858	•
7. 00 St	Sum of lines 3, 4, and 4.01, divided by line 6		0. 00	7. 00
	[ransitional corridor payment (see instructions)	000	0	8.00
1	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line	200	272, 129 0	
	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)		756	
	OMPUTATION OF LESSER OF COST OR CHARGES		, 00	
	easonabl e charges			
	Ancillary service charges		2, 250	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) Total reasonable charges (sum of lines 12 and 13)		2, 250	13. 00 14. 00
	ustomary charges		2, 230	14.00
	Aggregate amount actually collected from patients liable for payment for service	ces on a charge basis	0	15.00
	Amounts that would have been realized from patients liable for payment for serv	vices on a chargebasis	0	16. 00
1	nad such payment been made in accordance with 42 CFR §413.13(e)		0.000000	17.00
	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)		0. 000000 2, 250	
	Excess of customary charges over reasonable cost (complete only if line 18 exce	eeds line 11) (see	1, 494	
	nstructions)	, ,		
	Excess of reasonable cost over customary charges (complete only if line 11 exce	eeds line 18) (see	0	20. 00
1	nstructions)		756	21. 00
	esser of cost or charges (see instructions). nterns and residents (see instructions)		750	22.00
	Cost of physicians' services in a teaching hospital (see instructions)		Ö	23. 00
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		5, 757, 976	24.00
	OMPUTATION OF REIMBURSEMENT SETTLEMENT			
	Deductibles and coinsurance amounts (for CAH, see instructions) Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see	o instructions)	96, 108 1, 010, 814	1
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of li		4, 651, 810	1
	nstructions)	== ==, (===	.,,	
	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28. 00
28. 50 RE	REH facility payment amount			28. 50
	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27, 28, 28.50 and 29)		0 4, 651, 810	
	Primary payer payments		368	1
32. 00 St	Subtotal (line 30 minus line 31)		4, 651, 442	32.00
	LLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		_	
	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)		0 236, 798	33. 00 34. 00
	Adjusted reimbursable bad debts (see instructions)		153, 919	
1	Allowable bad debts for dual eligible beneficiaries (see instructions)		159, 461	
	Subtotal (see instructions)		4, 805, 361	
1	MSP-LCC reconciliation amount from PS&R		0	
1	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)		0	39. 00 39. 50
	195 respirator payment adjustment amount (see instructions)		0	39. 75
39. 97 De	Demonstration payment adjustment amount before sequestration		0	39. 97
1	Partial or full credits received from manufacturers for replaced devices (see	instructions)	0	39. 98
1	RECOVERY OF ACCELERATED DEPRECIATION		4 005 241	39. 99
	Subtotal (see instructions) Sequestration adjustment (see instructions)		4, 805, 361 96, 107	40. 00 40. 01
	Demonstration payment adjustment amount after sequestration		0	40. 02
	Sequestration adjustment-PARHM pass-throughs			40. 03
	nterim payments		4, 872, 762	
1	nterim payments-PARHM		0	41. 01
1	Fentative settlement (for contractors use only) Fentative settlement-PARHM (for contractor use only)		0	42. 00 42. 01
1	Balance due provider/program (see instructions)		-163, 508	
43. 01 Ba	Balance due provider/program-PARHM (see instructions)			43. 01
	Protested amounts (nonallowable cost report items) in accordance with CMS Pub.	15-2, chapter 1,	0	44.00
	§115.2 O BE COMPLETED BY CONTRACTOR			
	O BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)		327	90.00
1	Outlier reconciliation adjustment amount (see instructions)		0	91.00
1	The rate used to calculate the Time Value of Money			92.00
	Fime Value of Money (see instructions) Fotal (sum of lines 91 and 93)		0	
74. UU II	Total (Suii of 111165 71 and 70)		١	74.00

In Lieu of Form CMS-2552-10
Worksheet E
71/2022 Part B
730/2023 Date/Time Prepared:
11/30/2023 12:56 pm
Tal PPS Health Financial Systems

CALCULATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 14-0001 Peri od: From 07/01/2022 To 06/30/2023 Title XVIII Hospi tal 1. 00 MEDICARE PART B ANCILLARY COSTS 200.00 Part B Combined Billed Days

0 200. 00

Health Financial Systems

CALCULATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 14-0001 Peri od: From 07/01/2022 To 06/30/2023 Component CCN: 14-5572

In Lieu of Form CMS-2552-10
Worksheet E
Part B
B0/2023 Date/Time Prepared:
11/30/2023 12:56 pm
Wursing PPS Skilled Nursing Facility Title XVIII

		1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES	1.00	
1.00	Medical and other services (see instructions)	118	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3. 00 4. 00	OPPS or REH payments Outlier payment (see instructions)		3. 00 4. 00
4. 01	Outlier reconciliation amount (see instructions)		4. 01
5. 00	Enter the hospital specific payment to cost ratio (see instructions)		5. 00
6. 00	Line 2 times line 5	0	6. 00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	
8. 00 9. 00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	8. 00 9. 00
10.00	Organ acquisitions	0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)	118	
	COMPUTATION OF LESSER OF COST OR CHARGES		
10.00	Reasonable charges	252	10.00
12. 00 13. 00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	352	12. 00 13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)	352	
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		15.00
16. 00	Amounts that would have been realized from patients liable for payment for services on a chargebasis	0	16. 00
17. 00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)	0. 000000	17. 00
18. 00	Total customary charges (see instructions)	352	
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	234	19. 00
00.00	instructions)	0	00.00
20. 00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20. 00
21. 00	Lesser of cost or charges (see instructions)	118	21. 00
22. 00	Interns and residents (see instructions)	0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24. 00
25. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions)	0	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	, i	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	118	27. 00
20.00	instructions)	0	20.00
28. 00 28. 50	Direct graduate medical education payments (from Wkst. E-4, line 50) REH facility payment amount	0	28. 00 28. 50
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	118	30.00
31.00	Primary payer payments	0	31.00
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	118	32. 00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33. 00
34.00	Allowable bad debts (see instructions)	0	34.00
35. 00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37. 00 38. 00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R	118	37. 00 38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)		39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)	0	39. 75
39. 97	Demonstration payment adjustment amount before sequestration	0	39. 97
39. 98 39. 99	Partial or full credits received from manufacturers for replaced devices (see instructions) RECOVERY OF ACCELERATED DEPRECIATION	0	39. 98 39. 99
40. 00	Subtotal (see instructions)	118	40.00
40. 01	Sequestration adjustment (see instructions)	2	40. 01
40. 02	Demonstration payment adjustment amount after sequestration	0	40. 02
40. 03	Sequestration adjustment-PARHM pass-throughs	107	40. 03 41. 00
41. 00 41. 01	Interim payments Interim payments-PARHM	107	41.00
42. 00	Tentative settlement (for contractors use only)	0	42.00
42. 01	Tentative settlement-PARHM (for contractor use only)		42. 01
43.00	Balance due provider/program (see instructions)	9	43.00
43. 01 44. 00	Balance due provider/program-PARHM (see instructions)	0	43. 01 44. 00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	ا	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92. 00 93. 00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)		92. 00 93. 00
	1		

Heal th Financial Systems	SSOCIATION	In Lie	ıof Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0001	Peri od:	Worksheet E	
	Component CCN: 14-5572	From 07/01/2022 To 06/30/2023	Part B Date/Time Pre 11/30/2023 12	epared: 2:56 pm
	Title XVIII	Skilled Nursing	PPS	
		Facility		
			1.00	
94.00 Total (sum of lines 91 and 93)				94.00
			1.00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days				200. 00

Health Financial Systems GRAHA
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0001

					11/30/2023 12	: 56
			XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Pai	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
00	Total interim payments paid to provider		9, 122, 146		4, 942, 726	1.
00	Interim payments payable on individual bills, either		0		0	2.
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3.
50	amount based on subsequent revision of the interim rate					3
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider				•	
)1	ADJUSTMENTS TO PROVIDER	02/22/2023	365, 114		0	3
)2			0		0	3
)3			0		0	3
)4			0		0	3
)5	Dec 1 les 1 a December 1		0		0	3
0	Provider to Program ADJUSTMENTS TO PROGRAM	09/21/2022	181, 943	02/22/2023	69, 964	 3
1	ADJUST MENTS TO PROGRAM	09/21/2022	101, 943		09, 904	3
2		•				3
3			Ö		l ő	3
4			Ö		0	3
9	Subtotal (sum of lines 3.01-3.49 minus sum of lines		183, 171		-69, 964	3
	3. 50-3. 98)					
00	Total interim payments (sum of lines 1, 2, and 3.99)		9, 305, 317		4, 872, 762	4
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
0	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none,					`
	write "NONE" or enter a zero. (1)					
	Program to Provider	•			•	
1	TENTATI VE TO PROVI DER		0		0	5
2			0		0	5
3			0		0	5
^	Provi der to Program		_			_
0 1	TENTATI VE TO PROGRAM		0		0	5
1 2						5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines					5
,	5. 50-5. 98)		ĺ			۱
0	Determined net settlement amount (balance due) based on					6
	the cost report. (1)					
1	SETTLEMENT TO PROVIDER		0		0	6
2	SETTLEMENT TO PROGRAM		748, 420		163, 508	6
0	Total Medicare program liability (see instructions)		8, 556, 897		4, 709, 254	7
				Contractor	NPR Date	
)	Number	(Mo/Day/Yr) 2.00	
00	Name of Contractor	NATI ONAL GOVER		1. 00 06101	2.00	8
	INAME OF CONTRACTOR	INC.	ININILINI SERVICES	00101	1	ΙÖ

Health Financial Systems GRAHA
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 14-0001

Component CCN: 14-5572

In Lieu of Form CMS-2552-10

Period:
From 07/01/2022 Part I
To 06/30/2023 Date/Time Prepared:
11/30/2023 12:56 pm

Skilled Nursing PPS

Title XVIII Skilled Nursing

				Facility		
		I npati en	it Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4.00	
1. 00	Total interim payments paid to provider		646, 504		107	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,					
3. 00	write "NONE" or enter a zero 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		0		0	3. 01
3. 02			l o		ol	3. 02
3. 03			0		0	3. 03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3. 53			0		0	3. 53
3. 54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
	3. 50-3. 98)		50.		407	
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		646, 504		107	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,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		o	5. 02
5.03			0		o	5.03
	Provider to Program					
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 5.50-5.98)		0		0	5. 99
6. 00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		67, 317		9	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
7. 00	Total Medicare program liability (see instructions)		713, 821	01	116	7.00
				Contractor	NPR Date	
		,)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		NMENT SERVICES	06101	2.00	8. 00
3.00		INC.	ININILINI JENVIUES	00101		0.00
	I and the second	p 110.			1	

al th Financial Systems GRAHAM HOSPITAL ASSOCIATION

Health Financial Systems GRAHAM HOSPITAL ASSOCIATION In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 14-0001 Period: From 07/01/2022 Part II

	To 06/30/2023	Date/Time Prepared: 11/30/2023 12:56 pm
Title XVIII	Hospi tal	PPS

		PPS	
		1.00	
		1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days (see instructions)		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days (see instructions)		4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I		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	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

of the Financial Systems

GRAHAM HOSPITAL ASSOCIATION

Health Financial Systems GRAHAM HOSPITAL ASSOCIATION In Lieu of Form CMS-2552-10

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0001 | Period: From 07/01/2022 | To 06/30/2023 | Part VI Date/Time Prepared: 11/30/2023 12:56 pm

Title XVIII | Skilled Nursing Facility | PPS

		1. 00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART	A PPS SNF	
	SERVI CES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	706, 958	1.00
2.00	Routine service other pass through costs	61, 685	2.00
3.00	Ancillary service other pass through costs	5, 632	3.00
4.00	Subtotal (sum of lines 1 through 3)	774, 275	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E,		5. 00
	Part B. This line is now shaded.)		
6.00	Deducti bl e	0	6.00
7.00	Coi nsurance	47, 260	7.00
8.00	Allowable bad debts (see instructions)	0	
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11. 00	Utilization review	0	
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	727, 015	1
13. 00		0	
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	
	Recovery of accelerated depreciation.	0	
14. 99	Demonstration payment adjustment amount before sequestration	0	14. 99
15.00		727, 015	
15. 01	Sequestration adjustment (see instructions)	13, 194	1
	Demonstration payment adjustment amount after sequestration	0	
15. 75	Sequestration for non-claims based amounts (see instructions)	0	15. 75
16.00		646, 504	1
	Tentative settlement (for contractor use only)	0	
18. 00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)	67, 317	
19. 00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1,	0	19.00
	§115. 2		

Heal th Fi nanci al Systems GRAHAM HOSPI TAL ASSOCIATION

Capital outlier reconciliation adjustment amount (see instructions)

Time value of money for capital related expenses (see instructions)

Time value of money for operating expenses (see instructions)

The rate used to calculate the time value of money (see instructions)

In Lieu of Form CMS-2552-10 OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT Provi der CCN: 14-0001 Worksheet E-5 Peri od: From 07/01/2022 To 06/30/2023 Date/Time Prepared: 11/30/2023 12:56 pm Title XVIII PPS 1.00 TO BE COMPLETED BY CONTRACTOR Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions) 1.00 2.00 Capital outlier from Wkst. L, Pt. I, line 2 0 2.00 Operating outlier reconciliation adjustment amount (see instructions) 3.00 0 3.00

0

0

0

0.00

4.00

5.00

6.00

7.00

4.00

5.00

6.00

7.00

Heal th Fi nanci al Systems GRAHAM HOSPI TAL ASSOCIATION

Health Financial Systems

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

Provider CCN: 14-0001

In Lieu of Form CMS-2552-10

Period: Worksheet G
From 07/01/2022
To 06/30/2023 Date/Time Prepared:

fund-type accounting records, complete the General Fund column only)

From 07/01/2022 To 06/30/2023 Date/Time Prepared: 11/30/2023 12:56 pm

					11/30/2023 12	:56 pm
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund	Fund		
	[au	1.00	2.00	3. 00	4. 00	
	CURRENT ASSETS	1				
1.00	Cash on hand in banks	3, 720, 076	1	0	0	1.00
2.00	Temporary investments	1, 611, 428	1	0	0	2.00
3.00	Notes receivable	0 445 400	0	0	0	3.00
4.00	Accounts receivable	36, 445, 408	1	0	0	4.00
5.00	Other receivable	7, 583, 976		0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable			U	0	6.00
7. 00	Inventory	2, 132, 951		U	0	7.00
8.00	Prepaid expenses	1, 720, 833		O O	0	8.00
9. 00 10. 00	Other current assets	204	0	O O	0	9.00
11. 00	Due from other funds	386 29, 595, 486		0	0	10.00
11.00	Total current assets (sum of lines 1-10)	29, 393, 400	0	υĮ	U	11. 00
12. 00	FIXED ASSETS Land	9, 074, 236	0	ol	0	12.00
13. 00	Land improvements	3, 203, 718		0	0	13.00
14. 00	Accumulated depreciation	-2, 512, 422	1	0	0	14.00
15. 00	Buildings	118, 214, 508	1	0	0	15.00
16. 00	Accumulated depreciation	-45, 578, 750	1	0	0	16.00
17. 00	Leasehold improvements	6, 629, 898		0	0	17.00
18. 00	Accumulated depreciation	0,027,070	Ö		0	18.00
19. 00	Fi xed equi pment	1, 246, 672	· · · · · · · · · · · · · · · · · · ·		0	19.00
20. 00	Accumulated depreciation	-721, 647		0	0	20.00
21. 00	Automobiles and trucks	-721,047		0	0	21.00
22. 00	Accumulated depreciation		o	0	0	22.00
23. 00	Major movable equipment	39, 892, 716		0	0	23.00
24. 00	Accumul ated depreciation	-30, 258, 015		0	0	24.00
25. 00	Mi nor equi pment depreci abl e	-30, 230, 013		0	0	25.00
26. 00	Accumulated depreciation				0	26.00
27. 00	HIT designated Assets			o o	0	27.00
28. 00	Accumulated depreciation	1 0	Ö	o o	0	28.00
29. 00	Mi nor equi pment-nondepreci abl e	0	Ö	Ö	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	99, 190, 914		Ö	0	30.00
00.00	OTHER ASSETS	,,,,,,,,,,	<u> </u>	<u> </u>		00.00
31.00	Investments	130, 904, 883	0	0	0	31.00
32.00	Deposits on Leases	0	o	0	0	32.00
33.00	Due from owners/officers	0	o	0	0	33.00
34.00	Other assets	1, 770, 653	O	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	132, 675, 536	0	O	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	261, 461, 936	0	O	0	36.00
	CURRENT LI ABI LI TI ES					
37.00	Accounts payable	4, 480, 975	0	0	0	37.00
38.00	Salaries, wages, and fees payable	13, 793, 188	0	0	0	38. 00
39.00	Payroll taxes payable	115, 202	0	0	0	39. 00
40.00	Notes and Loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accel erated payments	0				42.00
43.00	Due to other funds	5, 858, 104	0	0	0	43.00
44.00	Other current liabilities	0		0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	24, 247, 469	0	0	0	45.00
	LONG TERM LIABILITIES					
46. 00	Mortgage payable	0	0	0	0	
47. 00	Notes payable	67, 320, 344	0	0	0	47.00
48. 00	Unsecured Loans	0	0	0	0	48. 00
49. 00	Other long term liabilities	0	0	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	67, 320, 344		0	0	50.00
51. 00	Total liabilities (sum of lines 45 and 50)	91, 567, 813	0	0	0	51.00
	CAPITAL ACCOUNTS					
52. 00	General fund bal ance	169, 894, 123	1			52.00
53. 00	Specific purpose fund		0			53.00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			O	2	56.00
57.00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	169, 894, 123	0	0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	261, 461, 936	1	0	0	60.00
50.00	[59]	201, 401, 730		٩	Ü	00.00
	1=:/	I	1	ı		ı

HOSPI TAL Health Financial Systems STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 14-0001

In Lieu of Form CMS-2552-10 Peri od: Worksheet G-1

From 07/01/2022 06/30/2023 Date/Time Prepared: 11/30/2023 12:56 pm General Fund Special Purpose Fund Endowment Fund 1. 00 2.00 3. 00 4.00 5.00 1.00 Fund balances at beginning of period 154, 508, 531 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 15, 137, 537 2.00 2.00 Total (sum of line 1 and line 2) 169, 646, 068 3.00 ol 3.00 4.00 INCREAE IN NET ASSETS WITH DONOR RES 0 248, 046 4.00 5.00 ROUNDI NG 0 5.00 0 6.00 0 0 0 0 6.00 0 7.00 0 7.00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 248, 055 0 10.00 169, 894, 123 Subtotal (line 3 plus line 10) 0 11.00 11.00 12.00 Deductions (debit adjustments) (specify) 0 12.00 13.00 00000 0 13.00 14.00 0 0 14.00 15.00 0 15.00 16.00 0 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 169, 894, 123 19.00 19.00 sheet (line 11 minus line 18) Endowment Plant Fund Fund 6.00 8.00 7.00 1.00 Fund balances at beginning of period 0 0 2.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 0 0 3.00 3.00 Total (sum of line 1 and line 2) 4.00 INCREAE IN NET ASSETS WITH DONOR RES 4.00 5.00 ROUNDI NG 5.00 6.00 0 6.00 7.00 0 7.00 8.00 0 8.00 9.00 0 9.00 Total additions (sum of line 4-9) 0 10.00 10.00 11.00 Subtotal (line 3 plus line 10) 0 11.00 Deductions (debit adjustments) (specify) 12.00 12.00 13.00 0 13.00 14.00 0 14.00 15.00 15.00 16.00 0 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 18.00 0 18.00

0

19.00

Fund balance at end of period per balance

sheet (line 11 minus line 18)

Health Financial Systems GR STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0001

In Lieu of Form CMS-2552-10 Peri od: Worksheet G-2 From 07/01/2022 Parts I & II To 06/30/2023 Date/Ti me Prepared: 11/30/2023 12:56 pm

					11/30/2023 12	:56 pm
	Cost Center Description		I npati ent	Outpati ent	Total	
			1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
1 00	General Inpatient Routine Services		10 410 10/		10 110 107	1 00
1.00	Hospi tal		12, 418, 186		12, 418, 186	1.00
2.00	SUBPROVIDER - I PF					2. 00 3. 00
3. 00 4. 00	SUBPROVI DER					4. 00
5. 00	Swing bed - SNF		0		0	5. 00
6. 00	Swing bed - NF		0		0	6. 00
7. 00	SKILLED NURSING FACILITY		1, 137, 182		1, 137, 182	7. 00
8. 00	NURSING FACILITY		1, 042, 154		1, 042, 154	8. 00
9. 00	OTHER LONG TERM CARE		1,012,101		1,012,101	9. 00
10.00	Total general inpatient care services (sum of lines 1-9)		14, 597, 522		14, 597, 522	10.00
	Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT		5, 238, 075		5, 238, 075	11.00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14. 00	SURGI CAL INTENSIVE CARE UNIT					14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)					15. 00
16. 00	Total intensive care type inpatient hospital services (sum of	Lines	5, 238, 075		5, 238, 075	16. 00
17. 00	11-15) Total inpatient routine care services (sum of lines 10 and 16)		19, 835, 597		19, 835, 597	17. 00
18.00	Ancillary services	,	36, 204, 779	140, 819, 068	177, 023, 847	18.00
19.00	Outpatient services		7, 177, 129	37, 606, 285	44, 783, 414	
20. 00	RURAL HEALTH CLINIC		0	25, 468, 092	25, 468, 092	
20. 01	ELMWOOD RHC		0	863, 288	863, 288	
20. 02	WILLIAMSFIELD RHC		o o	74, 231	74, 231	20. 02
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21. 00
22. 00	HOME HEALTH AGENCY			-		22. 00
23.00	AMBULANCE SERVICES					23.00
24.00	CMHC					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPI CE					26.00
27. 00	DURABLE MEDICAL EQUIP - RENTED		0	4, 140, 892	4, 140, 892	
27. 01	PROFESSI ONAL FEES		1, 782, 254	11, 579, 564	13, 361, 818	
27. 02	LAB GROSS-UP		0	0	0	27. 02
27. 03	SCHOOL OF NURSING		0	330, 673	330, 673	
27. 04	DIETARY		0	676, 252	676, 252	
27. 05	NON-RHC	to What	0 64, 999, 759	127, 965	127, 965	27. 05 28. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 G-3, line 1)	to wkst.	04, 999, 739	221, 686, 310	286, 686, 069	26.00
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			109, 947, 741		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
40. 00 41. 00						40.00
42.00	Total deductions (sum of lines 37-41)			n		41.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42	2)(transfer		109, 947, 741		43. 00
.5. 55	to Wkst. G-3, line 4)	-, (:: :::::::::::::::::::::::::::::::::		, , , , , , , , , , , , , , , , ,		.5. 55
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al th Financial Systems GRAHAM HOSPITAL ASSOCIATION

Heal th Financial Systems | GRAHAM HOSPITAL ASSOCIATION | In Lieu of Form CMS-2552-10 |
STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-0001 | Period: From 07/01/2022 | From 07/01/2022 | Period: From 07/01/2022 | Period:

	To 06/30/2023	Date/Time Prep 11/30/2023 12	
		1.00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	286, 686, 069	1.00
2.00	Less contractual allowances and discounts on patients' accounts	181, 649, 498	2.00
3.00	Net patient revenues (line 1 minus line 2)	105, 036, 571	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	109, 947, 741	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4, 911, 170	5.00
	OTHER I NCOME		
6.00	Contributions, donations, bequests, etc	2, 764, 474	6. 00
7.00	Income from investments	4, 171, 203	7. 00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9. 00
	Purchase discounts	0	10.00
11. 00	Rebates and refunds of expenses	0	11. 00
	Parking lot receipts	0	12.00
13.00	Revenue from Laundry and Linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
	Revenue from rental of living quarters	424, 080	
	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
	Revenue from sale of drugs to other than patients	77, 692	
	Revenue from sale of medical records and abstracts	5, 622	
	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19. 00
	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
	Rental of vending machines	0	21. 00
22. 00	Rental of hospital space	0	22. 00
	Governmental appropriations	0	23. 00
	OTHER OPERATING INCOME	1, 349, 161	
	340B RETAIL PHARMACY	4, 323, 378	
	CHANGE IN FV OF INTEREST RATE SWAP	967, 796	
	UNREALIZED GAIN ON INVESTMENTS	5, 965, 301	24. 03
	COVI D-19 PHE Funding	0	24. 50
	Total other income (sum of lines 6-24)	20, 048, 707	25. 00
	Total (line 5 plus line 25)	15, 137, 537	
	CHANGE IN FV OF INTERST RATE SWAP	0	27. 00
	LOSS ON DISPOSAL	0	27. 01
	UNREALIZED LOSS ON INVESTMENTS	0	27. 02
	Total other expenses (sum of line 27 and subscripts)	0	28. 00
29. 00	Net income (or loss) for the period (line 26 minus line 28)	15, 137, 537	29. 00

eal th Fi nanci al Systems GRAHAM HOSPI TAL ASSOCIATION

Heal th Financial Systems GRAHAM HOSPITAL ASSOCIATION In Lieu of Form CMS-2552-10

CALCULATION OF CAPITAL PAYMENT

Provider CCN: 14-0001 Period: From 07/01/2022 To 06/30/2023 Date/Time Prepared: 11/30/2023 12:56 pm

Title XVIII Hospital PPS

		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
1 00	CAPITAL FEDERAL AMOUNT			20/ 051	1 00
1. 00 1. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier			396, 051 0	1. 00 1. 01
2. 00	Capital DRG outlier payments			2, 217	2.00
2. 00	Model 4 BPCI Capital DRG outlier payments			2, 217	2.00
3. 00	Total inpatient days divided by number of days in the cost re	norting pariod (see instru	ictions)	17. 55	
4. 00	Number of interns & residents (see instructions)	portring period (see mistro	ictions)	0.00	4.00
5. 00	Indirect medical education percentage (see instructions)			0.00	
6. 00	Indirect medical education adjustment (multiply line 5 by the	sum of lines 1 and 1 01	columns 1 and	0.00	6.00
0.00	1.01) (see instructions)	Sum of Titles I and I. OI,	corumiis i and	O	0.00
7. 00	Percentage of SSI recipient patient days to Medicare Part A p	atient days (Worksheet E	nart A line	0. 00	7. 00
7.00	30) (see instructions)	attont days (norkshoot 2,	par t / Time	0.00	7.00
8. 00	Percentage of Medicaid patient days to total days (see instru	ctions)		0.00	8.00
9. 00	Sum of lines 7 and 8			0. 00	
10.00	Allowable disproportionate share percentage (see instructions)			10.00
11.00	Disproportionate share adjustment (see instructions)	,		0	11.00
12.00	Total prospective capital payments (see instructions)			398, 268	12.00
				·	
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)			0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	3.00
4.00	Capital cost payment factor (see instructions)			0	4.00
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
			_		
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1. 00	Program inpatient capital costs (see instructions)			0	1.00
2. 00	Program inpatient capital costs for extraordinary circumstanc	es (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)			0	3.00
4. 00	Applicable exception percentage (see instructions)			0. 00	
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	
6. 00	Percentage adjustment for extraordinary circumstances (see in			0. 00	
7.00	Adjustment to capital minimum payment level for extraordinary	circumstances (line 2 x l	ine 6)	0	7.00
8. 00	Capital minimum payment level (line 5 plus line 7)			0	8.00
9.00	Current year capital payments (from Part I, line 12, as appli			0	9.00
10.00	Current year comparison of capital minimum payment level to c			0	10.00
11. 00	Carryover of accumulated capital minimum payment level over c	apitai payment (from prior	year	0	11. 00
12. 00	Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital pa	ymonts (line 10 plus line	11)	0	12. 00
13. 00	Current year exception payment (if line 12 is positive, enter		'''	0	
14. 00	Carryover of accumulated capital minimum payment level over c	,	Lowing port od	0	
14.00	(if line 12 is negative, enter the amount on this line)	apitai payment for the for	Towring period	U	14.00
15. 00	Current year allowable operating and capital payment (see ins	tructions)		0	15. 00
16. 00	Current year operating and capital costs (see instructions)	431, 5113)		0	16.00
	Current year exception offset amount (see instructions)			0	
	1-2		Į.	0	

Heal th Fi nanci al Systems GRAHAM HOSPI TAL ASSOCIATION

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS Provider CCN: 14-0001 Peri od: Worksheet M-1 From 07/01/2022 Component CCN: 14-3493 To 06/30/2023 Date/Time Prepared: 11/30/2023 12:56 pm RHC I Recl assi fi ed Compensation Other Costs Total (col. 1 Reclassi fi cat Trial Balance + col. 2) i ons (col. 3 +col. 4) 1.00 2.00 3.00 4.00 5.00 FACILITY HEALTH CARE STAFF COSTS 12, 917, 784 11, 785, 450 1 00 4,022,650 8, 895, 134 -1, 132, 334 1 00 Physi ci an 2.00 Physician Assistant 643, 664 643,664 -150, 704 492, 960 2.00 3.00 Nurse Practitioner 2, 728, 616 2, 728, 616 -648, 314 2,080,302 3.00 Visiting Nurse 4.00 4.00 -536, 519 Other Nurse 3, 571, 337 3, 034, 818 5.00 3, 571, 337 5 00 6.00 Clinical Psychologist 6.00 7.00 Clinical Social Worker 35, 803 35,803 0 35,803 7.00 Laboratory Techni ci an 8.00 0 0 8.00 0 0 9.00 Other Facility Health Care Staff Costs \cap 9 00 10.00 Subtotal (sum of lines 1 through 9) 11, 002, 070 8, 895, 134 19, 897, 204 -2, 467, 871 17, 429, 333 10.00 11.00 Physician Services Under Agreement 11.00 Physician Supervision Under Agreement 12.00 12.00 0 0 0 C 0 13.00 Other Costs Under Agreement 0 C 0 0 0 13.00 Subtotal (sum of lines 11 through 13) 0 14.00 14.00 0 15.00 Medical Supplies 286, 620 286, 620 -19, 666 266, 954 15.00 Transportation (Health Care Staff) 0 16,00 Ω 16,00 17.00 Depreciation-Medical Equipment 0 17.00 Professional Liability Insurance 1, 527, 696 1, 527, 696 1, 422, 876 18.00 -104, 820 18.00 Other Health Care Costs 206, 221 19.00 19.00 113, 986 320, 207 -38, 801 281, 406 20.00 Allowable GME Costs 20.00 21.00 Subtotal (sum of lines 15 through 20) 206, 221 1, 928, 302 2, 134, 523 -163, 287 1, 971, 236 21.00 Total Cost of Health Care Services (sum of 22.00 11, 208, 291 10, 823, 436 22, 031, 727 -2, 631, 158 19, 400, 569 22.00 lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES Pharmacy 23.00 0 0 23.00 \cap 0 0 24.00 Dental 0 0 24.00 o 25.00 Optometry 25.00 0 0 0 25.01 Tel eheal th 11, 767 11, 767 11, 767 25.01 25. 02 Chronic Care Management 25.02 0 26.00 All other nonreimbursable costs 0 0 26.00 0 27.00 27.00 Nonallowable GME costs 28.00 Total Nonreimbursable Costs (sum of lines 23 11, 767 11, 767 11, 767 28.00 through 27) FACILITY OVERHEAD 29.00 Facility Costs 33, 451 33.451 49.136 82, 587 29.00 30.00 Administrative Costs 2, 424, 074 123, 511 2, 547, 585 -372, 641 2, 174, 944 30.00 31.00 Total Facility Overhead (sum of lines 29 and 2, 424, 074 156, 962 2, 581, 036 -323, 505 2, 257, 531 31.00 21, 669, 867 32 00 Total facility costs (sum of lines 22, 28 13 644 132 10, 980, 398 24, 624, 530 -2, 954, 663 32 00

In Lieu of Form CMS-2552-10

and 31)

In Lieu of Form CMS-2552-10

Heal th Financial Systems

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS Provi der CCN: 14-0001 Peri od: From 07/01/2022 To 06/30/2023 Worksheet M-1 Date/Time Prepared: 11/30/2023 12:56 pm Component CCN: 14-3493

Adj ustments						RHC I	Cost	
All location (col. 5 + col. 6) Col. 6 Col.			Adjustments	Net Expenses				
COL 5				for				
FACILITY HEALTH CARE STAFF COSTS								
FACILITY HEALTH CARE STAFF COSTS								
FACILITY HEALTH CARE STAFF COSTS								
1.00		EAGLELTY HEALTH CARE OTHER COOTS	6. 00	7. 00				
2.00 Physician Assistant 0 492, 960 2, 00 4.00 Visiting Nurse 0 0 0 6.00 Visiting Nurse 0 0 0 6.00 Clinical Psychologist 0 0 0 7.00 Clinical Social Worker 0 35,803 7,00 8.00 Laboratory Technician 0 0 0 9.00 Tinical Social Worker 0 0 0 1.00 Laboratory Technician 0 0 0 9.00 Tinical Social Worker 0 0 0 1.00 Laboratory Technician 0 0 0 1.00 Laboratory Technician 0 0 0 1.00 Dustotal (sum of lines 1 through 9) 0 17,429,333 10 1.10 Depriciation Allower Agreement 0 0 0 11 1.00 Dustotal (sum of lines 11 through 13) 0 0 0 13 1.00	1 00		0	11 705 450	I			1 00
3.00 Nurse Practitioner			•					
4.00		1 3	0		•			
5.00			0		i			
6.00			0	_	ı			
7.00			0	3, 034, 818				
8. 00			0	25 002				
9.00 Other Facility Health Care Staff Costs 0 0 0 0 0 0 1 0 0 0			0		•			
10.00 Subtotal (sum of lines 1 through 9) 0 17,429,333 10.00			0					
11.00 Physician Services Under Agreement 0 0 0 12.00 Physician Supervision Under Agreement 0 0 0 12.00 13.00 14.00 14.00 15.00 16.00 16.00 16.00 17.00 17.00 16.00 17.00			0	_				
12.00 Physician Supervision Under Agreement 0 0 0 0 0 0 0 0 0			0	17, 429, 333				
13.00 Other Costs Under Agreement 0 0 0 0 14.00 14.00 Subtotal (sum of lines 11 through 13) 0 0 0 15.00 Medical Supplies 0 0 0 0 16.00 Transportation (Heal th Care Stafff) 0 0 0 17.00 Depreciation-Medical Equipment 0 0 0 18.00 Professional Liability Insurance 0 1,422,876 18.00 19.00 Other Heal th Care Costs 0 281,406 19.00 20.00 Allowable GME Costs 20.00 21.00 Subtotal (sum of lines 15 through 20) 0 1,971,236 21.00 22.00 Total Cost of Heal th Care Services (sum of lines 10, 14, and 21) Costs of Heal th Care Services (sum of lines 10, 14, and 21) Costs of Heal th Care Services (sum of lines 10, 14, and 21) Costs of Heal th Care Services (sum of lines 10, 14, and 21) Costs of Heal th Care Services (sum of lines 10, 14, and 21) Costs of Heal th Care Services (sum of lines 10, 14, and 21) Costs of Heal th Care Services (sum of lines 10, 14, and 21) Costs of Heal th Care Services (sum of lines 10, 14, and 21) Costs of Heal th Care Services (sum of lines 10, 14, and 21) Costs of Heal th Care Services (sum of lines 10, 14, and 21) Costs of Heal th Care Services (sum of lines 20, 20, 20, 20, 20, 20, 20, 20, 20, 20,			0	0				
14.00 Subtotal (sum of lines 11 through 13) 0 0 0 14.00			0					
15. 00 Medical Supplies 0 266,954 15. 00 16. 00 Transportation (Heal th Care Staff) 0 0 0 17. 00 18. 00 17. 00 18. 00 17. 00 18. 00 18. 00 19. 00			0	1				
16. 00 Transportation (Heal th Care Staff) 0 0 0 17. 00 Depreciation-Medical Equipment 0 0 17. 00 Depreciation-Medical Equipment 0 0 17. 00 18. 00 Professional Liability Insurance 0 1,422,876 18. 00 19. 00 Other Heal th Care Costs 0 281,406 19. 00 20. 00 All owable GME Costs 20. 00 All owable GME Costs 21. 00 Subtotal (sum of lines 15 through 20) 0 1,971,236 21. 00 Subtotal (sum of lines 15 through 20) 0 1,971,236 21. 00 Pharmacy 22. 00 Total Cost of Heal th Care Services (sum of lines 10, 14, and 21) 22. 00 Dental 0 0 0 24. 00 Dental 0 0 0 24. 00 Dental 0 0 0 25. 00 Optometry 0 0 0 0 25. 01 Teleheal th 0 0 11,767 25. 01 Teleheal th 0 0 11,767 25. 01 Cronic Care Management 0 0 0 0 25. 01 Cronic Care Management 0 0 0 0 26. 00 All other nonreimbursable costs 0 0 0 27. 00 Nonall owable GME costs 10 0 0 11,767 28. 00 Total Nonreimbursable Costs (sum of lines 23 0 11,767 28. 00 Total Nonreimbursable Costs (sum of lines 23 0 11,767 28. 00 Total Statistics (sum of lines 29 and 476, 563 1,698, 381 30. 00 Total Facility Overhead (sum of lines 29 and 476, 563 1,780,968 30. 00 Total facility costs (sum of lines 22, 28 476, 563 21,193, 304 32. 00 Total facility costs (sum of lines 22, 28 476, 563 21,193, 304			0					
17. 00 Depreciation-Medical Equipment 0 17. 00 18. 00 Professional Liability Insurance 0 1,422,876 18. 00 281,406 19. 00 281,406 19. 00 281,406 281,406 29. 00 20. 00 21. 00 21. 00 20. 00 21. 00 21. 00 22. 00 21. 00 22. 00 22. 00 22. 00 22. 00 23. 00 24. 00 24. 00 24. 00 25. 00			0		1			
18. 00 Professional Liability Insurance 0 1,422,876 19. 00 19. 00 281,406 19. 00 281,406 19. 00 281,406 19. 00 281,406 281,406 281,406 29. 00			0	1				
19.00 Other Health Care Costs 0 281,406 20.00 20.00 20.00 21.00 20.00 22.00 21.00 22.00			0					
20. 00 21. 00 21. 00 22. 00 21. 00 22. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 29. 00 20		1	0		1			
21.00 Subtotal (sum of lines 15 through 20) 0 1,971,236 22.00 Total Cost of Heal th Care Services (sum of lines 10, 14, and 21) 22.00		1	Ü	281, 406				
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES 23.00 Pharmacy Dental Doptometry Dop		1	0	1 071 004				
Li nes 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES			0					
COSTS OTHER THAN RHC/FQHC SERVICES 23.00 24.00 24.00 24.00 25.00 25.00 0 0 0 0 0 24.00 25.00 25.00 0 0 0 0 0 25.00 25.00 25.00 26.00	22.00		0	19, 400, 569				22.00
23.00 Pharmacy								
24.00 Dental	22 00		0					22 00
25.00 Optometry 0 0 0 0 25.00 25.01 Tel eheal th 0 11,767 25.01 25.02 Chronic Care Management 0 0 0 25.02 26.00 All other nonreimbursable costs 0 0 0 26.00 27.00 Nonallowable GME costs 26.00 28.00 Total Nonreimbursable Costs (sum of lines 23 0 11,767 FACILITY OVERHEAD 29.00 Facility Costs 0 82,587 30.00 Administrative Costs 0 9.00 31.00 Total Facility Overhead (sum of lines 29 and 30) 32.00 Total facility costs (sum of lines 22, 28 -476,563 21,193,304) 32.00 Total facility costs (sum of lines 22, 28 -476,563 21,193,304)			0	1				
25. 01 Tel eheal th			0		•			
25. 02 Chronic Care Management 0 0 0 25. 02 26. 00 All other nonreimbursable costs 0 0 0 27. 00 Nonallowable GME costs 27. 00 28. 00 Total Nonreimbursable Costs (sum of lines 23 0 11, 767 29. 00 Facility OverHeAD 29. 00 Facility Costs 0 29. 00 30. 00 Administrative Costs -476, 563 1, 698, 381 30. 00 31. 00 Total Facility Overhead (sum of lines 29 and 30) 32. 00 Total facility costs (sum of lines 22, 28 -476, 563 21, 193, 304) 32. 00 Total facility costs (sum of lines 22, 28 -476, 563 21, 193, 304)			0	-	i .			
26.00 All other nonreimbursable costs 0 0 26.00 27.00 28.00 Nonallowable GME costs 0 11,767 28.00 27.00 28.00 27.00 28.00 27.00 28.00			0		i			
27.00 28.00 Nonallowable GME costs 27.00 28.00		9	0					
28.00 Total Nonreimbursable Costs (sum of lines 23 0 11,767 28.00 through 27) FACILITY OVERHEAD 29.00 Facility Costs 0 82,587 29.00 Administrative Costs -476,563 1,698,381 30.00 Total Facility Overhead (sum of lines 29 and 30) 32.00 Total facility costs (sum of lines 22, 28 -476,563 21,193,304 32.00		1	O	l				
through 27) FACILITY OVERHEAD 29.00 Facility Costs 30.00 Administrative Costs 31.00 Total Facility Overhead (sum of lines 29 and 30) 32.00 Total facility costs (sum of lines 22, 28 -476, 563 21, 193, 304) 32.00 Total facility costs (sum of lines 22, 28 -476, 563 21, 193, 304) 32.00			0	11 767				
FACILITY OVERHEAD 29.00 Facility Costs 30.00 Administrative Costs Total Facility Overhead (sum of lines 29 and 30) 32.00 Total facility costs (sum of lines 22, 28 -476, 563 21, 193, 304) 29.00 82, 587 29.00 1, 698, 381 30.00 21. 1780, 968 31.00 22. 28 -476, 563 21, 193, 304	20.00		O	11,707				20.00
29.00 Facility Costs								
30.00 Administrative Costs -476,563 1,698,381 30.00 31.00 Total Facility Overhead (sum of lines 29 and 30) 32.00 Total facility costs (sum of lines 22, 28 -476,563 21,193,304 32.00	29. 00		0	82, 587				29. 00
31.00 Total Facility Overhead (sum of lines 29 and 30) 32.00 Total facility costs (sum of lines 22, 28 -476, 563 21, 193, 304 32.00								
30) 32.00 Total facility costs (sum of lines 22, 28 -476, 563 21, 193, 304 32.00								
32.00 Total facility costs (sum of lines 22, 28 -476, 563 21, 193, 304 32.00			, 300	, , , , , , , ,				
	32.00		-476, 563	21, 193, 304				32.00
		and 31)						

Heal th Fi nanci al Systems GRAHAM HOSPI TAL ASSOCIATION

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS Provider CCN: 14-0001 Peri od: Worksheet M-1 From 07/01/2022 Component CCN: 14-8603 06/30/2023 To Date/Time Prepared: 11/30/2023 12:56 pm RHC II Recl assi fi ed Compensation Other Costs Total (col. 1 Reclassi fi cat + col . 2) Trial Balance i ons (col. 3 +col. 4) 1.00 2.00 3.00 4.00 5.00 FACILITY HEALTH CARE STAFF COSTS -402 1 00 -402 834, 257 1 00 Physi ci an 833, 855 2.00 Physician Assistant 0 1, 435 1, 435 2.00 -136 3.00 Nurse Practitioner 88, 656 -136 88, 520 3.00 Visiting Nurse 4.00 0 0 0 4.00 0 Other Nurse 0 0 5.00 111, 470 111, 470 5.00 6.00 6.00 Clinical Psychologist 0 0 7.00 Clinical Social Worker 0 0 0 0 0 7.00 Laboratory Techni ci an 0 0 0 8.00 8.00 0 0 Other Facility Health Care Staff Costs 0 0 O 9.00 Λ 9 00 10.00 Subtotal (sum of lines 1 through 9) 538 0 -538 1, 035, 818 1,035,280 10.00 11.00 Physician Services Under Agreement 0 11.00 0 0 Physician Supervision Under Agreement 0 12.00 0 0 12.00 0 0 0 13.00 Other Costs Under Agreement C 0 0 13.00 14.00 Subtotal (sum of lines 11 through 13) 0 0 0 14.00 15.00 Medical Supplies 0 15, 167 15.00 15, 167 Transportation (Health Care Staff) C 0 16,00 Ω 16,00 17.00 Depreciation-Medical Equipment C 0 0 17.00 Professional Liability Insurance 0 80, 841 80, 841 18.00 0 18.00 Other Health Care Costs 0 12, 468 19.00 19.00 12, 468 20.00 Allowable GME Costs 20.00 21.00 Subtotal (sum of lines 15 through 20) 0 0 0 108, 476 108, 476 21.00 Total Cost of Health Care Services (sum of 22.00 -538 -538 1, 144, 294 1, 143, 756 22.00 lines 10, 14, and 21)
COSTS OTHER THAN RHC/FQHC SERVICES Pharmacy 23.00 0 0 0 23.00 24.00 0 0 0 0 0 24.00 Dental 0 25.00 Optometry 0 0 0 0 25.00 0 538 25.01 Tel eheal th 538 0 538 25.01 25. 02 Chronic Care Management 0 0 0 0 0 25.02 26.00 All other nonreimbursable costs 0 0 0 0 26.00 27.00 Nonallowable GME costs 27.00 28.00 Total Nonreimbursable Costs (sum of lines 23 538 C 538 538 28.00 through 27) FACILITY OVERHEAD 29.00 29.00 Facility Costs 4,692 4,692 0 0 30.00 Administrative Costs C 82, 197 82, 197 30.00 31.00 Total Facility Overhead (sum of lines 29 and 0 0 0 86, 889 86, 889 31.00

0

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0

1, 231, 183

1, 231, 183

32 00

In Lieu of Form CMS-2552-10

32 00

and 31)

Total facility costs (sum of lines 22, 28

In Lieu of Form CMS-2552-10

Heal th Financial Systems

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS Provider CCN: 14-0001 Peri od: From 07/01/2022 To 06/30/2023 Worksheet M-1 Date/Time Prepared: 11/30/2023 12:56 pm Component CCN: 14-8603

					RHC II	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					1.00
2.00	Physician Assistant	0	1, 435				2.00
3.00	Nurse Practitioner	0	88, 520				3.00
4.00	Visiting Nurse	0	0	1			4.00
5.00	Other Nurse	0	111, 470				5. 00
6.00	Clinical Psychologist	0	0				6.00
7.00	Clinical Social Worker	0	0				7.00
8.00	Laboratory Techni ci an	0	0				8. 00
9.00	Other Facility Health Care Staff Costs	0	0				9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	1, 035, 280				10.00
11.00	Physician Services Under Agreement	0	0				11.00
12.00	Physician Supervision Under Agreement	0	0				12.00
13.00	Other Costs Under Agreement	0	0				13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0				14.00
15.00	Medical Supplies	0	15, 167				15.00
16.00	Transportation (Health Care Staff)	0	0	1			16.00
17. 00	Depreciation-Medical Equipment	0	0				17. 00
18. 00	Professional Liability Insurance	0	80, 841				18.00
19.00	Other Health Care Costs	0	12, 468				19.00
20.00	Allowable GME Costs		,				20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	108, 476				21.00
22. 00	Total Cost of Health Care Services (sum of	0					22.00
	lines 10, 14, and 21)		,,				
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0				23. 00
24.00	Dental	0	0				24.00
25.00	Optometry	0	0				25.00
25. 01	Tel eheal th	0	538				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	538				28. 00
	through 27)						
	FACILITY OVERHEAD						
29.00	Facility Costs	0	4, 692				29. 00
30.00	Administrative Costs	0	82, 197				30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	86, 889				31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28	0	1, 231, 183				32.00
	and 31)						

M HOSPI TAL Health Financial Systems SSOCI ATI ON

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS Provider CCN: 14-0001 Peri od: Worksheet M-1 From 07/01/2022 Component CCN: 14-8636 06/30/2023 To Date/Time Prepared: 11/30/2023 12:56 pm RHC III Recl assi fi ed Compensation Other Costs Total (col. 1 Reclassi fi cat Trial Balance + col. 2) i ons (col. 3 +col 4) 1. 00 2.00 3.00 4.00 5.00 FACILITY HEALTH CARE STAFF COSTS 1 00 0 90, 962 90, 962 1 00 Physi ci an 00000000000000000000 0 2.00 Physician Assistant 0 2.00 3.00 Nurse Practitioner 0 0 9,888 9,888 3.00 Visiting Nurse 4.00 0 0 4.00 Other Nurse 0 0 12,025 12,025 5.00 5.00 6.00 6.00 Clinical Psychologist 0 7.00 Clinical Social Worker 0 0 0 0 7.00 Laboratory Techni ci an 0 0 8.00 8.00 0 0 0 Other Facility Health Care Staff Costs 0 9.00 Λ 9.00 10.00 Subtotal (sum of lines 1 through 9) 0 0 112, 875 112, 875 10.00 11.00 Physician Services Under Agreement 11.00 0 Physician Supervision Under Agreement 0 12.00 0 12.00 0 0 13.00 Other Costs Under Agreement C 0 0 13.00 14.00 Subtotal (sum of lines 11 through 13) 14.00 0 Medical Supplies 15.00 0 1,652 15.00 1,652 Transportation (Health Care Staff) C 0 16,00 0 16,00 17.00 Depreciation-Medical Equipment C 0 0 17.00 Professional Liability Insurance 0 8,803 8,803 18.00 18.00 Other Health Care Costs 19.00 0 19.00 1.351 1, 351 20.00 Allowable GME Costs 20.00 21.00 Subtotal (sum of lines 15 through 20) 0 0 0 11,806 11,806 21.00 Total Cost of Health Care Services (sum of 0 22.00 0 124, 681 124, 681 22.00 lines 10, 14, and 21)
COSTS OTHER THAN RHC/FQHC SERVICES 23.00 Pharmacy 0 0 0 0 23.00 24.00 0 0 0 0 0 0 0 24.00 Dental 0 25.00 0 25.00 Optometry 0 0 0 25.01 0 25.01 Tel eheal th 0 0 25. 02 Chronic Care Management 0 0 0 0 25.02 All other nonreimbursable costs 0 26.00 0 0 0 26.00 27.00 Nonallowable GME costs 27.00 28.00 Total Nonreimbursable Costs (sum of lines 23 0 C 0 0 28.00 through 27) FACILITY OVERHEAD 29.00 512 29.00 Facility Costs 0 512 0 30.00 Administrative Costs 0 C 8, 874 8,874 30.00 31.00 31.00 Total Facility Overhead (sum of lines 29 and 0 0 0 9, 386 9, 386 32 00 Total facility costs (sum of lines 22, 28 0 134, 067

0

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In Lieu of Form CMS-2552-10

134, 067

32 00

and 31)

GRAHAM HOSPI TAL

In Lieu of Form CMS-2552-10

Heal th Financial Systems

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS Provider CCN: 14-0001 Peri od: From 07/01/2022 To 06/30/2023 Worksheet M-1 Date/Time Prepared: 11/30/2023 12:56 pm Component CCN: 14-8636

Adjustments
Allocation (col. 5 + col. 6) 6.00 7.00
Col. 5 + col. 6) 6.00 7.00
FACILITY HEALTH CARE STAFF COSTS 1.00 Physician
FACILITY HEALTH CARE STAFF COSTS 1.00 Physician 0 90,962 1.00
FACILITY HEALTH CARE STAFF COSTS 1.00 Physician 2.00 Physician Assistant 0 0 90,962 1.00 3.00 Nurse Practitioner 0 9,888 3.00 4.00 Visiting Nurse 0 0 0 4.00 5.00 Other Nurse 0 12,025 5.00 Clinical Psychologist 0 0 0 0 6.00 Clinical Social Worker 0 0 0 0 0 7.00 Clinical Social Worker 0 0 0 0 0 8.00 Laboratory Technician 0 0 0 0 0 0 0 0 0
1.00 Physician 0 90,962 1.00 2.00 Physician Assistant 0 0 2.00 3.00 Nurse Practitioner 0 9,888 3.00 4.00 Visiting Nurse 0 0 4.00 5.00 Other Nurse 0 12,025 5.00 6.00 Clinical Psychologist 0 0 6.00 7.00 Clinical Social Worker 0 0 6.00 8.00 Laboratory Technician 0 0 8.00 9.00 Other Facility Health Care Staff Costs 0 0 9.00 10.00 Subtotal (sum of lines 1 through 9) 0 112,875 10.00 11.00 Physician Services Under Agreement 0 0 0
2. 00 Physician Assistant 0 0 0 3. 00 Nurse Practitioner 0 9,888 3.00 4. 00 Visiting Nurse 0 0 4.00 5. 00 Other Nurse 0 12,025 5.00 6. 00 Clinical Psychologist 0 0 6.00 7. 00 Clinical Social Worker 0 0 7.00 8. 00 Laboratory Technician 0 0 8.00 9. 00 Other Facility Health Care Staff Costs 0 0 9.00 10. 00 Subtotal (sum of lines 1 through 9) 0 112,875 10.00 11. 00 Physician Services Under Agreement 0 0 0
3. 00 Nurse Practitioner 0 9,888 3.00 4. 00 Visiting Nurse 0 0 4.00 5. 00 Other Nurse 0 12,025 5.00 6. 00 Clinical Psychologist 0 0 6.00 7. 00 Clinical Social Worker 0 0 7.00 8. 00 Laboratory Technician 0 0 8.00 9. 00 Other Facility Health Care Staff Costs 0 0 9.00 10. 00 Subtotal (sum of lines 1 through 9) 0 112,875 10.00 11. 00 Physician Services Under Agreement 0 0 0
4.00 Visiting Nurse 0 0 4.00 5.00 Other Nurse 0 12,025 5.00 6.00 Clinical Psychologist 0 0 6.00 7.00 Clinical Social Worker 0 0 7.00 8.00 Laboratory Technician 0 0 8.00 9.00 Other Facility Health Care Staff Costs 0 0 9.00 10.00 Subtotal (sum of lines 1 through 9) 0 112,875 10.00 11.00 Physician Services Under Agreement 0 0 11.00
5. 00 Other Nurse 0 12,025 5.00 6. 00 Clinical Psychologist 0 0 6.00 7. 00 Clinical Social Worker 0 0 7.00 8. 00 Laboratory Technician 0 0 8.00 9. 00 Other Facility Health Care Staff Costs 0 0 9.00 10. 00 Subtotal (sum of lines 1 through 9) 0 112,875 10.00 11. 00 Physician Services Under Agreement 0 0 11.00
6. 00 Clinical Psychologist 0 0 6.00 7. 00 Clinical Social Worker 0 0 7.00 8. 00 Laboratory Technician 0 0 8.00 9. 00 Other Facility Health Care Staff Costs 0 0 9.00 10. 00 Subtotal (sum of lines 1 through 9) 0 112,875 10.00 11. 00 Physician Services Under Agreement 0 0 11.00
7. 00 Clinical Social Worker 0 0 7. 00 8. 00 Laboratory Technician 0 0 8. 00 9. 00 Other Facility Health Care Staff Costs 0 0 9. 00 10. 00 Subtotal (sum of lines 1 through 9) 0 112, 875 10. 00 11. 00 Physician Services Under Agreement 0 0 11. 00
8. 00 Laboratory Technician 0 0 8. 00 9. 00 Other Facility Health Care Staff Costs 0 0 9. 00 10. 00 Subtotal (sum of lines 1 through 9) 0 112, 875 10. 00 11. 00 Physician Services Under Agreement 0 0 11. 00
9. 00 Other Facility Health Care Staff Costs 0 0 10. 00 Subtotal (sum of lines 1 through 9) 0 112,875 10. 00 Physician Services Under Agreement 0 0 11. 00
10.00 Subtotal (sum of lines 1 through 9) 0 112,875 10.00 11.00 Physician Services Under Agreement 0 0 11.00
11.00 Physician Services Under Agreement 0 0 11.00
13. 00 Other Costs Under Agreement 0 0 13. 00
17. 00 Depreciation-Medical Equipment
17. 00 Other Hearth our c 00313
20.00 Allowable GME Costs 20.00 21.00 Subtotal (sum of lines 15 through 20) 0 11.806 21.00
22.00 Total Cost of Health Care Services (sum of 0 124,681 22.00 lines 10, 14, and 21)
COSTS OTHER THAN RHC/FQHC SERVICES
23. 00 Pharmacy 0 0 23. 00
24. 00 Dental 0 0 24. 00
25. 00 Optometry 0 0 25. 00
25. 01 Green the second of t
25. 02 Chronic Care Management
26. 00 All other nonreimbursable costs 0 0 26. 00
27. 00 Nonal Lowabl e GME costs 27. 00
28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 28.00
through 27)
FACI LI TY OVERHEAD
29. 00 Facility Costs 0 512 29. 00
30. 00 Administrative Costs
31.00 Total Facility Overhead (sum of lines 29 and 0 9, 386 31.00
30)
32.00 Total facility costs (sum of lines 22, 28 0 134,067 32.00
and 31)

Heal th Financial Systems

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0001 | Period

20.00 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)

Provider CCN: 14-0001 Peri od: Worksheet M-2 From 07/01/2022 Component CCN: 14-3493 06/30/2023 To Date/Time Prepared: 11/30/2023 12:56 pm RHC I Cost Number of FTE Total Visits Producti vi ty Mi ni mum Greater of col. 2 or Standard (1) Visits (col. Personnel 1 x col. col. 4 1.00 2.00 3.00 4.00 5.00 VISITS AND PRODUCTIVITY Posi ti ons 1 00 4, 200 67, 452 16.06 58, 822 1 00 Physi ci an 2.00 Physician Assistant 2.73 34, 527 2, 100 5, 733 2.00 3.00 Nurse Practitioner 14.26 6, 882 2, 100 29, 946 3.00 4.00 Subtotal (sum of lines 1 through 3) 33.05 100, 231 103, 131 103, 131 4.00 5.00 Visiting Nurse 0.00 C 0 5.00 6.00 Clinical Psychologist 0.00 0 6.00 7.00 Clinical Social Worker 0.40 680 680 7.00 7.01 Medical Nutrition Therapist (FQHC only) 0.00 7.01 C 0 Diabetes Self Management Training (FQHC 7.02 0.00 r 0 7.02 only) 8.00 Total FTEs and Visits (sum of lines 4 33.45 100, 911 103, 811 8.00 through 7) Physician Services Under Agreements 9.00 9.00 0 1.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES Total costs of health care services (from Wkst. M-1, col. 7, line 22) 10 00 19, 400, 569 10 00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 11, 767 11.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 12.00 19, 412, 336 12.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 0. 999394 13.00 13 00 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 1, 780, 968 14.00 Parent provider overhead allocated to facility (see instructions) 11, 551, 972 15.00 16,00 Total overhead (sum of lines 14 and 15) 13, 332, 940 16.00 Allowable GME overhead (see instructions) 17 00 17 00 Ω 18.00 Enter the amount from line 16 13, 332, 940 18.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 13, 324, 860 19.00

In Lieu of Form CMS-2552-10

32, 725, 429 20.00

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20.00 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES Provider CCN: 14-0001 Peri od: Worksheet M-2 From 07/01/2022 Component CCN: 14-8603 06/30/2023 To Date/Time Prepared: 11/30/2023 12:56 pm RHC II Cost Number of FTE Total Visits Producti vi ty Mi ni mum Greater of col. 2 or Standard (1) Visits (col. Personnel col. 4 1 x col. 1.00 2.00 3.00 4.00 5.00 VISITS AND PRODUCTIVITY Posi ti ons 1 00 4, 200 0.64 1,860 2, 688 1 00 Physi ci an 2.00 Physician Assistant 0.01 10 2, 100 2.00 3.00 Nurse Practitioner 1.48 3, 789 2, 100 3, 108 3.00 4.00 Subtotal (sum of lines 1 through 3) 2.13 5, 659 5, 817 5, 817 4.00 5.00 Visiting Nurse 0.00 0 5.00 6.00 Clinical Psychologist 0.00 0 6.00 7.00 Clinical Social Worker 0.00 0 0 7.00 7.01 Medical Nutrition Therapist (FQHC only) 0.00 7.01 C 0 Diabetes Self Management Training (FQHC 7.02 0.00 C 0 7.02 only) 8.00 Total FTEs and Visits (sum of lines 4 2.13 5,659 5, 817 8.00 through 7) Physician Services Under Agreements 9.00 Ω 9.00 1.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES Total costs of health care services (from Wkst. M-1, col. 7, line 22) 10 00 1, 143, 756 10 00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 538 11.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 12.00 1, 144, 294 12.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 0. 999530 13.00 13 00 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 86, 889 14.00 Parent provider overhead allocated to facility (see instructions) 630, 393 15.00 16.00 Total overhead (sum of lines 14 and 15) 717, 282 16.00 Allowable GME overhead (see instructions) 17 00 17.00 Ω 18.00 Enter the amount from line 16 717, 282 18.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 716, 945 19.00

In Lieu of Form CMS-2552-10

1, 860, 701 20.00

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ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES Provider CCN: 14-0001 Peri od: Worksheet M-2 From 07/01/2022 Component CCN: 14-8636 06/30/2023 To Date/Time Prepared: 11/30/2023 12:56 pm RHC III Cost Number of FTE Total Visits Producti vi ty Mi ni mum Greater of col. 2 or Standard (1) Visits (col. Personnel col. 4 1 x col. 1.00 2.00 3.00 4.00 5.00 VISITS AND PRODUCTIVITY Posi ti ons 1 00 913 4, 200 798 0.19 1 00 Physi ci an 2.00 Physician Assistant 0.00 2, 100 2.00 3.00 Nurse Practitioner 0.44 981 2, 100 924 3.00 4.00 Subtotal (sum of lines 1 through 3) 0.63 1, 894 1, 722 1, 894 4.00 5.00 Visiting Nurse 0.00 C 0 5.00 6.00 Clinical Psychologist 0.00 0 6.00 7.00 Clinical Social Worker 0.00 0 0 7.00 7.01 Medical Nutrition Therapist (FQHC only) 0.00 7.01 C 0 Diabetes Self Management Training (FQHC 7.02 0.00 C 0 7.02 only) 8.00 Total FTEs and Visits (sum of lines 4 0.63 1, 894 1, 894 8.00 through 7) Physician Services Under Agreements 9.00 Ω 9.00 1.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES Total costs of health care services (from Wkst. M-1, col. 7, line 22) 10 00 124, 681 10 00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 11.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 12.00 124, 681 12.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 13.00 1 000000 13 00 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 9, 386 14.00 Parent provider overhead allocated to facility (see instructions) 81, 292 15.00 16.00 Total overhead (sum of lines 14 and 15) 90,678 16.00 Allowable GME overhead (see instructions) 17 00 17.00 0 18.00 Enter the amount from line 16 90, 678 18.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 90, 678 19.00 20.00 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19) 215, 359 20.00

In Lieu of Form CMS-2552-10

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GRAHAM HOSPI TAL ASSOCIATION

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Heal th Financial Systems GRAHAM HOSPITAL ASSOCIATION In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC Provider CCN: 14-0001 From 07/01/2022 To 06/30/2023 Date/Time Prepared: 11/30/2023 12: 56 pm

Title XVIII RHC I Cost

	Title X	VIII	RHC I	Cost	
				1 00	
	DETERMINATION OF DATE FOR HOSPITAL DASER BUS /FOUR SERVICES			1. 00	
1. 00	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, I	ino 20)		32, 725, 429	1.00
2. 00	Cost of injections/infusions and their administration (from Wkst. M-4, line	,		724, 327	2.00
3. 00	Total allowable cost excluding injections/infusions (line 1 minus line 2)	, 13)		32, 001, 102	3.00
4. 00	Total Visits (from Wkst. M-2, column 5, line 8)			103, 811	4.00
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			103, 811	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			308. 26	7. 00
			Cal cul ati on	of Limit (1)	
			Rate Period 1	Rate Period 2	
			(07/01/2022	(01/01/2023	
			through	through	
			12/31/2022)	06/30/2023)	
0.00	Day visit as west limit (from CNC Dub. 100 04 shorter 0, 600 / as very		1.00	2. 00	0.00
8. 00 9. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your cor Rate for Program covered visits (see instructions)	itractor)	260. 97 260. 97	270. 88 270. 88	8. 00 9. 00
9.00	CALCULATION OF SETTLEMENT		200. 97	270.00	9.00
10. 00		ecords)	8, 128	7, 996	10.00
11. 00		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	2, 121, 164	2, 165, 956	
12.00	, ,)	0	42	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	11, 377	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	11, 377	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15. 00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	4, 298, 497	
16. 01	Total program charges (see instructions)(from contractor's records)			2, 241, 436	
16. 02	Total program preventive charges (see instructions) (from provider's records	s)		156, 096	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times line 16)	00)		299, 352	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) time (Titles V and XIX see instructions.)	es .80)		3, 001, 532	16. 04
16. 05	Total program cost (see instructions)		0	3, 300, 884	16. 05
17. 00	Primary payer amounts			0, 000, 001	17. 00
18. 00		ctor		247, 230	
	records)				
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from confrecords)	ractor		396, 618	19. 00
20.00	Net Medicare cost excluding vaccines (see instructions)			3, 300, 884	20.00
21. 00	Program cost of vaccines and their administration (from Wkst. M-4, line 16))		118, 740	21.00
22. 00				3, 419, 624	
23. 00	Allowable bad debts (see instructions)			0	23. 00
23. 01	Adjusted reimbursable bad debts (see instructions)			0	23. 01
24.00	3			0	24.00
25. 00				0	25.00
25. 50	Pioneer ACO demonstration payment adjustment (see instructions)			-	25. 50 25. 99
25. 99 26. 00	Demonstration payment adjustment amount before sequestration Net reimbursable amount (see instructions)			0 3, 419, 624	
26. 00	Sequestration adjustment (see instructions)			68, 392	
26. 02	, ,			00, 372	26. 02
27. 00				3, 187, 414	
28. 00				0	28. 00
29. 00	·	3)		163, 818	29.00
30.00		Pub. 15-II,		0	30.00
	chapter I, §115.2		1		

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GRAHAM HOSPI TAL ASSOCIATION

GRAHAM HOSPI TAL ASSOCIATION

ON CHILATION OF DEMONSORMER SETTI FARATE FOR HOSPI TAL ASSOCIATION

Heal th Financial Systems GRAHAM HOSPITAL ASSOCIATION In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC Provider CCN: 14-0001 From 07/01/2022 To 06/30/2023 Date/Time Prepared: 11/30/2023 12: 56 pm

Title XVIII RHC II Cost

		Title XVIII	RHC II	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wks			1, 860, 701	1.00
2.00	Cost of injections/infusions and their administration (from Wkst.			38, 909	2.00
3. 00 4. 00	Total allowable cost excluding injections/infusions (line 1 minus Total Visits (from Wkst. M-2, column 5, line 8)	Tine 2)		1, 821, 792 5, 817	3. 00 4. 00
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5, line	0)		0,617	5.00
6. 00	Total adjusted visits (line 4 plus line 5)	7)		5, 817	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			313. 18	7.00
7, 00	1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1		Cal cul ati on		71.00
			Rate Period 1	Rate Period 2	
			(07/01/2022	(01/01/2023	
			through	through	
			12/31/2022)	06/30/2023)	
			1. 00	2. 00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or	your contractor)	270. 69	280. 97	8.00
9. 00	Rate for Program covered visits (see instructions)		270. 69	280. 97	9. 00
10.00	CALCULATION OF SETTLEMENT Program covered visits excluding mental health services (from con-	tractor records)	387	382	10.00
10. 00 11. 00	Program cost excluding costs for mental health services (line 9 x		104, 757	107, 331	11.00
12. 00	Program covered visits for mental health services (from contractor	,	0	107, 331	12.00
13. 00	Program covered cost from mental health services (line 9 x line 12	,	o	281	13.00
14. 00	Limit adjustment for mental health services (see instructions)	-/	o	281	14.00
15. 00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and	3) *	0	212, 369	16.00
16. 01	Total program charges (see instructions) (from contractor's records	5)		98, 371	16. 01
16. 02	Total program preventive charges (see instructions)(from provider	s records)		7, 848	16. 02
16. 03	Total program preventive costs ((line 16.02/line 16.01) times line			16, 943	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.03 and	d 18) times .80)		140, 923	16. 04
44 05	(Titles V and XIX see instructions.)			457.0//	47.05
16. 05	Total program cost (see instructions)		0	157, 866	16. 05 17. 00
17. 00 18. 00	Primary payer amounts Less: Beneficiary deductible for RHC only (see instructions) (from	om contractor		0 19, 272	
10.00	records)	on contractor		17, 272	10.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instructions)	(from contractor		15, 806	19. 00
	records)	•			
20.00	Net Medicare cost excluding vaccines (see instructions)			157, 866	20.00
21. 00	Program cost of vaccines and their administration (from Wkst. M-4,	line 16)		11, 541	21.00
22. 00	Total reimbursable Program cost (line 20 plus line 21)			169, 407	22.00
23. 00	Allowable bad debts (see instructions)			0	23.00
23. 01	Adjusted reimbursable bad debts (see instructions)			0	23. 01
24. 00		ons)		0	24.00
25. 00 25. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)			0	25. 00 25. 50
25. 99	Demonstration payment adjustment amount before sequestration			0	25. 99
26. 00	Net reimbursable amount (see instructions)			169, 407	
26. 01	Sequestration adjustment (see instructions)			3, 388	
26. 02				0, 330	26. 02
27. 00	Interim payments			135, 700	
28. 00	Tentative settlement (for contractor use only)			0	28. 00
29. 00		27, and 28)		30, 319	29. 00
30.00	Protested amounts (nonallowable cost report items) in accordance v	vith CMS Pub. 15-II,		0	30. 00
	chapter I, §115.2				

Health Financial Systems GRAHAM HOSPI TAL CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FOHC Provider CCN: 14-0001 Peri od:

From 07/01/2022 Component CCN: 14-8636 06/30/2023 Date/Time Prepared: 11/30/2023 12:56 pm Title XVIII RHC III Cost 1.00 DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20) 215, 359 Cost of injections/infusions and their administration (from Wkst. M-4, line 15) 2.00 11, 136 2.00 Total allowable cost excluding injections/infusions (line 1 minus line 2) 204. 223 3.00 3 00 4.00 Total Visits (from Wkst. M-2, column 5, line 8) 1,894 4.00 5.00 Physicians visits under agreement (from Wkst. M-2, column 5, line 9) 0 5.00 Total adjusted visits (line 4 plus line 5) 6.00 1.894 6.00 107.83 7.00 Adjusted cost per visit (line 3 divided by line 6) 7.00 Calculation of Limit (1) Rate Period 1 Rate Period 2 (01/01/2023 (07/01/2022 through through 12/31/2022) 06/30/2023) 1. 00 2. 00 8.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor) 113.00 126.00 8.00 Rate for Program covered visits (see instructions) 107. <u>83</u> 9.00 107.83 9.00 CALCULATION OF SETTLEMENT Program covered visits excluding mental health services (from contractor records) 10.00 0 10.00 Program cost excluding costs for mental health services (line 9 x line 10) 0 11 00 0 11 00 12.00 Program covered visits for mental health services (from contractor records) 0 12.00 Program covered cost from mental health services (line 9 x line 12) 0 0 13.00 14.00 Limit adjustment for mental health services (see instructions) 0 0 14.00 Graduate Medical Education Pass Through Cost (see instructions) 15 00 15 00 16.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) * 0 0 16.00 Total program charges (see instructions)(from contractor's records) 0 16.01 16.02 Total program preventive charges (see instructions)(from provider's records) 0 16.02 Total program preventive costs ((line 16.02/line 16.01) times line 16) 16.03 16.03 0 Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) 0 16.04 (Titles V and XIX see instructions.) Total program cost (see instructions) 0 0 16.05 17.00 Primary payer amounts 0 17.00 18.00 Less: Beneficiary deductible for RHC only (see instructions) (from contractor 0 18.00 19.00 Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor 0 19.00 records) 20 00 Net Medicare cost excluding vaccines (see instructions) 0 20.00 21.00 Program cost of vaccines and their administration (from Wkst. M-4, line 16) 2, 198 21.00 Total reimbursable Program cost (line 20 plus line 21) 2, 198 22.00 Allowable bad debts (see instructions) 23.00 0 23.00 Adjusted reimbursable bad debts (see instructions) 23.01 0 23.01 24.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 24.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 25.00 Pioneer ACO demonstration payment adjustment (see instructions) 25. 50 25.50 0 25.99 Demonstration payment adjustment amount before sequestration 0 25.99 Net reimbursable amount (see instructions) 2, 198 26.00 26.00 Sequestration adjustment (see instructions) 26. 01 26, 01 44 26.02 Demonstration payment adjustment amount after sequestration 0 26.02

In Lieu of Form CMS-2552-10

Worksheet M-3

0

0 28.00

0 30.00

2, 154

27.00

29.00

27.00

28.00

29.00

30.00

Interim payments

chapter I, §115.2

Tentative settlement (for contractor use only)

Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)

Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II,

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Heal th Fi nanci al Systems GRAHAM HOSPITAL ASSOCIATION COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST Provider CCN: 14-0001 Period:

columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)

From 07/01/2022 Component CCN: 14-3493 То 06/30/2023 Date/Time Prepared: 11/30/2023 12:56 pm Title XVIII RHC I Cost PNEUMOCOCCAL INFLUENZA COVI D-19 MONOCLONAL VACCI NES **VACCINES** VACCI NES ANTI BODY **PRODUCTS** 1.00 2.00 2.01 2.02 17, 429, 333 1.00 Health care staff cost (from Wkst. M-1, col. 7, line 10) 17, 429, 333 17, 429, 333 17, 429, 333 1.00 Ratio of injection/infusion staff time to total health 2.00 0.001071 0.001818 0.000000 0.000000 2.00 care staff time 3.00 Injection/infusion health care staff cost (line 1 x line 18,667 31, 687 0 3.00 47, 013 4.00 Injections/infusions and related medical supplies costs 332,028 0 4.00 (from your records) Direct cost of injections/infusions (line 3 plus line 4) 5 00 350 695 78 700 5 00 0 6.00 Total direct cost of the hospital-based RHC/FQHC (from 19, 400, 569 19, 400, 569 19, 400, 569 19, 400, 569 6.00 Worksheet M-1, col. 7, line 22) 7.00 Total overhead (from Wkst. M-2, line 19) 13, 324, 860 13, 324, 860 13, 324, 860 7.00 13, 324, 860 Ratio of injection/infusion direct cost to total direct 0. 018077 0.000000 0.004057 0.000000 8.00 8.00 cost (line 5 divided by line 6) 9.00 Overhead cost - injection/infusion (line 7 x line 8) 240, 873 54,059 9.00 10.00 Total injection/infusion costs and their administration 591, 568 132, 759 0 0 10.00 costs (sum of lines 5 and 9) 11 00 Total number of injections/infusions (from your records) 1 513 2 569 11 00 0 12.00 Cost per injection/infusion (line 10/line 11) 390.99 51.68 0.00 0.00 12.00 13.00 Number of injection/infusion administered to Program 215 671 13.00 0 benefi ci ari es Number of COVID-19 vaccine injections/infusions 13.01 0 0 13.01 administered to MA enrollees Program cost of injections/infusions and their 14.00 84,063 34,677 0 14.00 administration costs (line 12 times the sum of lines 13 and 13.01, as applicable) COST OF INJECTIONS / INFUSIONS AND ADMI NI STRATI O Ν 1.00 2.00 15.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 724 327 15.00 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2) Total Program cost of injections/infusions and their administration costs (sum of 118, 740 16.00

In Lieu of Form CMS-2552-10

Worksheet M-4

Heal th Financial Systems

GRAHAM HOSPITAL ASSOCIATION

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-0001 | Period:

columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)

From 07/01/2022 Component CCN: 14-8603 То 06/30/2023 Date/Time Prepared: 11/30/2023 12:56 pm Title XVIII RHC II Cost PNEUMOCOCCAL INFLUENZA COVI D-19 MONOCLONAL VACCI NES **VACCINES** VACCI NES ANTI BODY **PRODUCTS** 1.00 2.00 2.01 2.02 1, 035, 280 1.00 Health care staff cost (from Wkst. M-1, col. 7, line 10) 1, 035, 280 1, 035, 280 1, 035, 280 1.00 Ratio of injection/infusion staff time to total health 2.00 0.000845 0.002234 0.000000 0.000000 2.00 care staff time 3.00 Injection/infusion health care staff cost (line 1 x line 875 2.313 0 3.00 4.00 Injections/infusions and related medical supplies costs 17,051 3,678 0 4.00 (from your records) Direct cost of injections/infusions (line 3 plus line 4) 5 00 17, 926 5 991 5 00 0 6.00 Total direct cost of the hospital-based RHC/FQHC (from 1, 143, 756 1, 143, 756 1, 143, 756 1, 143, 756 6.00 Worksheet M-1, col. 7, line 22) 7.00 Total overhead (from Wkst. M-2, line 19) 716, 945 7.00 716, 945 716, 945 716, 945 Ratio of injection/infusion direct cost to total direct 0.000000 0.000000 8.00 0.015673 0.005238 8.00 cost (line 5 divided by line 6) 9.00 Overhead cost - injection/infusion (line 7 x line 8) 11, 237 3, 755 0 9.00 10.00 Total injection/infusion costs and their administration 29, 163 9,746 0 0 10.00 costs (sum of lines 5 and 9) 11 00 Total number of injections/infusions (from your records) 201 11 00 76 0 12.00 Cost per injection/infusion (line 10/line 11) 383.72 48.49 0.00 0.00 12.00 13.00 Number of injection/infusion administered to Program 23 56 13.00 0 benefi ci ari es Number of COVID-19 vaccine injections/infusions 13.01 0 0 13.01 administered to MA enrollees Program cost of injections/infusions and their 14.00 8,826 2,715 0 14.00 administration costs (line 12 times the sum of lines 13 and 13.01, as applicable) COST OF INJECTIONS / INFUSIONS AND ADMI NI STRATI O 1.00 2.00 15.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 38 909 15.00 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2) Total Program cost of injections/infusions and their administration costs (sum of 11, 541 16.00

In Lieu of Form CMS-2552-10

Worksheet M-4

Heal th Fi nanci al Systems GRAHAM HOSPITAL ASSOCIATION

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST Provider CCN: 14-0001 Period:

columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)

Worksheet M-4 From 07/01/2022 Component CCN: 14-8636 06/30/2023 Date/Time Prepared: 11/30/2023 12:56 pm Title XVIII RHC III Cost PNEUMOCOCCAL INFLUENZA COVI D-19 MONOCLONAL VACCI NES **VACCINES VACCINES** ANTI BODY **PRODUCTS** 2.00 1.00 2.01 2.02 1.00 Health care staff cost (from Wkst. M-1, col. 7, line 10) 112, 875 112, 875 112, 875 112, 875 1.00 Ratio of injection/infusion staff time to total health 2.00 0.000790 0.002746 0.000000 0.000000 2.00 care staff time 3.00 Injection/infusion health care staff cost (line 1 x line 89 310 0 3.00 4.00 Injections/infusions and related medical supplies costs 4,712 1, 336 0 4.00 (from your records) Direct cost of injections/infusions (line 3 plus line 4) 5 00 5 00 4 801 1,646 0 6.00 Total direct cost of the hospital-based RHC/FQHC (from 124, 681 124, 681 124, 681 124, 681 6.00 Worksheet M-1, col. 7, line 22) 7.00 Total overhead (from Wkst. M-2, line 19) 90, 678 7.00 90,678 90,678 90,678 Ratio of injection/infusion direct cost to total direct 0.000000 0.038506 0.000000 8.00 0.013202 8.00 cost (line 5 divided by line 6) 9.00 Overhead cost - injection/infusion (line 7 x line 8) 3, 492 1, 197 9.00 10.00 Total injection/infusion costs and their administration 8, 293 2,843 0 0 10.00 costs (sum of lines 5 and 9) 11 00 Total number of injections/infusions (from your records) 11 00 73 0 12.00 Cost per injection/infusion (line 10/line 11) 394.90 38.95 0.00 0.00 12.00 13.00 Number of injection/infusion administered to Program 26 13.00 0 benefi ci ari es Number of COVID-19 vaccine injections/infusions 13.01 0 0 13.01 administered to MA enrollees Program cost of injections/infusions and their 14.00 1, 185 1,013 0 14.00 administration costs (line 12 times the sum of lines 13 and 13.01, as applicable) COST OF INJECTIONS / INFUSIONS AND ADMI NI STRATI O 1.00 2.00 15.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 15.00 11 136 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of injections/infusions and their administration costs (sum of 2, 198 16.00

In Lieu of Form CMS-2552-10

GRAHAM HOSPI TAL

In Lieu of Form CMS-2552-10 Provi der CCN: 14-0001

Health Financial Systems

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FOHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES Component CCN: 14-3493

			RHC I	Cost	
		·	Par	rt B	
			mm/dd/yyyy	Amount	
			1.00	2. 00	
00	Total interim payments paid to hospital-based RHC/FQHC		1.00	3, 187, 414	1.
00	Interim payments payable on individual bills, either submi	: ++ad an +a ba aubmi ++ad +a		3, 167, 414	2.
00	the contractor for services rendered in the cost reporting			0	~
	,	g period. II none, write			
	"NONE" or enter a zero				
00	List separately each retroactive lump sum adjustment amoun				3
	revision of the interim rate for the cost reporting period	d. Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				ļ
	Program to Provider				
)1				0	3
)2				0	3
)3				0	3
)4				0	3
)5				0	3
-	Provider to Program				1
0	110vruer to 110grum			0	3
1					3
2					3
				_	
3				0	3
54				0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-			0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (train	nsfer to Worksheet M-3, line		3, 187, 414	4
	27)]
	TO BE COMPLETED BY CONTRACTOR				
00	List separately each tentative settlement payment after de	esk review. Also show date of			5
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
01				0	5
)2				0	5
3				0	5
-	Provider to Program		·		1
0				0	1 5
1					5
2					5
9	Subtatal (sum of lines E O1 E 40 minus sum of lines E E0	E 00)			
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-				5
0	Determined net settlement amount (balance due) based on the	ne cost report. (1)			6
1	SETTLEMENT TO PROVI DER			163, 818	1
2	SETTLEMENT TO PROGRAM			0	6
0	Total Medicare program liability (see instructions)			3, 351, 232	7
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	
00	Name of Contractor	NATIONAL GOVERNMENT SERVICES			8
-		INC.			آ
		1	1	1	

GRAHAM HOSPI TAL

In Lieu of Form CMS-2552-10

Health Financial Systems

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FOHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES Provider CCN: 14-0001 Component CCN: 14-8603

			RHC II	Cost		
			Par	t B		
			mm/dd/yyyy	Amount		
			1, 00	2, 00		
1. 00	Total interim payments paid to hospital-based RHC/FQHC		1.00	135, 700	1. 00	
2. 00				133, 700	2. 00	
2.00				٩	2.00	
	the contractor for services rendered in the cost reporting p	perioa. It none, write				
	"NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment amount				3. 00	
	revision of the interim rate for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider		<u>'</u>			
3. 01				0	3. 01	
3. 02				0	3. 02	
				-		
3. 03				0	3. 03	
3.04				0	3. 04	
3.05				0	3.05	
	Provider to Program					
3.50				0	3.50	
3. 51				o	3. 51	
3. 52				ő	3. 52	
				0		
3. 53				-	3. 53	
3. 54				0	3. 54	
3. 99					3. 99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transf	fer to Worksheet M-3, line		135, 700	4.00	
	27)					
	TO BE COMPLETED BY CONTRACTOR					
5.00						
each payment. If none, write "NONE" or enter a zero. (1)					5. 00	
F 01	Program to Provider			0	F 01	
5. 01				0	5. 01	
5. 02				0	5. 02	
5.03				0	5. 03	
	Provi der to Program					
5.50				0	5. 50	
5. 51				ol	5. 51	
5. 52				o l	5. 52	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5. 99	
	Determined net settlement amount (balance due) based on the cost report. (1)			١		
6.00				20 212	6.00	
6. 01	SETTLEMENT TO PROVI DER			30, 319	6. 01	
6. 02	SETTLEMENT TO PROGRAM			0	6. 02	
7. 00	Total Medicare program liability (see instructions)			166, 019	7.00	
			Contractor	NPR Date		
			Number	(Mo/Day/Yr)		
		0	1. 00	2.00		
8. 00	Name of Contractor	<u> </u>		2.00	8. 00	
5. 00	Traine of contractor		1	·	0.00	

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Heal th Financial Systems GRAHAM HOSPITAL ASSOCIATION In Lieu of Form CMS-2552-10

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FOHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Component CCN: 14-8636

RHC III

Cost

Cost

			RHC III	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1.00	2. 00	
1. 00	Total interim payments paid to hospital-based RHC/FQHC		11.00	0	1. 00
2. 00	Interim payments payable on individual bills, either submitt	ad ar to be submitted to		0	2. 00
2.00	the contractor for services rendered in the cost reporting p			ď	2.00
		erroa. Il none, write			
0.00	"NONE" or enter a zero				0.00
3.00	List separately each retroactive lump sum adjustment amount				3.00
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
3. 01				0	3. 01
3.02				0	3. 02
3.03				ol	3.03
3.04				ol	3.04
3. 05				0	3. 05
0.00	Provider to Program				0.00
3. 50	Trovider to rrogiam			0	3. 50
3. 51				0	3.5
3. 52				0	3. 5
3. 53				0	3. 5
3. 54				0	3. 5
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	3. 9
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transf	er to Worksheet M-3, line		0	4.00
	27)				
	TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk	review. Also show date of			5.00
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
5. 01	Trogram to Trovidor			0	5.01
5. 02				0	5. 02
5. 02				0	5. 0.
5. 03	Dec. 1 Least December			U	5.0
	Provider to Program		I		
5. 50				0	5. 50
5. 51				0	5. 5
5. 52				0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5. 9
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)				6.0
6. 01	SETTLEMENT TO PROVIDER			2, 154	6.0
6. 02	SETTLEMENT TO PROGRAM			0	6. 02
7. 00	Total Medicare program liability (see instructions)			2, 154	7. 0
,. 00	Total modificate program trabitity (see thistractions)		Contractor	NPR Date	7.00
		0	Number	(Mo/Day/Yr)	
8. 00		0	1. 00	2. 00	
	Name of Contractor		1		8.00